NATIONAL SURVEY OF

COUNSELING CENTER DIRECTORS

1995

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MONOGRAPH SERIES

The publisher of this monograph is the International Association of Counseling Services (IACS).

As the accrediting agency for counseling centers in a wide variety of settings, the primary objective for the Association is the maintenance of quality service delivery. The basic purposes of the Association are to encourage and aid counseling centers and agencies to meet high professional standards, to inform the public about those that are competent and reliable, and to foster communication among the centers and agencies.

Titles in The Professional Series are selected to meet the needs of IACS members.

Steve Sena, Series Editor

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OVERVIEW

The National Survey of Counseling Center Directors has been conducted since 1981 and includes data provided by the administrative heads of college and university counseling centers in the United States and Canada. It began as a project of the Urban Task Force of the Association of University and College Counseling Center Directors, and is now a joint endeavor of AUCCCD and the International Association of Counseling Services.

The survey attempts to stay abreast of current trends in counseling centers, and to provide counseling center directors with ready access to the opinions and solutions of colleagues to problems and challenges in the field. The areas addressed cover a range of concerns including budget trends, current concerns, innovative programming, and a number of other administrative, ethical and clinical issues.

This year the total data will be shown separately followed by the data broken down by institution size. Some feedback will be appreciated as to whether this format works better than having the total data and the size breakdown on the same page. Some additional breakdowns for other groupings (e.g., AAU, AASCU) will be available later on request.

Responses to certain items are coded, allowing opportunity for directors to contact colleges for further information on programs or initiatives that they have undertaken. A directory of all participants is provided to assist with these networking opportunities.

The 1995 survey includes data provided by directors fro m 321 counseling centers, representing institutions from 47 states and 6 provinces.

Survey Highlights 1995
N= 321

The following highlights are based on total data only. Please note that additional comments are provided with the data summary.

9.0% of Centers charge students for personal counseling and generate anywhere from $1,500 to $55,000 a year. (Item 1)

7.2% of Centers reported collecting third party payments for individual session fees (up 2.4% since 1994.) (Item 2)

36.4% of Centers provide a national testing service (up 4.4% from 1992). 32% of the Centers use the income to support testing services and other Center programs. (Items 4 & 5)

28% of Centers are at least partially supported by a mandatory fee (up 3% from 1991). (Item 6)

32.4% of Centers took a budget cut last year (down 7% from 1994 and 11.8% from 1993). (Item 8)

Institutions considering downsizing (26.2%) or reorganizing (43.3%) Student Affairs, or downsizing (12.5%) or reorganizing (19.6%), or privatizing (15.3%) Counseling Centers. 6.2% of Directors feel that there is a real possibility of outsourcing on their campus (up from 2.9% from 1994). (Items 10 & 11)

48.6% of Directors feel that case notes should be maintained only in a central office file (up 10% from 1991). 92% of Directors see it as mandatory that they are able to access files in a counselor's absence (up 5% from 1991). (Items 13 & 14)

24% of Centers reported that there has been an increase in clients asking to view case records in recent years. 53.6% of Centers typically provide such access. (Items 15 & 16)

29.6% of Centers have a policy on what should/should not be included in case notes to protect against a court-ordered opening of records. 69 Centers will share policies. (Items 17 & 18)

85.7% of Centers provide written materials to clients explaining limits to confidentiality. (Item 19)

About 70% of Centers do not inform students about possible future pressure on them to release their records to potential government employers or to State Bar Associations. Most Directors (60%) feel that to so inform, might influence students' openness and/or participation in counseling. (Items 20 & 21)

Almost 74% of Directors favor a professional standard stating that psychologists and counselors are not permitted to release student records to anyone other than another treating professional. (Item 22)

28% of Centers have had records or counselors subpoenaed in the past year (up 14% since 1991). See item 24 for subpoena examples. (Items 24 &26)

21 (6.5%) Directors had to discipline or terminate a counselor or intern in the past year due to unethical practice (a 3.9% increase from 1994). See Appendix A for examples of other ethical/legal issues faced. (Items 30 & 31)

11.2% of Centers would provide services to a student from another college and 20.6% of Centers would provide services to non-students (e.g. children of faculty, occasional walk-ins). Two-thirds of these assume this risk without assurance of institutional support. (Items 33-35)

36% of Centers have malpractice insurance paid for by the institution, 35.5% have general institutional insurance offered to all employees and in 22% of Centers, the counselors pay their own insurance. (Item 36)

37.7% of Centers gained a new staff position and 19.3% lost a staff position without replacement. This is similar to the percentages of 1994 and represents a shift from 1992 and 1993 when more positions were lost then gained. (Items 37 & 38)

Average salary information for different professionals including breakdowns for length of employment, are available in Items 39-41. The 2:1 female to male ratio for hires has continued now for the fourth straight year.

40% of Directors hold academic rank at their institution. 16.5% of Directors are eligible for tenure and 26.8% are eligible for sabbaticals. (Item 42)

In 15.6% of the schools, other Center therapists hold faculty appointments, and 18.4% of the Centers have staff that are eligible for sabbaticals. (Items 43 & 44)

11% of Centers give counselors one-half day per week or more for consultation (down 3.4% from 1991). 25.2% of Centers allow counselors to use their offices for after-hours private practice (up 1.2% from 1993). (Items 45 & 46)

55.5% of schools provide psychiatric services on campus (down 3.5% from 1994). (Item 47)

Almost 49% of Centers require that a client who receives medication from an on-campus psychiatrist be followed by the Counseling Center for psychotherapy. (Item 49)

44.2% of Centers contract with staff on how to spend their time. (Item 52)

54.2% of Centers count client cancellations/no-shows as part of a counselor's hour count. (Item 56).

54.4% of Centers limit the number of counseling sessions allowed a client (no change from 1994). Of those who limit sessions, 55.5% of Centers will see clients over the limit for a crisis situation, 46.4% will see the client for a second series of sessions in the following year, and 44.2% of Centers will see clients each year for a series of time-limited sessions. (Items 57 & 58)

To more effectively manage their caseloads: 65% of Centers see students in therapy less than once a week, 32% reduce the number of students seen more than once a week, 30% no longer have holding appointments for students, and 27% assign more students to groups directly from the intake. See item for additional actions. (Item 61)

77.3% of Centers collect written evaluations from clients (up 8% from 1992). In 19% of the Centers, the evaluation forms are distributed by the counselors which may raise some questions about the validity of the results. (Items 62-64)

82% of Centers report an increase in clients with severe psychological problems. However, since 1992, fewer Directors are reporting an increase in waiting list problems (down 21.6%) and sexual assault cases (down 31.8%). See item 65 for listing of other concerns.

81% of Centers had to hospitalize a student for psychological reasons in the past year (steady for last 3 years). Information is provided on when directors would notify parents. (Items 66-68)

41% of schools had a student suicide in the past year (up 6% from 1994 and up 13% from 1991). 31 Centers (10%) had a client suicide (up 4% from 1994), with three Centers reporting legal actions against them. (Items 69-72)

55% of Centers had to notify a third party about a potentially suicidal student during the past year and 21% of Centers gave Tarasoff type warnings. (Items 73 & 74)

58% of Directors noticed an increase in violent incidents involving students over the past five years. (Item 75)

61% of Centers have written polices on dealing with potentially suicidal students (up 15% from 1994), 44% have policies for dealing with potentially violent students and policies for outlining types of problems accommodated by the Counseling Center and 37% have policies for having a psychotic student hospitalized and for having an emotionally disturbed student removed from the residence halls or school. Only 20% have written statements about the risks of counseling. 67% of Centers were willing to share their policies with other Centers. (Item 76)

88% of Directors will refer clients following intake when there is a lack of staff expertise in the client's problem area, 81% will refer for longer term treatment, and 25% will refer clients if they have insurance which covers their treatment. (Item 78)

84% of Centers have seen students in the past year due to sexual exploitation or harassment by another student, 65% from a faculty member or supervisor, and 16.5% from another therapist. (Item 79)

44.5% of Centers have special programs for gay, lesbian, and bisexual students (up 8% from 1990); 41% for racial minorities, 32% for international students, 9% for single mothers, and 8% for the financially disadvantaged. (Item 80)

91% of Centers have not reviewed APA ethical guidelines for working with multicultural students, and 93.5% of Directors feel that their staff is not well-versed about these guidelines. (Items 81 & 82)

30% of Directors feel that the number of students seeking help for eating disorders is increasing (up 13% from 1994), 11% think there is a decrease (down 8% from 1994), and 58% report no change (down 4% from 1994). (Item 83)

43% of Centers have seen one or more HIV positive clients within the past year. 17% of Directors felt that they had HIV positive clients who posed a potential risk to a third party. Of these, just over 2% found it necessary to warn a third party. See item for comments. (Items 84 & 85)

50% of Directors would encourage disclosures but take no further action if an HIV positive client states that he/she has not informed his/her partner of the health situation (down 6% from 1994). Another 30% would inform the client that if he/she did not inform partner, the Director would be ethically bound to do so. 1% would take no action and the rest indicated "other" which included such actions as: obtaining legal counsel, evaluating safe sex practices, and involving a public health agency. (Item 86)

73% of Directors have noticed an increase in the number of students who report having been sexually abused as children, and 80% believe that these students present more serious psychological problems than other clients. 40.5% of Centers have had in-service training on abuse issues for staff within the past year. 50% of Centers offer groups for students who have been sexually abused (up 11% since 1992). (Items 87-90)

20% of Centers have reported to child welfare agencies on a client who had been abused in the past (up 3% from 1990), 10% reported on clients who were being abused concurrent with counseling, 9% reported on a client who had previously abused a child, and 9% reported on a client who was abusing a child concurrent with counseling (down 7.5% from 1990). (Item 91)

31 Centers (10%) had counseling staff who were legally involved in cases to support clients who were child abuse victims. 6 Centers (2%) had staff testify on behalf of clients who had perpetrated abuse. (Item 92)

About 33% of Centers routinely inquire about prior sexual abuse during assessment of clients. Another 5% ask only female clients about prior sexual abuse. (Item 93)

17 Centers have policies or procedures about how to handle reports of recovered memories of childhood sexual abuse. 60% of Centers have briefly addressed the recovered and false memory controversy, 27% have had frequent discussions and/or training, and 12.5% have never discussed the topic. (Items 94 & 95)

41% of Centers accept mandated referrals for assessment and counseling, and another 41% accept referrals for assessment only. 17% of Centers accept no mandated referrals. (Item 96) See vol 9, no. 4 of the 1995 Journal of College Student Psychotherapy for a good debate on this issue.

41% of Centers will see a student who was mandated due to a drug and alcohol problem for one visit, 34% will see the student for a series of mandatory sessions, and 18% accept no such referrals. Of those Centers that see mandatory drug and alcohol cases, 60% report moderate success, 3% report great success and 34% report a lack of success. (Item 97)

22% of schools have received a FIPSE grant through the Counseling Center (up 8% from 1990), 12.5% through the Health Center (up 5% from 1990) and 26% through another office. 12% of schools have had other external grants to support alcohol-related programming. (Items 99 & 100)

Methods which schools have used to reduce alcohol use include the following: 87.5% have implemented on-campus prevention programs, 77% have implemented policy changes, 62% make off-campus referrals to treatment programs, and 37% have on-campus treatment programs. (Item 101)

79% of schools have used peer education to address alcohol-related problems on campus, 57% have used social marketing , 48% have increased regulation of the Greek system, and 46% have adopted a low tolerance policy for alcohol related crimes. (Item 102)

23% of schools offer alcohol free floors in residence halls, 23% of schools have totally alcohol-free residence halls, 17% have select alcohol-free residence halls, and 4% have contracted alcohol-free rooms. (Item 103)

40.5% of Directors feel that the level of alcohol use has not changed in the past five years, 23% feel that there is an increase in all levels of drinking, and 22% feel that there has been an increase in binge drinking. Only 4% feel that there has been a decrease in all levels of drinking, and 4% feel that there has been a decrease in binge drinking only. (Item 104)

54% of Centers have increased emphasis on short-term counseling to prepare for managed care. Other popular actions include the following: 22% require more detailed documentation of treatment progress, 21% have increased emphasis on quality assurance and utilization review methods, 19% use DSM coding on most/all clients, and 16% require written treatment plans. (Item 105)

See Appendix D for a listing of innovative programs or projects. (Item 106)

1995 DIRECTORS' SURVEY SUMMARY DATA

Raw data reported outside brackets (frequency data inside)

NOTE ON INTERPRETING THIS SUMMARY: There is missing data for nearly every question in this year's survey: most Directors skip a question or two. The result is that percentages may not add up to 100 for some questions. Please assume that the differences indicate missing data, or "no response" to a question. Numbers correspond to questions on survey, those that have been omitted are highlighted in comments. Thank you!

DEMOGRAPHIC INFORMATION

Directors' Gender

Male	187	(58.3%)
Female	134	(41.7%)

Directors' Racial/Ethnic Identification

African American	11	(3.4%)
Asian American	2	(0.6%)
Hispanic American	9	(2.8%)
Native American	0	(0.0%)
White/Caucasian	297	(92.5%)
Other	2	(0.6%)
No response	0	(0.0%)

		TOTAL (N=321)		COMMENTS
1.	Centers that charge fees for the following services:			
a)	Personal counseling to students	29	(9.0%)	$\bar{x}$=$21,310 Range 1500 to 55717
b)	Personal counseling to faculty/staff	12	(3.7%)	$\bar{x}$=$16,642 Range 300 to 112,837
c)	Personal counseling to alumni	6	(1.9%)	N/A
d)	Personal counseling to community	8	(2.5%)	$\bar{x}$=$500 (one center responded)
e)	Career counseling to students	15	(4.7%)	$\bar{x}$=$8,066 Range 400 to 35000
f)	Career counseling to faculty/staff	17	(5.3%)	$\bar{x}$=$1,060 Range 100 to 5000
g)	Career counseling to alumni	30	(9.3%)	$\bar{x}$=$419 Range 60 to 1200
h)	Career counseling to community	27	(8.4%)	$\bar{x}$=$662 Range 100 to 3220
i)	Career testing to students	61	(19.0%)	$\bar{x}$=$2,446 Range 40 to 35000
j)	Career testing to faculty/staff	36	(11.2%)	$\bar{x}$=$269 Range 23 to 1000
k)	Career testing to alumni	50	(15.6%)	$\bar{x}$=$332 Range 20 to 1700
l)	Career testing to community	40	(12.5%)	$\bar{x}$=$723 Range 23 to 4000
m)	Personality testing to students	50	(15.6%)	$\bar{x}$=$2,101 Range 25 to 35000
n)	Personality testing to faculty/staff	20	(6.2%)	$\bar{x}$=$454 Range 25 to 2000
o)	Personality testing to alumni	12	(3.7%)	$\bar{x}$=$87 Range 25 to 150
p)	Personality testing to community	15	(4.7%)	$\bar{x}$=$262 Range 25 to 500
2.	Centers which collect third party payments for personal counseling:	23	(7.2%)	This is up 2.4% since 1994, but is still well below the 15% of Centers collecting such fees in 1988.
3.	Centers that provide the following services: (Directors checked all that applied)			
a)	National tests (eg. GMAT, GRE, LSAT, CLEP)	117	(36.4%)	The range of income generated by these services is from $30-150,000. Mean = $8,696.
b)	Scoring for faculty exams	14	(4.4%)	
c)	Evaluation of teaching	8	(2.5%)	
d)	Consultation for students on testing	88	(27.4%)	
5.	When applicable, the income generated by testing programs:			
a)	Supports testing services	39	(28.2%)	Percentages based on those responded to item. Other responses: money went directly to staff, used for travel or seminar expenses, buying software and computer equipment, petty cash funds, or as an aid in balancing the Center's budget.
b)	Supports testing program and other Center programs	58	(42.0%)	
c)	Goes back into general funds	28	(20.2%)	
d)	Other	13	(9.4%)	
6.	Centers that receive support through a mandated fee:	90	(28.0%)	Mandated fees have climbed gradually from 24.5% in 1991 to 28% in 1995. While this is an effective way of funding programs it is becoming more difficult to establish because fees have been introduced for so many other services. It should be noted however, that in large schools, mandated fees support 43% of Centers (up 7% since 1993).
7.	For Centers supported by any mandatory fee: (% based ONLY on responses to this question)			
a)	less than 25% of budget covered	12	(13.3%)	
b)	25-49% of budget covered	14	(15.6%)	
c)	50-74% of budget covered	13	(14.4%)	
d)	75-100% of budget covered	49	(54.4%)	
8.	Centers that took a budget cut in 1994-1995:	104	(32.4%)	Shows a 7% decrease from 1994 and a 11.8% decrease from 1993. Perhaps because earlier reductions have made it difficult to cut further.
9.	How these budget cuts affected Centers (Directors checked all responses that applied):			
a)	reduced staff	26	(25.0%)	Other responses included: limits on hiring temporary staff, demoralization, frozen operating costs, cuts on payment of malpractice insurance and the charging of session fees.
b)	little or no salary increases	42	(40.4%)	
c)	education in salaries	5	(4.8%)	
d)	reduced "other costs" budget	81	(77.9%)	
e)	other	11	(10.6%)	

		TOTAL (N=321)		COMMENTS
10.	Institutions considering the following: (Directors checked all responses that applied)			Each of these reflects a decrease since 1994 except for privatizing/outsourcing which shows a 5% increase. New York State employees have been protected from privatization by a state law (Taylor law) however current negotiations are threatening this. One university reported returning services to campus after several years of outsourcing. Another college is partially outsourced by development of community outreach center through behavioral sciences however communication and client transfer posed problems.
	a) Downsizing Student Affairs	84	(26.2%)	
	b) Reorganizing Student Affairs	139	(43.3%)	
	c) Downsizing the Counseling Center	40	(12.5%)	
	d) Reorganizing the Counseling Center	63	(19.6%)	
	e) Outsourcing/Privatizing the Counseling Center	49	(15.3%)	
11.	Directors that feel there is a real possibility that outsourcing/privatization may happen on their campus:	20	(6.2%)	In 1994 only 9 out of 310 Directors (2.9%) felt outsourcing was a real threat compared with 6.2% this year, a significant increase.
13.	Directors that support the following Counseling Center policies on case notes:			Since 1991 there was a 10% increase in the number of Directors that believed client files should be maintained in a central file. Three Directors suggested that case notes should be kept by the counselor while the case is active and stored centrally thereafter. 92.5% of Directors see it as mandatory that be able to access files in a counselor's absence.
	a) Case notes should be kept only at the discretion of the counselor	9	(2.8%)	
	b) Case notes should be kept on each client, but should remain under the care of the client's counselor	11	(11.2%)	
	c) Case notes should be maintained only in a central office file	156	(48.6%)	
	d) Case notes should be maintained in either a central file or they in counselor's offices, depending on what works best for the Center.	115	(35.8%)	
15.	Centers where there has been an increase in clients asking to view case records in recent years:	77	(24.0%)	
16.	Centers that typically provide clients with access to counselors' reports or case notes on request:	172	(53.6%)	Directors should know their state laws concerning whether clients have a legal right to view their records.
17.	Centers that have developed a policy on what should or shouldn't be included in case notes to protect against a court-ordered opening of records:	95	(29.6%)	Write for a listing of Centers that are willing to share policies.
19.	Centers that provide written materials to clients explaining limits to confidentiality:	275	(85.7%)	This reflects a 21.7% increase since 1988.
20.	Centers that inform students that in the future, they may be pressured to sign release of information forms if seeking employment in government agencies or admittance to the Bar:	95	(29.6%)	193 Directors (60%) believe that if this information were provided, many students might not seek counseling, or be less open in counseling.
22.	Directors in favor of a professional standard stating that psychologists and counselors are not permitted to release student records to anyone other than another treating professional (barring a court order), even with the signed release of the client/patient:	237	(73.8%)	CA and VA Centers reported that this violates state laws. One Center advocated use of the ADA Act to prevent mental health discrimination. Several Centers reported that it is the client's right to decide. There was a question about releasing records to an insurance company for possible viewing by non-professionals.
23.	Directors who feel that it would be a good idea to establish a small group to work on developing a statement in support of limited release of information:	268	(83.5%)	
24.	Centers that have had records or counselors subpoenaed in the past year:	90	(28.0%)	This shows a 14% increase from 1991. The most common subpoenas dealt with the psychological after effects of sexual assault or harassment (16 cases). Most were in support of client however three cases involved an attempt to discredit clients. Insurance claims following an auto accident, employment injury, or disability were also common (15 cases). Other reasons included: client suicides, divorce cases, a false memory case, malpractice charges against a former therapist, and suits against universities by former clients. Nineteen counselors had to appear in court.
25.	Centers where it was necessary to comply with the subpoena: (percentages based on responses to item 24)	67	(74.4%)	
26.	Subpoenaed records were used: (percentages based on responses to item 24)			
	a) in support of a claim by Center client	62	(68.9%)	
	b) against a client	32	(35.6%)	

Important questions raised by some of these cases:

1. How do counselors protect themselves from being used by clients who seek counseling following an accident in order to establish psychological damage?
2. Can records of a client who attempted suicide be subpoenaed as part

of a hunting expedition to determine whether there is adequate reason to sue the counselor for malpractice?

3. Does a University have the legal right to view a student's counseling records when that student is suing the University and the suit does not involve the Counseling Center?

		TOTAL (N=321)		COMMENTS
29.	Centers that have had suits against them in the past year:	4	(1.2%)	Suits included: a sexual harassment claim, suing psychiatrist for malpractice for adverse drug reaction, reverse discrimination hiring suit, and an involuntary commitment for an evaluation.
30.	Directors who have had to discipline or terminate a counselor or intern in the past year due to unethical practices: See Appendix A for examples of other legal/ethical dilemmas.	21	(6.5%)	Problems included: breaches of confidentiality (5), dual relationships (3), inappropriate behavior (sexual comments, confrontations, defamation of others , missed appointments (6), abuse of prescription medication (1) and alcohol (1), failure to keep adequate records, and use of mail/phone for private profit. This represents a 3.9% increase from 1994.
32.	Centers that have a reciprocity agreement with another Counseling Center (For example, an agreement to provide counseling to students from another institution, with the understanding that the other Center would provide services for your students, should the need arise):	23	(7.2%)	
33.	Centers that would, in general, provide services to a student from another college or university:	36	(11.2%)	Some Centers offer services under certain conditions including: crisis intervention, if application fee was paid to university, if student is doing a clinical rotation, a transfer student, or partner of enrolled student.
34.	Centers that provide services to non-students not affiliated with the University (eg. children of faculty, occasional walk-ins):	66	(20.6%)	Nine Centers offer services to partners and/or children of students. Two Centers offer services to potential students.
35.	When these services are provided, schools which would assume legal responsibility in the event of a suit by an external client: (% based on response to #34)	22	(33.3%)	Two-thirds of the Centers providing these services seem to be doing so at their own risk. It is likely however, that if a suit is filed, institutions will be drawn into the suit.
36.	Centers where malpractice insurance is:			Many Directors reported that their staff buy additional insurance independently or through their professional organizations.
	a) Paid for by institution	116	(36.1%)	
	b) Paid for by counselors	71	(22.1%)	
	c) Not used; counselors are covered by general institutional insurance for all employees	114	(35.5%)	
	d) Other	17	(5.3%)	
37.	Centers which have gained new staff positions in the past year:			In 1994 and 1995, Centers have gained more positions than they have lost. This reverses a trend in the opposite direction that was noted in 1992 and 1993.
	a) Professional	57	(17.8%)	
	b) Clerical	19	(5.9%)	
	c) Graduate student assistant or 1/2 time intern	27	(8.4%)	
	d) Intern (full time)	18	(5.6%)	
38.	Centers that have lost a staff position in the past year (not replaced)			
	a) Professional	34	(10.6%)	
	b) Clerical	11	(3.4%)	
	c) Graduate student assistant or 1/2 time intern	15	(4.7%)	
	d) Intern (full time)	2	(0.6%)	

39. Average salaries for professional staff hired in the past year:

		Minority Male	Minority Female	Caucasian Male	Caucasian Female
a)	Director	N/A	55,000 n=1	59,500 n=3	60,250 n=8
b)	Training Director	N/A	N/A	N/A	42,250 n=2
c)	Assistant or Associate Director	49,500 n=2	48,000 n=2	54,000 n=3	45,500 n=2
d)	Counselor with Ph.D. and experience	39,714 n=7	42,415 n=8	40,198 n=10	38,550 n=8
e)	Counselor with new doctorate	35,826 n=5	36,625 n=4	32,015 n=7	33,900 n=11
f)	Counselor with A.B.D.	33,500 n=1	34,328 n=7	33,414 n=7	31,929 n=7
g)	Counselor with MA and experience	35,250 n=2	35,500 n=4	31,400 n=5	32,760 n=15
h)	Counselor with new MA	29,000 n=1	29,000 n=1	26,500 n=1	24,833 n=6
I)	Counselor with MSW and experience	N/A	36,667 n=3	34,500 n=2	35,875 n=4
j)	Counselor with new MSW	N/A	N/A	N/A	35,250 n=2
k)	Counselor with BA	N/A	N/A	24,000 n=1	N/A
l)	Psychiatrist/MD (annual salary)	N/A	N/A	115,250 n=2	70,000 n=1
m)	Psychiatrist/MD (hourly rate)	N/A	N/A	116 n=2	60 n=1
n)	Other	N/A	N/A	N/A	28,000 n=2

	TOTAL (N=321)		COMMENTS

40. Average salary paid to the following professional staff (averaged if more than one per Center):

	Average salary	Range	Mean years in position	Range of years in position
a) Director (n=290)	57,728	27-120K	9.72	1-31
b) Training Director (n=88)	47,983	32-73K	7.80	1-28
c) Clinical Director (n=35)	48,638	33-88K	4.48	1-15
d) Associate Director (n=69)	47,134	27-71K	7.94	1-25
e) Assistant Director (n=55)	42,246	25-70K	7.80	1-27
f) Psychiatrist/MD (annual salary) (n=25)	92,073	73-136K	7.96	1-22
g) Psychiatrist (hourly consultation) (n=67)	90.87	42-200	3.91	1-12

41. Average salary paid to professional staff according to number of years in the position (One representative salary reported per category when available):

	4-6 years in position	9-11 years in position	15+ years in position
a) Counselor with Ph.D.	38,664; Range26-88K(n=135)	44,565; Range27-80K(n=78)	53,044; Range38-98K(n=80)
b) Counselor with MA	31,183; Range14-57K(n=101)	37,326; Range20-58K(n=55)	45,400; Range27-68K(n=42)
c) Counselor with MSW	33,832; Range20-45K(n=38)	37,079; Range20-58K(n=29)	46,387; Range30-75K(n=13)
d) Counselor with A.B.D.	35,039; Range27-48K(n=14)	36,063; Range29-41K(n=4)	46,500; Range35-52K(n=5)

	Item	Total	%	Comments
42.	a) Directors that hold academic rank at their institution:	128	(39.9%)	One Director is an "Academic Related" Student Services Professional which includes a seat on the senate.
	b) Directors that are eligible for tenure:	53	(16.5%)	
	c) Directors that are eligible for sabbaticals:	86	(26.8%)	
43.	Schools where other Center therapists hold faculty appointments:	50	(15.6%)	Some Centers offer adjunct status only.
44.	Centers where faculty or non-faculty staff are eligible for sabbaticals:	59	(18.4%)	
45.	Centers where counselors are given time off for consultation:			This represents a 3.4% decrease from 1991. Eight Directors allot time as needed. Four Directors reported that consultation time is negotiated as needed. Seven Centers average 1-3 hours per week and two Centers report allotting one day monthly. Comp-time and personal time are also used.
	a) Half a day per week	31	(9.7%)	
	b) Full day per week	4	(1.2%)	
	c) Other	54	(16.8%)	
46.	Centers where counselors are allowed to use their offices for after-hours private practice:	81	(25.2%)	This reflects a 1.2% increase since 1993. This is reportedly against a Wisconsin state law.
47.	Schools which provide psychiatric services on campus (either in Counseling Center or another service unit):	178	(55.5%)	This is down 3.5% from 1994. One Center offers these services to staff only.
48.	Number of FTE psychiatrists that are available for students:	$\bar{x}$=.67	Range .01 to 4	
49.	Centers that require that a client receiving medication from an on-campus psychiatrist be followed by the Counseling Center for psychotherapy: (Percentage based on responses to # 47)	83	(48.8%)	
50.	Number of FTE mental health professionals which provide services to students on campus (includes all paid staff and interns at Centers and other service units on campus except for services provided by students in departmental clinics):	$\bar{x}$=6.96	Range .50 to 37	Small schools have the best counselor to client ratio (1 to 714) and large schools the worst (1 to 2292).
	Approximate ratio of mental health counselors to FTE students:	1 to 1588		
51.	Number of FTE career counselors professionals which provide services to students on campus (includes all paid staff and interns at Centers and other service units on campus)	$\bar{x}$=4.20	Range .0 to 29	
	Approximate ratio of career counselors to FTE students:	1 to 2510		
52.	Centers that contract with staff on how they spend their time:	142	(44.2%)	This is up 3.2% from last year.
53.	Average number of individual client sessions in a week for FTE staff (intakes, assessments, counseling/therapy sessions):	$\bar{x}$=19.82	Range 10 to 35	
54.	Average number of group hours a week for FTE staff (therapy, support and theme groups)	$\bar{x}$=2.18	Range .0 to 27	
55.	Average number of workshop/outreach/consultation hours a week for FTE staff:	$\bar{x}$=3.18	Range .0 to 15	
56.	Centers that count client cancellations/no-shows as part of a counselor's hour count:	174	(54.2%)	

		TOTAL (N=321)		COMMENTS
57.	Centers which limit the number of counseling sessions allowed a client:	174	(54.2%)	One Center reported limiting part-time students only.
58.	If a limit is set, maximum number of sessions allowed:	$\bar{x}$=11.22	Range 3 to 25	One Center varies limit according to percentage of caseload, another charges after six sessions.
59.	If a session limit is set, and the maximum number of sessions has been reached, Centers that allow the following:			
	a) Client can be seen again for crisis situations	178	(55.5%)	
	b) Client can be seen for a second series of sessions in the following year	149	(46.4%)	
	c) Client can be seen each year for a series of time-limited sessions	142	(44.2%)	
60.	Average number of sessions per client in the past year:	$\bar{x}$=5.18	Range 1.5 to 16	
61.	Centers that have taken the following actions to more effectively manage caseloads:			
	a) Seeing more students in therapy less than once a week	210	(65.4%)	Additional actions that Centers have taken are reported in Appendix B.
	b) Reducing number of students seen more than once a week	102	(31.8%)	
	c) No longer have holding appointments for students (Instead of having a regular time each week, students make next appointment as counselor's schedule allows)	96	(29.9%)	
	d) Using waiting list "support" group (students attend group until an individual appointment is available)	25	(7.8%)	
	e) Assigning more students to groups directly from intake/assessment	86	(26.8%)	
	f) Using telephone assessment/intake system	14	(4.4%)	
	g) Using computerized assessment/intake system	6	(1.9%)	
	h) Other	47	(14.6%)	
62.	Centers that collect written evaluations from clients:	248	(77.3%)	
63.	In Centers that collect evaluations, it is completed			Fourteen Centers evaluate every 2-3 years and 14 Centers report evaluations at termination. Other responses included: after each intake, once or twice a semester, biannually, or after a certain number of sessions
	a) Ongoing	52	(21.0%)	
	b) Once a term	62	(25.0%)	
	c) Once a year	73	(29.4%)	
	d) Other	61	(24.6%)	
64)	In Centers that collect evaluations, the following methods of distribution and reviewing the forms are used: See school size for break down:			Most Centers (55%) mail the evaluations to clients and have them returned to the Director; 28% have support staff give the evaluations to clients and then have them returned to the Director. However, 19% have counselors give the evaluations form to clients (it is speculated that this practice may create bias in answering thus effecting the validity of their results).
65.	Present concerns of Centers:			Waiting list problems have decreased 14.4% since 1994 17.4% since 1993, and 21.6% since 1992, perhaps reflecting the increase in brief therapy approaches and other adjustments. The number of Directors reporting increases in sexual assaults has also decreased from 61.7% in 1992 to 29.9% in 1995. Campus initiatives addressing this problem may be having a positive effect. See Appendix C. for comments on other concerns.
	a) Waiting list problems	76	(23.7%)	
	b) An increase in the number of students with severe psychological problems	264	(82.2%)	
	c) Difficulty in filling groups	214	(66.7%)	
	d) An increase in sexual assault cases	96	(29.9%)	
	e) An increase in crisis counseling	129	(40.2%)	
	f) Pressure on the Center to do more about drug and alcohol abuse on campus	97	(30.2%)	
	g) The need to find better referral sources for students who need long-term therapy	212	(66.0%)	
	h) Referrals by outside agencies to your Center of clients needing long-term therapy	63	(19.6%)	
	i) Responding to the needs of learning disabled students	160	(49.8%)	
	j) A growing demand for services with no increase in resources or fewer resources	185	(57.6%)	
	k) Other	77	(24.0%)	
66.	Centers that had to hospitalize a student for psychological reasons within the past year:	259	(80.7%)	This percentage has held steady for the past three years. $\bar{x}$=5.72; Range 1 to 50
67.	Directors who would notify parents against a student's wishes if the student is hospitalized for psychological reasons:			
	a) Yes, but only if student is under age	88	(27.4%)	
	b) Yes, but only if student is still being supported by parents, or requires parents' insurance coverage	52	(16.2%)	
	c) Yes, in all cases	50	(15.6%)	
	d) No	92	(28.7%)	

		TOTAL (N=321)		COMMENTS
68.	Directors who would notify parents when a student is not capable of expressing his/her wishes about informing the parents:			
	a) Yes, but only if student is under age	39	(12.1%)	
	b) Yes, but only if student is still being supported by parents, or requires parents' insurance coverage	49	(15.3%)	
	c) Yes, in all cases	131	(40.8%)	
	d) No	53	(16.5%)	
69.	Campuses that had an enrolled student suicide in the 94-95 school year:	131	(40.8%)	$\bar{x}$=1.74; Range 1 to 6
70.	Centers that had a client suicide in the 94-95 school year:	31	(9.7%)	$\bar{x}$=1.16; Range 1 to 3. Three Centers had two clients suicide and one Center had three.
71.	Centers that have had legal action taken against them following a client or former client suicide:	3	(0.9%)	
72.	How these cases were settled (% based on response to #71):			[n=3]
	a) Out of court	2	(66.7%)	
	b) In favor of Center	0	(0.0%)	
	c) Against Center	0	(0.0%)	
	d) Still in progress	1	(33.3%)	
73.	Centers that have had to notify a third party about a potentially suicidal student during the past year:	177	(55.1%)	Number of notifications - $\bar{x}$=3.68; Range 1 to 20
74.	Centers that have had to give warning during the past year to a third party about a student who posed danger to another person:	67	(20.9%)	Number of warnings - $\bar{x}$=1.92; Range 1 to 12
75.	Directors that have noted a difference in violent incidents involving students:			
	a) Noticed increase over last five years	185	(57.6%)	
	b) Remained same over last five years	126	(39.3%)	
	c) Noticed decrease over last five years	4	(1.2%)	
76.	Centers that have written statements or policies on the following:			
	a) Having an emotionally disturbed student removed from the residence halls or school	119	(37.1%)	15% more schools have written policies on dealing with potentially suicidal students than in 1994. Over 67% of Centers have written policies that they are willing to share.
	b) Having a psychotic student hospitalized	118	(36.8%)	
	c) Dealing with a potentially suicidal student	196	(61.1%)	
	d) Dealing with a potentially violent student	142	(44.2%)	
	e) Risks of counseling	63	(19.6%)	
	f) Kinds of client problems appropriate to be seen at the Counseling Center	143	(44.5%)	
78.	Clients are most likely to be referred following intake when: (Directors checked all responses that applied)			
	a) longer term treatment required	261	(81.3%)	
	b) insurance covers outside treatment	79	(24.6%)	
	c) there is lack of staff expertise in client's problem area	283	(88.2%)	
79.	Directors who know of students who have come to their Center in the past year because of sexual exploitation or harassment by:			
	a) another therapist	53	(16.5%)	
	b) faculty member of supervisor	209	(65.1%)	
	c) another student	269	(83.8%)	
80.	Centers that have special programs for:			
	a) gay, lesbian, and bisexual students	143	(44.5%)	There has been an 8% increase in programs for gay, lesbian, and bisexual students since 1990.
	b) racial minorities	131	(40.8%)	
	c) international students	102	(31.8%)	
	d) financially disadvantaged	25	(7.8%)	
	e) single mothers	29	(9.0%)	
81.	Centers that have thoroughly reviewed APA ethical guidelines for working with multicultural students	30	(9.3%)	These two questions suggest that Centers could benefit from some attention to these guidelines.
82.	Directors that feel their staff is very well-versed about these guidelines:	21	(6.5%)	
83.	Directors that feel the number of students seeking help for eating disorders is:			
	a) increasing	96	(29.9%)	There has been a 13% increase since 1994 in Directors who feel that the number of students seeking help for eating disorders is increasing.
	b) decreasing	36	(11.2%)	
	c) remaining about the same as previous years	186	(57.9%)	
84.	Centers that have seen one or more HIV positive clients within the past year:	139	(43.3%)	

		TOTAL (N=321)		COMMENTS
85.	Directors who felt that any of these HIV positive clients posed a risk to any third party:	24	(17.3%)	Three Directors did not have enough information to inform and another four Directors were legally advised not to inform.
	When clients posed a risk, directors who found it necessary to warn a third party:	3	(2.2%)	
86.	How Directors would generally handle it if an HIV positive client states that he/she has not informed his/her partner of the health situation:			Thirteen Directors would obtain legal and/or other professional consultation. Seven Directors would evaluate safe sex practices, and five would involve public health agencies.
	a) Would take no action	2	(0.6%)	
	b) Would encourage disclosure but otherwise take no action	153	(47.7%)	
	c) Would inform client that if he/she did not inform partner, that you would be ethically bound to do so	97	(30.2%)	
	d) Other	41	(12.8%)	
87.	Directors who have noticed an increase in the number of students who report having been sexually abused as children:	234	(72.9%)	
88.	Directors who feel students reporting earlier sexual abuse typically have more serious psychological problems than other personal counseling clients:	254	(79.1%)	
89.	Centers where staff have had in-service training in the past year on how to work with students who have been sexually abused as children:	130	(40.5%)	
90.	Centers that have run groups for students who have been sexually abused as children:	161	(50.2%)	This reflects an 11% increase since 1992.
91.	Centers where counselors have made a child abuse report for the following:			Other reports included: client's parent abusing the client's child, reports on siblings being abused, client's husbands abuse of child, abuse of family friend, and a client who was obsessing about child abuse.
	a) a client who had been abused in the past	63	(19.6%)	
	b) a client who was being abused concurrent with counseling	33	(10.3%)	
	c) a client who had previously abused a child	28	(8.7%)	
	d) a client who was abusing a child concurrent with counseling	28	(8.7%)	
92.	Clients where counseling staff have been legally involved in cases:			
	a) to support a child abuse victim	31	(9.7%)	
	b) to support a child abuse offender	6	(1.9%)	
	c) called to testify due to family suit alleging false memory	0	(0.0%)	
93.	Centers that routinely ask about childhood sexual abuse in assessment of clients:			
	a) for female clients	17	(5.3%)	
	b) for all clients	107	(33.3%)	
	c) not routinely	191	(59.5%)	
94.	Centers that have policies/procedures on how reports of recovered memories of childhood sexual abuse should be handled:	17	(5.3%)	See the April 1995 Counseling Psychologist for a good review of this topic.
95.	Centers where the debate between recovered memory (suggesting that recovered memories of abuse are real memories) and false memory (suggesting that recovered memories are therapist-induced fictions) has become an issue:			
	a) It was never been discussed at our Center	40	(12.5%)	
	b) The issue has been briefly mentioned	193	(60.1%)	
	c) Our staff has had special training/frequent discussions around this issue:	86	(26.8%)	
96.	Centers that accept mandated referrals from a campus administrator or Judicial Board:			An excellent review of varying positions on mandatory referrals can be found in the Journal of College Student Psychotherapy vol. 9, no. 4, 1995.
	a) for assessment and counseling	131	(40.8%)	
	b) for assessment only (no mandatory counseling)	132	(41.1%)	
	c) we accept no mandated referrals	54	(16.8%)	
97.	If a campus judicial board or administrator makes a mandatory referral to the Center of a student with a drug or alcohol problem, it is generally handled in the following manner:			
	a) No such referrals are accepted	59	(18.4%)	
	b) Will see the student for no more than one mandatory visit	133	(41.4%)	
	c) Will see the student for a series of mandatory sessions	110	(34.3%)	
98.	Level of success for Centers who see mandatory drug & alcohol cases:			
	a) very successful	11	(5.4%)	
	b) moderately successful	122	(60.0%)	
	c) not very successful	70	(34.4%)	

		TOTAL (N=321)		COMMENTS
99.	Schools that have received a FIPSE grant:			
	a) through the Counseling Center	71	(22.1%)	Since 1990, there has been an 8% increase in schools receiving FIPSE grants through their Counseling Centers and a 5% increase of those receiving grants through their Health Centers.
	b) through the Health Center	40	(12.5%)	
	c) through some other office	84	(26.2%)	
100.	Schools that have had external grants apart from FIPSE to support alcohol-related programming:	38	(11.8%)	Other sources include: State Departments of Health or Transportation, trustees, alumni, and assorted local grants.
101.	Schools that have attempted to reduced alcohol on campus using these methods: (Directors checked all that applied)			
	a) on a policy level	248	(77.3%)	
	b) on-campus prevention programs have been implemented	281	(87.5%)	
	c) on-campus treatment focused programs have been implemented	118	(36.8%)	
	d) off-campus referrals to treatment/prevention programs are offered	198	(61.7%)	
	e) alcohol use is not considered a problem on our campus	14	(4.4%)	
102.	Schools that have implemented any of the following policies and programs to address alcohol-related problems on campus: (Directors checked all that applied)			
	a) peer education	254	(79.1%)	
	b) social marketing for prevention of alcohol abuse	182	(56.7%)	
	c) low tolerance policy for alcohol related crimes	148	(46.1%)	
	d) increased regulation of the Greek system	154	(48.0%)	
103.	Schools that have instituted the following alcohol reduction residence options: (Directors checked all that applied)			
	a) all residence halls totally alcohol-free	75	(23.4%)	
	b) select residence halls alcohol-free	56	(17.4%)	
	c) alcohol-free floors in residence halls	75	(23.4%)	
	d) contracted alcohol-free rooms	12	(3.7%)	
104.	Directors' opinions about current alcohol use on their campus vs. five years ago:			
	a) increase in all levels of drinking	75	(23.4%)	One Center reports that clients are coming in with more extensive drinking histories, and another director reports an increase among women drinkers which is in agreement with national data.
	b) increase in binge drinking, but not overall drinking	71	(22.1%)	
	c) level of alcohol use has not changed	130	(40.5%)	
	d) decrease in binge drinking, but not overall drinking	12	(3.7%)	
	e) decrease in all levels of drinking	14	(4.4%)	
105.	Centers that are taking the following actions to prepare for managed care: (Directors checked all that applied)			
	a) Using DSM coding on all/most clients	62	(19.3%)	Other actions included: diversifying services, increasing education and outreach services, educating administration, increasing master's level clinicians (vs. Ph.D.s), and computerizing productivity records.
	b) No longer counting client cancellations or no-shows as part of counselor contact hours	20	(6.2%)	
	c) Requiring written treatment plans	50	(15.6%)	
	d) Requiring more detailed documentation of treatment progress	71	(22.1%)	
	e) Increased emphasis/training on quality assurance and utilization review methods	67	(20.9%)	
	f) Increased emphasis on consultation/outreach to campus community	148	(46.1%)	
	g) Increased emphasis/training on short-term counseling	173	(53.9%)	
	h) Lobbying government officials and/or insurance companies on inclusion of Counseling Centers as preferred providers	13	(4.0%)	
	i) Other	26	(8.1%)	
106.	Innovative programs or projects at Counseling Centers:			See Appendix D.

SUMMARY DATA BY SCHOOL SIZE

Raw data reported outside brackets (frequency data inside)

SCHOOL SIZE

	Under 2,500 (n=60)		2,500 - 7,500 (n=91)		7,500 - 15,000 (n=80)		Over 15,000 (n=90)	
1. Centers that charge fees for the following services:								
a) Personal counseling to students	1	(1.7%)	1	(1.1%)	9	(11.3%)	18	(20.0%)
b) Personal counseling to faculty/staff	1	(1.7%)	1	(1.1%)	6	(7.5%)	4	(4.4%)
c) Personal counseling to alumni	1	(1.7%)	2	(2.2%)	1	(1.3%)	2	(2.2%)
d) Personal counseling to community	2	(3.3%)	2	(2.2%)	0	(0.0%)	4	(4.4%)
e) Career counseling to students	1	(1.7%)	0	(0.0%)	6	(7.5%)	8	(8.9%)
f) Career counseling to faculty/staff	1	(1.7%)	1	(1.1%)	9	(11.3%)	6	(6.7%)
g) Career counseling to alumni	5	(8.3%)	2	(2.2%)	11	(13.8%)	12	(13.3%)
h) Career counseling to community	2	(3.3%)	3	(3.3%)	11	(13.8%)	11	(12.2%)
i) Career testing to students	2	(3.3%)	12	(13.2%)	22	(27.5%)	25	(27.8%)
j) Career testing to faculty/staff	1	(1.7%)	7	(7.7%)	15	(18.8%)	13	(14.4%)
k) Career testing to alumni	5	(8.3%)	11	(12.1%)	16	(20.0%)	18	(20.0%)
l) Career testing to community	2	(3.3%)	7	(7.7%)	15	(18.8%)	16	(17.8%)
m) Personality testing to students	4	(6.7%)	3	(3.3%)	19	(23.8%)	24	(26.7%)
n) Personality testing to faculty/staff	1	(1.7%)	1	(1.1%)	10	(12.5%)	8	(8.9%)
o) Personality testing to alumni	2	(3.3%)	1	(1.1%)	4	(5.0%)	5	(5.6%)
p) Personality testing to community	1	(1.7%)	2	(2.2%)	4	(5.0%)	8	(8.9%)
2. Centers which collect third party payments for personal counseling:	2	(3.3%)	1	(1.1%)	8	(10.0%)	12	(13.3%)
3. Centers that provide the following services: (Directors checked all that applied)								
a. National tests (e.g. GMAT, GRE, LSAT, CLEP)	11	(18.3%)	32	(35.2%)	40	(50.0%)	34	(37.8%)
b. Scoring for faculty exams	2	(3.3%)	1	(1.1%)	6	(7.5%)	5	(5.6%)
c. Evaluation of teaching	1	(1.7%)	0	(0.0%)	3	(3.8%)	4	(4.4%)
d. Consultation for students on testing	16	(26.7%)	20	(22.0%)	24	(30.0%)	28	(31.1%)
5. When applicable, the income generated by testing programs:								
a. Supports testing services only	2	(3.3%)	9	(9.9%)	14	(17.5%)	14	(15.6%)
b. Supports testing program and other Center programs	3	(5.0%)	11	(12.1%)	23	(28.8%)	21	(23.3%)
c. Goes back into general funds	3	(5.0%)	9	(9.9%)	7	(8.8%)	9	(10.0%)
d. Other	1	(1.7%)	3	(3.3%)	6	(7.5%)	3	(3.3%)
6. Centers that receive support through a mandated fee:	11	(18.3%)	13	(14.3%)	27	(33.8%)	39	(43.3%)
7. For Centers supported by a mandatory fee: (% based ONLY on responses to this question)								
a) less than 25% of budget covered	2	(18.2%)	2	(15.4%)	4	(14.8%)	4	(10.3%)
b) 25-49% of budget covered	2	(18.2%)	3	(23.1%)	6	(22.2%)	3	(7.7%)
c) 50-74% of budget covered	0	(0.0%)	2	(15.4%)	4	(14.8%)	7	(17.9%)
d) 75-100% of budget covered	6	(54.5%)	6	(46.2%)	13	(48.1%)	24	(61.5%)
8. Centers that took a budget cut in 1994-1995:	26	(43.3%)	25	(27.5%)	23	(28.8%)	30	(33.3%)
9. How these budget cuts affected the centers (Directors checked all responses that applied):								
a) reduced staff	3	(11.5%)	5	(20.0%)	7	(30.4%)	11	(36.7%)
b) little or no salary increases	10	(38.5%)	9	(36.0%)	12	(52.2%)	11	(36.7%)
(Directors checked all responses that applied)								
a) Downsizing Student Affairs	13	(21.7%)	27	(29.7%)	25	(31.3%)	19	(21.1%)
c) reduction in salaries	1	(3.8%)	1	(4.0%)	0	(0.0%)	3	(10.0%)
d) reduced "other costs" budget	24	(92.3%)	21	(84.0%)	16	(69.6%)	20	(66.7%)
e) other	1	(3.8%)	3	(12.0%)	1	(4.3%)	6	(20.0%)
10. Institutions considering the following:								
b) Reorganizing Student Affairs	23	(38.3%)	39	(42.9%)	45	(56.3%)	32	(35.6%)
c) Downsizing the Counseling Center	6	(10.0%)	10	(11.0%)	13	(16.3%)	11	(12.2%)
d) Reorganizing the Counseling Center	8	(13.3%)	13	(14.3%)	23	(28.8%)	19	(21.1%)
e) Outsourcing/Privatizing the Counseling Center	7	(11.7%)	13	(14.3%)	11	(13.8%)	18	(20.0%)
11. Directors that feel there is a real possibility that outsourcing/privatization may happen on their campus:	2	(3.3%)	2	(2.2%)	7	(8.8%)	9	(10.0%)

	Under 2,500 (n=60)		2,500 - 7,500 (n=91)		7,500 - 15,000 (n=80)		Over 15,000 (n=90)	
13. Directors that support the following Counseling Center standards on case notes:								
a. Case notes should be kept only at the discretion of the counselor	2	(3.3%)	3	(3.3%)	1	(1.3%)	3	(3.3%)
b. Case notes should be kept on each client, but should remain under the care of the client's counselor	17	(28.3%)	8	(8.8%)	9	(11.3%)	2	(2.2%)
c. Case notes should be maintained only in a central office file	20	(33.3%)	34	(37.4%)	45	(56.3%)	57	(63.3%)
d. Case notes should be maintained in either a central file or in counselor's offices, depending on what works best for the Center	21	(35.0%)	43	(47.3%)	24	(30.0%)	27	(30.0%)
15. Centers where there has been an increase in clients asking to view case records in recent years:	5	(8.3%)	17	(18.7%)	23	(28.8%)	32	(35.6%)
16. Centers that typically provide clients with access to counselors' reports or case notes on request:	25	(41.7%)	46	(50.5%)	40	(50.0%)	61	(67.8%)
17. Centers that have developed a policy on what should or shouldn't be included in case notes to protect against a court-ordered opening of records:	15	(25.0%)	25	(27.5%)	22	(27.5%)	33	(36.7%)
19. Centers that provide written materials to clients explaining limits to confidentiality:	44	(73.3%)	76	(83.5%)	72	(90.0%)	83	(92.2%)
20. Centers that inform students that in the future, they may be pressured to sign release of information forms if seeking employment in government agencies or admittance to the Bar:	11	(18.3%)	28	(30.8%)	29	(36.3%)	27	(30.0%)
21. Directors that believe that if this information were provided, students who are considering government work or Law School might not seek counseling, or be less open in counseling:	33	(55.0%)	57	(62.6%)	48	(60.0%)	55	(61.1%)
22. Directors in favor of a professional standard stating that psychologists and counselors are not permitted to release student records to anyone other than another treating professional (barring a court order), even with the signed release of the client/patient:	47	(78.3%)	67	(73.6%)	60	(75.0%)	63	(70.0%)
23. Directors who feel that it would be a good idea to establish a small group to work on developing a statement in support of limited release of information:	50	(83.3%)	77	(84.6%)	70	(87.5%)	71	(78.9%)
24. Centers that have had records or counselors subpoenaed in the past year:	10	(16.7%)	20	(22.0%)	20	(25.0%)	40	(44.4%)
25. Centers where it was necessary to comply with the subpoena: (percentages based on responses to item 24)	6	(60.0%)	16	(80.0%)	17	(85.0%)	28	(70.0%)
26. Subpoenaed records were used: (percentages based on responses to item 24)								
a) in support of a claim by Center client	4	(40.0%)	12	(60.0%)	14	(70.0%)	32	(80.0%)
b) against a client	3	(30.0%)	9	(45.0%)	7	(35.0%)	13	(32.5%)
27. Counselors who had to appear in court: (percentages based on responses to item 24)	3	(30.0%)	5	(25.0%)	2	(10.0%)	9	(22.5%)
29. Centers that have had suits against them in the past year:	0	(0.0%)	1	(1.1%)	0	(0.0%)	3	(3.3%)
30. Directors who have had to discipline or terminate a counselor or intern in the past year due to unethical practices:	1	(1.7%)	2	(2.2%)	6	(7.5%)	12	(13.3%)
31. Centers which have experienced other legal/ethical dilemmas in the past year: Comments: See Appendix A	13	(21.7%)	23	(25.3%)	27	(33.8%)	34	(37.8%)
32. Centers that have a reciprocity agreement with another Counseling Center (For example, an agreement to provide counseling to students from another institution, with the understanding that the other Center would provide services for your students, should the need arise):	4	(6.7%)	3	(3.3%)	6	(7.5%)	10	(11.1%)
33. Centers that would, in general, provide services to a student from another college or university:	5	(8.3%)	13	(14.3%)	8	(10.0%)	10	(11.1%)

		Under 2,500 (n=60)	2,500 - 7,500 (n=91)	7,500 - 15,000 (n=80)	Over 15,000 (n=90)
34.	Centers that provide services to non-students not affiliated with the University (e.g. children of faculty, occasional walk-ins):	12 (20.0%)	16 (17.6%)	19 (23.8%)	19 (21.1%)
35.	Schools where, if these services are provided, the institution would assume legal responsibility in the event of a suit by one of these clients: (% based on response to #34)	1 (8.3%)	4 (25.0%)	9 (47.4%)	8 (42.1%)
36.	Centers where malpractice insurance is:				
	a. Paid for by institution	34 (56.7%)	37 (40.7%)	23 (28.8%)	22 (24.4%)
	b. Paid for by counselors	10 (16.7%)	20 (22.0%)	19 (23.8%)	22 (24.4%)
	c. Not used; counselors are covered by general institutional insurance for all employees	10 (16.7%)	28 (30.8%)	36 (45.0%)	40 (44.4%)
	d. Other	4 (6.7%)	6 (6.6%)	2 (2.5%)	5 (5.6%)
37.	Centers which have gained new staff positions in the past year:				
	a) Professional	7 (11.7%)	14 (15.4%)	13 (16.3%)	23 (25.6%)
	b) Clerical	3 (5.0%)	5 (5.5%)	2 (2.5%)	9 (10.0%)
	c) Graduate student assistant or 1/2 time intern	7 (11.7%)	9 (9.9%)	5 (6.3%)	6 (6.7%)
	d) Intern (full time)	1 (1.7%)	3 (3.3%)	5 (6.3%)	9 (10.0%)
38.	Centers that have lost a staff position in the past year (not replaced)				
	a) Professional	5 (8.3%)	9 (9.9%)	8 (10.0%)	12 (13.3%)
	b) Clerical	0 (0.0%)	3 (3.3%)	2 (2.5%)	6 (6.7%)
	c) Graduate student assistant or 1/2 time intern	0 (0.0%)	3 (3.3%)	5 (6.3%)	7 (7.8%)
	d) Intern (full time)	1 (1.7%)	0 (0.0%)	0 (0.0%)	1 (1.1%)
39.	Average salaries for professional staff are listed in the total section.				
42.	a. Directors that hold academic rank at their institution:	17 (28.3%)	24 (26.4%)	38 (47.5%)	49 (54.4%)
	b. Directors that are eligible for tenure:	2 (3.3%)	11 (12.1%)	19 (23.8%)	21 (23.3%)
	c. Directors that are eligible for sabbaticals:	12 (20.0%)	19 (20.9%)	24 (30.0%)	31 (34.4%)
43.	Schools where other Center therapists hold faculty appointments:	8 (13.3%)	28 (30.8%)	40 (50.0%)	53 (58.9%)
44.	Centers where faculty or non-faculty staff are eligible for sabbaticals:	14 (23.3%)	27 (29.7%)	26 (32.5%)	30 (33.4%)
45.	Centers where counselors are given time off for consultation:				
	a. Half a day per week	2 (3.3%)	12 (13.2%)	6 (7.5%)	11 (12.2%)
	b. Full day per week	0 (0.0%)	1 (1.1%)	2 (2.5%)	1 (1.1%)
	c. Other	12 (20.0%)	13 (14.3%)	11 (13.8%)	18 (20.0%)
46.	Centers where counselors are allowed to use their offices for after-hours private practice:	21 (35.0%)	22 (24.2%)	18 (22.5%)	20 (22.2%)
47.	Schools which provide psychiatric services on campus (either in Counseling Center or another service unit):	16 (26.7%)	37 (40.7%)	48 (60.0%)	77 (85.6%)
48.	Number of FTE psychiatrists that are available for students:	$\bar{x}$= .23 Range .03 to .75	$\bar{x}$=.31 Range .02 to 2.0	$\bar{x}$=.48 Range .03 to 4	$\bar{x}$=1.02 Range .01 to 4
49.	Centers that required that a client receiving medication from an on-campus psychiatrist be followed by the Counseling Center for psychotherapy:	13 (21.7%)	19 (20.9%)	24 (30.0%)	27 (30.0%)
50.	Number of FTE mental health professionals which provide services to students on campus (includes all paid staff and interns at Centers and other service units on campus except for services provided by students in departmental clinics):	$\bar{x}$=2.57 Range .50 to .90	$\bar{x}$=4.3 Range .75 to 20	$\bar{x}$=6.91 Range 2 to 14.3	$\bar{x}$=12.67 Range 3 to 37
	Approximate ratio of mental health counselors to FTE students:	1 to 714	1 to 1279	1 to 1818	1 to 2292
51.	Number of FTE career counselors professionals which provide services to students on campus (includes all paid staff and interns at Centers and other service units on campus)	$\bar{x}$=2.03 Range .0 to 8.0	$\bar{x}$=3.17 Range .0 to 12	$\bar{x}$=4.06 Range 0 to 13	$\bar{x}$=6.92 Range 0 to 28.5
	Approximate ratio of career counselors to FTE students:	1 to 943	1 to 1948	1 to 3129	1 to 3670
52.	Centers that contract with staff on how they spend their time:	11 (18.3%)	36 (39.6%)	37 (46.3%)	58 (64.4%)
53.	Average number of individual client sessions in a week for FTE staff (intakes, assessments, counseling/therapy sessions):	$\bar{x}$=21.62 Range 12 to 35	$\bar{x}$=20.6 Range 10 to 30	$\bar{x}$=19.38 Range 10 to 30	$\bar{x}$=18.29 Range 11 - 32

	Under 2,500 (n=60)	2,500 - 7,500 (n=91)	7,500 - 15,000 (n=80)	Over 15,000 (n=90)
54. Average number of group hours a week for FTE staff (therapy, support and theme groups)	$\bar{x}$=1.85 Range 0 to 6	$\bar{x}$=2.38 Range 0 to 27	$\bar{x}$=1.86 Range 0 to 6	$\bar{x}$=2.48 Range 0 to 6
55. Average number of workshop/outreach/consultation hours a week for FTE staff:	$\bar{x}$=4.01 Range 0 to 12	$\bar{x}$= 3.26 Range 0 to 15	$\bar{x}$=2.84 Range .5 to 15	$\bar{x}$=2.89 Range .25 to 12
56. Centers that count client cancellations/no-shows as part of a counselor's hour count:	24 (40.0%)	43 (47.3%)	49 (61.3%)	58 (64.4%)
57. Centers which limit the number of counseling sessions allowed a client:	16 (26.7%)	44 (48.4%)	48 (60.0%)	66 (73.3%)
58. If a limit is set, maximum number of sessions allowed:	$\bar{x}$=10.00 Range 6 to 15	$\bar{x}$=10.49 Range 3 to 24	$\bar{x}$=11.23 Range 5 to 25	$\bar{x}$=12.02 Range 6 to 20
59. If a session limit is set, and the maximum number of sessions has been reached, Centers that allow the following:				
a. Client can be seen again for crisis situations	19 (31.7%)	47 (51.6%)	47 (58.8%)	65 (72.2%)
b. Client can be seen for a second series of sessions in the following year	18 (30.0%)	39 (42.9%)	37 (46.3%)	55 (61.1%)
c. Client can be seen each year for a series of time-limited sessions	16 (26.7%)	40 (44.0%)	39 (48.8%)	47 (52.2%)
60. Average number of sessions per client in the past year:	$\bar{x}$=5.53 Range 2 to 10.8	$\bar{x}$=5.02 Range 1.5 to 15	$\bar{x}$=5.13 Range 2 to 16	$\bar{x}$=5.14 Range 2.5 to 12
61. Centers that have taken the following actions to more effectively manage caseloads:				
a. Seeing more students in therapy less than once a week	30 (50.0%)	60 (65.9%)	52 (65.0%)	68 (75.6%)
b. Reducing number of students seen more than once a week	23 (38.3%)	28 (30.8%)	20 (25.0%)	31 (34.4%)
c. No longer have holding appointments for students (Instead of having a regular time each week, students make next appointment as counselor's schedule allows)	24 (40.0%)	28 (30.8%)	21 (26.3%)	23 (25.6%)
d. Using waiting list "support" group (students attend group until an individual appointment is available)	0 (0.0%)	5 (5.5%)	7 (8.8%)	13 (14.4%)
e. Assigning more students to groups directly from intake/assessment	2 (3.3%)	20 (22.0%)	22 (27.5%)	42 (46.7%)
f. Using telephone assessment/intake system	4 (6.7%)	1 (1.1%)	5 (6.3%)	4 (4.4%)
g. Using computerized assessment/intake system	1 (1.7%)	1 (1.1%)	1 (1.3%)	3 (3.3%)
h. Other	4 (6.7%)	15 (16.5%)	9 (11.3%)	19 (21.1%)
See Appendix B. for comments				
62. Centers that collect written evaluations from clients:	30 (50.0%)	78 (85.7%)	61 (76.3%)	79 (87.8%)
63. In Centers that collect evaluations, it is completed				
a. Ongoing	4 (13.3%)	14 (17.9%)	11 (18.0%)	23 (29.1%)
b. Once a term	7 (23.3%)	19 (24.4%)	20 (32.8%)	16 (20.3%)
c. Once a year	11 (36.7%)	28 (35.9%)	11 (18.0%)	23 (29.1%)
d. Other	8 (26.7%)	17 (21.8%)	19 (31.1%)	17 (21.5%)
64. In Centers that collect evaluations, the following methods of distribution and reviewing the forms are used:				
Evaluations are mailed to clients and:				
a. are returned to Director or the Director's representative	24 (80.0%)	49 (62.8%)	30 (49.2%)	34 (43.0%)
b. are returned directly to evaluated counselors, who then pass them on to Director	1 (3.3%)	2 (2.6%)	1 (1.6%)	2 (2.5%)
Evaluations are given to clients by support staff as they complete counseling or after a certain number of sessions and:				
a. are returned to Director or the Director's representative	7 (23.3%)	17 (21.8%)	25 (41.0%)	20 (25.3%)
b. are returned directly to evaluated counselors, who then pass them on to Director	0 (0.0%)	0 (0.0%)	1 (1.6%)	3 (3.8%)
Evaluations are given to client by counselors and:				
a. are returned to Director or the Director's representative	1 (3.3%)	15 (19.2%)	8 (13.1%)	19 (24.1%)
b. are returned directly to evaluated counselors, who then pass them on to Director	0 (0.0%)	1 (1.3%)	1 (1.6%)	2 (2.5%)
Other:	2 (6.7%)	10 (12.8%)	6 (9.8%)	12 (15.2%)
65. Present concerns of Centers:				
a) Waiting list problems	3 (5.0%)	16 (17.6%)	25 (31.3%)	32 (35.6%)
b) An increase in the number of students with severe psychological problems	48 (80.0%)	73 (80.2%)	67 (83.8%)	76 (84.4%)

	Under 2,500 (n=60)		2,500 - 7,500 (n=91)		7,500 - 15,000 (n=80)		Over 15,000 (n=90)	
c) Difficulty in filling groups	38	(63.3%)	62	(68.1%)	58	(72.5%)	56	(62.2%)
d) An increase in sexual assault cases	22	(36.7%)	27	(29.7%)	24	(30.0%)	23	(25.6%)
e) An increase in crisis counseling	20	(33.3%)	40	(44.0%)	30	(37.5%)	39	(43.3%)
f) Pressure on the Center to do more about drug and alcohol abuse on campus	31	(51.7%)	30	(33.0%)	20	(25.0%)	16	(17.8%)
g) The need to find better referral sources for students who need long-term therapy	31	(51.7%)	56	(61.5%)	56	(70.0%)	69	(76.7%)
h) Referrals by outside agencies to your Center of clients needing long-term therapy	1	(1.7%)	19	(20.9%)	22	(27.5%)	21	(23.3%)
i) Responding to the needs of learning disabled students	34	(56.7%)	47	(51.6%)	35	(43.8%)	44	(48.9%)
j) A growing demand for services with no increase in resources or fewer resources	31	(51.7%)	60	(65.9%)	40	(50.0%)	54	(60.0%)
k) Other	12	(20.0%)	15	(16.5%)	22	(27.5%)	28	(31.1%)

See Appendix C. for comments.

	Under 2,500		2,500 - 7,500		7,500 - 15,000		Over 15,000	
66. Centers that had to hospitalize a student for psychological reasons within the past year:	47	(78.3%)	71	(78.0%)	64	(80.0%)	77	(85.6%)
67. Directors who would notify parents against a student's wishes if the student is hospitalized for psychological reasons:								
a) Yes, but only if student is under age	13	(21.7%)	25	(27.5%)	23	(28.8%)	27	(30.0%)
b) Yes, but only if student is still being supported by parents, or requires parents' insurance coverage	16	(26.7%)	19	(20.9%)	12	(15.0%)	5	(5.6%)
c) Yes, in all cases	12	(20.0%)	17	(18.7%)	11	(13.8%)	10	(11.1%)
d) No	14	(23.3%)	21	(23.1%)	20	(25.0%)	37	(41.1%)
68. Directors who would notify parents when a student is not capable of expressing his/her wishes about informing the parents:								
a) Yes, but only if student is under age	3	(5.0%)	12	(13.2%)	10	(12.5%)	14	(15.6%)
b) Yes, but only if student is still being supported by parents, or requires parents' insurance coverage	12	(20.0%)	18	(19.8%)	12	(15.0%)	7	(7.8%)
c) Yes, in all cases	32	(53.3%)	41	(45.1%)	33	(41.3%)	25	(27.8%)
d) No	6	(10.0%)	9	(9.9%)	11	(13.8%)	27	(30.0%)
69. Campuses that had an enrolled <u>student</u> suicide in the 94-95 school year:	4	(6.7%)	24	(26.4%)	39	(48.8%)	64	(71.1%)
70. Centers that had a <u>client</u> suicide in the 94-95 school year:	2	(3.3%)	5	(5.5%)	9	(11.3%)	15	(16.7%)
71. Centers that have had legal action taken against them following a client or former client suicide:	0	(0.0%)	0	(0.0%)	0	(0.0%)	3	(3.3%)
72. How these cases were settled (% based on response to #71):	[n=3]							
a) Out of court	N/A		N/A		N/A		2	(66.7%)
b) In favor of Center	N/A		N/A		N/A		0	(0.0%)
c) Against Center	N/A		N/A		N/A		0	(0.0%)
d) Still in progress	N/A		N/A		N/A		1	(33.3%)
73. Centers that have had to notify a third party about a potentially suicidal student during the past year:	24	(40.0%)	55	(60.4%)	47	(58.8%)	51	(56.7%)
74. Centers that have had to give warning during the past year to a third party about a student who posed danger to another person:	10	(16.7%)	14	(15.4%)	16	(20.0%)	27	(30.0%)
75. Directors that have noted a difference in violent incidents involving students:								
a. Noticed increase over last five years	28	(46.7%)	53	(58.2%)	43	(53.8%)	61	(67.8%)
b. Remained same over last five years	29	(48.3%)	36	(39.6%)	35	(43.8%)	26	(28.9%)
c. Noticed decrease over last five years	1	(1.7%)	1	(1.1%)	1	(1.3%)	1	(1.1%)
76. Centers that have written statements or policies on the following:								
a. Having an emotionally disturbed student removed from the residence halls or school	23	(38.3%)	43	(47.3%)	27	(33.8%)	26	(28.9%)
b. Having a psychotic student hospitalized	22	(36.7%)	32	(35.2%)	29	(36.3%)	35	(38.9%)
c. Dealing with a potentially suicidal student	32	(53.3%)	64	(70.3%)	48	(60.0%)	52	(57.8%)
d. Dealing with a potentially violent student	22	(36.7%)	43	(47.3%)	37	(46.3%)	40	(44.4%)
e. Risks of counseling	11	(18.3%)	19	(20.9%)	16	(20.0%)	17	(18.9%)
f. Kinds of client problems appropriate to be seen at the Counseling Center	22	(36.7%)	46	(50.5%)	40	(50.0%)	35	(38.9%)
77. Centers willing to share their written policies with other Centers:	31	(51.7%)	61	(67.0%)	57	(71.3%)	67	(74.4%)

	Under 2,500 (n=60)		2,500 - 7,500 (n=91)		7,500 - 15,000 (n=80)		Over 15,000 (n=90)	
78. Clients are most likely to be referred following intake when: (Directors checked all responses that applied)								
a. longer term treatment required	41	(68.3%)	72	(79.1%)	67	(83.8%)	81	(90.0%)
b. insurance covers outside treatment	8	(13.3%)	17	(18.7%)	20	(25.0%)	34	(37.8%)
c. there is lack of staff expertise in client's problem area	52	(86.7%)	80	(87.9%)	72	(90.0%)	79	(87.8%)
79. Directors who know of students who have come to their Center in the past year because of sexual exploitation or harassment by:								
a. another therapist	8	(13.3%)	9	(9.9%)	12	(15.0%)	24	(26.7%)
b. faculty member of supervisor	31	(51.7%)	53	(58.2%)	56	(70.0%)	69	(76.7%)
c. another student	47	(78.3%)	78	(85.7%)	67	(83.8%)	77	(85.6%)
80. Centers that have special programs for:								
a. gay, lesbian, and bisexual students	20	(33.3%)	30	(33.0%)	35	(43.8%)	58	(64.4%)
b. racial minorities	14	(23.3%)	25	(27.5%)	33	(41.3%)	59	(65.6%)
c. international students	12	(20.0%)	30	(33.0%)	18	(22.5%)	42	(46.7%)
d. financially disadvantaged	6	(10.0%)	6	(6.6%)	3	(3.8%)	10	(11.1%)
e. single mothers	3	(5.0%)	8	(8.8%)	7	(8.8%)	11	(12.2%)
81. Centers that have thoroughly reviewed APA ethical guidelines for working with multicultural students	4	(6.7%)	6	(6.6%)	6	(7.5%)	14	(15.6%)
82. Directors that feel their staff is very well-versed about these guidelines:	3	(5.0%)	4	(4.4%)	5	(6.3%)	9	(10.0%)
83. Directors that feel the number of students seeking help for eating disorders is:								
a. increasing	22	(36.7%)	25	(27.5%)	24	(30.0%)	25	(27.8%)
b. decreasing	5	(8.3%)	7	(7.7%)	12	(15.0%)	12	(13.3%)
c. remaining about the same as previous years	33	(55.0%)	58	(63.7%)	43	(53.8%)	52	(57.8%)
84. Centers that have seen one or more HIV positive clients within the past year:	16	(26.7%)	35	(38.5%)	36	(45.0%)	52	(57.8%)
85. Directors who felt that any of these HIV positive clients posed a risk to any third party:	2	(12.5%)	6	(17.1%)	5	(13.9%)	11	(21.2%)
When clients posed a risk, directors who found it necessary to warn a third party:	0	(0.0%)	1	(2.9%)	1	(2.8%)	1	(1.9%)
86. How Directors would generally handle it if an HIV positive client states that he/she has not informed his/her partner of the health situation:								
a. Would take no action	0	(0.0%)	0	(0.0%)	1	(1.3%)	1	(1.1%)
b. Would encourage disclosure but otherwise take no action	29	(48.3%)	36	(39.6%)	45	(56.3%)	43	(47.8%)
c. Would inform client that if he/she did not inform partner, that you would be ethically bound to do so	15	(25.0%)	31	(34.1%)	24	(30.0%)	27	(30.0%)
d. Other	8	(13.3%)	12	(13.2%)	6	(7.5%)	15	(16.7%)
87. Directors who have noticed an increase in the number of students who report having been sexually abused as children:	40	(66.7%)	71	(78.0%)	62	(77.5%)	61	(67.8%)
88. Directors who feel students reporting earlier sexual abuse typically have more serious psychological problems than other personal counseling clients:	44	(73.3%)	76	(83.5%)	65	(81.3%)	69	(76.7%)
89. Centers where staff have had in-service training in the past year on how to work with students who have been sexually abused as children:	18	(30.0%)	36	(39.6%)	33	(41.3%)	43	(47.8%)
90. Centers that have run groups for students who have been sexually abused as children:	11	(18.3%)	36	(39.6%)	51	(63.8%)	63	(70.0%)
91. Centers where counselors have made a child abuse report for the following:								
a. a client who had been abused in the past	4	(6.7%)	14	(15.4%)	21	(26.3%)	24	(26.7%)
b. a client who was being abused concurrent with counseling	2	(3.3%)	4	(4.4%)	8	(10.0%)	19	(21.1%)
c. a client who had previously abused a child	1	(1.7%)	6	(6.6%)	8	(10.0%)	13	(14.4%)
d. a client who was abusing a child concurrent with counseling	2	(3.3%)	8	(8.8%)	6	(7.5%)	12	(13.3%)
92. Clients where counseling staff have been legally involved in cases:								
a. to support a child abuse victim	3	(5.0%)	4	(4.4%)	8	(10.0%)	16	(17.8%)

	Under 2,500 (n=60)		2,500 - 7,500 (n=91)		7,500 - 15,000 (n=80)		Over 15,000 (n=90)	
b. to support a child abuse offender	0	(0.0%)	3	(3.3%)	1	(1.3%)	2	(2.2%)
c. called to testify due to family suit alleging false memory	0	(0.0%)	0	(0.0%)	0	(0.0%)	0	(0.0%)
93. Centers that routinely ask about childhood sexual abuse in assessment of clients:								
a. for female clients	5	(8.3%)	3	(3.3%)	6	(7.5%)	3	(3.3%)
b. for all clients	17	(28.3%)	28	(30.8%)	27	(33.8%)	35	(38.9%)
c. not routinely	37	(61.7%)	56	(61.5%)	47	(58.8%)	51	(56.7%)
94. Centers that have policies/procedures on how reports of recovered memories of childhood sexual abuse should be handled:	3	(5.0%)	6	(6.6%)	6	(7.5%)	2	(2.2%)
95. Centers where the debate between recovered memory (suggesting that recovered memories of abuse are real memories) and false memory (suggesting that recovered memories are therapist-induced fictions) has become an issue:								
a. It was never been discussed at our Center	9	(15.0%)	12	(13.2%)	8	(10.0%)	11	(12.2%)
b. The issue has been briefly mentioned	36	(60.0%)	55	(60.4%)	47	(58.8%)	55	(61.1%)
c. Our staff has had special training/frequent discussions around this issue:	14	(23.3%)	23	(25.3%)	25	(31.3%)	24	(26.7%)
96. Centers that accept mandated referrals from a campus administrator or Judicial Board:								
a. for assessment and counseling	31	(51.7%)	39	(42.9%)	31	(38.8%)	30	(33.3%)
b. for assessment only (no mandatory counseling)	20	(33.3%)	35	(38.5%)	33	(41.3%)	44	(48.9%)
c. we accept no mandated referrals	9	(15.0%)	16	(17.6%)	15	(18.8%)	14	(15.6%)
97. If a campus judicial board or administrator makes a mandatory referral to the Center of a student with a drug or alcohol problem, it is generally handled in the following manner:								
a. No such referrals are accepted	9	(15.0%)	16	(17.6%)	19	(23.8%)	15	(16.7%)
b. Will see the student for no more than one mandatory visit	25	(41.7%)	33	(36.3%)	30	(37.5%)	45	(50.0%)
c. Will see the student for a series of mandatory sessions	25	(41.7%)	38	(41.8%)	25	(31.3%)	22	(24.4%)
98. Level of success for Centers who see mandatory drug & alcohol cases:								
a. very successful	4	(6.7%)	4	(4.4%)	1	(1.3%)	2	(2.2%)
b. moderately successful	24	(40.0%)	33	(36.3%)	32	(40.0%)	33	(36.7%)
c. not very successful	14	(23.3%)	20	(22.0%)	16	(20.0%)	20	(22.2%)
99. Schools that have received a FIPSE grant:								
a. through the Counseling Center	15	(25.0%)	21	(23.1%)	19	(23.8%)	16	(17.8%)
b. through the Health Center	2	(3.3%)	4	(4.4%)	14	(17.5%)	20	(22.2%)
c. through some other office	12	(20.0%)	27	(29.7%)	19	(23.8%)	26	(28.9%)
100. Schools that have had external grants apart from FIPSE to support alcohol-related programming:	1	(1.7%)	13	(14.3%)	13	(16.3%)	11	(12.2%)
101. Schools that have attempted to reduced alcohol on campus using these methods: (Directors checked all that applied)								
a. on a policy level	47	(78.3%)	71	(78.0%)	62	(77.5%)	68	(75.6%)
b. on-campus prevention programs have been implemented	48	(80.0%)	81	(89.0%)	72	(90.0%)	80	(88.9%)
c. on-campus treatment focused programs have been implemented	17	(28.3%)	33	(36.3%)	33	(41.3%)	35	(38.9%)
d. off-campus referrals to treatment/prevention programs are offered	33	(55.0%)	58	(63.7%)	53	(66.3%)	54	(60.0%)
e. alcohol use is not considered a problem on our campus	5	(8.3%)	1	(1.1%)	5	(6.3%)	3	(3.3%)
102. Schools that have implemented any of the following policies and programs to address alcohol-related problems on campus: (Directors checked all that applied)								
a. peer education	40	(66.7%)	74	(81.3%)	67	(83.8%)	73	(81.1%)
b. social marketing for prevention of alcohol abuse	27	(45.0%)	53	(58.2%)	47	(58.8%)	55	(61.1%)
c. low tolerance policy for alcohol related crimes	30	(50.0%)	45	(49.5%)	34	(42.5%)	39	(43.3%)
d. increased regulation of the Greek system	19	(31.7%)	38	(41.8%)	44	(55.0%)	53	(58.9%)
103. Schools that have instituted the following alcohol reduction residence options: (Directors checked all that applied)								
a. all residence halls totally alcohol-free	6	(10.0%)	23	(25.3%)	19	(23.8%)	27	(30.0%)
b. select residence halls alcohol-free	16	(26.7%)	13	(14.3%)	14	(17.5%)	13	(14.4%)
c. alcohol-free floors in residence halls	19	(31.7%)	16	(17.6%)	25	(31.3%)	15	(16.7%)
d. contracted alcohol-free rooms	0	(0.0%)	2	(2.2%)	3	(3.8%)	7	(7.8%)

	Under 2,500 (n=60)		2,500 - 7,500 (n=91)		7,500 - 15,000 (n=80)		Over 15,000 (n=90)	
104. Directors' opinions about current alcohol use on their campus vs. five years ago:								
a. increase in all levels of drinking	12	(20.0%)	23	(25.3%)	25	(31.3%)	15	(16.7%)
b. increase in binge drinking, but not overall drinking	14	(23.3%)	19	(20.9%)	17	(21.3%)	21	(23.3%)
c. level of alcohol use has not changed	26	(43.3%)	32	(35.2%)	26	(32.5%)	46	(51.1%)
d. decrease in binge drinking, but not overall drinking	2	(3.3%)	5	(5.5%)	3	(3.8%)	2	(2.2%)
e. decrease in all levels of drinking	1	(1.7%)	6	(6.6%)	3	(3.8%)	4	(4.4%)
105. Centers that are taking the following actions to prepare for managed care: (Directors checked all that applied)								
a. Using DSM coding on all/most clients	2	(3.3%)	14	(15.4%)	19	(23.8%)	27	(30.0%)
b. No longer counting client cancellations or no-shows as part of counselor contact hours	0	(0.0%)	6	(6.6%)	5	(6.3%)	9	(10.0%)
c. Requiring written treatment plans	4	(6.7%)	15	(16.5%)	14	(17.5%)	17	(18.9%)
d. Requiring more detailed documentation of treatment progress	8	(13.3%)	22	(24.2%)	18	(22.5%)	23	(25.6%)
e. Increased emphasis/training on quality assurance and utilization review methods	5	(8.3%)	11	(12.1%)	18	(22.5%)	33	(36.7%)
f. Increased emphasis on consultation/outreach to campus community	19	(31.7%)	37	(40.7%)	46	(57.5%)	46	(51.1%)
g. Increased emphasis/training on short-term counseling	21	(35.0%)	47	(51.6%)	45	(56.3%)	60	(66.7%)
h. Lobbying government officials and/or insurance companies on inclusion of Counseling Centers as preferred providers	1	(1.7%)	4	(4.4%)	6	(7.5%)	2	(2.2%)
i. Other	4	(6.7%)	5	(5.5%)	6	(7.5%)	11	(12.2%)

106. Innovative programs or projects at Counseling Centers: See Appendix D.

Appendix A

Ethical Dilemmas- Question 31

Confidentiality/Release of Information Issues:

Reports from clients and past interns that a current staff member inappropriately talks about his own issues in groups and sessions.

An insurance company for the University wanted the Counseling Center Director to report rape cases to the University lawyer. The Director refused.

One Director wondered about the limits to confidentiality with drug and alcohol abuse and how to determine an emergency situation. He conveyed a story about a student who reported that a client had been drinking in her room and the Director's difficulty in determining when the RA should be informed.

Regarding family therapy cases-who needs to give consent to release records (which family members are "clients," etc.). Also, one Center expressed concern about parents who call and want the counselor to keep the call secret.

Conflicting "needs to know" among Student Affairs staff, resulting in pressure from Dean of Students to release confidential counseling information. In another situation, an Assistant Vice-President was asking for information on clients. Several Centers expressed concern about parents or university staff (i.e. residence hall staff) who pressure for information before a release has been signed.

How to handle computerization of our records to insure maximum confidentiality.

There continues to be ongoing concern regarding when there is sufficient threat to self or others for confidentiality to be broken? One Center expressed concern about when to break confidentially with eating disordered clients.

Questions about what to do with knowledge about professors who have patterns of exploiting graduate students (sexual and non-sexual exploitation) when students were afraid or unwilling to take action.

Maintaining confidentiality for client of sexual assault vs. responsible institutional response to insure protection of other students. The role of treatment vs. advocacy has also been debated within several Counseling Centers. Can Centers do both?

A woman was attacked by an unknown assailant on campus. She did not want to inform Security. Do I inform Security without using her name, so they can increase surveillance of the area? Dilemma concerning individual versus community needs.

A Student Health Service illegally released confidential information involving counseling about a student.

Client session audio tapes stolen from a practicum student.

Request for sharing confidential information with parents of student who committed suicide.

Staff Issues

One Center reported that only an unlicensed psychologist (in process of gaining license) was available to supervise unpaid interns.

Rivalry and triangulation on the part of one staff against another: how much information should be shared with the rest of the staff?

Trainee suddenly decided to resign and the Director had to deal with home program about the decision and its implications.

Ongoing public accusations against a Director, a counselor, and eventually a number of other University personnel by a former client of the counselor - under what circumstances should the Director give information during inquiries?

Two Centers reported dilemmas involving impaired employees whose work had deteriorated. One was dismissed and the other was counseled into another position.

Standards/Legal

University received a complaint from the Office of Civil Rights concerning not providing accommodations for graduate students with an Axis II 301.22 Schizotypal Disorder.

IACS standards state that "when appropriate" Centers should play an active role in advocating needs of students to campus community. In advocating for support of needs of gay/lesbian/bisexual students, one Center became object of college senate inquiry.

A staff psychologist was asked to attend a hearing in support of a client who filed sexual harassment charges against a faculty member.

Assault on therapist who took legal action against client, who in turn filed harassment charges against therapist.

One Center received reports from different students that a university official is ignoring their complaints of sexual harassment-but the students gave no permission to reveal.

One Director was instructed by the university president to do an illegal job search for a newly created position (i.e., pretend to follow affirmative action guidelines). When the Director refused the position was pulled.

One Director reported that he/she advocated for a student with the understanding that ADA prohibits the use of psychiatric history in admission decisions. Another Director wondered about the implications of ADA for eating disordered students. What are the implications of ADA?

What about the ethics of a mandatory requirement for all new students to have career assessment?

Dual Relationships

What do you do when a friend, roommate, partner of a client requests to enter therapy with that client's counselor?

A Director is seeing one-half of a relationship while the staff counselor sees the other (suicidal client). The Director needs to both supervise the counselor and keep distance because of his own client.

Dual relationship issues included: staff psychologist as professor, clients who are also student assistants and dual roles with former (or future, given advance registration) students requesting therapy.

Situation in which employee, as spouse of clinical director, may have to report to clinical director.

Community member sought information re: the ethics of private practitioner establishing personal relationship with the woman's husband while he was still in treatment.

Clinical Issues

A duty to warn dilemma that might have resulted in the potential victim then killing the potential perpetrator.

Evaluation of admitted student subsequently found to have murdered her mother.

Considered ethics of hospitalizing/not hospitalizing a student who had intermittent suicidal crises.

A minor (17 year old) admitted as part of session that she was abused as a child by father. Other small children remain at home but she did not want to report abuse.

Clinical and ethical issues around "repressed memory" of abuse or vague sense that something happened in the past-which has been described by several clients. One Center expressed concern about providing services to such students within a short term model.

Untrue anonymous accusation (widely disseminated) of psychologist and former client in a sexual relationship.

Assessment and disposition in case involving an international student who spoke poor English and was suicidal.

Student developed obsessive infatuation with her psychologist.

Systems Issues

Several Centers wrote of the difficulty in finding psychiatrists for medication review or hospitalization needs unless the student had good insurance. One Center wondered about the implications of having the university psychiatrist prescribe medication for over the summer. Outpatient follow-up is particularly difficult if the student lives out of state.

Use of "mandated evaluations" by the Office of Residence Life to determine a student's ability to continue in campus housing.

Conflict between data collection on sexual aggression-harassment, assault, and confidentiality.

Faculty committee on women requested that our EAP provide a support group for women faculty members dealing with sexual harassment; a number of whom were contemplating suits against the University. Two possible group members were clients and are initiating lawsuits.

An Assistant Dean of Academics would continuously and deliberately misconstrue the counseling facts of her referrals on mutual clients, then claim we gave bad service. We could not defend or explain what we did because of confidentiality.

In moving disabilities services administratively into Counseling Center, it was necessary to coordinate two different ethical/confidentiality codes.

Referrals from administration as part of disciplinary process; involvement of parents prior to 302 petition.

Conflict arose between state psychology board's interpretation of state law and the campus attorney general's office. Center got caught in the middle.

One Director feels at odds philosophically within the medical model and feels a lack of authority and adovcacy within the larger system.

We are caught as a public institution between a state law against "making a gift of state funds" which our VP interprets to mean no services during academic breaks, and the opposing needs for continuity of care and the hazard of abandonment.

Record Keeping Issues

Client wanting information in her file pertaining to her disclosure that she has Down's Syndrome to be expunged from her record. Felt (after parents' overreaction, we suspect) that the disclosure was coerced and afraid others (teachers, students) would find out.

The possibility of records being subpoenaed for a lawsuit on a current client did not come about, but it forced us to address questions of how to write defensive notes.

Student asked that her records be destroyed after she was provided with a copy. We refused to do this. Her lawyer has contacted university counsel, but has not brought suit as yet.

Whether/how to respond to a request for records for a disability claim when our records indicated there had been an illegal name change.

Student requested we shred his records; previous client asked Counseling Center to sign for room in Student Union so she could offer rape survivors' support group.

Appendix B

Actions that Centers have taken to Effectively Manage Caseloads: Question 61

Eight Centers reported employing more outside referrals, four Centers reported reducing session time, and two centers hire more graduate assistants or interns. Some Centers reported that they increased therapists' caseloads and/or hours at peak times. Several Centers have adjusted their intake system in the following ways: use of paper and pencil intake/assessment, do intake when students walk in, shorten intake process and assign students more quickly to group or individual counseling.

Other suggestions included:

-Seeing career clients in a group for initial session. Seeing career clients for 30 minute appointments.

-Charging after 6 sessions

-Have emergency hour each day to handle crisis situations

-Reduced number of sessions from 12 to 10

-See two students together

-We automatically terminate if client no-shows once or if cancels 2 of 3 consecutive appointments

-Ongoing training on brief therapy techniques, case conferences providing peer supervision and support; charging $10 per missed/non-canceled appointment

-1) Acuity system; 2) Productivity system with weekly feedback; 3) Limited annual leave during high demand time; 4) Redefinition of psychiatrist's role; 4) Eliminate comp time; 5) Limited educational leave; 6) Clear priority on face-to-face billable hours over outreach, workshops, etc.

-Do pre-screening testing on P.I./or CD testing

-Forming small (3-5 clients) “problem-solving” groups

-Offering drop-in hours for brief problem-solving

-Using 1-2 session assessment/brief therapy model (for very specific and easily addressed concerns)

-Clients have three working days following a missed appointment to reschedule, or else lose their regular weekly time

-Central scheduling

-Wait-list schedule matching

-Set maximum number of appointments to be scheduled with clients per day for individual therapy

-Restructuring work day schedule to free up another hour (multiplied by 6 counselors, means 6 more service hours per day)

-Stop putting clients on waiting list after spring break-counselor and client must find some other option

Appendix C

Concerns of Centers: Question 65

The most prevalent other concerns expressed by Centers included: budget cuts and outsourcing/privatization (17 comments), psychiatric consultation and hospital admission and insurance issues (17 comments) and lack of adequate space (4 comments). Two Centers had concerns about losing or replacing staff members. Some Centers had concerns about different kinds of treatment populations including: eating disorders, alchohol abuse, sexual assualt, ethnic minority, and international students.

Other concerns expressed by Centers include:

-Increase in requests for ADHD services

-Closing down Center completely

-Need to develop evaluation procedures; need to become more engaged in University program evaluation research

-Our concerns are developing multicultural initiatives and raising community awareness around eating disorders

-Pressure to do more research and see more clients

-Dealing with fall-out repercussions of six suicides this year

-Academic department accepting more students into counselor training program than client flow can support

-Students not utilizing services

-Demands from the campus community for assistance with disturbed/distressed students who are not Center clients

-Students wanting and fighting for more control and management of student services-including budget

-Increased pressure to provide more outreach when we are busy providing emergency services and ongoing therapy

-Finding sufficient number of appropriate clients for practicum students who need mild to moderate somewhat long term clients

-Violence against students

-Administrative pressure to justify the existence of the Center

-VP of Student Affairs is mandating we increase our caseloads of student contacts

-Increasing demand for programming (preparation and presentation) cuts into available clinical hours

-More pressure from parents

-Concern for career counseling resources; overmedication by Health Services

-Political pressure to do therapy and LD services the way campus officials want it done, regardless of ethical or therapeutic or standard of care issues

-Health care reform & change issues directly affecting the Student Health Center, i.e., funding threats, student insurance problems, increased competition from HMOs, accreditation expectation, continuous quality improvement"

-Need for anger management program

-Increased demand for outreach and prevention training for students on issues of suicide and date rape; correcting campus misperceptions of A&D use

-We have seen more pregnancy/abortion related issues this year than ever-from 0 in the past 2 years to about 8 this year

Appendix D

Innovative Programs (Schools have been identified by their Director numbers for networking purposes) Question 106

Several Centers have started Peer Education and Peer Counseling for areas such as dissertation support group, tutoring, survey research eating disorders, mentoring for sexual minorities, and outreach to culturally diverse students. Several other Centers reported beginning special sexual assualt services for students, including videotapes to illustrate school policies and volunteers to educate and advocate in the community. Four Centers have developed Critical Incident Stress Debriefing Teams and/or better risk evauluation proceures (256, 262, 290, 079). Several Centers have begun interdisciplinary eating disorders assessment and treatment teams with collaboration in case conferences (i.e. incorporating assessments in plan from physician, nutrition-dietician, exercise physiologist and psychologist) (132, 138, 250). Several Centers have offered workshops during evening or lunch times on topics such as: relationships, psychopathology, stress, self-esteem, and depression.

007 S.O.R.T. (Survivors of Rape Trauma) Support Group (partially funded through local mental health center - clients referred to group by campus and off-campus mental health providers)

010 Meditation based relaxation training program

026 A multicultural training program called REACH-Reaffirming Ethnic Awareness and Community Harmony

044 Summer Bridge Program involves interns and staff working with minority and disadvantaged high school students considering a college education.

047 Sisterhood Support Group: support group for African American women students co-sponsored by the Women's Resource Center

056 "Kiss and Make Up" week (distribution of coupons advertising free resources, relationship programs) "Get off my Back" week (communication/assertion programs, massage and stretching programs, assertion training)

065 "Neuropsychological testing program: response to increased needs of students with hearing disability, head injury, ADD, etc.; biofeedback services for performance anxiety, etc.; retention program for students on probation."

081 "Guerilla theater" - a theater group which presents social issues (racism, ageism, homophobia) followed by discussion

105 Alumni network for gay/lesbian/bisexual students-in development-related to job search, workplace issues

114 Mental health newsletter to students and faculty-Faculty diversity sensitivity training

127 Started a peer late night hotline this year, called "Nighttalk."

154 Developed a support group for Directors of one person or small staffed college Counseling Centers - we meet four times a year to discuss issues of interest and concerns.

157 During fall semester, all first-year students participate in a workshop required before pre-registration called "Exploring College Goals" which provides individual Myers-Briggs results and career/life planning information"

172 We offered groups and gave them titles from movie titles, like a transition group called "Reality Bites" and a survivors of abuse group called "Safe Passage."

177 Images of Me, a self-esteem group for African-American female students. Smoking cessation group for employees.

178 Traditional Male and Female Roles and Values: Couples Communication, Men & Violence, Men and Health Risks"

188 Multicultural program; Lesbian-Bisexual groups; Major suicide prevention programming

221 Cross-Cultural Consultation Team - sponsored campus multicultural summit focusing on campus environment

226	Outreach program series including "Lunch and Learn-The Relationship Series," and "Career Quest." One particular outreach program that received considerable attention was "Using Soaps to Explore Your Unconscious"
229	1) ALLY Program - network of gay/lesbian/bisexual supportive faculty and staff; 2) Intergroup Relations Program - program to enhance dialogue among diverse groups; 3) "Inner Voices" - Open form issue oriented theater troupe
244	Risque Business- a music/drama performing troupe which dramatizes health lifestyle issues-travels to junior and senior high schools in the region.
263	Proposing a program to get highly respected faculty, staff and students to assist us in reducing the alcohol abuse problem on campus.
265	Eating disorder educator: senior psychology intern position that will research, develop workshop/group materials and give residence hall programs.
266	CAI-based intake program, organ donation pilot program
285	Guided Self Change for alcohol use
289	Mental health topical outreach booth in Union; covering only 1-2 topics per week (stress and depression, relationship break-ups, anxiety disorders,etc.)
293	Student destigmatization poster campaign about using counseling services

The following pages contain directories to assist you in matching counseling centers with their three digit identification numbers. Beginning on this page is an alphabetical listing by last name of all counseling center directors. On the following pages is a list which is organized alphabetically by institution name. Some institutions whose surveys were not included in the data analysis can be found at the end of that list.

ALPHABETIZED LISTING OF PARTICIPANTS - Directory number follows name

Aiken, Jim (025)
Alishio, Kip C. (114)
Allbritten, Bill (121)
Andre, Bellerive (204)
Anton, William D. (271)
Arnold, Elizabeth (128)
Atkins, Pam (188)
Azar, James A. (152)
Backels, Steve (142)
Baker, Deborah (274)
Baker, Ted (111)
Balderrama, Sylvia (297)
Balistrieri, Thomas J. (243)
Ball, Wilbert (054)
Barclay, Rosalyn (056)
Bayne, Robert D. (175)
Bentley, Charles (318)
Bertsch, Donald (036)
Biegen, Sharon (247)
Birge, Susan N. (211)
Birky, Ian (098)
Bishop, John B. (223)
Bloom, Linda (061)
Bolland, Herbert R. (038)
Booth, Janis C. (118)
Bowersock, Roger B. (269)
Boyd, Vivian S. (235)
Brandel, Irvin W. (206)
Brian, Tom J. (281)
Brooke, Jo (260)
Brown, Bernice E. (107)
Brown, Steve D. (226)
Browning, Bobbe (028)
Brummels, Lin (302)
Bucell, Michael (058)
Buckles, Nancy B. (084)
Burgan, W. Michael (039)
Burmaster, Carrie (236)
Canavan, Margaret (279)
Cannici, James (196)
Carney, Clarke G. (093)
Chagnon, Jean (033)
Chandler, David (156)
Chappelle, Joan M. (005)
Chirico, Bernie (110)
Chislett, Lise (262)
Cimbolic, Peter (035)
Clack, James R. (283)
Coffman, Janet (171)
Cook, Donelda A. (103)
Cooper, Stewart E. (295)
Corazzini, John G. "Jack" (298)
Corirossi, Della (049)
Covington, James D. (116)
Cozzens, David S. (137)
Craig, Donald H. (108)
Cross, David (253)
Curoe, Bernadine (101)
Danchise, Roger (014)
Daughhetee, Charlotte (161)
Davidshofer, Charles O. (044)
Deakin, Spencer (069)
Deneselya, Helen A. (120)
DePalma, Diane M. (071)
DePauw, Mary E. (157)
DeSalvo, Francis J. (231)
DeStefano, Thomas J. (131)
Diggs, Connie (029)
Donahoe, Patrick M. (119)
Donn, Patsy A. (009)
Doran, Lindley E. (148)
Dore, Patricia (153)
Douce, Louise A. (135)
Dowis, Jerome D. (242)
Doyle, Diana (043)
Doyle, Ellen (122)
Doyle, Michael (104)
Dreeben, Jane (315)
Drum, David J. (278)
Dugan, Meg (124)
Dyer, James (102)
Easton, Robert (301)
Edgerly, John W. (258)
Ehrenworth, Jonathan (166)
Erickson, Lloyd (004)
Erskine, Charlene (046)
Evans, Sally (306)
Everhart, Deborah (254)
Ferrari, Nancy (303)
Fields, Anika C. (066)
Filicetti, Peter (096)
Foreman, Milton E. (220)
Frank, Edith (125)
Freeman, Sally (238)
Fuchs, Kathleen Fitzgerald (097)
Fulks, Nikki J. (232)
Fygetakis, Leah M. (019)
Gabbard, Clinton E. (145)
Gahnz, Sharon (292)
Gale, Diane (184)
Gallagher, Robert P. (263)
Garni, Ken (183)
Gault, Frank (277)
Geller, Marvin H. (144)
Gellert, Jane (165)
Gibson, Joan M. (192)
Giebink, John W. (216)
Gilchrist, Lou Ann (129)
Glore, Susan J. (310)
Gonzales, Eloy M. (305)
Gordhamer, Rolf (195)
Gordon, Michael (088)
Graham, Donald S. (027)
Granosky, E.M. (265)
Grant, Charles O. (233)
Grayson, Paul A. (127)
Greer, Richard (309)
Grosz, Richard (259)
Guthman, John C. (079)
Hadley, Virginia P. (239)
Hageseth, Jon A. (287)
Hallahan, Patricia (174)
Halstead, Rick (320)
Hammond, Barbara (300)
Handy, Lee C. (212)
Hanek, Michael (136)
Hansche, Janet H. (200)
Harman, Robert L. (218)
Harris, Harold J. Jr. (117)
Hattauer, Edward A. (024)
Hatton, John M. (031)
Heitzmann, Dennis (141)
Hensley, Steve (109)
Hersh, Jeffrey B. (047)
Hewing, Venus (017)
Hocking, Thomas K. (290)
Holmes, James R. (286)
Hopkins, Warren P. (267)
Hotelling, Kathy (132)
Howland, John S. (317)
Hoyt, Arlyne E. (023)
Hurley, George (257)
Indenbaum, Fred (012)
Irvine, John S. (126)
Jacks, Richard N. (313)
Jaeger, Theresa (179)
John, Kenneth B. (068)
Johnson, Marilyn (155)
Johnston, Paul J. (249)
Jones, Ann (020)
Jones, Jean K. (244)
Jones, Linda S. (159)
Jones, William H. (074)
Joy-Newman, Stephany (308)
Kafka, Eric (178)
Kahn, Malcolm (241)
Kazin, Robert (077)
Keane, Jeri (252)
King, Bradford D. (272)
King, Michael M. (312)
Kiracofe, Norman M. (311)
Kirts, Donald K. (095)
Kissinger, R. David (016)
Klukken, P. Gary (276)
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