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ABSTRACT

Changes in administrative policies and budgetary cutbacks add to the vulnerability of many university counseling centers. Two possible solutions, currently existing within two state-affiliated universities, entail housing student counseling in student health centers and either linking counseling administratively with health services or keeping their management separate. This symposium discusses the challenges in practice, administration, and ideology which counseling centers may face in operating under such a health center linkage. Some of the specific issues addressed here include: administrative challenges; supervisory challenges; practice issues; challenges for psychology trainees; and prevention and health promotion challenges. Some of the conclusions recommend that university counseling centers should strive to retain service autonomy; that they exercise care as they co-exist with other health-related units; that with shrinking budgets they continue dialogue with officials to minimize the challenges to practice and maximize the ability to provide effective service; that variables such as the physical environment, client first contacts, and medical staff perceptions of mental health services be considered if merging is necessary; and that counseling centers address the root causes of psychological disorders. Failing this, campus counseling center practitioners will be confined to tertiary services as they attempt to ameliorate existing disorders. (RJM)

STUDENT FUNDED UNIVERSITY COUNSELING CENTERS: OPERATIONAL CHALLENGES FOR YEAR 2000

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Student Funded University Counseling Centers: Operational Challenges for Year 2000

Introduction

Changes in administrative policies and budgetary cutbacks add to the vulnerability of many university counseling centers (Gilbert, 1989; Harris & Kranz, 1991; Robbins, May, & Corazzini, 1985). As funding for student services decreases and the demand for such services increases, university administrators must develop unique solutions to the numbers problem. Barclay and Scheffer (1986) reported that budget cuts in student services required some faculty members to provide some of the counseling to students. Many universities are unwilling or unable to provide more general budgetary funding to their counseling centers while looking for unique solutions to the dilemma.

Two possible solutions currently exist within state-affiliated university systems. At the University of Wisconsin—Milwaukee, the counseling unit is both administratively and physically housed within the Student Health Center. This arrangement occurred about 15 years ago, and since that time, two other University of Wisconsin branch campuses have gone to this model. 99.79% of the funding for the U.W.—Milwaukee Student Health Center comes from student segregated fees collected through tuition. This health center has received a large number of calls from other colleges and universities desiring information on how to copy this model. At the State University of New York (SUNY) College at Brockport, the Counseling Center is housed within the same building as the Student Health Service, but is administratively separate.

Clinical practitioners in university settings need to be aware of the costs incurred by counseling centers that become linked to a health center, especially

those that may require mental health to function under the traditional medical model. Although under such a linkage, funding may be guaranteed, but operational difficulties may exist.

The presenters of this symposium will discuss an array of new challenges that will be faced in the areas of practice, administration, and ideology which counseling centers may face in operating under the health center linkage.

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University Counseling Center Administrative Challenges: Year 2000

The counseling services unit within the Norris Health Center at the University of Wisconsin—Milwaukee had long been the only such unit physically and administratively housed within a "medical center". In the past two years, the University of Wisconsin—Whitewater, and the University of Wisconsin—Madison, have each merged their counseling centers with the health centers. Several other University of Wisconsin System campuses are actively resisting the merger concept. It is felt this type of merger will become a future trend if university counseling centers are to survive into the next millennium.

Nearly 15 years ago on the University of Wisconsin—Milwaukee campus, an administrative financial decision was made to relocate the counseling center staff to the Norris Health Center. At that time, this arrangement made a great deal of financial sense. The university did not want to continue using its general administrative funds to operate the counseling service. All Health Center operating costs are financed by segregated fees allocated from student tuition. In short, all Health Center services are funded by "hard" money, rather than "soft" money provided by the general administrative budget. Typically, in times of fiscal restraint, "soft" money becomes the first cut made by university administrations and/or boards of regents.

It has been difficult to survey what is happening in counseling centers comparable to our setting. While other universities have been able to identify and empathize with our situation, some are reluctant to go on record regarding any similarly experienced difficulties. However, a cross-section of five other

institutions can provide some interesting comparisons (Archer, Gale, Newton, Heitzman, & Boyd, 1993). The University of Florida in Gainesville has a student population of 36,000. The counseling center there is funded through the university's general budget, and staffed by 10 faculty members and 5 interns. Their ratio is one counselor for every 2,400 students. The University of Maryland has a student population of 40,000. The counseling center there is also funded through the university's general budget, and staffed by 14 full-time staff, with 4 clinical psychology interns, and 60-70 practicum students. Not counting the practicum students, their ratio is one counselor for every 2,222 students. The waiting time for services at the University of Maryland is 2 to 3 weeks. Penn State University has a student population of 38,000. The counseling center there is state funded as well, and staffed by 11 full-time staff and 4 interns. Their ratio is one counselor for every 2,533 students. Penn State University has a lengthy waiting list, despite trying to resolve most student issues in 1 to 2 sessions, and offering numerous group programs.

Of the five university counseling centers reviewed, two receive some portion of student funding, but not approaching that of the University of Wisconsin—Milwaukee. Kansas State University has a student population of 21,000 and receives 50% of its funding from state funds and 50% from a health fee. The counseling center was merged with the health center. There are 11 full-time staff and 4 interns providing counseling services, a ratio of one counselor for every 1,400 students. The State University of New York—Buffalo has a student population of 26,000 and receives 75% of its funding from student health. There are 7 full-time staff and 3 interns providing counseling services, a ratio of one counselor for every 2,600 students.

SUNY—Buffalo attempts to get students in as quick as possible for intake sessions, but students seen for intake in October may likely not be seen for follow-up sessions until winter break. The five institutions average a student population of 32,200 and a counseling center staff of 14.6, a ratio of one counselor for every 2,205 students.

In a survey of 29 selected urban universities (see Appendix for list of universities) done by Beeler (1993), 92.6% of the respondents reported having student health services. 52% of the respondents reported not charging students for services. Of those respondents charging a fee, the average charge was $35 per semester. 36% of the respondents charged a fee for all services. 84% reported total income exceeding a million dollars, with the mean at $1,013,086. 64% of the respondents offered "counseling" services. However, most university counseling centers are still separate entities.

The Norris Health Center on the University of Wisconsin—Milwaukee campus serves a commuter student population of 25,000 (of which only 2,000 students live in campus housing), producing about 54,000 total patient contacts per year. Medical services had been provided on a 63% walk-in / 37% appointment basis. All counseling services are on an appointment basis. It is estimated that 99.79% of the health center funding comes from student segregated fees, which is part of tuition. The cost to each student to use the Health Center is $39 per academic semester, and $20 during summer school. The revenues for the Health Center through June 1993 totaled $1,926,400, of which $1,732,200 came from segregated fees and the remaining $194,200 coming from user fees. The expenditures for the Health Center through June 1993 totaled $1,642,700. Current counseling center staff consists of only 3.5

providers, a ratio of one counselor for every 7,142 students. The counseling unit has 3,500 contacts per year with an intake waiting time of ***3 days or less***.

A change of medical directors during 1992 led to several modifications in Health Center operating/accessing procedures. Medical services attempted to switch to an all-appointment system. The final result was a 63% appointment / 37% same-day/walk-in system. Nursing staff triages cases for the medical providers to ensure that those who were most ill received immediate or same-day assessment and treatment. The students quickly became disgruntled about the change in their access to the Health Center, and were also upset at having to co-pay for medications. The current cost is a co-pay of $3.00 for some widely used generics, and students pay the actual cost for any non-generic medication. The co-pay concept creates particular problems when consulting psychiatrists prescribe Prozac. During the fall 1993 semester, student clients had to co-pay for sports medicine treatment. It is speculated that students will soon be required to co-pay for counseling services in order to recoup costs for individual work station hardware and software that all providers now utilize.

The University of Wisconsin—Milwaukee Psychology Department has an APA-approved clinical psychology training program which operates a small clinic where its students can get some psychotherapy training and experience. They are able to see clients, some of whom are not university students, on a longer-term basis than at the counseling center. This year, the Psychology Clinic is charging its clients a minimum of $5 per session, and an additional fee for any psychological testing. The monies collected from this go back into

the general administrative funds. This situation is somewhat worse than what we have experienced, as the Psychology Clinic has no say in how the fees they collect are to be allocated. The co-pay concept has had some serious adverse financial consequences for students attending large urban universities, as the inability to co-pay has discouraged some students from seeking treatment.

The Norris Health Center counseling unit has experienced on-going administrative challenges caused by operating under the traditional medical model, resulting in the inability to recommend the unit's functioning be emulated or copied by other universities. Our unit has run into obstacles that would not normally exist if the unit had departmental and budgetary status (Good, 1992; May, Corazzini, & Robbins, 1990; Parham, 1992; Phelps, 1992).

At present, the counseling unit has no fit within the medical hierarchy and is often at the bottom of the needs list where internal funding matters are concerned. Prioritizing service need areas and even scheduling of counseling clients for follow-up sessions have been done in micromanagerial fashion by the medical director without input from the counseling staff. The medical providers see 3-4 patients per hour to the counseling providers 1 per hour, which has led to a medical staff perception that the counseling unit does not see enough clients. With the number of clients seen by medical providers being quite high compared to counseling staff client numbers, it has been impossible to justify any additions to the counseling staff. This most significant, yet statistically artifactual challenge, has made it difficult to both recruit and retain counseling staff.

The students also have direct input into what services are offered by the Health Center, making it incumbent that student needs be met. Otherwise, the

Student Health Advisory Committee, the student government representative, can ask to reapportion funds, eliminate positions, and/or terminate services. In the past year, the Health Center had lost funds, which were used by the students to create a Women's Center to meet the special counseling needs of women. The decision to create a campus Women's Center, was questionable considering that 70% of our clients are women. Although the Health Center has not lost any medical positions, many openings are underfilled, either by percentage of time allocation, or by lesser credentialled professionals. The counseling unit lost a half-time position, due to an individual being assigned to be part of a campus multicultural training team. The students also voted in early January of 1994 to eliminate the dental service after eight years. The students viewed the dental program as a "pilot program". We now have thousands of dollars worth of useless dental equipment. It is uncertain as to how the Clinton health reform initiatives will affect our Health Center. There is a strong probability that our Health Center will be able to exist due to students' preference to receive services on campus. There is the possibility that our medical and mental health services can become reimbursable under the Clinton health reform. But, many health and/or counseling centers might not be so lucky.

To briefly address student health services in general, either colleges and universities will have exclusive control of healthcare delivery for the student populations or else college health will be a non-factor under health care reforms (Beckley & Grace, 1994). The first question that many chief student affairs officers must answer in regard to student health programs is whether or not the university should even be in the mental health/health care business

(Bridwell & Kinder, 1993). A college health center's future will be assured only if college health services are solving the problem of uninsured and underinsured college students, and if college health is a distinct entity with the sole responsibility of providing healthcare delivery and financing/insurance to *all* students (Beckley & Grace, 1994). Much of the increase in the uninsured student population reflects the number of uninsured Americans, with the age group 19-24 accounting for 25% of all uninsured persons (Beckley & Grace, 1994). Even more problematic is the underinsured students, especially those covered by managed care plans. Students typically have only life-threatening emergency medical coverage while at school, and must return home to the managed care area to receive other health services (Beckley & Grace, 1994).

One means by which student health centers can continue to exist is to expand the HMO Act of 1973 to create "qualified student health plans", or QSRP's (Beckley & Grace, 1994). This expansion would combine separate health services and student insurance programs, and would allow HMO's and other insurance organizations to contract with colleges and universities to cover their members under a QSRP program. Another option that is available, more on the East Coast, is a private organization, Collegiate Health Care, who specializes in creating student HMO's on campuses that had formerly offered health services and providing the staffing to those HMO's. The typical selling point used is that the HMO can provide health and/or mental health service to the university better and cheaper than can the university, which seldom happens. Yet another option is to turn toward funding strictly from student segregated fees, as has happened at our campus, which is an outdated mode of funding.

Regardless of what ultimately occurs in funding university student health centers, it is recommended that university counseling centers do whatever it takes to retain any sense of service autonomy as they feel the effects of both the budget crunch and the Clinton health reforms. Should a "forced merger" become the only option in retaining a counseling center, contingencies should be made so the service can retain some budget and staff selection autonomy.

While the American Psychological Association would prefer not taking a position in such matters, it should closely monitor developments so that intervention on behalf of counseling center psychologists can occur if administrative expectations become contradictory to APA's recommended service standards.

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Appendix

Beeler's (1993) Universities Surveyed

University of Akron
University of Alabama-Birmingham
University of Central Florida
University of Cincinnati
City College of New York
Cleveland State University
Univ. of the District of Columbia
Florida International University
University of Houston
Univ. of Illinois at Chicago
University of Louisville
Univ. of Massachusetts-Boston
Memphis State University
Univ. of Missouri-St. Louis
Univ. of Nebraska at Omaha
Oakland University
University of Pittsburgh
University of South Alabama
Temple University
Univ. of Texas at Arlington
Virginia Commonwealth Univ.
Univ. of Wisconsin-Milwaukee
Wichita State University
Wright State University
Youngstown State University

University Counseling Center Supervisory Challenges: Year 2000

The situation at the University of Wisconsin—Milwaukee, in which the counseling center was merged with the health center, is likely to become a fact of life for a number of colleges and universities in the near future as we approach the year 2000. As mentioned earlier, such a merger becomes the easiest means available to fund both units. However, unique challenges occur when administrative decisions have implications upon the provision of clinical services.

Our institution has managed to develop a cohesive multidisciplinary mental health staff consisting of two doctoral level, licensed clinical psychologists, an ABD clinical psychologist, titled a "Senior Counselor", and a doctorally trained psychotherapist who has a master's degree in social work and a Ph.D. in Urban Education with an emphasis in educational psychology. This latter individual, along with the two licensed psychologists, carry the job title, "Senior Psychologist" which is allowed in accordance with the Wisconsin Psychology Examining Board Statute (Chapter 455, sub .02). In addition, there are two consultants to the mental health staff, including a psychiatrist and a psychiatric resident. Of course, this mental health unit is but one part of a much larger staff including physicians, physician assistants, nurses, and pharmacist, with a fair amount of interdisciplinary interaction occurring among the members.

Multidisciplinary staffs such as ours are common, particularly in medical settings, and they have some obvious benefits. Pinkerton, Moorman, and Rockwell (1987) noted that the Counseling and Psychological Services of

Duke University, a merger of the Student Mental Health Service and the University Counseling Center, took place so that "different disciplines trained to address varying aspects of student problems would provide services of maximum effectiveness and minimal duplication" (p. 657). They found the response of the student body to be "markedly favorable" (p. 660) increasing the number of students served by 39 percent and doubling the number of service hours. Although there are definite pluses from multidisciplinary staffing, problems for psychologists associated with these teams have also been noted, especially with respect to medical settings. Altmeier (1991) stated that "health care settings have historically been defined as practice settings for physicians" (p. 395). In addition, Altmeier observed there are differences between physicians often action-oriented approach to problems and psychologists more cautious approach heavily involving the patient in decision-making. According to Belar, Deardorff, and Kelly (1987), these differences can result in psychologists experiencing some disadvantages. One major disadvantage being that psychologists often operate in a subsidiary role to physicians and other medical personnel with this primarily adversely affecting practice issues. However, role and power differentials can also affect supervisory issues. For example, the lack of sensitivity by the leadership of the University of Wisconsin—Milwaukee Student Health Center to the *General guidelines for providers of psychological services* (APA, 1987), and the *Specialty guidelines for the delivery of services* (APA, 1981), has at times created awkward situations for the licensed psychologists involved.

According to the APA specialty guidelines, "***one or more clinical psychologists providing professional services in a multidisciplinary setting***

constitutes a clinical psychological service unit... (p. 5). Additionally, the specialty guidelines suggest, "***providers of clinical psychological services who do not meet the requirements for the professional clinical psychologist are supervised directly by a professional psychologist who assumes professional responsibility and accountability for the services provided...*** (p. 6); and that "***a professional psychologist is the administrative head of the service...*** (p. 6).

However, in a medical clinic these guidelines are not always used. To clarify, one has to look at the overall power hierarchy of the college student health center. Typically, a Medical Director is at the helm of the health center. Over this individual is a Vice-Chancellor of Student Affairs. Assisting both of these individuals is a Business Manager. These aforementioned individuals rarely have the expertise in the practice of psychology, let alone the APA Guidelines for psychologists. In addition, the provision of mental health services is valued and supported according to the biases and values of the individual leaders involved. Having experienced four different medical directors in five years, granted an atypical situation, nonetheless has clearly demonstrated these points at the University of Wisconsin—Milwaukee Student Health Center and created the awkward situations previously mentioned.

Six years ago, the Medical Director appointed a psychotherapist, not eligible for licensure as a psychologist, to be the supervisor of the counseling/mental health unit. A succeeding Medical Director eliminated the supervisory position/function and he, a family practice physician, was the head of the mental health unit. The current interim Medical Director, who incidentally started the job after this symposium proposal was submitted to

Division 17, has placed a licensed psychologist temporarily in that spot with this likely to become an official position.

Although licensed clinical psychologists comprise half of the staff, until recently, the unit technically was *not* a "clinical psychological service unit". The head of the unit essentially evaluated the other staff and made administrative decisions. What was most disturbing for the licensed psychologists was the fact that the unusual power hierarchy created a vacuum with respect to clinical supervision, even though a mandate for such supervision in terms of case discussion exists. Since the mental health staff is composed of professionals, we have acted in this vacuum similarly to a group of independent practitioners, and have consulted about cases among ourselves on an as-needed basis. However, the licensed psychologists have had an unsettled sense of not living up to the professional guidelines established by their discipline.

This dilemma is intensified when taking on advanced clinical psychology graduate students for practicum placements, with the students coming from our institution's APA-approved clinical psychology program. Each psychologist has supervised a student and followed the APA guidelines in providing one hour of supervision per week for the student's 4-5 client caseload. But, the context in which supervision is provided clearly cannot be defined as that consistent with a "psychological services unit". Again, the psychologist acts as an independent practitioner/supervisor with a one-to-one relationship with the supervisee, with little overall staff involvement in the training. It seems somewhat awkward to be providing supervision and training to future psychologists in an environment that does not seem to value or

understand clinical supervision of staff. The most unique challenge in settings such as ours, as we near the year 2000, is to develop clear guidelines for multidisciplinary staffs, as such guidelines appear to be presently non-existent. With clear guidelines the "muddy waters" we have waded through in the past several years would not exist. Even in the absence of APA guidelines, there are several things psychologists can do to prevent problems should they face a merger of their counseling center with their health center. First of all, they can take a proactive stance in the form of establishing a clear set of policies and procedures for mental health/counseling services which have the support of the chief student affairs officer. Educating the medical leadership and the chief student affairs officer about APA practice guidelines and ethics is also helpful. Requesting consultation from a faculty member on campus, who is not part of the counseling center and thus can be viewed as a non-self serving, neutral party, to help educate the various parties is also beneficial. Doing all of these things before a merger takes place is vital preventive medicine for a host of supervisory problems. A clear set of guidelines that show the counseling/mental health unit is a strong and legitimate force on campus regardless of where it is housed is essential.

The unusual power hierarchy of counseling center personnel finding themselves under the leadership of a physician is also a typical reality of such mergers. Although initially problematic, these issues can be dealt with constructively. Rozensky (1990) noted we must abide by Ethical Principle 7 (APA, 1987) which suggests maximizing positive professional relationships and cooperation between colleagues. Rozensky also noted that over time the discipline of psychology is gaining more respect from medical providers.

Miller and Swartz (1990) challenged that "psychologists have a responsibility to make explicit the issues of power that are usually not acknowledged and to negotiate ways of working with other professionals, particularly medical professionals. This is not something that can be achieved in a simple discussion nor is it always likely to be welcomed" (p. 52). Furthermore, Miller and Swartz suggested that these discussions are "necessary if health care is to reap maximum benefit from the expertise of psychologists" (p. 52).

Another part of the unusual power hierarchy in multidisciplinary staffs in medical settings is that frequently, as we experienced, a non-psychologist mental health worker is the administrative head over the psychologists. Often this leads to difficult issues around who should provide clinical supervision, with the dilemma leading to clinical supervision often going by the wayside. At the risk of sounding elitist, this problem would be avoided if psychologists were in more leadership roles especially when 50% or more of a staff is composed of psychologists. One of the reasons psychologists may be passed over for such consideration is that unlike, for example many social work programs, most clinical or counseling psychology doctoral programs do not teach courses in administration. Thus, psychologists are often viewed as inappropriate for placement in administrative roles. It seems for psychology to maintain its standards in the future, we must not be ignorant or naive about business procedures, or, as Margolis, Duckro, and Merkel (1992) noted, "policies will be determined by those who know nothing about diagnosis and treatment, and patient care ultimately will be compromised" (p. 296).

Challenges for training as we approach the year 2000 are numerous. One consideration is for psychology programs to not only teach science and

practice, but to also give students the option of administrative specialties. The future reality of psychology is that it is not just a discipline to be studied or practiced, but it is often a business. Additionally, training programs need to prepare their students for the realities of multidisciplinary departments. Perhaps as Pinkerton et al. (1987) noted, multidisciplinary training is a very effective approach. But reviewing Quartaro and Hutchisons' (1976) work, these authors "stressed the importance of administrative and faculty support for the multidisciplinary training effort. Skepticism at the top can lead to failure in the classroom" (p. 657). Unfortunately, due to fiscal constraints, support for training regardless of type is not always present. These days, even in university settings, there appears to be a trend towards accountability and productivity over training.

In summary, the next few years will become the real test of how diverse providers of care can co-exist under the type of administrative and supervisory hierarchies described. It seems that the nature of the outcomes will be largely dependent on who is at the top, and their level of understanding and valuing what quality counseling services and training entail, and supporting these efforts on campuses.

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University Counseling Center
Practice Challenges: Year 2000

Practice in university counseling centers that are student funded and medically administered will increase in number as we approach the year 2000. As a result, university counseling staff will face many challenges, some of which may be welcomed, while others will be met with grave concern.

A challenge of significant concern to university counseling staff are budget cuts and the impact those cuts will have upon practice. The 1992 national survey of counseling center directors indicated that 54.7% of the 298 participants suffered budget cuts in 1991-1992 (Gallagher, 1992). Of importance is the fact that budget cuts frequently result in student service divisions being cut which typically fund university counseling centers at some level (Joy-Newman, in Kimmerling 1993). Such budget cuts threaten the existence, stability, and quality of services provided by university counseling staff. Budget cuts also frequently result in university counseling staff losses. Gallagher's (1992) study also indicated that counseling center directors reported more staff losses than gains in the year 1991-1992. This national trend toward decreased budgets and loss of staff is distressing given the documented trend of students presenting more severe difficulties, chronic problems, and increased need for crisis intervention services (Robins et al., 1985; Harris & Kranz, 1991; and Meilman et al., 1992). Gallagher's (1992) study also found that 87% of the counseling center directors were seeing students with severe problems which was a 31% increase from 1988.

Kraft (1992) states that despite fiscal constraints institutions of higher learning have a responsibility to provide not only direct clinical care, but also prevention and protective services. Hoffman and Mastrianni (1989) stressed

the importance of the institution creating an environment that is responsive to and supportive of the student in distress and suggested that such an environment could result in significant educational benefits to the institution. Steenbarger (in Kimmerling, 1993) also views institutions of higher learning as responsible for providing a range of counseling services as part of their commitment to student development. In fact, Steenbarger (in Kimmerling, 1993), claims that institutions make an implicit contract when they accept students that they are going to help them get through college. In addition, Bertocci et al. (1992) stressed the importance of school administrators budgeting student psychological, medical, educational, and advisory services, and suggests that the provision of these ancillary services is "one of the most prudent means for the institution to make good on its financial investments" in the students enrolled.

As a result of the budget cuts, employees of college counseling centers will find that they are asked to do more with fewer resources (Harris & Kranz, 1991; Kimmerling, 1993). Counselors will feel pressures of increased demands for services by students, administrators, and other staff members, despite decreased resources. The end result for the university counseling staff will be burnout unless the scope of duties are redefined and limits are set. A shift in priorities in terms of types of services to offer may also result from budget cuts, along with restructuring of the service. Budgets cuts may also lead to decreased funding for professional activities which are critical to the continued growth and development of university counseling staff. Joy-Newman (in Kimmerling, 1993) also suggests the budget cuts could result in university counseling staff becoming more focused and directed in their

treatment of college students and lead to increased participation in networking and consulting. On a more preventive note, Kimmerling (1993) stressed the importance of university counseling staff learning to anticipate trends affecting financial decision-making. According to Kimmerling (1993), this will help counseling staff plan a response to those conditions in advance and lessen their painful impact. In addition, Kimmerling (1993) suggests that counseling staff establish a bottom-up information flow rather than waiting for administrators to provide top-down direction for the counseling center.

Another challenge to practice for university counseling staff is administrative support. Gross (1968) alluded to the importance of administrative support in stating that personal counseling in student counseling centers is most effective when administrators understand and appreciate the skills, responsibilities, and commitment required of the personal counselor. This becomes a significant challenge that university counseling staff will face as more counseling centers merge with health centers. With the merge it is highly likely that university counseling centers will be headed by professional staff who may not have the academic background or work experience in mental health services. If this proves to be the case, there will be misunderstandings or disagreements between the administrator and university counseling staff as to the expectations or conceptions of the role the university counseling staff is to play (Geller, 1986). Gilbert (1989) also suggested that conflicting expectations related to the role, scope, and function of a university counseling center could result in "a stormy marriage" between the institution and the counseling center if concerns are not articulated and discussed. Oetting et al. (1970) also concluded that the attitude of the director

of a university counseling center is a central factor in determining the model of counseling and services provided. The administrator's attitude also affects the organizational structure of a university counseling center. According to May (1986), the organizational structure of a university counseling center is vital, as university counseling centers are "specialized parts of organizations whose major purposes and energies may lie elsewhere". This frequently results in university counseling staff having an ambiguous and insecure place in the organizational structure (Gilbert, 1989). The management style of the administrator of university counseling services and the degree of authoritarianism in administrative superiors influences the degrees of freedom the counseling center is allowed by other parts of the institution (Gilbert, 1989).

The past decade of practice in a university counseling center has made it apparent to this writer that administrators with limited knowledge of the functioning of a university counseling center; the skills required of the staff; the counseling process; and the instruments critical to the delivery of mental health services to students are ineffective and adversely affect the service. In addition, such administrators frequently set policy without consultation with university counseling staff related to the duration of treatment, the number of clients scheduled per day, and the type of treatment.

The primary benefit of the operation of a university counseling center under the leadership of an administrator committed to the service and sensitive to the needs of the staff would be the presence of an in-house advocate for the service and the staff. This would increase the likelihood of additions to staff, salary adjustments, purchase of basic assessment instruments, and support for

participation in educational activities. Such an administrator would also be more likely to make budget cuts when necessary in areas that would have the least impact on the service.

Another practice challenge in university college centers will be finding ways to function effectively with a decrease in support staff for the service. As a result of the decrease in support staff, a significant amount of time will be spent facilitating referrals and disseminating information that could be provided prior to a student having contact with a counselor. In addition, as more counseling providers enter the computer era and have individual work stations, a significant amount of time will be spent performing clerical duties, such as typing electronic treatment summary notes, evaluations, verification of treatment statements, etc. Adequate support staff would make it possible for university counseling center staff to spend more time engaging in clinical activities.

Future trends suggest that university counseling centers will continue to experience budget cuts, some of which will be less palatable than others. As we approach the year 2000, it will be critical for university counseling center staff and administrators to continue dialogue in order to minimize the challenges to practice and maximize the ability to provide effective service.

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University Counseling Center Challenges For Psychology Trainees: Year 2000

The practice and delivery of mental health care is changing, as the independent practitioner with their own office disappear. It is becoming more apparent that a closer working alliance between the medical and psychological fields is inevitable, regardless of what each profession thinks about the change. "Collaborative practice is the wave of the future" (Sleek, 1994, p. 22). Mental health care is moving in the direction where both medical and psychological services are delivered in the same building, as it occurs at the Norris Health Center. To facilitate this new alliance, there needs to be a recognition of the important differences between the professions. In the past, differences in training, vernacular, working environment, and stereotypes have created barriers to cooperation between the two professions (Sleek, 1994). The ideal place and time for this to occur might be during practicum and internship, where professional identities are still fluid and open to changes (Burnstein, Barnes, & Quesada, 1987).

The actual practice of therapy within the medical setting presents some unique dilemmas. Both the selection and treatment of clients can be heavily influenced by the practitioner's environment. In a medical setting, all clients are viewed and treated as having the same needs. The impact of initial contact with the health center, its physical surroundings, and the development of a relationship have different implications for medical versus psychological clients. Treatment requires an awareness of how these other issues affect clients. In addition, the practitioner needs to be aware that the conceptualization of the practice of psychotherapy may be heavily weighted in the direction of the medical model, which uses a more psychosomatic—

pharmacological basis for treatment (Burnstein, et al., 1987).

When clients call the health center they often feel as if they are at their last resort. If clients are greeted by central office brisk efficiency, and indifference, they may think they are not important and that no one cares. The initial contact with the health center sets the stage for the building of a relationship. Psychotherapy clients are preparing to reveal pieces of themselves or what they believe to be "terrible secrets" that they may have never revealed to anyone before. Clients need to feel that they are going to be accepted and not judged negatively because of anything they reveal or because they are seeking psychological services. Medical patients are not anticipating or expecting empathic treatment as a part of their care, whereas, psychotherapy clients do, and more importantly should.

The process of psychotherapy rests upon developing a good relationship with one's client. Part of building trust is having clients feel that their needs are going to be met. Clients must feel they can rely upon the therapist to be there for them. A lost message to a physician's appointment may mean a delay in delivery of service and treatment of a medical problem. That same lost message may have greater implications for a psychotherapeutic relationship. That same lost message could lead to a loss of trust and a questioning of the therapist's investment in the client. The end result may be a disruption or destruction of the therapeutic relationship and any progress achieved.

One of the most conspicuous problems in working at the Norris Health Center was the physical characteristics of the "therapy rooms" available to practicum students and other consultants. I was assigned to a vacant nurse's office equipped with gynecological examining table, contraceptive literature,

and cut-away anatomical diagrams. The setting was sterile, with no pictures, plants, or personal touches that would make a client feel at ease. At the finish of one session, a client who had been reticent about seeking psychotherapy mentioned that she wondered what was going to happen to her when she saw the stirrups on the examining table. Attempts to make the gynecological table and surroundings less "medical" did not succeed due to the configuration of the room and the replacement of equipment to its original position by medical service providers using the room during my absence. While this type of setting may be appropriate for the practice of medicine, it can create intense feelings of discomfort in clients having their first exposure to psychotherapy.

The last issue that is important in being assigned to a medical setting is the theoretical orientation or beliefs of the medical staff with whom you are working. A psychosomatic or pharmacotherapeutic approach tends to de-emphasize the emotional or psychological components (Burnstein et al., 1987), or even worse, it becomes what a problem is blamed on if it does not appear to have a basis in real biological factors. At the Norris Health Center, students seeking psychiatric consultations that might result in having psychotropic medications prescribed for them had to be seen by one of the psychology/ counseling providers first. Having to act as a "medical gatekeeper" became a double-edged sword. It was an advantageous approach in the sense that it prevented clients from seeking a pill to solve all their problems. However, it did lead to some disappointment and resentment by clients who believed they would be seeing a medically-trained provider, not a psychologist/counselor. It was also learned that medical staff did not possess a good understanding as to what psychotherapy was or its process, leading to

numerous inappropriate referrals.

Psychology trainees in the near future can anticipate having to learn about the practice of psychotherapy in facilities that may not be appropriately equipped to render that service. Office assignments may be made on the basis of available unused building space. It is hoped that any university counseling centers either considering, being required to, or needing to merge with health centers, or vice versa, will take variables such as the physical environment, client first contacts, and medical staff perceptions of mental health services into account while the merger is in the planning stages. Not doing so can have adverse implications for both the psychologist-in-training, and the clients.

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University Counseling Center Prevention and Health Promotion Challenges: Year 2000

One of the most significant changes in university-housed counseling centers over the last fifteen years has been the incorporation of principles of prevention and health promotion into the range of services provided. Authors in both community psychology (e.g., Albino, 1983) and counseling psychology have noted that the current, most pressing mental health needs of college-aged adults are those which cry for a prevention or health promotion focus. Counseling centers not offering these services presently may need to in the future to continue operating.

Paramount concerns confronting campus providers are often areas for which primary prevention is particularly well-suited. Three representative examples are 1) substance use and abuse; 2) sexually-transmitted diseases, and 3) bias-related injury or emotional distress. All of these areas receive programmatic attention from the Division of Student Health at the State University of New York-College at Brockport. At SUNY Brockport, offices under this division include a Counseling Center and Health Service as at most universities. However, there is a third, innovative service also: the Office of Health and Wellness. A master's level counselor (who is also a registered nurse) directs this office, serving as the full-time "Health and Wellness Educator", and coordinating all preventively-oriented programs. This office, like the others, is funded through student fees.

In discussing the three target areas I have just mentioned, it is important first to note that it is really difficult to talk about the three separately; *all* are related and interconnected (Dimitroff, 1994). For example, misuse of alcohol is frequently a factor in acquaintance rape, which can be seen as a gender bias

issue. Alcohol is also a factor in the loosening of inhibitions that can lead to unsafe sex, even if consensual. Conversely, if one is the object of prejudice or bias-related injury, turning to drugs or alcohol may be the most accessible (though not most appropriate) route to assuage feelings of rejection and depression. So, it is impossible to speak of these things in isolation, and it is important to keep that in mind.

The first area above, prevention of substance use, is addressed in a number of ways at SUNY Brockport. The need for this within college populations is well-documented. National surveys continue to spotlight the return of alcohol as the drug of choice on campuses today and its function as a "gateway" to other drug use (U.S. Public Health Service, 1986). To tell you a little bit about SUNY Brockport and the particular relevance of this issue at our campus, let me say that Brockport is in upstate New York -- forty miles east of Buffalo -- and it is a very small town. Like many college towns, there are way too many bars operating; and the winters are long and cold. In offering services to address the area of substance abuse at Brockport, we strive to be primary preventive whenever possible. One useful avenue to impart information has been through creation of introductory workshops for incoming students, held every fall semester. These workshops, which are called the "*Brockport: 14420*" series, include a module entitled, "*Alcohol and Substance Abuse: Risky Business*". Attendance at the "*Brockport: 14420*" presentations is often a required "homework assignment" for a pass / fail college orientation and planning course mandatory for incoming freshmen. Floor programs on the responsible use of alcohol are also conducted in dormitories with the assistance of resident advisors and other Residential Life staff. Peer

counseling programs have been initiated, such as the *B.A.S.E.S.* program (*B*rockport *A*dvocates *S*tudents *E*ducating *S*tudents). Furthermore, selected college athletes are involved in a program designed to prevent alcohol abuse by providing these athletes the opportunity to serve as "role models" to 3rd grade students in the village of Brockport elementary schools. Finally, in cases where primary prevention fails, the College has plans to hire a half-time counselor at the Counseling Center whose role will be to work exclusively with alcohol or drug abuse referrals. Lest we forget that alcohol is not the only "consumable" that can be used in excess, may I also mention that Counseling Center staff here, as at other places, have also coordinated groups for eating disorders and smoking cessation.

The prevention of sexually transmitted diseases on the SUNY Brockport campus is a focal mission of the Sexual Health Clinic, founded by the Wellness Coordinator in 1990. The opening of this "clinic" was not the construction of a new building. Rather, its creation implied a mandate that staff at the existent Health Services facilities would hold, two mornings and one evening per week, a "clinic" exclusively providing services relevant to students' needs surrounding all aspects of sexual health, including contraception; safer sex; prevention and education regarding sexually transmitted diseases, including AIDS; and all other aspects of sexuality, both emotional and physical. Services offered include counseling and information, diagnosis, treatment, and where necessary, referral. The Wellness Coordinator also regularly gives talks to residence halls on STD's, "Safer Sex", and HIV. Requests from teaching faculty for guest lectures on these issues are also honored (for example, from the instructors of Health Psychology, Community

Psychology). Furthermore, the Wellness Coordinator herself has taught a 3-credit course entitled "*The AIDS Crisis*" for several years. Finally, summer orientation programs for new students are also utilized as a medium for sharing information on these subjects.

The third area, bias-related injury, is also addressed through programs created at the campus-wide level. *R.A.C.E.* (*R*acial *A*wareness through *C*ultural *E*ducation) is an interdisciplinary team of staff (and some faculty) which organizes educational workshops on racism and the need for multicultural sensitivity. There are recurrent educational programs in dorms on issues of date rape, gender bias, and sexism. Sensitivity to gay and lesbian issues has also been addressed by the *R.A.C.E.* team this past year, with one of eight in a series of weekly seminars dealing with homophobia. Pamphlets are made available to students in dorms and cafeterias on all of the university programs and policies on prevention of bias, sexual harassment, and acquaintance rape.

There are a number of sensitive issues that arise whenever college counseling services attempt to go beyond a traditional medical model. Most common is one as old as prevention itself: the question of cost effectiveness. Fortunately, study after study has proven that prevention works, in these areas and others (see *Fourteen ounces of prevention: A casebook for practitioners*, published by APA, for an excellent detailing of model programs around the country). In trying to advocate for money to fund preventive services it is very important to have your college administration be aware of the effectiveness of prevention; e.g. through disseminating results of prevention studies. Conducting needs assessments prior to, and then collecting program

evaluation data following, new programs can also be a big help in gaining the support of administrators. A second criticism that is common is more philosophical than financial is that the incorporation of, or even a recognition of, a diversity focus on campus is a bow to "political correctness". In other words, prevention efforts that revolve around themes of multiculturalism, equality, or social justice, may be criticized as favoring "special interest groups". Since these kinds of lines have been frequently drawn throughout the decade of the 1990's, there is no automatic antidote to those kinds of objections to primary prevention programs. I mention it as something to be aware of, and try to counter with facts. In that arena, psychological science again is solidly in our corner -- minority status, especially in hostile environments, is a documented social stressor (see Moritsugu and Sue, 1983). Furthermore, statistics of *hate crimes*, now kept nationally by the FBI, show a minimal estimate of nearly 8,000 bias-related incidents in the U.S. in 1993, approximately 3,000 of these being physical assaults, including 20 murders. 571 of these crimes, or about 8 percent, occurred in New York State alone (Associated Press, 1994). College campuses are no more immune to bias and the other "isms" of our society than any other American institution. Obviously, a student does not stop being Jewish, or African-American, or gay or lesbian when they pass through the doors of academia. At such a sensitive period in their lives, they should be affirmed for who they are, and hopefully, for a brief time, allowed to feel somewhat safer than in the "outside world". Along these lines, please let me stress that it is important to be *proactive* rather than *reactive* in the creation of preventively-oriented programs. Don't wait to start thinking about dealing with these things only after there has already been

a racial incident on campus, or after an increase in sexual assault or incidence of HIV. Efforts taken after such an impetus appear to affected students as little more than "lip service", or only reluctant support.

A final issue to recognize is that one "occupational hazard" of being a *preventionist*, or wellness educator, is that you may be the one person on campus who is knowledgeable about the issues addressed through your programs. Indeed, you may be the only person on campus who is comfortable dealing with them ! Thus, one runs the risk of becoming "the only game in town" for any and all referrals. At SUNY Brockport there have been occasions where Health Service staff, rather than try to deal with any questions from students which make them uncomfortable, have responded to students by saying, "*Go see Lynda Dimitroff*". This raises the issue of the need for sensitivity training with health services staff themselves before services can be realistically widened to address *all* students' needs. One very *positive* thing to note is that if you make the effort to be an advocate for prevention, it *is* contagious (if you'll excuse the expression). Two examples from last spring at Brockport illustrate this. The first is relevant to a recent tradition at Brockport allowing for cancellation of classes on the first Wednesday in April to hold "Scholars' Day" -- a daylong series of presentations by faculty and students of their research, art, or dramatic productions. Coincidentally with this, local tavern owners have seen fit to advertise drink specials the night *before* "*Scholars' Day*", apparently because they know that there are no classes for students to get up for the next day. Needless to say, this impacts attendance at "*Scholars' Day*" events and defeats its purpose. Most years, this has gone on unchallenged, but this year our Vice-President for Academic Affairs wrote

letters to the editor of the village and campus newspapers voicing the campus' disappointment over this practice. Similarly, last spring an anti-homosexual incident occurred on campus. In response, the students themselves held a rally and formed "*S.A.B.R.E.*" (*S*tudents *A*gainst a *B*ias-*R*uled *E*nvironment) to try to prevent further incidents. The point here is that these things might not have happened had not consciousness been raised by the activities of the Health and Wellness Office. So, if you do these things, you may feel like a solitary voice at first, but it will not be that way forever.

In conclusion, the goal of impacting on as many of the root causes of psychological disorders as possible must become a counseling center imperative as the 21st Century approaches. Short of this, campus counseling center practitioners will be confined to tertiary services, largely involving attempts to ameliorate disorders that already exists and which cannot stem the incidence of new cases. As Albee (1991) has noted, the time to change our outlook is now, and this can significantly add to the wellness of the university community, regardless of its setting.

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