Student Services Annual Department Report
Department: Counseling and Psychological Services

Humboldt State University

Enrollment Management and Student Affairs

Counseling and Psychological Services

Counseling and Psychological Services Mission Statement

Mission Statement
Counseling and Psychological Services contributes to the mission of the Division of Enrollment Management and Student Affairs and the University by promoting and supporting the well-being of HSU students through a range of services including counseling, consultation, outreach, education, research, and training. Our services are offered with recognition and appreciation of each student's unique personality and background, and we are honored to play a part in helping students to achieve emotional, psychological, social, and intellectual growth and development.

Related Items

1: To provide counseling, crisis, and referral services

Description of Goal
To provide confidential, effective, and efficient psychological counseling, crisis, and referral services for students facing developmental, transitional, and/or mental health challenges.

1a.: Reduce size, and duration, of wait list for individual therapy

Type of Outcome: General Outcome
Learning Domain:

Description of Outcome
Reduce the number of individuals added to the CAPS wait-list for individual therapy (post-intake).

Reduce the average wait time for therapy compared to 2014-15.

Measurement Strategy: Existing Data, Tracking

Assessment Method
Our electronic mental health record system allows us to track the number of individuals on the wait list as well as the wait time for therapy.

Results of Assessment
There were 250 total waitlist entries this year. Average wait was 19.99 days, though those at the higher end had usually been offered (and declined) appointments prior.

In 2014-15: There were 309 total waitlist entries. Average wait was 28.33 days for an appointment following intake. Thus we had an almost 20% improvement in terms of the size of our waitlist and average wait time was significantly reduced (by about 30%).

Conclusions
We made a significant change this year. Clinicians became responsible for the disposition of every client for which they were the first point of contact (through intake or crisis session). They could refer the student for alternative services (e.g., a workshop, group, or off-campus therapy), absorb the client into their caseload, or add the client to their own personal waitlist. If the client was deemed "practicum appropriate," they could refer the client to our practicum-level therapists as well.

In our old system (prior to Fall 2015), once CAPS was "at capacity" for individual counseling, all clients were placed on a general waitlist (if they declined referrals out and were not added to one of our therapy groups). The first available clinician to have an opening would go this general waitlist to take the next client "in line" that fit the scheduling of this opening.

Our new system dramatically cut down on the waitlist both in terms of the number of clients added (20% improvement) and in terms of the wait time for ongoing individual counseling (30% improvement). Therapists that are being held accountable for "taking care of" all clients that they see, seem to be less likely to add clients to their waitlists in the first place and to "get to" their waitlist clients more quickly to provide on-going services. This appears to be a change in our service delivery model that is worth keeping.

1b.: Track Staff Productivity in Direct Service

Type of Outcome: General Outcome
Learning Domain: KA: Knowledge Acquisition, Construction, Integration & Application

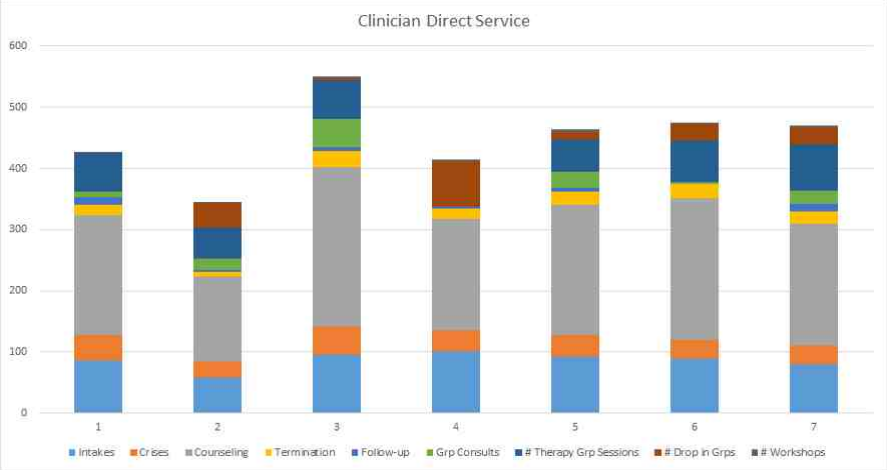
Description of Outcome
Track staff productivity in direct service (intakes, crises, individual and group therapy, workshops) with the goal of creating more uniformity and fairness in clinical time for 2016-17 and to better identify and maximize use of staff strengths. I also plan to identify whether there are any correlations between number of waitlist entries or average length of wait for therapy and staff clinical load.

Measurement Strategy: Existing Data, Tracking

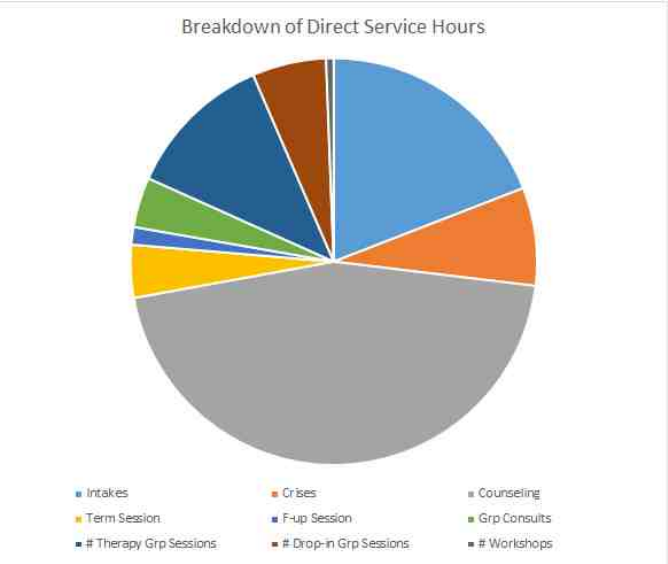
Assessment Method
I will collect data for all full-time faculty counselors for the 2015-16 year on: intakes, crisis appointments, and all individual and group counseling, as well as number of waitlist entries and length of wait. I will explore correlations between clinical load and waitlist data. In other words, do the busiest clinicians have the longest wait times and the biggest waitlists or do they have the smallest wait lists (because they are "squeezing" these clients in to their schedules)?

Results of Assessment

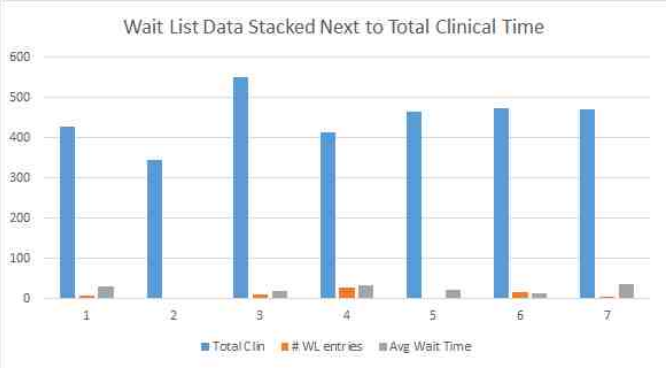
There were two significant outliers in clinician direct service hours, clinician 3 (at 550 hours) and clinician 2 (at 345 hours). The rest of the clinicians were grouped more closely in terms of hours spent in direct clinical service (range from 414 to 474). The average for all clinicians combined was 449 hours spent in direct clinical service.



The breakdown in clinical services revealed that most of the time spent is in individual counseling (45%) and first-time intake appointments (19%). Significant time was also spent in providing crisis services (8%), therapy group sessions (12%), drop-in group sessions (6%). Chart reveals these patterns below.



There was no significant correlation between the amount of direct service a clinician provided and the number of, or length of wait for, wait list entries. Three staff members made 5 or fewer wait list entries for the duration of the year, another four staff members made 8, 11, 15, and 27 entries respectively. The staff member with the most entries (27) had several practicum supervisees over the course of the year; her entries can be explained by her effort to fill their clinical schedules (by adding clients to the practicum waitlist).



Conclusions
Clinician time was spent in a logical and fairly predictable manner. Most clinical time was spent providing on-going counseling services (45% individual counseling and 18% group counseling [therapy and drop-in groups]). Intakes and crisis services accounted for 27% of clinician direct service time. Very little time was spent in psychoeducational workshops (1%) reflecting our difficulty in securing good attendance in these groups as well as our tendency to "react to" what comes through our doors rather than being pro-active in our outreach and prevention efforts. Counseling centers often get into a pattern of over-emphasizing psychological treatment at the expense of doing preventative outreach because "clients just keep on coming" and clinicians often feel guilty for taking the time to develop and offer psychoeducational workshops. Yet it is the hope that in doing such outreach, students may develop the knowledge and tools they need to help mitigate and prevent psychological symptoms and disorders such that they do not need on-going counseling services. This will be a topic for our fall start-up retreat.

We will also discuss use of wait lists for on-going counseling at our Fall 2016 retreat. How were some therapists able to avoid using a waitlist at all (or using it only rarely) while others sometimes had clients waiting for up to 30 days or more? This cannot be explained by number of intakes and crisis sessions (or overall clinical load) as one might have guessed. Three of the busiest clinicians in terms of intakes and crises had among the lowest wait list entries (11 or fewer).

Finally, it was apparent in charting the figures that two of our clinicians were outliers in terms of direct service. One, at 345 hours, and the other at 550 hours, significantly veered from the group norm (average) at 449 hours. I plan to provide more direction and oversight on a month to month basis in the upcoming year to provide more uniformity in these numbers. "Overdoing it" as a clinician at CAPS leads to burn-out, and "empathy fatigue," while a staff member who contributes less than the rest can lead to poor morale in other staff members who may perceive that someone isn't doing "their fair share." Note: all staff members can view each others schedules and can run reports and compare time expenditures...

1c: Develop; Offer; and Evaluate New CAPS Workshops
Type of Outcome: Student learning outcome
Learning Domain: KA: Knowledge Acquisition, Construction, Integration & Application, CC: Cognitive Complexity, IC: Interpersonal Competence, ID: Intrapersonal Development

Description of Outcome
CAPS clinicians will research and develop workshops on the following:
1. Positive Psychology / Wellness ("The Happy Map")
2. Acceptance Commitment Therapy (ACT) for Anxiety and Depression
3. Dialectical Behavior Therapy (DBT) for Mood Dysregulation ("Mind over Mood")
4. "Trauma: What is it? And how do I live with it?
5. Tools and Tips for Attention Deficit Hyperactivity Disorder (ADHD)
6. Dare to Self Care

The workshops will be offered in the fall and spring semesters and attendance will be tracked. Evaluations will be provided to participants and compiled by CAPS office manager.

Measurement Strategy: Evaluations, Tracking

Assessment Method
Workshop dates and attendance will be tracked in Titanium (our electronic mental health record system).

Evaluations will be turned into our office manager for compilation.

Results of Assessment
Workshop Referrals and Participation:

Workshop	# referrals at intake	% of referrals at intake	# workshops (with at least 1 in attendance)	Total Participants
ACT Workshop	48	5.2	3	7
ADHD Workshop	9	1	4	49
Happy Map	52	5.6	2	6
Mind Over Mood Workshop	105	11.3	5	22
Trauma Workshop	6	.6	1	1
Dare to Self Care	Unk	Unk	2	25

Workshop attendance was improved once we teamed with the Library in offering workshops as part of their wellness program. Attendance was particularly good when we were able to present the material as part of a pre-existing course (e.g., one of the ADHD workshops above had 37 participants who were part of an existing psychology course).

Evaluations

Dare to Self Care 4/7/16

To assist us in improving our programs, we would like some feedback from you about this presentation/workshop. Please take a couple of minutes to answer the questions below.

1. **How well did the workshop address the topic?**
   *She did a great job of addressing the topic.

   *On point

   *Very well.

   *Made me feel that I can deal with stress

   *Decently – covered everything well with time give but wasn't very impressive

   *It was great, very helpful.

   *Well enough

2. **What could have made this better?**
   *It was great (:

   *Possibly having coloring pages

   *More talk

   *More time

   *Nothing

   *Longer meditation

   *Given the time frame…NOTHING

3. **What part(s) was/were most helpful?**
   *Us going through the meditation together

   *Meditation

   *Making the boxes. Just the act of doing it was stress-relieving. I also liked the sheets with ways to nurture yourself. Also, it was timed perfectly with enough to fill up an hour but not go over if you didn't want to.

   *Trigger sheet

   *Discussions about feelings and dealing with them.

   *The handouts and tea and mediation

   *Learned how to meditate

4. **What part(s) was/were least helpful?**

   *It was all helpful.

   *The guided meditation – I personally didn't like the guide. It didn't feel like a sun(?) glow.

   *Emergency card

   *There was nothing that was not helpful.

   *Everything was helpful.

*Us making the box was fun, but for some difficult and me easily could have.

5. What other comments do you have?

*Thanks! I really liked this.

*This was the most fun workshop on a serious topic I have been to in a long time.

*Great workshop

*Loved the meditation portion

*Thank you!

Mind Over Mood Fall, 2015

	Group Leader:Stephanie McGrath			1	2	3	4	5	6	7	NA	Mode	#of Evals	Raw Total	Avg.
1	Creates a safe atmosphere										3			3	21	7.00
2	Understands me and my concerns									2	1			3	19	6.33
3	Professional and competent										3			3	21	7.00
4	Helps me set appropriate/relevant goals									1	2			3	20	6.67
5	Helps me stay focused/make progress on goals										3			3	21	7.00
	As a result of counseling, experienced improvements in:	Yes	No												0	
1	Emotional state	3						2	1				3		16	5.33
2	Thinking/perspective	3					1	1		1			3		16	5.33
3	Reducing negative coping strategies	3				1		1		1			3		15	5.00
4	Class Attendance	2	1						2				2		12	6.00
5	Academic habits and/or performance	1	2							1			1		7	7.00
6	Motivation/commitment to complete academics at HSU	1	2						1				1		6	6.00
7	Relationship/s	3			1				2				1		14	14.00
8	Ability to cope with loss		3			1							1		3	3.00
9	Ability to copy with past trauma or negative incidents	2	1			1	1						2		7	3.50
10	Self-care	3					2			1			3		15	5.00
11	Counseling influenced ability to remain in school									1	1			2	13	6.50
12	Satisfied with counseling experience										2			2	14	7.00
13	Now have better tools/techniques for resolving difficulties and/or coping with stress										2			2	14	7.00

Name of Group: Mind Over Mood

Name of Group Leader(s): Stephanie McGrath, Judy Kidd

Additional comments about your therapist/s:

- Both were very good. Maybe Judy could make more suggestions and comments because I felt she was really smart and helpful as well.

I found the following useful/helpful about group counseling:

- I really enjoyed the listening to the sounds portion today and the handout of ways to help cope with stressful situations.
- I enjoyed the chocolate time. Very memorable experience. I'm glad I came to these sessions but I feel like something could make it more exciting or fun, but I did really enjoy the worksheets.

I did not find the following useful/helpful about group counseling:

- Everything was helpful in some way.
- Maybe use the projector or TV more to help bring more of these ideas together. Visual reinforcement

Unfortunately, due to low participation and/or failure of counselors to turn evaluations in to our office manager for compilation, we do not have evaluative data on the other workshops.

Conclusions

We continue to struggle with promoting our workshops and getting good attendance and participation, despite making referrals to our workshops at the time of intake. Partnering with other departments on campus appears to be the best course of action for increasing

attendance. We will explore the possibility of "taking our workshops on the road" next year. For example, we could advertise to relevant departments that with at least two weeks notice, we may be able to come to a classroom or meeting to present the material (e.g., to help fill in for a professor's absence that day, etc.). We should continue to present our workshops in the library as part of their ongoing programming as this certainly increased our numbers.

The good news: We were successful in designing and implementing all of our intended workshops which means they are "ready to go" next year with minimal preparation time. The evaluations we did collect on the workshops were positive. All counselors involved in the effort reported that their workshops were well received by those who attended (i.e., verbal feedback was quite positive). The main push for us next year is simply to "fill the seats" as well as to be more vigilant about data collection and compilation.

1d.: Track referrals and participation patterns for CAPS groups

Type of Outcome: General Outcome
Learning Domain:

Description of Outcome
Track clinician referrals to CAPS groups as well as eventual participation patterns in those groups.

Measurement Strategy: Existing Data

Assessment Method
Review and compare data on:
1) Intake paperwork

2) Weekly group participation

Results of Assessment
Clients referred to a group at CAPS during the intake session: 381 (41%).

Referrals at Intake:

Therapy Groups	#	%
ACT for Anxiety & Depression	68	7.3
Breaking Free from Anxiety	43	4.6
Grief and Loss	27	2.9
Healthy Relationships	61	6.6
Support for Eating Issues	11	1.2
Survive & Thrive: Sexual Abuse/Assault Survivors	25	2.7
Drop-in Groups		
Asian & Pacific Islander Support Group	4	.4
Best of You (social support group)	42	4.5
Creative Self-Expression	132	14.2
One Breath Meditation	261	28
SMART Recovery (AOD)	48	5.2
Trans Support	12	1.3

What Happened?

Therapy Groups	Fall Attendance	Spr Attendance	Total
ACT for Anxiety & Depression	36	42	78
Breaking Free from Anxiety	45	36	81
Grief and Loss	28	50	78
Healthy Relationships			
Amelia and Scott (Fri)	67	85	152
Cat and Pio (Tues)	20	78	98
Stephie and Amelia (Mon)	29	75	104
Support for Eating Issues	N/A	17	17
Survive & Thrive: Sexual Abuse/Assault Survivors	44	115	159
Drop-in Groups			
Asian & Pacific Islander Support Group	N/A	69	69
Best of You (social support group)	58	53	111
Creative Self-Expression	60	26	86
One Breath Meditation	104	83	187
SMART Recovery (AOD)	19	18	37
Trans Support	114	91	205

The correlation between referrals to a particular group and actual participation in that group was low (r = .23).

Conclusions
The CAPS group program (both therapy and drop-in groups) continued to be strong this past year. Therapists often made referrals to our groups at the time of intake (41% of all intake clients were given group referrals), though strangely, the referrals had little correlation with actual attendance patterns.

The groups with the most liberal referrals were: Creative Self-Expression, One Breath, ACT, and Healthy Relationships. These groups

were also fairly popular with students. One Breath attracted a wide range of attendees, while groups like "Trans Support" had a smaller but very consistent membership. Healthy Relationships continued to be our most well attended group at 354 attended appointments. Trans Support and One Breath were also remarkably well attended (at 205 and 187 appointments, respectively). Our sexual abuse survivor and social skills groups were also very well attended. One of our new groups (Asian/Pacific Islander Support) was a great hit, despite having few direct referrals. It met weekly during the spring semester and had a consistently high participation pattern (with an average of 6.3 students attending each week). Our groups that focus on substance use (SMART Recovery) and disordered eating had irregular and poor attendance. It will be important to consider whether such groups warrant continuation next year.

2: To promote and support the psychological health of individual students

Description of Goal
To promote and support the psychological (e.g., behavioral, emotional, social, intellectual) health of individual students and our campus community.

2a: Further develop and track use of CAPS on-line educational resources

Type of Outcome: General Outcome
Learning Domain: KA: Knowledge Acquisition, Construction, Integration & Application

Description of Outcome
CAPS will track use of our on-line resources, such as:

1. Mental Health Screenings
2. Educational Prezis
3. Suicide Prevention: Messages of Hope

CAPS will add 1 or more prezis to our site this year and 1 or more messages in the area of suicide prevention.

Measurement Strategy: Tracking

Assessment Method
Mental Health Screenings are automatically tracked and I have access to this data online through the company's website.

Prezis and Suicide: Messages of Hope-- the number of views are tracked automatically and I have access to this data through my accounts.

Results of Assessment
Suicide Prevention: Messages of Hope

Magali's message: 88 views

Jen's message: 525 views

Kim's message: 154 views

Krystal's message: 118 views

Total Message of Hope Views: 885

Prezis

Prezi Title	# Views as of July 12, 2016
Alcohol: Party Safe	669
Anger management	839
Overcoming Anxiety	2507
Assertiveness	1833
Being a Better Bystander	176
Positive Body Image	1145
Coping with a Break-up	1441
Coping with Grief after the Death of a Loved One	36
Career Indecision	456
Decision Making	776
Depression: Help	2840
Eat, Sleep, & Be Well	67
For the Record: College, Alcohol, & Other Drugs	102
Growing a Happy & Healthy Love Relationship	155
Happiness & Well Being	2230
Healthy Relationships 101	1171
Helping Your Freshman Succeed	130
Homesickness	842
LGBQ: Be Who You Are	181
Manage Your Moods	226
Mental Health Stigma	6
Money Matters	129
Panic Attacks	721
Pot: Party Safe	1896
Understanding Self-Harm	867
To Sleep	1327
Healing after a Sexual Assault	60
Sexual Health	121
Social Anxiety	942
Social Skills	149
Stress Less	614
Grand Total	**24,654 Views**

Screening for Mental Health

From July 1, 2015 through June 30, 2016 we had 650 students complete our online mental health screening. Detailed results follow.

ANDS® Depression

Screenings	Not Consistent	Consistent	Highly Consistent
249	6%	56%	39%

AUDIT Alcohol

Screenings	Not Consistent	Consistent – hazardous or harmful	Consistent – alcohol dependence or abuse
15	13%	80%	7%

CD-GAD Generalized Anxiety

Screenings	Not Suggestive	Suggestive
201	1%	99%

SPRINT-4 PTSD

Screenings	Not Consistent	Somewhat Consistent	Correspond
46	15%	39%	46%

EAT-11 Eating Disorders

Screenings	Not At Risk	At Risk	May be at risk
48	42%	35%	23%

MDQ Bipolar

Screenings	Not consistent	Consistent
84	31%	69%

ASSIST

Screenings	Low Risk	Moderate Risk	High Risk
7	14%	14%	71%

Questions pertaining to suicide risk and intention to seek help:

Have you thought about or wanted to end your life?
None or little of the time 234 or 59%

Some of the time 133 or 34%

Most of the time 24 or 6%

All of the time 5 or 1%

TOTAL 396

Will you seek help?
Yes 94 or 76%

No 29 or 24%

TOTAL 123

Over the past two weeks, how often have you: Thought about or wanted to commit suicide?
For none or little of the time 137 or 55%

For some of the time 79 or 32%

For most of the time 17 or 7%

For all of the time 16 pr 6%

TOTAL 249

Conclusions
CAPS added three new Prezis in 2016: Healing after a Sexual Assault, as well as LGBQ: Being Who you Are (both added at the end of last academic year in May) and Mental Health Stigma (added this April). Our prezis continue to be popular and to generate a lot of "views." Since they were implemented, our prezis have been watched 24,654 times! The most popular prezis thus far have been: Getting Help for Depression, Overcoming Anxiety, Happiness & Well-Being, Pot: Part Safe, Assertiveness, and Sleep (all with between 1327 to 2840 views a piece). Also with over 1,000 views each were: Positive Body Image, Coping with a Break-up, and Healthy Relationships 101. CAPS has in-person services for many of these topics, with groups and workshops focused on relationships, depression, anxiety, substance use, disordered eating/body image issues, and happiness. It may be beneficial in planning for the next year to consider developing a workshop or group that is specific to dealing with break-ups (although such individuals often find their way to one of our Healthy Relationships groups).

Our Messages of Hope geared to those contemplating suicide also continue to be utilized with 885 total views. We had planned to add one new message to the four existing messages, but, while it was completed, it was not yet quite ready for "prime time" and needs to be edited. We will plan to post it to our website sometime this fall.

Many students have taken advantage of our online mental health screening service. In this past year, we had 650 individuals complete one or more instruments. These screenings include depression, Bipolar, PTSD, anxiety, etc. Many individuals were found to have results that were consistent or highly consistent with a mental health diagnosis. They were referred to CAPS for further assessment and treatment. Of the students that answered the question on whether they would indeed seek help, 76% said that they would. Because the screenings are anonymous, we have no way of following up on actual numbers.

The preceding results help to validate that our efforts to reach students that might not otherwise seek in-person help are having results. Students are utilizing our mental health screenings, messages of hope, and educational prezis. Many of these students likely become clients of the center, but some may be helped enough through these mediums that they do not feel the need to seek in-person help. Given our limited resources at CAPS, it seems important that we are extending ourselves in these ways to reach and impact as many HSU students as we can.

2b: Focus on Health & Wellness in Residential Life
Type of Outcome: General Outcome

Learning Domain:

Description of Outcome
CAPS will work with Residential Life to hire a new faculty counselor to address issues relevant to the first year experience by Fall 2016. We will create a job description and move through the hiring process in spring, 2016.

Measurement Strategy: Tracking

Assessment Method
Tracking progress toward the hire.

Job description, announcement, interviews, hire...

Results of Assessment
CAPS was successful in recruiting and hiring an accomplished psychologist to serve as our residential life specialist in 2016-17. He is a licensed psychologist with several years of university counseling center experience in the California higher education system. His name is Craig Beeson and he begins the position on August 17, 2016.

Conclusions
Craig Beeson, our residential life specialist, will provide a variety of services to promote the health and well-being of our residential community on campus. He will work with students directly (through outreach and counseling) as well as working with Housing staff in a consulting and educational capacity. We are very excited to see what this position can do to improve the collaboration between Housing and CAPS and to help students to be successful in completing their first year experience and to continue their academic careers at HSU.

2c.: Track frequency of various mental health issues
Type of Outcome: General Outcome
Learning Domain: KA: Knowledge Acquisition, Construction, Integration & Application

Description of Outcome
Track and evaluate themes and trends in mental health issues and life stressors in the current academic year. Note frequency of various psychological issues and compare to previous year/s. This will allow us to be thoughtful (data driven) in designing future workshops and groups to address current trends.

Measurement Strategy: Existing Data

Assessment Method
Client intake forms

Therapist intake and termination reports

Results of Assessment
Data provided by Students (on self-completed intake forms) at time of first appointment:

Relationship break-up	No. of Forms	% of Forms	No. of People	% of People
Checked	156	16.0	156	16.3
Not checked	816	84.0	806	84.0
	972			

Relationship problems (e.g., with partner, parent/s, and/or friend/s)	No. of Forms	% of Forms	No. of People	% of People
Checked	343	35.3	343	35.7
Not checked	629	64.7	620	64.6
	972			

Death of a loved one	No. of Forms	% of Forms	No. of People	% of People
Checked	146	15.0	146	15.2
Not checked	826	85.0	814	84.8
	972			

Using alcohol and/or drugs in ways that have been detrimental or worrisome	No. of Forms	% of Forms	No. of People	% of People
Checked	147	15.1	145	15.1
Not checked	825	84.9	815	84.9
	972			

Problems with anxiety	No. of Forms	% of Forms	No. of People	% of People
Checked	708	72.8	702	73.1
Not checked	264	27.2	261	27.2
	972			

Feel sad and/or depressed	No. of Forms	% of Forms	No. of People	% of People
Checked	760	78.2	755	78.6
Not checked	212	21.8	208	21.7
	972			

Problems with concentration, memory, &/or energy levels	No. of Forms	% of Forms	No. of People	% of People

Checked	641	65.9	638	66.5
Not checked	331	34.1	324	33.8
	972			

Problems with sleep	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	488	50.2	485	50.5
Not checked	484	49.8	479	49.9
	972			

Problems with appetite and/or eating	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	374	38.5	373	38.9
Not checked	598	61.5	589	61.4
	972			

Discomfort with my weight or appearance	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	327	33.6	327	34.1
Not checked	645	66.4	634	66.0
	972			

Poor self-esteem	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	401	41.3	399	41.6
Not checked	571	58.7	563	58.6
	972			

Feel homesick and/or I'm having trouble adjusting to HSU	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	201	20.7	200	20.8
Not checked	771	79.3	762	79.4
	972			

Discomfort in social situations / Shy	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	342	35.2	340	35.4

Not checked	630	64.8	623	64.9
	972			

Legal or judicial concerns	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	36	3.7	36	3.8
Not checked	936	96.3	924	96.3
	972			

Feel harrassed or picked on by others	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	80	8.2	80	8.3
Not checked	892	91.8	882	91.9
	972			

Issues with my academics	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	354	36.4	354	36.9
Not checked	618	63.6	610	63.5
	972			

Problems with my anger	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	187	19.2	186	19.4
Not checked	785	80.8	774	80.6
	972			

Have thoughts of harming other/s	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	36	3.7	36	3.8
Not checked	936	96.3	924	96.3
	972			

Have thoughts of killing myself	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	173	17.8	173	18.0

Not checked	799	82.2	789	82.2

972

Self-harm (such as cutting or burning myself)	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	132	13.6	132	13.8
Not checked	840	86.4	829	86.4

972

Have thoughts or experiences that would seem odd or bizarre to others	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	171	17.6	171	17.8
Not checked	801	82.4	790	82.3

972

Have periods of excess energy, unusually "high" moods, &/or reduced need for sleep	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	183	18.8	183	19.1
Not checked	789	81.2	777	80.9

972

Experienced a sexual assault, rape, or other unwanted sexual occurence	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	145	14.9	144	15.0
Not checked	827	85.1	817	85.1

972

Experienced a (non-sexual) trauma	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	136	14.0	136	14.2
Not checked	836	86.0	824	85.8

972

Questions or concerns about my gender identity	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
Checked	25	2.6	25	2.6
Not checked	947	97.4	935	97.4

972

Questions or concerns about my sexual orientation	No. of Forms	% of Forms	No. of People	% of People
Checked	44	4.5	44	4.6
Not checked	928	95.5	917	95.5

972

Health related concerns	No. of Forms	% of Forms	No. of People	% of People
Checked	137	14.1	137	14.3
Not checked	835	85.9	825	85.9

972

Concern about a friend or family member	No. of Forms	% of Forms	No. of People	% of People
Checked	142	14.6	141	14.7
Not checked	830	85.4	821	85.5

972

Financial concerns	No. of Forms	% of Forms	No. of People	% of People
Checked	221	22.7	221	23.0
Not checked	751	77.3	742	77.3

972

Data from Therapist-completed Intake Reports:

Issues that are a CURRENT concern (check all that apply).	No. of Forms	% of Forms	No. of People	% of People
<No Response>	4	0.4	4	0.4
Academic Concerns	360	38.4	359	38.6
Anger Problems	122	13.0	122	13.1
Anxiety / Anxiety Disorders	616	65.7	613	65.8
ADD or ADHD	38	4.1	38	4.1
Bipolar Disorder / Significant Mood Swings	57	6.1	57	6.1
Break-up of Romantic Relationship	107	11.4	106	11.4
Career-related Issues	24	2.6	24	2.6
Depression / Depressive Symptoms	562	59.9	559	60.0
Eating Disorder or Disordered Eating	59	6.3	59	6.3
Family Problems	200	21.3	199	21.4
Grief over the Death of a Loved One	104	11.1	104	11.2
Health Issues	90	9.6	90	9.7
Homesickness	99	10.6	99	10.6
Identity Issues	77	8.2	77	8.3
Insomnia or Other Sleep Issues	213	22.7	212	22.8
Multicultural / Cultural Concerns	30	3.2	30	3.2
Other (See Presenting Problem for Description)	124	13.2	124	13.3
Panic Attacks	83	8.8	83	8.9
Psychotic Symptoms / Psychotic Disorder	17	1.8	17	1.8
Relationship Problems (non familial)	231	24.6	231	24.8
Sexuality Concerns	29	3.1	29	3.1
Significant Self-Esteem Issues	137	14.6	137	14.7

Social Isolation / Loneliness	140	14.9	140	15.0
Substance Abuse &/or Dependence	131	14.0	131	14.1
Trauma: sexual assault or sexual abuse	112	11.9	112	12.0
Trauma: emotional or physical (non-sexual in nature)	130	13.9	130	14.0
	3896			

Mental health diagnoses / issues in client's history	**No. of Forms**	**% of Forms**	**No. of People**	**% of People**
<No Response>	164	17.5	164	17.6
Depression	431	45.9	429	46.1
Bipolar	29	3.1	29	3.1
Anxiety	372	39.7	370	39.7
Eating Disorder / Disordered Eating	37	3.9	37	4.0
Schizophrenia or Another Psychotic Disorder	10	1.1	10	1.1
Substance Abuse / Dependence	70	7.5	70	7.5
Other	63	6.7	62	6.7
Unknown at this Time (to be assessed)	167	17.8	166	17.8
	1343			

Suicidal ideation	No. of Forms	% of Forms	No. of People	% of People
<No Response>	3	0.3	3	0.3
None	589	62.8	586	62.9
Fleeting	269	28.7	269	28.9
Moderate	51	5.4	51	5.5
Persistent	26	2.8	26	2.8
	938			

History of Suicide Attempts	No. of Forms	% of Forms	No. of People	% of People
<No Response>	18	1.9	18	1.9
None	720	76.8	717	77.0
Acute (past month)	15	1.6	15	1.6
Recent (1-6 months)	7	0.7	7	0.8
Past (over 6 months ago)	127	13.5	126	13.5
Unknown / To be Assessed	26	2.8	26	2.8
	913			

Current Alcohol Use (Frequency)	No. of Forms	% of Forms	No. of People	% of People
<No Response>	8	0.9	8	0.9
Frequent (5-7 days/week)	55	5.9	55	5.9
Often (2-4 days/week)	134	14.3	133	14.3
Occasional (2-5 times/month)	214	22.8	214	23.0
Rare (monthly or less)	150	16.0	149	16.0
Never	212	22.6	212	22.8
Unknown	165	17.6	165	17.7
	938			

Alcohol patterns include regular binge and/or heavy alcohol consumption (if yes, explain above)	No. of Forms	% of Forms	No. of People	% of People
<No Response>	41	4.4	41	4.4
Yes	170	18.1	170	18.3
No	519	55.3	519	55.7
Unknown / To be assessed	208	22.2	207	22.2
	938			

Current Marijuana Use (Frequency)	No. of Forms	% of Forms	No. of People	% of People
<No Response>	7	0.7	7	0.8
Frequent (5-7 days/week)	189	20.1	189	20.3
Often (2-4 days/week)	90	9.6	89	9.6
Occasional (2-5 times/month)	88	9.4	88	9.5
Rare (montly or less)	79	8.4	79	8.5
Never	328	35.0	327	35.1
Unknown	157	16.7	157	16.9
	938			

Does client view his/her AOD use as problematic? (If yes, describe in narrative summary above)	No. of Forms	% of Forms	No. of People	% of People
<No Response>	30	3.2	30	3.2
Yes	180	19.2	180	19.3
No	551	58.7	550	59.1
Unknown / To be assessed	177	18.9	176	18.9
	938			

History of Trauma	No. of Forms	% of Forms	No. of People	% of People
<No Response>	224	23.9	224	24.1
History of Childhood Neglect	38	4.1	38	4.1
History of Emotional Abuse	116	12.4	115	12.4
History of Physical Abuse	63	6.7	63	6.8
History of Sexual Assault / Abuse	149	15.9	149	16.0
Witnessed Emotional or Physical Violence Within the Home	58	6.2	58	6.2
Witnessed Violence Outside the Home	9	1.0	9	1.0
History of Being Bullied (by Peers)	40	4.3	40	4.3
Victim of a Traumatic Crime / Event	28	3.0	28	3.0
Victim of a Traumatic Accident	12	1.3	12	1.3
Unknown	366	39.0	364	39.1
Other (see below)	46	4.9	46	4.9
	1149			

Social Functioning (check all that apply)	No. of Forms	% of Forms	No. of People	% of People
<No Response>	76	8.1	76	8.2
Good Social Support from Friends at Home	134	14.3	133	14.3
Good Social Support from Local Friends	328	35.0	327	35.1
Lacks (Not Satifisfied with Degree of) Current Social Support	281	30.0	281	30.2
Has Difficulty Making Friends	105	11.2	105	11.3
Has Difficulty Maintaining Friends	51	5.4	51	5.5
Does Not Confide in Friends or Ask for Help	199	21.2	199	21.4
Not Interested in Having Friends	8	0.9	8	0.9
Interested in Improving Social Skills	75	8.0	75	8.1
Unknown / To Be Assessed	158	16.8	158	17.0
	1415			

Academic Functioning (check all that apply)	No. of Forms	% of Forms	No. of People	% of People
<No Response>	62	6.6	62	6.7
In Good Academic Standing	492	52.5	490	52.6
Close to Being on Academic Probation	54	5.8	54	5.8
On Academic Probation	32	3.4	32	3.4
Struggling with Course Material	96	10.2	96	10.3
Lack / Loss of Academic Motivation	123	13.1	123	13.2
Problems with Focus or Concentration	228	24.3	227	24.4
Unsure about Direction / Choice of Major	38	4.1	38	4.1
Feels like s/he is at the Wrong School	19	2.0	19	2.0
Poor Academic Attendance	62	6.6	62	6.7
Poor Study Habits	22	2.3	22	2.4

Considering Withdrawal from HSU	39	4.2	39	4.2
Unknown / To Be Assessed	130	13.9	130	14.0

Conclusions
On their self-reported intake form (at time of initial CAPS appointment), the majority of our students reported feeling sad and/or depressed (79%), having problems with anxiety (73%), having problems with concentration, memory or energy (67%) and sleep (51%). A great many students reported having relationship problems (36%), problems with appetite and/or eating (39%), poor self-esteem (42%), discomfort in social situations (35%), and issues with academics (37%). A significant number of students self-reported that they were currently having thoughts of killing themselves (173 people, 18% of the forms), and many reported that they had experienced a sexual (15%) or non-sexual (14%) form of trauma.

These results are consistent with clinician judgments at the time of psychological assessment. Therapists viewed clients as having issues of depression (60%), anxiety (66%), insomnia (23%), as well as (non-familial) relationship problems (25%) and family problems (22%). Self-esteem issues and social isolation/loneliness were also significant (both at 15%). When clinicians inquired about mental health history, many clients expressed past issues/diagnoses of depression (46%) and anxiety (40%). Close to 16% of our clients reported a history of suicide attempts at the time of intake and many reported daily marijuana use (20%), with 19% of our clients overall viewing their AOD use as problematic. Trauma histories were fairly frequent with 16% of our clients endorsing a history of sexual assault/abuse, 7% a history of physical abuse, and 12% a history of emotional abuse. Many of our clients reported problems in their social functioning-- lacking social support (30%), having difficulty making or maintaining friends (17%), and failing to confide in friends or ask for help (21%).

Given these results, CAPS current groups, workshops, and prezis (i.e., focusing on anxiety, depression, relationships, sexual abuse/trauma, insomnia, etc.) continue to be very relevant. The results, though, point to some possible enhancements. For example, at our fall 2016 retreat, I would like for us to consider the possibility of more workshops (or groups) focused on assertiveness and other social/communication skills, generalized trauma, and self-esteem. For the last couple of years, a few of our clinicians have been offering workshops and groups featuring tools and techniques from Dialectical Behavior Therapy (DBT) and Acceptance Commitment Therapy (ACT). These methodologies lend themselves well to many of the issues that our clients face (e.g., with depression, anxiety, self-esteem, lack of positive coping skills [sometimes leading to ruminative thoughts of suicide]). Last month I purchased DVDs featuring these frameworks so that all of us can do professional development on these effective strategies. Likewise, I purchased an entire 36 hour professional development series on trauma that our staff can complete for continuing education credit which will be of great benefit to our clients given their histories of trauma.

3: To create a therapeutic environment

Description of Goal
To create a therapeutic environment in which students of diverse backgrounds feel safe, valued, and supported.

3a.: Track access across race, gender, and sexual orientation

Type of Outcome: General Outcome
Learning Domain:

Description of Outcome
Track usage of CAPS to determine if all groups are accessing our services proportionate to their representation at HSU.

Measurement Strategy:

Assessment Method
Use Titanium data.

Results of Assessment

	At CAPS	At HSU
Female	**62.7%**	56%
Male	31.2%	**44%**
Transgender	.9%	Not tracked
Other (self-identified)	3%	Not tracked

	At CAPS	At HSU
African American/Black	3.7%	3.3%
American Indian or Alaskan Native	1%	1.1%
Asian American / Asian	2.9%	3.4%
Hispanic / Latino/a	25%	**31.5%**
Native Hawaiian or Pacific Islander	.7%	.2%
Multi-racial	**9.6%**	6.3%
White	50.5%	45.5%
Self-identified (18 were Mexican/Latino)	**3.2%**	N/A
Declined to answer	3.5%	7.1%

	At CAPS	ACHA-NCHA Survey at HSU
Heterosexual	63.8%	66%
Lesbian	1.9%	1.8%
Gay	2.6%	2%
Bisexual	**14.1%**	10.1%
Questioning	4.6%	3.3%
Self-identified (pansexual, asexual, queer, open...)	7.1%	**16.9%**
Declined to answer	5.8%	N/A

30% live on-campus

59% are single

58% are juniors and seniors [same as HSU]; 19% are freshman [compared to 23% HSU]; 14% are sophomores [compared to 12% HSU]; 5% are grad students [4-6% HSU]

10% are registered with SDRC

69% have roommates; 15% live with a partner/spouse; 12% live alone

Religious/spiritual preferences are distributed broadly (with 10% identifying as Christian; 7% as Catholic; 15% as Agnostic; 10% as Atheist... Most (36%) had "no preference")

Conclusions
The results of my analysis indicate that men continue to underutilize (and women to overutilize) counseling relative to their numbers at HSU. This is a national trend which is in large part due to our differing socialization patterns (e.g., men are often taught to minimize or not talk about their feelings) and the stigma attached to going to therapy (which likely disproportionately impacts men). Given that this feels like a societal issue, it is difficult to think of ways that the center can make a significant difference, although we can certainly make sure that we are marketing our services directly to men and that our groups and workshops hold relevance for them.

It appears that CAPS has been fairly well accessed by all racial and ethnic groups relative to proportion sizes on campus. African American/Black, American Indian/Alaskan Native, and Native Hawaiian/Pacific Islander groups were all well-represented at CAPS given their campus representation. Asian American/Asian students were slightly under-represented (2.9% versus their HSU presence at 3.4%), which may be due to cultural factors which discourage talking about problems with a therapist (outsider) and may stigmatize someone for doing so. Similarly, Hispanic/Latino/a students appeared to be under-represented at CAPS upon first glance (25% versus 31.5%), but several of our students identified as multi-racial (9.6% versus the HSU statistic of 6.3%) or self-identified (3.2%) as Mexican or another identity that would typically be grouped within the Hispanic/Latino/a designation. Thus it is quite possible that over 6% of CAPS clients may have identified differently on their HSU forms than on their CAPS forms in relation to their Hispanic/Latino/Multi-racial identities. This likely bridges (at least some of) the initial assumed discrepancy. We are likely serving the Hispanic/Latino/a students at the expected rates, although I think it is important that CAPS continues to do outreach to these communities (as well as to the Asian American/Asian communities) to assure that we are viewed as a safe, welcoming, and helpful resource. CAPS has hired a Bilingual (Spanish/English) therapist who specializes in working with Hispanic/Latino communities that is to start in August 2016. We will plan to have him serve as a liaison with relevant student groups to collaborate on possible needs and services, etc.

In terms of sexual orientation, CAPS tends to provide counseling services to self-identified LGBQ students at higher rates than are likely present on campus (extrapolating from the ACHA-NCHA Survey at HSU), though many students tended to self-identify as something other than heterosexual or LGBQ on the survey which clouds these results.

CAPS continues to see a high proportion of students who live on campus (30%) and to see juniors and seniors at higher rates than freshman and sophomores. Freshman representation on campus (23%) is slightly higher than their rates at CAPS (19%) indicating that they could be underutilizing CAPS. Our hiring of a dedicated clinician (to start Aug 2016) that will focus on the first year experience and in working with freshman in the residence halls will be a big asset in assuring that freshman are aware of our services and know how to access them.

3b.: Focus professional development for CAPS clinicians on diversity-related topics
Type of Outcome: General Outcome
Learning Domain: KA: Knowledge Acquisition, Construction, Integration & Application, PC: Practical Competence

Description of Outcome
CAPS staff will participate in diversity-related "inservices" throughout the academic year (2015-16).

Measurement Strategy: Tracking

Assessment Method
Track attendance at trainings through Titanium scheduling program.

Results of Assessment

Date	Training	# CAPS Staff in Attendance
8/18/15	Institute for Student Success	7
8/19/15	North Coast Rape Crisis Services (+how to support survivors)	11
8/20/15	Child Abuse Reporting Requirements	11

8/28/15	Diversity with Melissa Meiris	10
9/18/15	Humboldt Domestic Violence Services	12
10/2/15	Transgender + Social Justice Discussion w/ Jessica Pettit	15
10/23/15	Microaggressions w/ Maxwell Schnurer & Sheila Rocker Heppe	12
11/20/15	Suicide Assessment	17
1/14/16	Institute for Student Success	8
1/15/16	Native American Discussion w/ Marlett Grant-Jackson	11
1/22/16	Working with those with Disabilities (Kevin O-Brien & Jayne McGuire	11
3/25/16	Group Therapy w/ Stephanie McGrath	10
1/1/16	IPNB-- Cultural Considerations w/ Brian McElwain	5
4/15/16	Women and Diversity w/ Kim Berry	10

Conclusions
We successfully geared this past year's professional development trainings to diversity related topics as can be seen above. Staff took part in facilitated discussions on doing therapy with a diverse student population, women's issues/sexism, transgender issue and social justice, the impact of microaggressions, etc. We also continued our liaison relationships across campus with various cross-cultural centers and student groups (Asian, Latino/a, LGBT, etc.) and hope to continue to broaden and deepen these relationships in the year to come. Incidentally, one of these liaison relationships led to the establishment of a new student support group this past spring for Asian American/Asian students that was quite successful.

4.: Apply for CAPS Accreditation through IACS

Description of Goal
CAPS would like to achieve the "gold standard" in accreditation for university counseling centers. We will apply for IACS accreditation and hope for a site visit (evaluation) in the 2016-17 academic year.

4a.: Complete IACS Application and Supplemental Material and Mail

Type of Outcome: General Outcome
Learning Domain:

Description of Outcome
Complete application, including data analysis, staff resumes, etc.

Revise Staff Manual and update procedures to be in alignment with standards.

Put together all material, including supplementary items.

Mail packet of material to IACS and await the scheduling of a site visit.

Measurement Strategy:

Assessment Method
Check off items when completed. Save a copy of application and forms. Save receipt of mailed material.

Results of Assessment
Application packet was mailed and received by IACS. We await the scheduling of a site visit.

Conclusions
We have successfully applied for professional accreditation through IACS and await a site visit which will ideally lead to a 3 year accreditation.

Staffing and Budget Snaphot

Investments

D407 CAPS

Related Items
There are no related items.

End of Year Summary

Summary and Conclusions
Overall, Counseling and Psychological Services (CAPS) appears to be functioning well and in concert with the needs of our students.

We continue to produce and offer online resources (educational interactive presentations [prezis], messages of hope [to facilitate suicide prevention], and anonymous mental health screenings, all of which are extremely well utilized and well evaluated. Our prezis, for example, are now approaching almost 25,000 views and had an average rating of 6.5 on a 7 point scale!

A change in our service delivery practices has led to significant improvements in our waitlist for ongoing therapy. We had a moderate reduction (by 20%) in the number of people added to the waitlist and reduced our wait time fairly dramatically (a 30% improvement). Our workshop and group offerings seem to be "on point" with the issues that our students struggle with (depression, anxiety, relationships, sexual assault/abuse, etc.) although we were challenged for much of the year with "filling the seats" at our workshops. This improved in the spring semester, and the workshop evaluations that were completed indicated that students were satisfied and helped.

Groups continued to be strong this year (as they have been in the last few years) with good participation and high satisfaction. Healthy Relationships, Trans Support, One Breath (meditation), Survivors of Sexual Assault/Abuse, Social Skills, and Asian/Pacific Islander Support groups all had high and regular attendance. Groups focusing on eating issues and substance use had low and irregular attendance and we will want to re-think such groups in the future.

For the most part, if we don't have a workshop or group focused on a topic of interest, we likely have a prezi of relevance (e.g., insomnia, assertiveness). All of these resources together provide a fairly broad-based approach to meeting our students "where they are at" in terms of both readiness for counseling and issues of import to them.

One of my concerns going into the year was in making sure that ALL student populations felt safe about using our services and felt that they could access us when needed. Two student populations may be slightly under-represented: Asian American/Asian students and Hispanic/Latino/a students (although the latter conclusion may be faulty due to the way statistics were generated). When one considers that all students of color have faced issues of oppression and bias, it would seem that students of color should perhaps access CAPS at higher rates than their population size at HSU might suggest. We will continue to focus this next year on building relationships with all of the Cross-Cultural Centers of Academic Excellence and various student clubs in order to make sure we are doing our part to improve access and be known to these communities (as well as in better understanding and collaborating with them about their needs and wishes). We are doing our best to make sure that we are well trained in the area of diversity and that all of staff members are multiculturally competent (as our diversity-related inservice trainings of 2015-16 would indicate).

This year, I analyzed clinician direct-service time in a more detailed way in an effort to assure equity and a sense of fairness across staff. Staff members who work too hard (e.g., squeezing in clients to the 8 am and lunch-time hours, for example) tend to "burn out" while staff members who may not be perceived as doing their fair share can create issues with overall morale across the department. The breakdown of direct service hours was as expected-- most of our clinical time is spent doing ongoing counseling (45%), intakes (19%), groups (12%), and crisis services (8%). I found two "outliers" among the full time clinicians-- one that had done 550 direct service hours and another who had done 345 direct service hours (with an average among all clinicians at 449 hours). I plan to meet with these two individuals about the results of this analysis in August and to track clinical time more regularly throughout the year to correct any inequities as they arise.

Finally, CAPS was also successful in completing three other important goals moving into the 2016-17 academic year. We have hired a bilingual therapist with expertise in Latino/Hispanic cultures that will help us to better serve these growing populations on campus, and we have hired a faculty member that will focus on serving Housing and Residential Life by doing consultations, programming, and counseling that is specific to the needs of residents, and particularly, new freshman. This position will be partially located in Housing and thus situated to best understand and meet the needs of our residential population. Lastly, CAPS successfully completed the application process for professional accreditation through International Association of Counseling Services (IACS). We now await an evaluative on-site visit from IACS to complete the process (hopefully in 2016-17), and look forward to having an outside perspective of our strengths and areas for improvement.

Next Steps and Plans for Improvement
Plans for 2016-17:

1. We have hired 3 new faculty members that will start in August 2016. These faculty members will go through orientation and training and will be assigned liaison relationships with other units on campus. All staff will be expected to serve as liaisons to other units and we will revisit these assignments in August.
    - We will particularly focus on liaison relationships that provide outreach to those who may under-utilize CAPS, such as students of color (and in particular, Asian American/Asian and Hispanic/Latino/a students), international students, male students, and new freshman.
2. We will collaborate with Housing/Residential Life in shaping the new residence life focused counseling position and will test and hone ideas over the course of the year.
3. We will have a process in place to assure equity in clinician direct service time (in the context of other assigned duties) such that there is fairness and accountability for all.
    - We will also have a process in place to assure that clinicians complete clinical documentation in a timely manner (given that we had huge variability in this task in the current year).
4. We will continue our new procedure in regard to the waitlist given that it is working significantly better than our last system.
5. We will look for ways to improve workshop attendance including:
    - Continuing to partner with the library and others across campus (e.g., Health Education) in programming and marketing
    - Seeking opportunities to do more "in-classroom" presentations where we are assured an "audience".
6. We will do a better job of collecing evaluations for our workshops and making sure that these are turned in to our office manager for compilation.
7. We will continue in the process of IACS accreditation as the organization becomes ready to review our site.
8. We will take a hard look at our group and workshop offerings moving into next year to determine whether we should let certain groups or workshops go and/or develop others. In doing so, we will consider the data contained within this report (e.g. client presenting issues and mental health histories; attendance/participation patterns, etc.).
9. We will focus on clinician professional development in the areas of trauma and evidence-based treatments. We purchased several self-study programs in June that will be available to all staff during the course of 2016-17.
    - New workshops or groups (or modifications to existing ones) may result from our expanding knowledge/tools in these areas.
10. We hope to be able to submit material for a student fee increase referendum in the upcoming year. CAPS has never increased our fee and it is time to do so in order to keep up with the growing demand for mental health services on campus.
    - If we are able to secure more funding, CAPS will seek to hire a new Assistant Director to begin Fall 2017 given our loss of the staff member in this position in June,

2016.

- If CAPS is able to expand our clinical staffing, we will explore the possibility of expanding our "satellite" counseling sites or our departmental hours.

Related Items

There are no related items.