2024

ANNUAL REPORT

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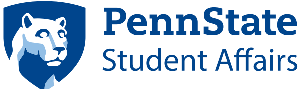

Center for Collegiate
Mental Health

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2024 Report Introduction

The 2024 Annual Report summarizes data contributed to CCMH during the 2023-2024 academic year, beginning July 1, 2023 and closing on June 30, 2024. De-identified data were contributed by 213 college and university counseling centers, describing 173,536 unique college students seeking mental health treatment, 4,954 clinicians, and 1,215,151 appointments.

The following are critical to understand when reading this report:

1. This report describes college students who received mental health services at counseling centers and **NOT** the general college student population.
2. Year-to-year changes in the number of students represented in this report are unrelated to changes in counseling center utilization. These changes are more likely due to the number and type of centers contributing data from one year to the next.
3. This report **is not a survey**. The data summarized herein is gathered during routine clinical practice at participating counseling centers, de-identified, and then contributed to CCMH.
4. The number of clients for each instrument and question might differ due to variations in clinical procedure and the utilization rates of the particular CCMH instruments or questions.
5. Counseling centers are required to receive permission from their institution (e.g., Institutional Review Board) to participate in client-level data contribution to CCMH. Although CCMH maintains membership of over 800 institutional counseling centers, only a percentage of these institutions participate in client-level data contribution. However, all counseling center members contribute center-level data for research.

REMINDERS FROM PRIOR REPORTS

- **2015** – Increasing Demand: Between Fall 2009 and Spring 2015, counseling center utilization increased by an average of 30-40%, while enrollment increased by only 5%. Increasing demand is primarily characterized by a growing frequency of students with a lifetime prevalence of threat-to-self indicators. These students also used 20-30% more services than students without threat-to-self indicators.
- **2016** – Impact of Increasing Demand on Services: Between Fall 2010 and Spring 2016, counseling center resources devoted to "rapid access" services increased by 28% on average, whereas resources allocated to "routine treatment" decreased slightly by 7.6%.
- **2017** – Treatment Works: Treatment provided by counseling centers was found to be effective in reducing mental health distress, comparable to results from randomized clinical trials. Length of treatment varies by presenting concern.
- **2018** – Center Policies and Treatment Outcomes: Counseling centers that use a treatment model (students assigned to a counselor when an opening exists) versus absorption model (clinicians expected to acquire clients for routine care regardless of availability) provided students with more sessions with fewer days in between appointments, and demonstrated greater symptom reduction than centers that prioritize absorption regardless of capacity. Additionally, the question of Electronic Medical Record (EMR) sharing policy between counseling and health center staff was examined. No differences in treatment outcomes were found between centers who share EMRs with health centers compared to those with separate EMRs.
- **2019** – The Clinical Load Index (CLI) was introduced, which provides each counseling center with a standardized and comparable score that can be thought of as "clients per standardized counselor" (per year) or the "standardized caseload" for the counseling center. Higher CLI scores were associated with substantially lower treatment dosages (fewer appointments with more days between appointments) and significantly less improvement in depression, anxiety, and general distress by students receiving services.
- **2020** – Differences in counseling center practices were evaluated between centers at the low and high ends of the CLI distribution. Low CLI centers were more likely to provide full-length initial intake appointments and weekly treatment, while they were less likely to experience a depletion of treatment capacity during periods of high demand. Conversely, High CLI centers provided fewer appointments that were scheduled further apart and produced less improvement in symptoms. Additionally, High CLI centers were more likely to refer students to external services and require clinicians to absorb clients in their schedules regardless of available openings in an effort to serve more students.
- **2021** – CCMH investigated the relationship between CLI and the amount of treatment received by students with critical and key needs often prioritized by institutions (e.g., students with suicidality, sexual assault survivors, students with a registered disability, and first generation students). Results indicated that all presenting concerns and identities that were examined received less treatment at High CLI centers, including clients with recent serious suicidal ideation and self-injury, histories of sexual assault and trauma, transgender identity, registered disability, first generation identity, and various racial/ethnic identities.

Findings showed that institutions cannot fund counseling centers at a level that yields high annual counselor caseloads and concurrently expect those centers to provide enhanced care for students with any high intensity concern. Therefore, it is essential that all stakeholders seek alignment around the realities of the counseling center staffing levels and service capabilities, institutional messaging related to mental health services especially for emphasized concerns, and funding to address institutional priorities.

- **2022** – CCMH explored how counseling centers contribute to the academic mission of institutions by examining the risk and protective factors associated with voluntary withdrawal from school during services. The study found that students who identified as a freshman/first-year status with elevated levels of academic distress paired with a history of psychiatric hospitalization were 48% more likely to withdraw from school during treatment than clients without these factors. Protective factors that reduce the risk of withdrawal were also identified: improvement of Depression, Generalized/Social Anxiety, Academic Distress, and overall distress symptoms during counseling services. Most notably, when students experience a decrease in Academic Distress during counseling while concurrently participating in an extracurricular activity, they were 50% less likely to withdraw from school. These findings suggest when students improve during counseling, they are more likely to persist in school. Institutions should be aware of the critical role college counseling centers play in the academic success of college students.
- **2023** – CCMH investigated if experiences of self-reported discrimination or unfair treatment based on six identities are associated with mental health concerns and symptom improvement at college counseling centers. Findings revealed a strong relationship between discrimination and increased general distress, social isolation, and suicidal thoughts at the beginning of treatment. Counseling centers were shown to effectively treat clients with experiences of discrimination, as they demonstrated commensurate improvement in symptoms of distress, social isolation, and suicidal ideation during services as students with no discrimination. However, clients who reported discrimination consistently ended treatment with higher average levels of distress, demonstrating a persistent outcome disparity. These findings highlight the critical role college counseling centers serve in supporting the Diversity, Equity, Inclusion, and Belonging (DEIB) goals that are a priority for many institutions. Institutions and leaders who prioritize and value mental health and wellness must simultaneously support DEIB initiatives to close the disparities in mental health symptoms and treatment outcomes among students who face identity-based discrimination.

2024 HIGHLIGHTS

The following are key findings and implications contained in this year's Annual Report:

This investigation examined students with a history of suicidal or self-injurious behaviors (S/SIB) who receive college counseling center services. Specifically, CCMH examined these students' symptoms, presenting concerns, stressors and contextual factors, service utilization, and treatment outcomes. The study was deemed critical given the growing problem of suicide within the United States and subsequent emphasis on suicide prevention efforts within higher education over the past 20 years. The findings revealed that students with past S/SIB, compared to those without, began treatment with more severe distress, demonstrated a higher degree of complex co-occurring problems, utilized more services and specialized care (i.e., case management and psychiatric treatment), and experienced more critical events during services (e.g., self-harm or a suicide attempt). Counseling center staff provided effective support to these students, as demonstrated by their substantial improvement in distress and suicidal ideation during treatment. While these findings underscore that counseling centers provide impactful care to clients with suicide risk, these students still ended treatment with higher levels of distress and suicidal ideation than those without historical S/SIB.

The current Annual Report highlights the critical role college counseling centers serve in supporting suicide prevention and campus safety efforts within higher education. Counseling centers are remarkably effective in reducing distress and suicidal ideation symptoms for students with elevated suicide risk despite the persistent challenges of operating within short-term treatment models and with limited specialty capacity (i.e., case management, psychiatric care). Given the collective complex needs of these at-risk students, coupled with their increased likelihood of attempting suicide while in college, institutions can support counseling center efforts to treat this population in a variety of ways. In particular, institutions can invest in locally informed and collaborative care, which includes psychological treatment, psychiatric care, and case management at centers, as well as adjunctive support services (e.g., Title IX, Dean of Students, Financial Aid, and Student Disability) that are crucial to support this population and ultimately better position them for academic success.

ADDITIONAL 2024 FINDINGS

- Rates of prior counseling and psychotropic medication usage showed an increase in the past year and are at their highest levels since this data was first collected in 2012.
- History of counseling continued to be the mental health history item with the largest 12-year increase: over 63% of students entered services with prior counseling. Notably, history of a psychiatric hospitalization has demonstrated a slight upward trend since 2020, although the general trajectory remains relatively stable over the past 12 years.
- After a period of annual increases since 2012, history of trauma slightly declined in the past year, however, it has increased overall during the past 12 years, rising from 37.5% in 2012 to 45.5% this past year.
- Threat-to-self characteristics were relatively stable over the past year, with some variables slightly increasing (histories of non-suicidal self-injury and suicide attempts) and others marginally declining (history of serious suicidal ideation, serious suicidal ideation over the past month). History of suicide attempt(s) has shown a faint upward trend over the past 12 years, increasing from 8.7% in 2012 to its highest level of 10.9% in the past year.
- All areas of self-reported distress remained relatively unchanged or slightly declined over the past year. This included areas that were previously increasing, such as Generalized and Social Anxiety. Social Anxiety continued to display the greatest 14-year change across all areas of distress.
- Although it somewhat decreased the past year, Anxiety continues to be the most common presenting concern, with 64.4% of clients having anxiety as assessed by clinicians. Relationship problem (specific) continued to show an upward trend as a top concern since 2020, while Trauma demonstrated a slight decline after gradual annual increases since 2016.
- After the onset of the COVID-19 pandemic in 2020, CCMH began collecting data on the mode of counseling service delivery, which included in-person, video, audio, or text. From 2020 to 2024, the percentage of students who received exclusive in-person individual counseling services increased from 1.7% to 63.7%, and the proportion of those who were solely provided video care declined from 96.1% to 13.5%. For the past three years (2021-2024), approximately 25% of students received hybrid care (combination of in-person and video sessions).

Clinical Load Index (CLI)

BACKGROUND OF THE CLI

The Clinical Load Index (CLI) was developed in 2018-2019 by the Center for Collegiate Mental Health (CCMH), with support from the International Accreditation of Counseling Services (IACS) and the Association of University and College Counseling Center Directors (AUCCCD). The CLI was designed to provide a more accurate and consistently comparable supply-demand metric that describes the landscape of staffing levels. CLI scores can be conceptually thought of as the "average annual caseload" for a "standardized counselor" within a counseling center, or the average number of clients a typical full-time counselor would see in a year at that center. The CLI helps to shift the question that institutions should be asking from "How many staff should we have?" to "What services do we want to provide to our students?" This reframe helps centers and institutions better align messaging about services with partner/institutional expectations that is based on the service capacities connected to current staffing levels.

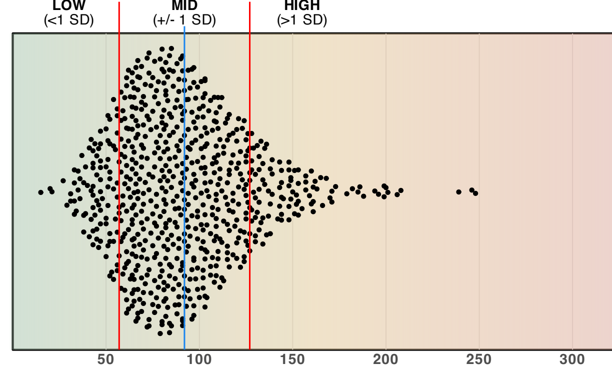
Complete information about the development and utilization of the CLI can be found on the interactive CLI tool. In brief, the CLI is calculated using two numbers from the same academic year, between July 1st and June 30th: 1. Utilization: The total number of students with at least 1 attended appointment. 2. Clinical Capacity: The total number of contracted/expected clinical hours for a typical/busy week when the center is fully staffed (not including case management and psychiatric services). Because of the standardized/annual/aggregate nature of CLI scores, the following guidelines should be observed:

- CLI scores should never be used to compare/evaluate individual counselors.
- The average CLI score is not a staffing recommendation, nor is there an ideal CLI score. The distribution of CLI scores describes the range of real-world staffing levels that are associated with particular clinical outcomes (i.e. treatment dosages and distress change). Thus, the CLI allows institutions to align service goals with staffing levels.
- The CLI neither includes psychiatry nor dedicated case-management because these are considered specialties that are not consistently available at all schools. Future years may lead to the development of guidance specific to these types of service.
- The CLI does not describe expenses related to the administration of a counseling center.

2023–2024 CLI DISTRIBUTION

To accompany this Annual Report, CCMH updated the CLI distribution based on new data from 696 CCMH member college counseling centers during the 2023-2024 Academic Year (7/1/2023 to 6/30/2024). Complete details about the 2023-2024 CLI (and an interactive tool to calculate your CLI) can be found on the CLI page of the CCMH website. The following describes the CLI distribution for 2023-2024:

- N = 696
- Range = 15-248
- Mean = 92
- Median = 88
- Standard Deviation = 35
- Zones
  - Low: Less than 57
  - Mid: Between 57 and 127
  - High: Greater than 127



Students with Elevated Suicide Risk: The Benefits Provided by Counseling Center Services

Between 2000 and 2022, suicide rates in the United States increased by 36% (Center for Disease Control, 2024). While suicide affects every age and demographic group, it is the second leading cause of death for individuals between the ages of 10 and 34, which encompasses the ages of most college students. Indeed, it is estimated that approximately 1,100 college students die by suicide annually (The JED Foundation, 2002).

Given the gravity of this problem, there have been concerted efforts to enhance suicide prevention programming within higher education over the past two decades. Prevention programs have ranged in size and scope with many interventions implemented that identify at-risk students and refer them to essential support services. Overall, these initiatives appear to have been successful, leading to more students seeking necessary mental health services, particularly those experiencing risk factors for suicide (e.g., past serious consideration of suicide and self-injurious behavior) (CCMH 2015 Annual Report, Healthy Minds Network, 2024). In fact, college students are less likely to die by suicide than their same-age peers in the general population, which may be due in part to the collective services and comprehensive support systems available on college campuses (The National Academies of Sciences, Engineering, Medicine, 2021).

College counseling centers play a central role in suicide prevention efforts, historically treating a significant proportion of students with elevated suicide risk, including those with prior suicidal attempts and self-injurious behavior. This vital function of centers has expanded over the years, as the percentage of students served nationally at counseling centers with suicidal/self-injurious behavior histories has grown from 26% in 2010-2011 to 30% in 2023-2024. The notable portion of students at counseling centers who report a history of past suicidal attempts or self-injurious behavior is important because these are two of the primary risk factors that increase the likelihood of dying by suicide (Hayes et al., 2020, Van Orden et al., 2010).

While counseling centers have historically treated a considerable segment of students with heightened suicide risk, ongoing questions remain about the complexity of co-occurring problems experienced, the scope of services they utilize, and whether gaps in care exist. CCMH investigated how these students' clinical characteristics, stressors and contextual factors, service utilization, and treatment outcomes differed from those without these historical risk factors. In the current investigation the following questions were answered:

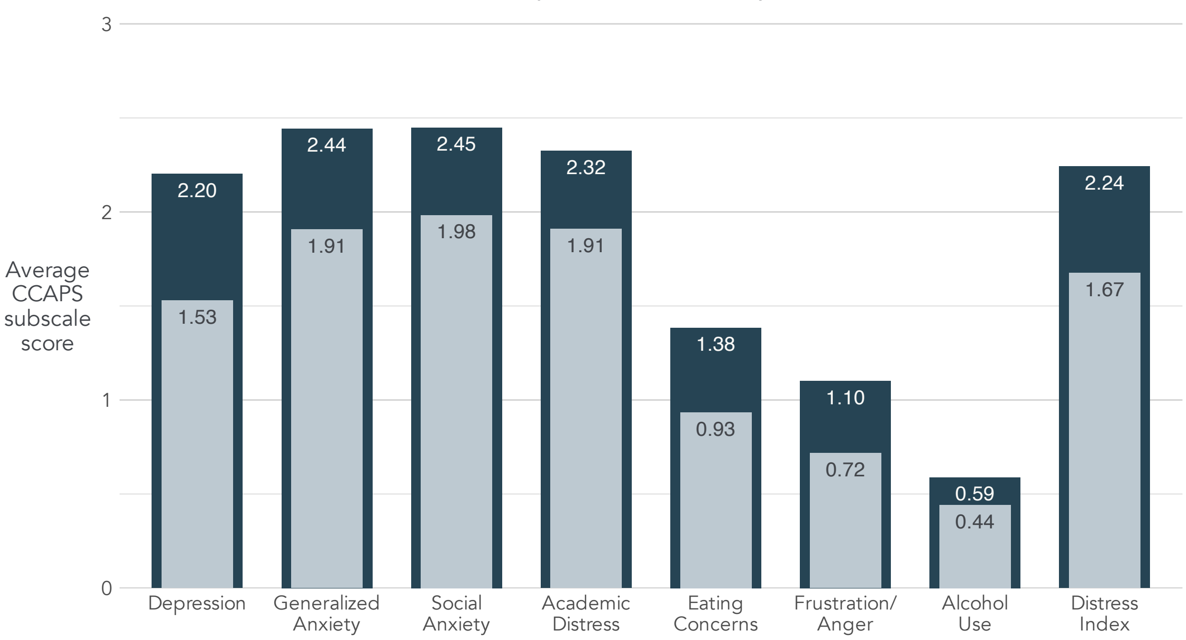
1. At the beginning of treatment, do clients with histories of suicidal/self-injurious behavior (S/SIB):
   - experience higher levels of distress?
   - report more severe problems?
   - display a greater level of clinical complexity?
2. During treatment, do clients with S/SIB histories:
   - utilize more services?
   - demonstrate a higher rate of critical events?
3. At the end of treatment, do clients with histories of S/SIB show improvement in general distress and suicidal ideation that is comparable to students without these risk factors?

Data for the current Annual Report include 302,579 students who were treated at 190 different college counseling centers in the United States from 2021 to 2024. Information was collected from the Standardized Data Set (SDS) – Client Information Form, Counseling Center Assessment of Psychological Symptoms (CCAPS), and two measures completed by clinicians (Clinician Index of Client Concerns [CLICC], Case Closure Form). The SDS, CCAPS and CLICC are typically completed when students initiate services, and the CCAPS is commonly delivered to students throughout treatment to monitor progress. The Case Closure Form is completed at the end of services.

BEGINNING OF TREATMENT

Levels of Distress

Students with histories of S/SIB enter counseling services with higher levels of self-reported distress on all CCAPS subscales compared to those without a history of S/SIB. The largest differences were discovered in Depression, Generalized Anxiety, and General Distress symptoms. Smaller differences were observed in Social Anxiety, Academic Distress, Eating Concerns, Frustration/Anger, and Alcohol Use.

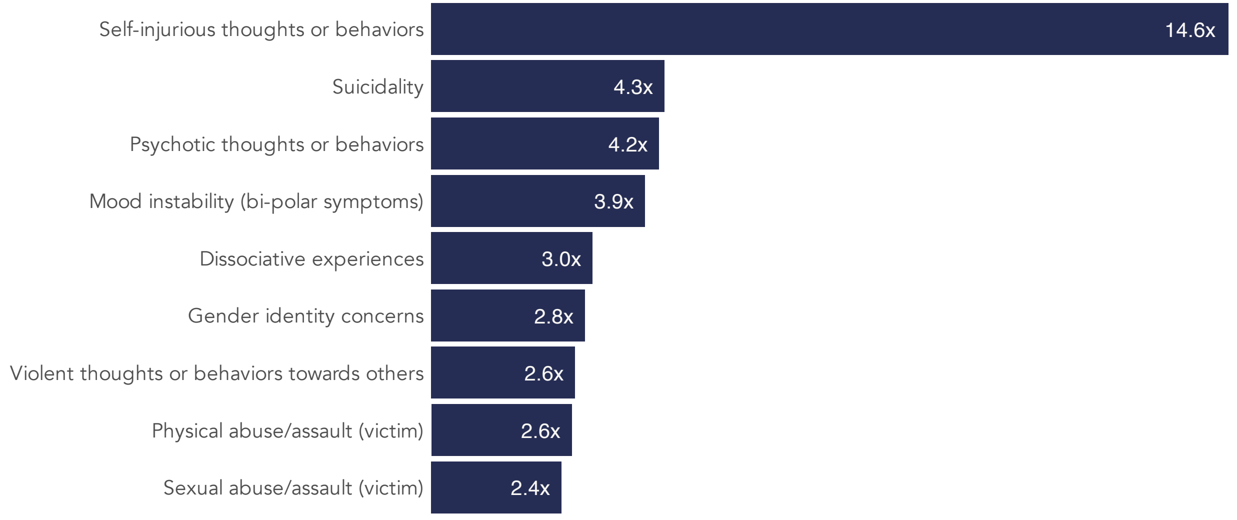


Presenting Concerns

The presenting concerns identified by clinicians for students with and without S/SIB histories differed in several ways. The figure below shows how many times more likely clients with a S/SIB history were to be assessed with a particular presenting concern than clients without past S/SIB. The specific concerns displayed below were chosen for examination because they often indicate that a student is experiencing a high level of distress, impairment, or safety risk.

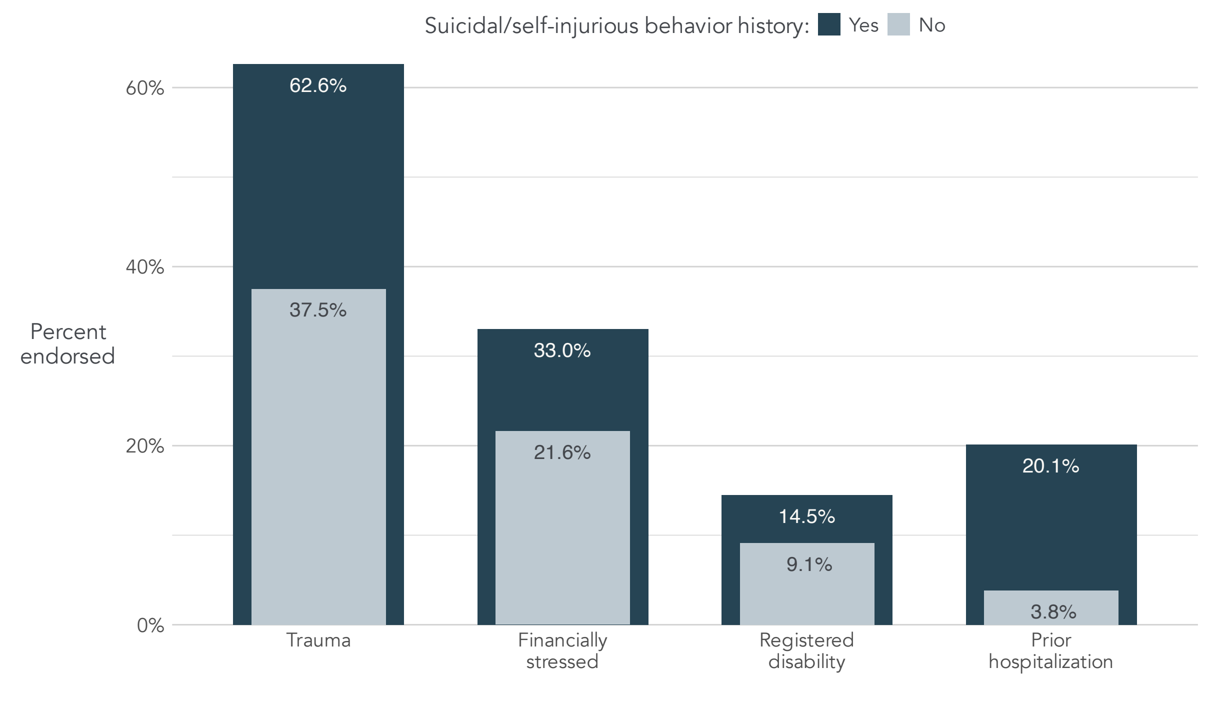
Students with a S/SIB history were much more likely (14.6 times) to have self-injurious thoughts and behaviors identified as an existing concern at the beginning of treatment. Additionally, they were 3 to 4.3 times more likely to experience dissociation, mood instability, psychotic thoughts or behaviors, and suicidality. Smaller, yet notable differences, were observed in several other presenting concerns, including experiencing abuse/assault, violent thoughts or behaviors, and gender identity concerns.

It is important to note that these concerns were infrequently identified in both students with and without S/SIB histories but at much different prevalence rates. For example, 3.3% of students with past S/SIB and 1.1% of those without these histories began counseling with dissociative experiences as a presenting problem. In other words, regardless of their history of S/SIB, a student has a low likelihood of entering counseling with any of these concerns. However, these results demonstrate that students with S/SIB histories are disproportionately more likely to present to counseling with severe comorbid problems.



Case Complexity

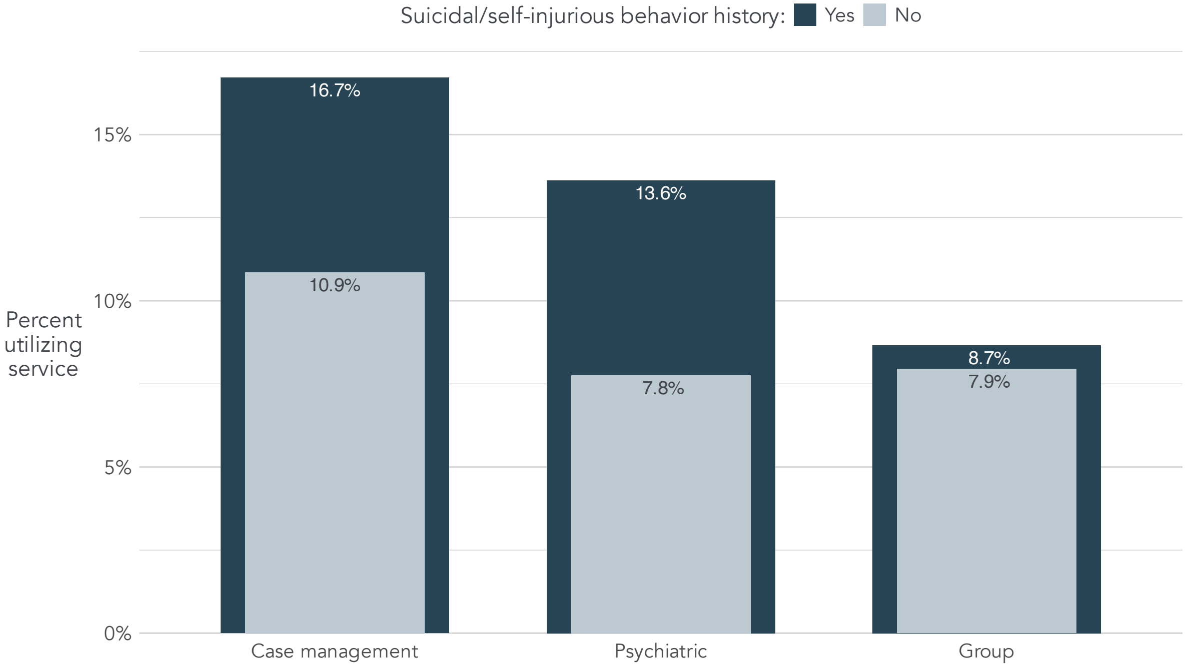
Students with a history of S/SIB, compared to those without, were substantially more likely to enter services with complex histories and co-occurring stressors. These include a history of trauma and psychiatric hospitalization, as well as current financial stress and disability status. The specific historical and contextual factors shown below were selected for investigation because they often require multi-department or external collaborations (e.g., referrals and/or consultations with Title IX supports, Dean of Students, Financial Aid offices, Disability Services, and external outpatient/inpatient treatment providers).



DURING TREATMENT

Utilization

Overall, students with past S/SIB had 1 more total appointments scheduled, on average, than students without these histories, which is equivalent to utilizing 15% more services. Students with and without S/SIB histories were compared in terms of the proportion of each group who utilized various types of comprehensive services offered by some counseling centers. A greater percentage of students with S/SIB histories received case management (16.7% vs. 10.9%) and psychiatric services (13.6% vs. 7.8%), while group therapy was utilized at a similar rate in both groups.

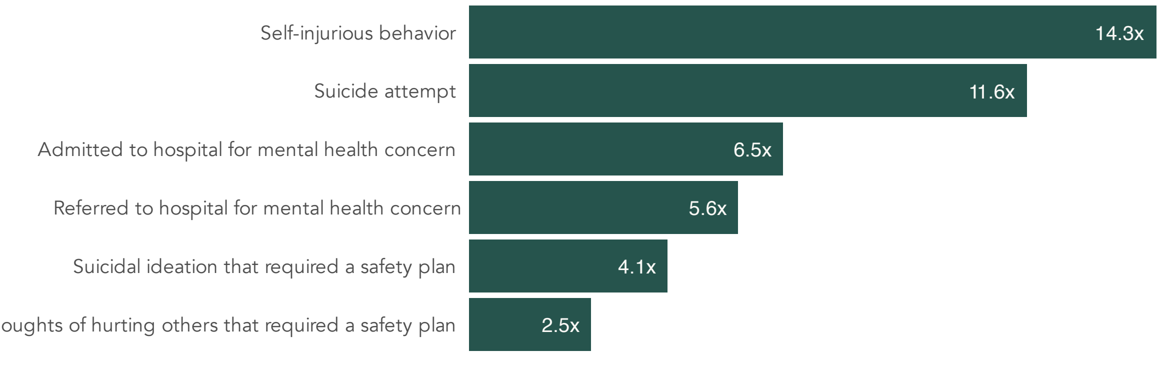


Critical Events

Students with S/SIB histories experienced substantially more critical case events during treatment than those without. The figure below displays how many times more likely students with S/SIB histories were to experience a particular critical event. The specific critical events shown below were chosen because of their established association with risk of harm to self or others.

Students with past S/SIB were 14.3 times more likely to engage in self-injury and 11.6 times more likely to attempt suicide during services. Additionally, they were 5.6 to 6.5 times more likely to be referred and admitted for hospitalization and 2.5 to 4.1 times more likely to need an active safety plan to manage their threat to themselves or others.

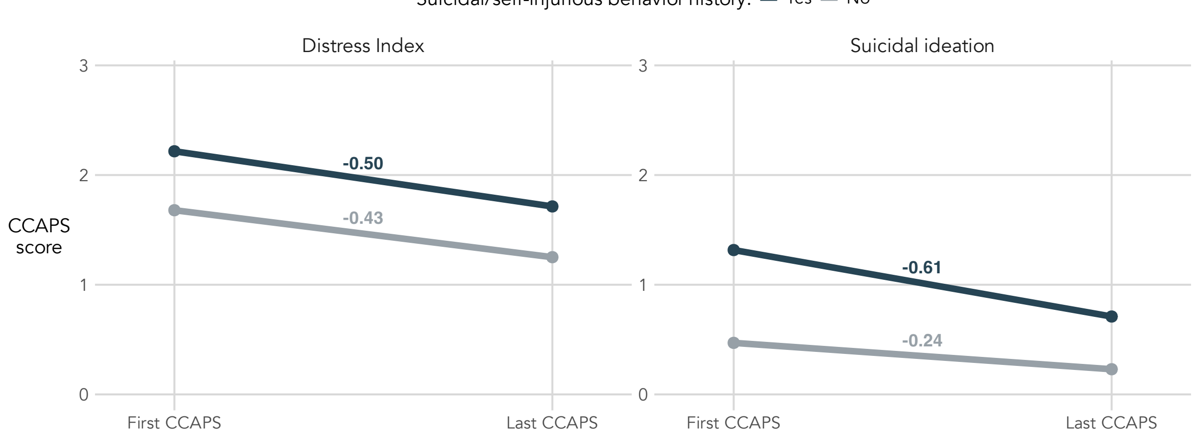
It is important to note that these critical events were uncommon in both students with and without past S/SIB. For example, approximately 1 in 180 (0.55%) students with S/SIB histories and 1 in 2,000 (0.05%) of those without attempted suicide during counseling services. Despite the low incidence rates, results show that students with S/SIB histories are disproportionately more likely to experience these events during treatment.



END OF TREATMENT

Improvement in general distress and suicidal ideation (i.e., change between first and last administrations of the CCAPS) were compared between students with and without past S/SIB. The changes were examined for all students, regardless of their level of symptoms at the beginning of treatment. The lines connecting first and last CCAPS administrations represent total improvement, where steeper lines indicate more change. The numbers above each line indicate the average raw change in symptoms for each type of distress.

Clients with S/SIB histories began treatment (first administration) with higher levels of general distress and suicidal thoughts than those without past S/SIB. Both groups showed similar rates of improvement in general distress symptoms during treatment. However, clients with past S/SIB demonstrated greater reductions comparatively in suicidal ideation during services. Despite demonstrable improvement on each outcome (general distress and suicidal thoughts), students with S/SIB histories, compared to those without, still ended services with considerably higher levels of symptoms.



SUMMARY

Findings

Suicide is a growing problem in the United States that has impacted college-aged individuals and motivated a robust implementation of prevention efforts on college campuses over the past two decades. As an indicator of success of these programs, more students have been initiating care at college counseling centers, particularly those with histories of suicidal/self-injurious behavior (S/SIB), which are known prominent risk factors for suicide. As such, the current investigation examined the symptoms, presenting concerns, stressors and contextual factors, service utilization, and treatment outcomes of students who receive services with a S/SIB history.

The findings revealed that students with past S/SIB, compared to those without, began treatment with more severe symptoms of Depression, Generalized Anxiety, and overall distress symptoms. Clients with S/SIB histories were more likely to be assessed by clinicians as having current self-injury or suicidality, psychotic symptoms, mood instability, dissociation, gender identity concerns, violent thoughts or behaviors, and experiences of abuse/assault at the outset of treatment. Additionally, students with past S/SIB utilized 1 more scheduled appointment or 15% more services, which included individual and group psychotherapy, case management, and psychiatric treatment. In terms of critical case events, students with S/SIB histories were 14 and 11 times more likely, respectively, to engage in self-harm and suicide attempts while receiving services at the counseling center. Finally, counseling center staff provided effective support to these students, as demonstrated by students' substantial improvement in distress and suicidal ideation during treatment.

While these findings highlight that counseling centers play an essential role in providing care to students with suicide risk, these students still ended treatment with higher levels of distress and suicidal ideation. Given many counseling centers have shifted to short-term treatment models to manage demand/supply imbalances for services, these findings underscore the importance of preserving and fortifying the comprehensive, collaborative, specialized, and potentially longer-term care needed to effectively support students with elevated suicide risk.

Additional Considerations

It is important to note several considerations related to the current findings. The factors selected to define students with heightened risk of suicide included histories of suicidal/self-injurious behavior were based on prior research and theory emphasizing the salience of these variables. However, there are many other known risk factors for suicide among students receiving care at counseling centers (e.g., substance use, impulsivity, social isolation, access to lethal means). Thus, the group of students CCMH examined does not encompass the entirety of students in treatment at counseling centers who are at elevated suicide risk. Moreover, while 30% of students seen at counseling centers nationally reported a S/SIB history, this percentage varied across individual centers: at the majority of centers, between 20% and 50% of students reported past S/SIB. Therefore, it is important for centers to examine their local data to determine how these findings might inform their services.

Additionally, although students with past suicidal/self-injurious behavior were more likely to engage in critical events during services (e.g., make a suicide attempt), these actions were uncommon for all students. As such, regardless of their history of S/SIB, a student is much more likely to not experience any critical events during their care at counseling centers.

Finally, the current findings underscored the enhanced needs for comprehensive services by students with elevated suicide risk, which especially included case management and psychiatric support. However, the actual amount of care at-risk students receive may be even higher than this examination was able to detect. For instance, clinicians often spend time outside of scheduled sessions consulting and collaborating with other providers, campus offices, and caregivers of students with acute or complex needs, which is not reflected in the number of sessions scheduled.

Furthermore, many counseling centers have neither case management nor psychiatric services available for a multitude of reasons, such as lack of financial resources or difficulty recruiting specialized providers. In fact, only 40.9% of centers nationally have a dedicated position to case management, and 38% of centers offer psychiatric care. Centers without dedicated case management or psychiatric providers are inevitably faced with formidable challenges, including having therapists conduct case management during counseling sessions without the assistance of a specialized case manager, coordinating with external providers for psychiatric care, or contracting with a service unaffiliated with the institution to provide these services. Consequently, many clinicians working at centers with a scarcity of these specialized services might become overburdened with managing multiple tasks in their finite amount of time with students, which could dilute the overall quality of care they provide. Therefore, it is imperative that colleges and universities invest in under-resourced counseling centers to ease the burden on counseling center staff and optimize treatment for students with heightened suicide risk.

Conclusions

The current findings highlight the critical role college counseling centers serve in supporting suicide prevention and campus safety initiatives within higher education, while concurrently identifying areas where potential gaps exist for under-resourced centers. A significant proportion (approximately 30%) of students treated at centers nationally are at elevated risk of dying by suicide, as defined by a history of suicide attempts or self-injurious behavior. Thus, it is imperative for colleges and universities to understand the gravity of mental health concerns and suicide risk among students receiving care at counseling centers and the unique and comprehensive service needs of this population. Given the majority of centers nationally lack the necessary resources to deliver comprehensive specialized services, institutions can support counseling center efforts to treat these at-risk students by investing in onsite psychological treatment, psychiatric care, and case management services, which enhances the capacity to collaborate with campus/external partners and provide longer-term care. These comprehensive services are a vital support system that is sometimes the only option for care available since many students with increased suicide risk might not meet criteria for treatment by external telehealth providers and vendors due to their S/SIB history. Despite these challenges, some institutions might need to creatively explore avenues to offer comprehensive services through a third-party provider. Regardless, investments in locally informed and collaborative counseling center care that includes adjunctive support services (e.g., Title IX, Dean of Students, Financial Aid, and Student Disability) are crucial to support this population, form campus/external partnerships, and achieve mental, emotional, and academic improvement for these students, which ultimately increases the likelihood of student success.

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Recent CCMH Publications

- Isadore, K. M., Hayes, J. A., Cutter, C. J., & Beitel, M. (2024). **Native American college students in counseling: Results from a large-scale, multisite effectiveness study**. *Psychotherapy, 61*(3), 173-183. https://doi.org/10.1037/pst0000526
- Hayes, J. A. (2024). *College Student Mental Health and Wellness: Coping on Campus.* Emerald Group Publishing.
- Trusty, W. T., Scofield, B. E., Janis, R. A., Cummins, A. L., & White, T. D. (2024). **Psychotherapy dose, clinical outcome, and academic withdrawal at university counseling centers**. *Psychological Services.* Advance online publication. https://dx.doi.org/10.1037/ser0000895
- Locke, B. D., Scofield, B. E., Janis, R., & Cummins, A. (2024). **Clinical Load Index (CLI): Design, Development, and Review of Research**. *Journal of College Student Mental Health,* 1–23. https://doi.org/10.1080/28367138.2024.2391750
- Trusty, W. T., Castonguay, L. G., Chun-Kennedy, C. L., Magruder, S. A. N., Janis, R. A., Davis, K. A., Augustin, D. C., & Scofield, B. E. (2024). **Client characteristics and early working alliance development: A person-centered research approach**. *Psychotherapy Research,* 1–15. https://doi.org/10.1080/10503307.2024.2418868
- Zhao, F., Hayes, J. A., McClain, J. M., Janis, R. A., Panlilio, C., Lei, P., Castonguay, L. G., & Scofield, B. (In Press) **How Full is the Glass? Examining the Validity of the Counseling Center Assessment of Psychological Symptoms-62 Across Five Ethnoracial Groups**. *Journal of Counseling Psychology*

Annual Trends

MENTAL HEALTH TRENDS

As of this report, CCMH has generated 14 annual data sets (2010-2011 through 2023-2024), making it possible to examine numerous years of trends. To investigate trends across key mental health indicators, items from the Mental Health History section of the Standardized Data Set (SDS) were simplified to "Yes" or "No," providing a proxy for the lifetime prevalence of each item. These items may have changed slightly over time; please refer to the SDS Manual for details on revision history details. Specifically, the wording for many items changed in 2012, resulting in a larger change in response rate to some items after that year.

Data Sets

The table below summarizes the amount of data contributed to CCMH over the past 14 academic years. It is important to note the annual changes in number of clients merely reflect an increase in data that has been contributed by counseling centers and not an increase in utilization of counseling center services.

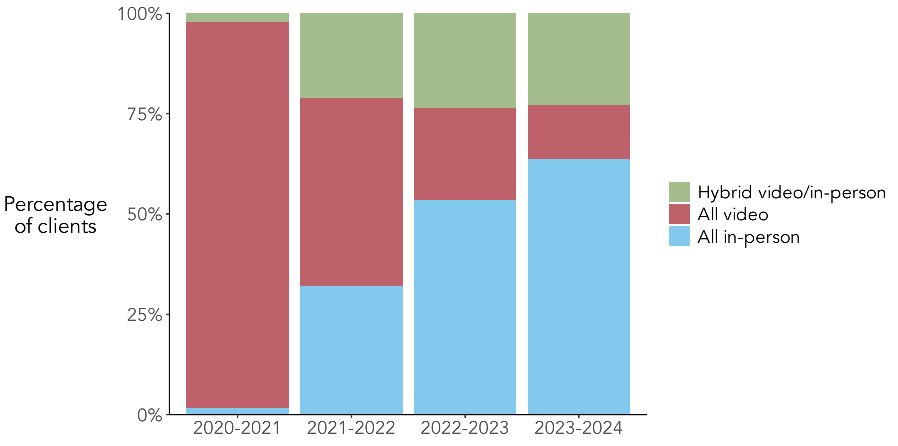
Year	Number of Centers	Number of Clients
2010-2011	97	82,611
2011-2012	120	97,012
2012-2013	132	95,109
2013-2014	140	101,027
2014-2015	139	100,736
2015-2016	139	150,483
2016-2017	147	161,014
2017-2018	152	179,964
2018-2019	163	207,818
2019-2020	153	185,440
2020-2021	180	153,233
2021-2022	180	190,907
2022-2023	195	185,114
2023-2024	213	173,536

Mental Health Trends (2012 to 2024)

Several mental health history trends shifted in 2023-2024. Rates of prior counseling and psychotropic medication usage continued to increase and currently are at their highest levels since this data was collected in 2012. Past counseling is the mental health history item with the largest 12-year increase: over 63% of students entered services with prior counseling. Notably, history of a psychiatric hospitalization has demonstrated a slight upward trend since 2020, although the overall trajectory remains relatively stable over the past 12 years. After a period of annual increases since 2012, history of trauma slightly declined in the past year, however, it has notably increased overall during the past 12 years, growing from 37.5% in 2012 to 45.5% this past year. The rates of students with histories of threat-to-self characteristics were generally stable over the past year, with some variables slightly increasing (histories of non-suicidal self-injury and suicide attempts) and others marginally declining (history of serious suicidal ideation, serious suicidal ideation over the past month). History of suicide attempt(s) has shown a faint upward trend over the past 12 years, increasing from 8.7% in 2012 to its highest level of 10.9% in the past year.

MODE OF SERVICE TRENDS

After the onset of the COVID-19 pandemic in 2020, CCMH began collecting data on the mode of counseling service delivery, which included in-person, video, audio, or text. The figure below highlights the changes in the mode of services from 2020 to 2024 for individual counseling appointments. Audio and text were excluded from the analyses due to their relative infrequent usage across the years. From 2020 to 2024, the percentage of students who received exclusive in-person individual counseling services increased from 1.7% to 63.7%, and the proportion of those who were solely provided video care declined from 96.1% to 13.5%. For the past three years (2021-2024), approximately 25% of students received hybrid care (combination of in-person and video sessions).



Mental Health Trends (2012–2024)

Item	12-Year Change	2012-2024	Lowest	Highest	2023–2024
Prior Treatment					
Counseling	+15.4%		47.8%	63.3%	63.3%
Medication	+6.8%		32.4%	39.3%	39.3%
Hospitalization	-0.3%		8.0%	10.3%	9.8%
Threat-to-Self					
Non-Suicidal Self-Injury	+5.7%		23.0%	29.1%	28.7%
Serious Suicidal Ideation	+4.0%		30.1%	36.9%	34.0%
Serious Suicidal Ideation (last month)	-1.3%		5.7%	8.2%	5.7%
Suicide Attempt(s)	+2.2%		8.7%	10.9%	10.9%
Some Suicidal Ideation (past 2 weeks)	+0.3%		33.9%	39.6%	34.3%
Threat-to-Others					
Considered causing serious physical injury to another person	-5.1%		5.2%	11.2%	6.1%
Intentionally caused serious injury to another person	-2.0%		1.2%	3.4%	1.3%
Traumatic Experiences					
Had unwanted sexual contact(s) or experience(s)	+6.7%		18.9%	27.4%	25.7%
Experienced harassing, controlling, and/or abusive behavior	+4.2%		32.8%	39.6%	37.4%
Experienced traumatic event	+8.0%		37.5%	46.8%	45.5%
Drug and Alcohol					
Felt the need to reduce alcohol/drug use	-1.3%		25.6%	27.5%	25.8%
Others concerned about alcohol/drug use	-4.5%		13.0%	17.6%	13.0%
Treatment for alcohol/drug use	-2.7%		1.7%	4.4%	1.7%
Binge drinking	-11.2%		30.3%	41.5%	30.3%
Marijuana use	+3.8%		19.1%	26.0%	24.6%

CCAPS TRENDS

The Counseling Center Assessment of Psychological Symptoms (CCAPS) is a multidimensional assessment and routine outcome monitoring instrument used by CCMH counseling centers that measures eight distinct areas of distress commonly experienced by college students. The frequency and clinical timing of CCAPS administration varies by counseling center. Students respond to how well the items describe them during the past two weeks on a five-point Likert scale ranging from 0 (*not at all like me*) to 4 (*extremely like me*). The following figures provide information regarding trends in student clients' self-reported distress when initiating counseling services.

CCAPS Trends: Average Subscale Scores (2010 to 2024)

All CCAPS Subscale scores remained relatively flat or slightly declined over the past year. This included areas that were previously increasing, such as Generalized and Social Anxiety. Academic Distress continues to recede from the substantial elevation after the onset of the COVID-19 pandemic in 2020, however, the magnitude of distress remains above pre-pandemic levels. Social Anxiety continued to display the greatest 14-year change across all CCAPS subscales. While all symptoms of Social Anxiety increased, the symptom that grew the most across the years is "concerns that others do not like me."

CCAPS Trends (2010–2024)

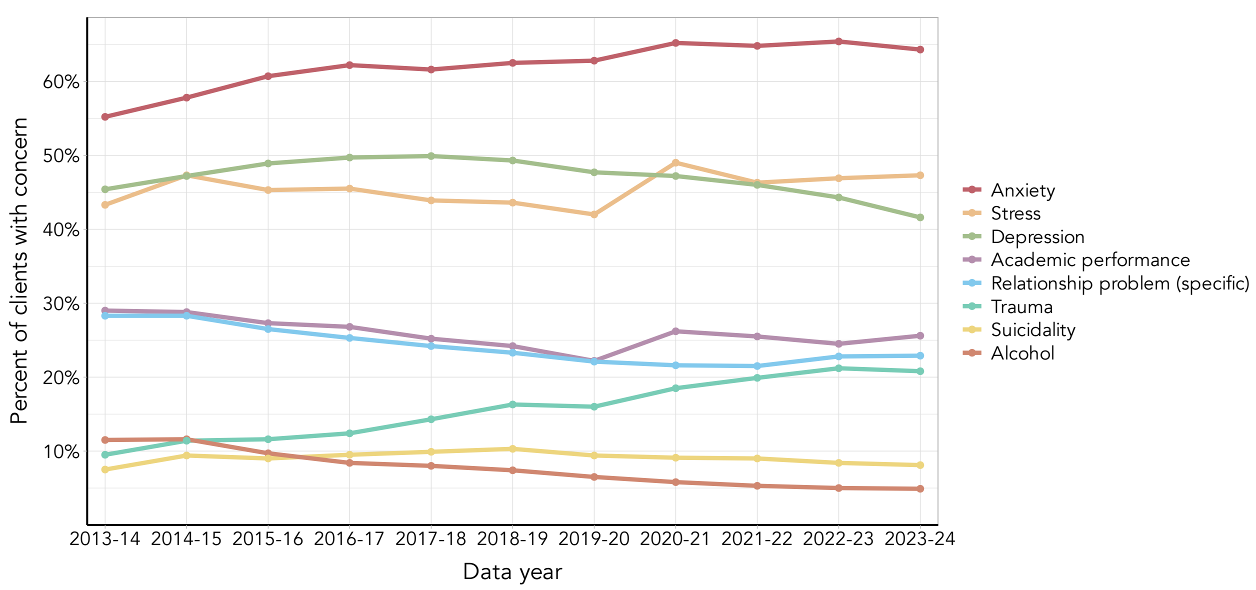
Item	14-Year Change	2010-2024	Lowest	Highest	2023–2024
CCAPS-62					
Depression	+0.18		1.59	1.84	1.77
Generalized Anxiety	+0.26		1.61	1.91	1.87
Social Anxiety	+0.31		1.82	2.14	2.12
Academic Distress	+0.04		1.85	2.05	1.89
Eating Concerns	+0.11		1.00	1.12	1.11
Frustration/Anger	-0.07		0.96	1.04	0.98
Substance Use	-0.23		0.54	0.77	0.54
Family Distress	+0.15		1.29	1.45	1.44
CCAPS-34					
Depression	+0.08		1.55	1.74	1.63
Generalized Anxiety	+0.22		1.77	2.05	1.99
Social Anxiety	+0.31		1.77	2.10	2.08
Academic Distress	+0.01		1.92	2.10	1.93
Eating Concerns	+0.10		0.94	1.07	1.05
Frustration/Anger	-0.12		0.80	0.93	0.81
Alcohol Use	-0.29		0.44	0.73	0.44
Distress Index	+0.11		1.65	1.83	1.76

CLICC TRENDS

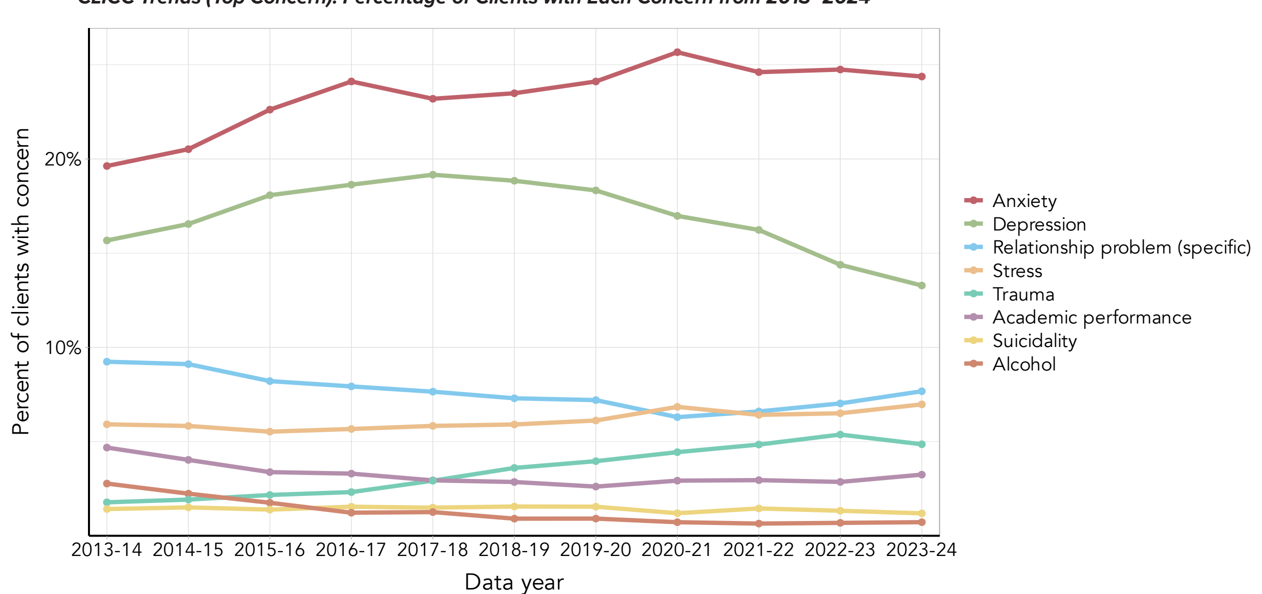
The Clinician Index of Client Concerns (CLICC) captures the presenting concerns of counseling center clients, as assessed by the clinician during an initial appointment. The CLICC includes 54 concerns and asks the clinician (a) to check all that apply and (b) to identify the "top concern" of those selected.

The graphs below display trends in the most frequently assessed CLICC items by clinicians. As a general (check all that apply) and top concern, Anxiety slightly declined this past year, and Depression displayed a more marked reduction. After increasing since 2014-2015, Trauma as a general and top concern was relatively flat or somewhat decreased this past year. Notably, relationship problem (specific) continued to show an upward trend as a top concern since 2020.

CLICC Trends (Check All That Apply): Percentage of Clients with Each Concern from 2013–2024



CLICC Trends (Top Concern): Percentage of Clients with Each Concern from 2013–2024



Appointment Statistics

UTILIZATION

Data from 2023-2024 was analyzed to determine how counseling center resources were distributed among students seeking services. The following points describe how counseling center appointments were utilized by 164,103 students across participating CCMH centers:

- The most common number of appointments per client per year is one.
- Clients averaged 5.9 total attended appointments of any kind, with a median of 4 appointments, and a range of 1-170 appointments.
- Clients averaged 5.17 attended *Individual Treatment* (initial clinical evaluations and individual counseling) appointments, with a median of 4 attended appointments, and a range of 1-157 attended appointments.
- 20% of clients accounted for 57% of all appointments, averaging 15 appointments.
- 10% of clients accounted for 38% of all appointments, averaging 19 appointments.
- 5% of clients accounted for 22% of all appointments, averaging 25 appointments.
- 1% of clients accounted for 7% of all appointments, averaging 36 appointments.

ATTENDANCE

Out of 1,215,151 appointments, 76% were marked as attended.

Client Attendance	Frequency	Percent
Attended	918,953	75.8%
Center Closed	4,947	0.4%
Client Cancelled	56,191	4.6%
Client Cancelled Late	25,947	2.1%
Client No Show	90,740	7.5%
Client Rescheduled	63,534	5.2%
Counselor Cancelled	30,327	2.5%
Counselor Rescheduled	22,499	1.9%

When examining the attendance rates of specific types of appointments, Brief Screening or Walk-in had the highest attendance rate, while Group (psychotherapy, workshop, clinic) appointments had the lowest.

Appointment Category	Total Sessions	Percent Attended
Individual psychotherapy/counseling	700,808	74.0%
Initial clinical evaluation	113,401	79.5%
Brief Screening or Walk-in	94,899	86.8%
Group – psychotherapy	94,498	63.9%
Psychiatric follow-up	43,974	74.6%
Case management	41,124	82.2%
Specialized individual treatment	10,295	76.3%
Group – workshop	8,376	50.3%
Psychiatric evaluation	7,890	79.6%
Couple's therapy	7,717	74.1%
Psychological Testing or Assessment	3,792	79.1%
Group – clinic	3,247	59.8%

APPOINTMENT LENGTH

Appointment length for all types of appointments was rounded up to the next 15-minute increment for 0 to 60 minutes and the next 30-minute mark for appointments 60 to 120 minutes in length. Over two thirds of appointments were 60 minutes. Only 8.1% of appointments were over 60 minutes in length.

Appointment Length (Minutes)	Frequency	Percent
15	52,241	5.7%
30	125,602	13.7%
45	42,841	4.7%
60	624,109	67.9%
90	64,274	7.0%
120	9,887	1.1%

APPOINTMENT MODE

Appointment mode information was provided for 561,151 attended appointments in 2023-2024. Across all appointment categories, 71.5% were in-person and 20% were video-based.

Mode	Frequency	Percent
In person	401,333	71.5%
Audio	24,873	4.4%
Video	112,390	20.0%
Text	22,555	4.0%

WAIT TIME FOR FIRST APPOINTMENT

Wait time captures the time (in days) between when an appointment was scheduled and attended. If an appointment was attended on the same day it was scheduled, the wait time is 0 days. The table below describes the average wait time in business and calendar days for the first attended Brief Screening/Walk-In (quick screen, triage, or walk-in consultation) and Initial Clinical Evaluation (first appointment or "Intake" that includes detailed information gathering) appointments of the year. The data is from 116,796 students who sought care in 2023-2024.

	Business Days	Calendar Days
Brief Screening/Walk-In	1.53	2.09
Initial Clinical Evaluation	4.26	5.92

Approximately 35% of students were seen for their first appointment of the year on the same day it was scheduled, while 82% were seen within 5 business days or 7 calendar days.

Standardized Data Set (SDS)

The Standardized Data Set (SDS) is a set of standardized data materials used by counseling centers during routine clinical practice. In this section, we provide a closer analysis of selected forms from the SDS: the Clinician Index of Client Concerns (CLICC); the Case Closure Form; and client, provider, center, and institutional demographic information.

CLINICIAN INDEX OF CLIENT CONCERNS (CLICC)

The CLICC was designed by CCMH to capture and facilitate reporting on the most common presenting concerns of counseling center clients, as assessed by the clinician during an initial appointment The resulting data allows CCMH and individual centers to quickly and easily report on the most common client concerns treated at each center, as well as support a wide array of research initiatives. The CLICC includes 54 concerns, and beginning in July 2017, the category of "Anxiety" was expanded to include options for 6 specific types of anxiety, including Generalized, Social, Test Anxiety, Panic Attacks, Specific Phobias, as well as unspecified/other.

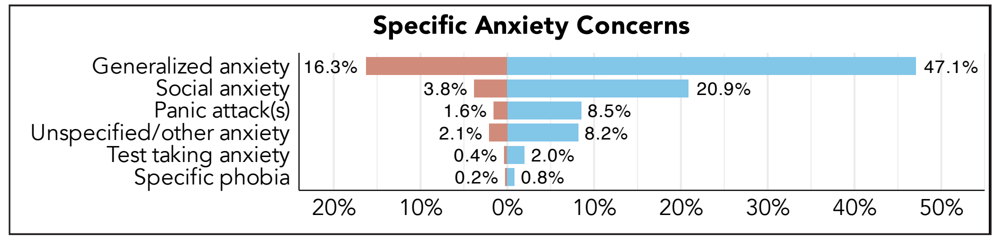
The graph on the next page illustrates the presenting concerns of 61,473 clients during the 2023-2024 academic year. For each client, clinicians are asked to "check all that apply" from the list of CLICC concerns (as one client can have many concurrent concerns). The blue bars on the right portion of the graph illustrate the frequency of each concern regardless of how many other concerns a student experienced.

Clinicians are then asked to choose one primary concern (i.e., the top concern) per client. The red bars on the left in the graph provide the frequency of each primary (top) concern.

Collectively the two bars highlight the proportion of clients who were experiencing each concern (check all that apply) and the proportion for which the specific concern was the primary problem (top concern). For example, while many clients experienced sleep as concern (14.4%), it was the top concern for far fewer clients (0.3%). On the other hand, 22.9% of clients had Relationship problem (specific) endorsed as a concern, but a higher percent (7.7%) had it endorsed as their top concern. The Anxiety category is displayed broken out into the specific types of anxiety below the main graph.

CLICC Combined Top Concern and Check All That Apply

Concern	Top Concern	Check All That Apply
Anxiety	24.4%	64.4%
Stress	7.0%	47.3%
Depression	13.3%	41.6%
Family	3.9%	29.2%
Academic performance	3.2%	25.6%
Relationship problem (specific)	7.7%	22.9%
Interpersonal functioning	3.5%	21.4%
Trauma	4.9%	20.8%
Self-esteem/confidence	2.3%	20%
Eating/body image	1.6%	16.1%
Adjustment to new environment	3.7%	15.9%
Attention/concentration difficulties	2.5%	14.7%
Sleep	0.3%	14.4%
Social isolation	0.8%	12.3%
Emotion dysregulation	2.2%	11.4%
Grief/loss	3.4%	10.9%
Identity development	1.4%	9.8%
Career	0.6%	8.2%
Suicidality	1.2%	8.1%
Perfectionism	0.7%	8%
Sexual abuse/assault (victim)	1.1%	7.1%
Health/medical	0.7%	5.8%
Self-injurious thoughts or behaviors	0.4%	5.3%
Harassment/emotional abuse (victim)	0.4%	5.3%
Anger management	0.8%	5%
Alcohol	0.7%	4.9%
Financial	0.2%	4.3%
Drugs	0.4%	4.1%
Obsessions or compulsions	1.1%	3.8%
Other	1.8%	3.5%
Physical abuse/assault (victim)	0.1%	3.2%
Mood instability (bi-polar symptoms)	1.1%	3.2%
Racial, ethnic or cultural concerns	0.1%	3%
Sexual orientation	0.1%	2.2%
Autism spectrum	0.3%	1.9%
Dissociative experiences	0.2%	1.8%
Gender identity	0.4%	1.7%
Religion/spirituality	0.1%	1.3%
Sexual concern	0.3%	1.3%
Discrimination	0.1%	1%
Violent thoughts or behaviors towards others	0.1%	0.8%
Legal/judicial/conduct	0.2%	0.8%
Learning disorder/disability	0.0%	0.8%
Addiction (not drugs or alcohol)	0.2%	0.6%
Psychotic thoughts or behaviors	0.1%	0.4%
Stalking (victim)	0.0%	0.4%
None	0.1%	0.4%
Pregnancy related	0.1%	0.2%

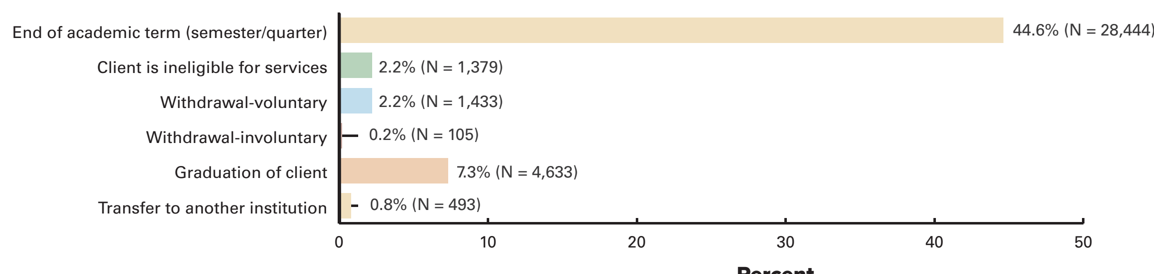


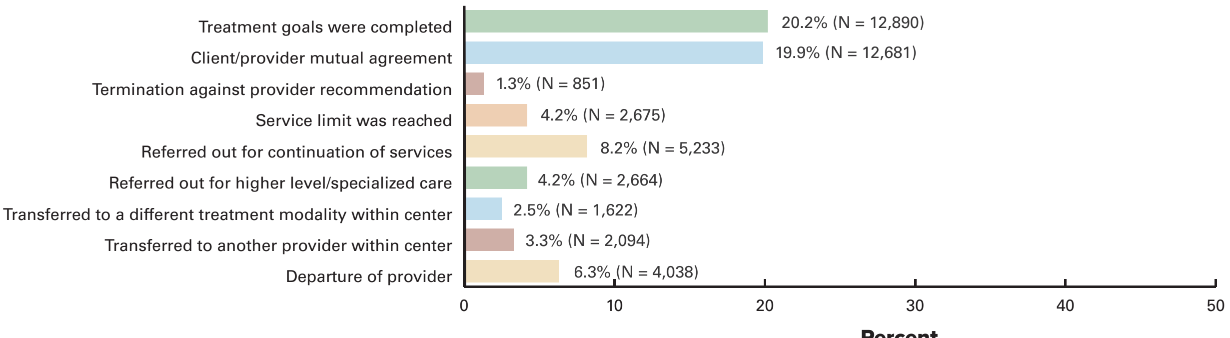
CASE CLOSURE FORM

The Case Closure Form captures a wide array of reasons (academic, clinical, and client factors) why services ended, as well as significant events that might have occurred during the course of a student's services. Clinicians are asked to complete this form following the end of their service provision with a client. Clinicians can "select all that apply" from a checklist of 20 reasons why services may have ended for a given client and indicate the top reason. They can also specify any of 14 significant events that might have occurred during services.

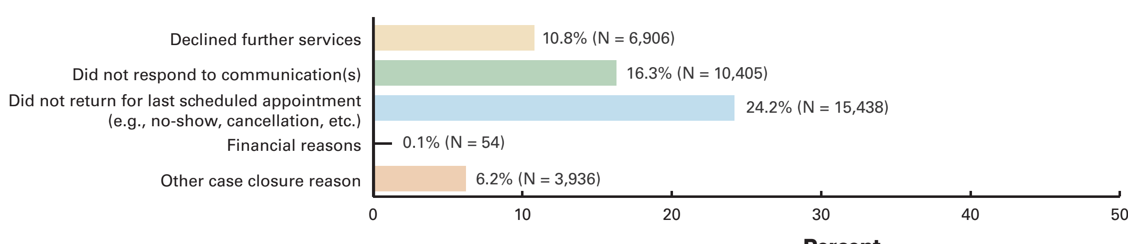
Reasons for Closure of Case

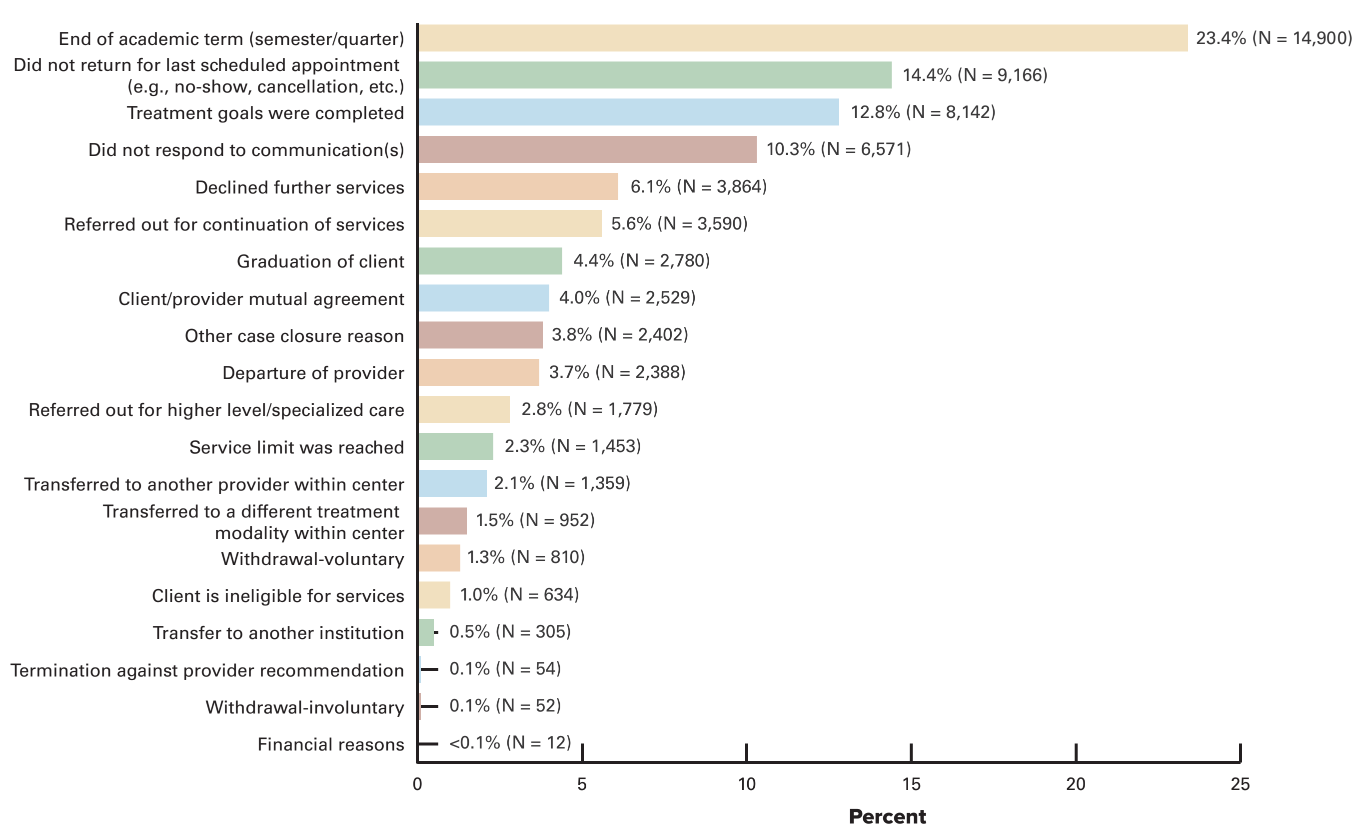
This graph describes the frequency of various reasons why services ended for students who received treatment during the 2023-2024 academic year (N = 63,754). Of note, the top most endorsed reasons were the ending of the academic term (44.6%), followed by the client not returning for their last appointment (24.2%), treatment goals being completed (20.2%), and client/provider mutual agreement (19.9%).





Client Factor Reasons

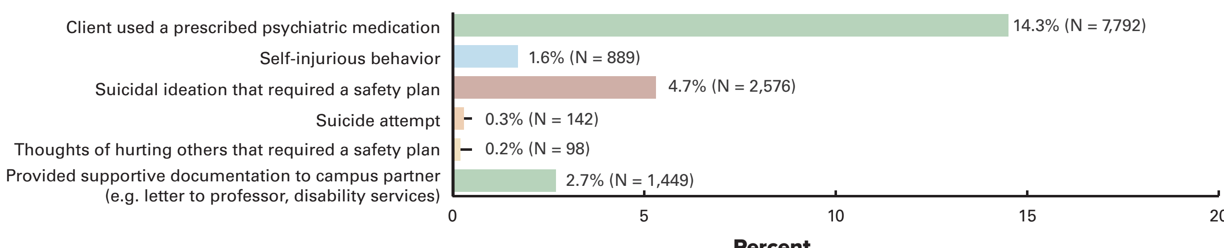

Declined further services
10.8% (N = 6,906)
Did not respond to communication(s)
16.3% (N = 10,405)
Did not return for last scheduled appointment (e.g., no-show, cancellation, etc.)
24.2% (N = 15,438)
Financial reasons
0.1% (N = 54)
Other case closure reason
6.2% (N = 3,936)
0
10
20
30
40
50
Percent


Top Case Closure Reason
End of academic term (semester/quarter)
23.4% (N = 14,900)
Did not return for last scheduled appointment (e.g., no-show, cancellation, etc.)
14.4% (N = 9,166)
Treatment goals were completed
12.8% (N = 8,142)
Did not respond to communication(s)
10.3% (N = 6,571)
Declined further services
6.1% (N = 3,864)
Referred out for continuation of services
5.6% (N = 3,590)
Graduation of client
4.4% (N = 2,780)
Client/provider mutual agreement
4.0% (N = 2,529)
Other case closure reason
3.8% (N = 2,402)
Departure of provider
3.7% (N = 2,388)
Referred out for higher level/specialized care
2.8% (N = 1,779)
Service limit was reached
2.3% (N = 1,453)
Transferred to another provider within center
2.1% (N = 1,359)
Transferred to a different treatment modality within center
1.5% (N = 952)
Withdrawal-voluntary
1.3% (N = 810)
Client is ineligible for services
1.0% (N = 634)
Transfer to another institution
0.5% (N = 305)
Termination against provider recommendation
0.1% (N = 54)
Withdrawal-involuntary
0.1% (N = 52)
Financial reasons
<0.1% (N = 12)
0
5
10
15
20
25
Percent

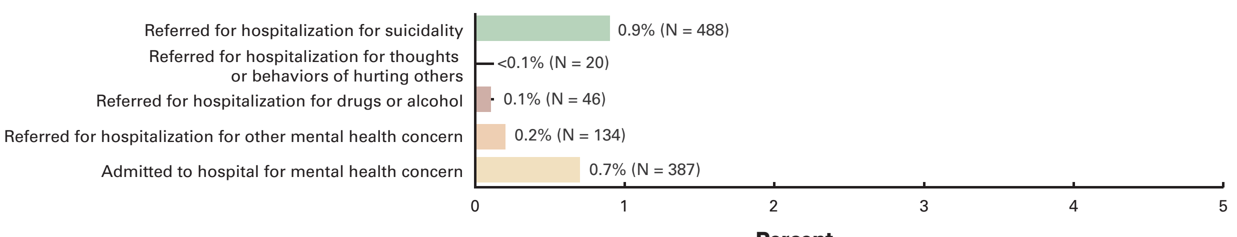
Case Events

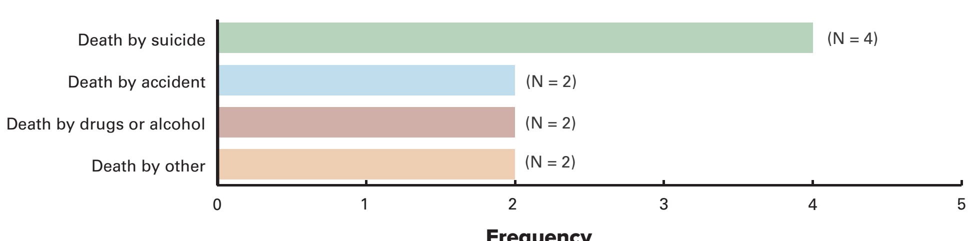
This graph describes the frequency of significant events occurring during a course of services for students during the 2023-2024 academic year (N= 54,315).

Clinical Events



Hospitalization Events





CLIENT DEMOGRAPHIC INFORMATION

The Standardized Data Set (SDS) for client demographic information contains numerous different questions related to client demographics. The tables below include the specific item text and number. Because counseling centers differ in the questions they choose to ask from the SDS, the total number of responses varies by question.

Client Age

Mean	SD	Range
22.06	4.24	18-60

What is your gender identity?

SDS 88 (N = 102,101)	Frequency	Percent
Woman	61,869	60.6%
Transgender woman	619	0.6%
Man	34,211	33.5%
Transgender man	840	0.8%
Non-binary	3,483	3.4%
Self-identify	1,079	1.1%

What was your sex at birth?

SDS 90 (N = 25,177)	Frequency	Percent
Female	16,132	64.1%
Male	9,037	35.9%
Intersex	8	<0.1%

Do you consider yourself to be:

SDS 91 (N = 96,499)	Frequency	Percent
Asexual	2,798	2.9%
Bisexual	13,844	14.3%
Gay	2,715	2.8%
Heterosexual/Straight	63,958	66.3%
Lesbian	2,645	2.7%
Pansexual	3,071	3.2%
Queer	3,400	3.5%
Questioning	3,031	3.1%
Self-identify	1,037	1.1%

What is your race/ethnicity?

SDS 95 (N = 97,440)	Frequency	Percent
African American/Black	9,518	9.8%
American Indian or Alaskan Native	547	0.6%
Asian American/Asian	11,318	11.6%
Hispanic/Latino/a	11,612	11.9%
Native Hawaiian or Pacific Islander	206	0.2%
Multi-racial	5,134	5.3%
White	57,630	59.1%
Self-identify	1,475	1.5%

What is your country of origin?

Country	Frequency
United States	85,727
India	2,840
China	2,296
Mexico	713
Korea, Republic of	534
Bangladesh	458
Iran, Islamic Republic of	431
Nigeria	367
Canada	366
Puerto Rico	357
Brazil	353
Vietnam	337
Colombia	333
Philippines	316

Country	Frequency
Pakistan	297
Venezuela	264
Taiwan	235
United Kingdom	229
Nepal	201
Russian Federation	195
Peru	190
Germany	178
Ghana	163
Cuba	156
Dominican Republic	153
Jamaica	140
Turkey	138
Ecuador	129

Country	Frequency
Haiti	128
Egypt	126
Japan	126
United States Minor Outlying Islands	124
Guatemala	123
Saudi Arabia	120
Italy	117
El Salvador	107
Honduras	105
Ethiopia	102
Spain	100

Countries with less than 100 (0.1%) individuals:
Afghanistan; Aland Islands; Albania; Algeria; American Samoa; Andorra; Angola; Antarctica; Antigua and Barbuda; Argentina; Armenia; Aruba; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Barbados; Belarus; Belgium; Belize; Benin; Bermuda; Bhutan; Bolivia; Bosnia and Herzegovina; Botswana; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Cape Verde; Cayman Islands; Central African Republic; Chad; Chile; Christmas Island; Comoros; Congo; Congo, The Democratic Republic of the; Costa Rica; Cote D'ivoire; Croatia; Cyprus; Czech Republic; Denmark; Djibouti; Dominica; Equatorial Guinea; Eritrea; Estonia; Fiji; Finland; France; French Southern Territories; Gabon; Gambia; Georgia; Greece; Grenada; Guam; Guinea; Guyana; Hong Kong; Hungary; Iceland; Indonesia; Iraq; Ireland; Israel; Jersey; Jordan; Kazakhstan; Kenya; Korea, Democratic People's Republic of; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Liberia; Libyan Arab Jamahiriya; Lithuania; Luxembourg; Macao; Macedonia, The Former Yugoslav Republic of; Madagascar; Malawi; Malaysia; Mali; Marshall Islands; Mauritius; Moldova, Republic of; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Netherlands; Netherlands Antilles; New Zealand; Nicaragua; Niger; Northern Mariana Islands; Norway; Oman; Palau; Palestinian Territory; Panama; Paraguay; Poland; Portugal; Qatar; Romania; Rwanda; Saint Kitts and Nevis; Saint Lucia; Samoa; Senegal; Serbia; Sierra Leone; Singapore; Slovakia; Slovenia; Somalia; South Africa; Sri Lanka; Sudan; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Tanzania, United Republic of; Thailand; Timor-leste; Togo; Tokelau; Tonga; Trinidad and Tobago; Tunisia; Turkmenistan; Uganda; Ukraine; United Arab Emirates; Uruguay; Uzbekistan; Virgin Islands, British; Virgin Islands, U.S.; Yemen; Zambia; Zimbabwe

Are you an international student?

SDS 32 (N = 107,987)	Frequency	Percent
No	97,865	90.6%
Yes	10,122	9.4%

Are you the first generation in your family to attend college?

SDS 56 (N = 103,515)	Frequency	Percent
No	77,930	75.3%
Yes	25,585	24.7%

Current academic status:

SDS 1037 (N = 85,679)	Frequency	Percent
1st year undergraduate	20,048	23.4%
2nd year undergraduate	17,400	20.3%
3rd year undergraduate	16,481	19.2%
4th year undergraduate	11,943	13.9%
5th year or more undergraduate	3,229	3.8%
Graduate student	14,298	16.7%
Professional degree student	1,416	1.7%
Non-student	89	0.1%
High-school student taking college classes	12	<0.1%
Non-degree student	165	0.2%
Faculty or staff	120	0.1%
Other (please specify)	478	0.6%

Graduate or professional degree program:

SDS 39 (N = 32,608)	Frequency	Percent
Post-Baccalaureate	2,510	7.7%
Masters	5,269	16.2%
Doctoral degree	3,538	10.9%
Law	888	2.7%
Medical	939	2.9%
Pharmacy	290	0.9%
Dental	148	0.5%
Veterinary Medicine	410	1.3%
Not applicable	16,846	51.7%
Other (please specify)	1,770	5.4%

What year are you in your graduate/professional program?

SDS 41 (N = 18,452)	Frequency	Percent
1	7,243	39.3%
2	4,537	24.6%
3	2,821	15.3%
4	2,816	15.3%
5+	1,035	5.6%

Did you transfer from another campus/institution to this school?

SDS 46 (N = 99,813)	Frequency	Percent
No	82,505	82.7%
Yes	17,308	17.3%

Where do you currently live?

SDS 1042 (N = 56,363)	Frequency	Percent
On-campus	23,668	42.0%
Off-campus	32,341	57.4%
I do not live in one stable, secure residence	147	0.3%
Other (please specify)	207	0.4%

With whom do you live (check all that apply):

SDS 44 (N = 92,323)	Frequency	Percent
Alone	13,730	14.9%
Spouse, partner, or significant other	8,743	9.5%
Roommates	59,916	64.9%
Children	1,757	1.9%
Parent(s) or guardian(s)	12,445	13.5%
Family (other)	5,207	5.6%
Other	1,290	1.4%

Relationship status:

SDS 33 (N = 102,548)	Frequency	Percent
Single	62,513	61.0%
Serious dating or committed relationships	34,984	34.1%
Civil union, domestic partnership, or equivalent	407	0.4%
Married	3,934	3.8%
Divorced	305	0.3%
Separated	373	0.4%
Widowed	32	<0.1%

Please indicate your level of involvement in organized extra-curricular activities (e.g., sports, clubs, student government, etc.):

SDS 48 (N = 52,941)	Frequency	Percent
None	17,264	32.6%
Occasional participation	11,781	22.3%
One regularly attended activity	9,132	17.2%
Two regularly attended activities	7,320	13.8%
Three or more regularly attended activities	7,444	14.1%

Do you currently participate in any of the following organized college athletics? Intramurals:

SDS 1151 (N = 73,607)	Frequency	Percent
No	67,816	92.1%
Yes	5,791	7.9%

Do you currently participate in any of the following organized college athletics? Club:

SDS 1152 (N = 74,296)	Frequency	Percent
No	62,050	83.5%
Yes	12,246	16.5%

Do you currently participate in any of the following organized college athletics? Varsity:

SDS 1153 (N = 73,111)	Frequency	Percent
No	70,023	95.8%
Yes	3,088	4.2%

Are you a member of a social fraternity or sorority?

SDS 117 (N = 32,878)	Frequency	Percent
No	29,014	88.2%
Yes	3,864	11.8%

Religious or Spiritual Preference:

SDS 97 (N = 92,425)	Frequency	Percent
Agnostic	15,445	16.7%
Atheist	9,163	9.9%
Buddhist	843	0.9%
Catholic	12,223	13.2%
Christian	27,091	29.3%
Hindu	2,095	2.3%
Jewish	1,741	1.9%
Muslim	2,102	2.3%
No preference	18,695	20.2%
Self-identify	3,027	3.3%

To what extent does your religious or spiritual preference play an important role in your life?

SDS 36 (N = 75,243)	Frequency	Percent
Very important	11,642	15.5%
Important	15,139	20.1%
Neutral	25,552	34.0%
Unimportant	12,283	16.3%
Very unimportant	10,627	14.1%

How would you describe your financial situation right now?

SDS 57 (N = 88,615)	Frequency	Percent
Always stressful	10,962	12.4%
Often stressful	18,297	20.6%
Sometimes stressful	31,082	35.1%
Rarely stressful	20,404	23.0%
Never stressful	7,870	8.9%

How would you describe your financial situation while growing up?

SDS 58 (N = 63,012)	Frequency	Percent
Always stressful	6,718	10.7%
Often stressful	10,018	15.9%
Sometimes stressful	15,431	24.5%
Rarely stressful	17,721	28.1%
Never stressful	13,124	20.8%

What is the average number of hours you work per week during the school year (paid employment only)?

SDS 1055 (N = 76,660)	Frequency	Percent
0	31,391	40.9%
1-5	4,918	6.4%
6-10	8,928	11.6%
11-15	8,216	10.7%
16-20	10,662	13.9%
21-25	4,626	6.0%
26-30	2,604	3.4%
31-35	1,355	1.8%
36-40	2,012	2.6%
40+	1,948	2.5%

Are you a member of ROTC?

SDS 51 (N = 62,398)	Frequency	Percent
No	61,785	99.0%
Yes	613	1.0%

Have you ever served in any branch of the US military (active duty, veteran, National Guard or reserves)?

SDS 98 (N = 104,495)	Frequency	Percent
No	103,092	98.7%
Yes	1,403	1.3%

Did your military experience include any traumatic or highly stressful experiences which continue to bother you?

SDS 53 (N = 1,102)	Frequency	Percent
No	652	59.2%
Yes	450	40.8%

MENTAL HEALTH HISTORY ITEMS

Attended counseling for mental health concerns:

SDS 01 (N = 103,083)	Frequency	Percent
Never	37,839	36.7%
Prior to college	26,019	25.2%
After starting college	20,178	19.6%
Both	19,047	18.5%

Taken a prescribed medication for mental health concerns:

SDS 02 (N = 102,249)	Frequency	Percent
Never	62,105	60.7%
Prior to college	10,564	10.3%
After starting college	14,012	13.7%
Both	15,568	15.2%

NOTE: The following paired questions ask the student to identify *"How many times"* and *"The last time"* for each experience/event. Frequencies for *"The last time"* questions are based on students who reported having the experience one time or more.

Been hospitalized for mental health concerns (how many times):

SDS 64 (N = 107,627)	Frequency	Percent
Never	97,094	90.2%
1 time	7,031	6.5%
2-3 times	2,685	2.5%
4-5 times	441	0.4%
More than 5 times	376	0.3%

Been hospitalized for mental health concerns (the last time):

SDS 65 (N = 10,111)	Frequency	Percent
Within the last 2 weeks	599	5.9%
Within the last month	357	3.5%
Within the last year	1,792	17.7%
Within the last 1-5 years	4,731	46.8%
More than 5 years ago	2,632	26.0%

Purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.) (how many times):

SDS 72 (N = 105,747)	Frequency	Percent
Never	75,386	71.3%
1 time	5,459	5.2%
2-3 times	8,448	8.0%
4-5 times	3,272	3.1%
More than 5 times	13,182	12.5%

Purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.) (the last time):

SDS 73 (N = 29,120)	Frequency	Percent
Never	4	<0.1%
Within the last 2 weeks	2,940	10.1%
Within the last month	2,252	7.7%
Within the last year	6,247	21.5%
Within the last 1-5 years	11,018	37.8%
More than 5 years ago	6,659	22.9%

Seriously considered attempting suicide (how many times):

SDS 74 (N = 104,020)	Frequency	Percent
Never	68,615	66.0%
1 time	12,151	11.7%
2-3 times	13,059	12.6%
4-5 times	2,718	2.6%
More than 5 times	7,477	7.2%

Seriously considered attempting suicide (the last time):

SDS 75 (N = 33,865)	Frequency	Percent
Never	13	<0.1%
Within the last 2 weeks	3,329	9.8%
Within the last month	2,601	7.7%
Within the last year	6,821	20.1%
Within the last 1-5 years	14,642	43.2%
More than 5 years ago	6,459	19.1%

Made a suicide attempt (how many times):

SDS 76 (N = 104,145)	Frequency	Percent
Never	92,775	89.1%
1 time	7,216	6.9%
2-3 times	3,238	3.1%
4-5 times	427	0.4%
More than 5 times	489	0.5%

Made a suicide attempt (the last time):

SDS 77 (N = 11,095)	Frequency	Percent
Never	3	<0.1%
Within the last 2 weeks	287	2.6%
Within the last month	215	1.9%
Within the last year	1,253	11.3%
Within the last 1-5 years	5,335	48.1%
More than 5 years ago	4,002	36.1%

Considered causing serious physical injury to another (how many times):

SDS 78 (N = 103,663)	Frequency	Percent
Never	97,362	93.9%
1 time	2,043	2.0%
2-3 times	2,355	2.3%
4-5 times	448	0.4%
More than 5 times	1,455	1.4%

Considered causing serious physical injury to another (the last time):

SDS 79 (N = 5,968)	Frequency	Percent
Never	5	0.1%
Within the last 2 weeks	733	12.3%
Within the last month	574	9.6%
Within the last year	1,438	24.1%
Within the last 1-5 years	2,154	36.1%
More than 5 years ago	1,064	17.8%

Intentionally caused serious physical injury to another (how many times):

SDS 80 (N = 102,961)	Frequency	Percent
Never	101,582	98.7%
1 time	696	0.7%
2-3 times	444	0.4%
4-5 times	66	0.1%
More than 5 times	173	0.2%

Intentionally caused serious physical injury to another (the last time):

SDS 81 (N = 1,314)	Frequency	Percent
Within the last 2 weeks	59	4.5%
Within the last month	48	3.7%
Within the last year	168	12.8%
Within the last 1-5 years	452	34.4%
More than 5 years ago	587	44.7%

Someone had sexual contact with you without your consent (e.g., you were afraid to stop what was happening, passed out, drugged, drunk, incapacitated, asleep, threatened or physically forced) (how many times):

SDS 82 (N = 102,073)	Frequency	Percent
Never	75,856	74.3%
1 time	13,012	12.7%
2-3 times	8,606	8.4%
4-5 times	1,459	1.4%
More than 5 times	3,140	3.1%

Someone had sexual contact with you without your consent (e.g., you were afraid to stop what was happening, passed out, drugged, drunk, incapacitated, asleep, threatened or physically forced) (the last time):

SDS 83 (N = 25,130)	Frequency	Percent
Never	3	<0.1%
Within the last 2 weeks	563	2.2%
Within the last month	653	2.6%
Within the last year	4,270	17.0%
Within the last 1-5 years	11,604	46.2%
More than 5 years ago	8,037	32.0%

Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, authority figure) (how many times):

SDS 84 (N = 103,494)	Frequency	Percent
Never	64,751	62.6%
1 time	7,023	6.8%
2-3 times	8,722	8.4%
4-5 times	2,401	2.3%
More than 5 times	20,597	19.9%

Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, authority figure) (the last time):

SDS 85 (N = 36,244)	Frequency	Percent
Never	3	<0.1%
Within the last 2 weeks	2,810	7.8%
Within the last month	2,593	7.2%
Within the last year	7,702	21.3%
Within the last 1-5 years	15,067	41.6%
More than 5 years ago	8,069	22.3%

Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror (how many times):

SDS 86 (N = 100,965)	Frequency	Percent
Never	55,073	54.5%
1 time	15,775	15.6%
2-3 times	16,355	16.2%
4-5 times	3,408	3.4%
More than 5 times	10,354	10.3%

Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror (the last time):

SDS 87 (N = 42,562)	Frequency	Percent
Never	3	<0.1%
Within the last 2 weeks	3,264	7.7%
Within the last month	2,518	5.9%
Within the last year	8,861	20.8%
Within the last 1-5 years	17,553	41.2%
More than 5 years ago	10,363	24.3%

Please select the traumatic event(s) you have experienced:

SDS 99 (N = 38,923)	Frequency	Percent
Childhood physical abuse	8,340	21.4%
Childhood sexual abuse	5,874	15.1%
Childhood emotional abuse	21,082	54.2%
Physical attack (e.g., mugged, beaten up, shot, stabbed, threatened with a weapon)	4,246	10.9%
Sexual violence (rape or attempted rape, sexually assaulted, stalked, abused by intimate partner, etc.)	13,018	33.4%
Military combat or war zone experience	297	0.8%
Kidnapped or taken hostage	411	1.1%
Serious accident, fire, or explosion (e.g., an industrial, farm, car, plane, or boating accident)	3,735	9.6%
Terrorist attack	175	0.4%
School/mass shooting	1,519	3.9%
Near drowning	3,015	7.7%
Diagnosed with life threatening illness	1,275	3.3%
Natural disaster (e.g., flood, quake, hurricane, etc.)	1,932	5.0%
Imprisonment or torture	250	0.6%
Animal attack	1,270	3.3%
Other (please specify)	9,600	24.7%

Felt the need to reduce your alcohol or drug use (how many times):

SDS 66 (N = 97,041)	Frequency	Percent
Never	72,013	74.2%
1 time	8,178	8.4%
2-3 times	9,704	10.0%
4-5 times	1,828	1.9%
More than 5 times	5,318	5.5%

Felt the need to reduce your alcohol or drug use (the last time):

SDS 67 (N = 24,191)	Frequency	Percent
Never	5	<0.1%
Within the last 2 weeks	6,775	28.0%
Within the last month	4,412	18.2%
Within the last year	7,889	32.6%
Within the last 1-5 years	4,443	18.4%
More than 5 years ago	667	2.8%

Others have expressed concern about your alcohol or drug use (how many times):

SDS 68 (N = 97,053)	Frequency	Percent
Never	84,436	87.0%
1 time	5,179	5.3%
2-3 times	4,608	4.7%
4-5 times	820	0.8%
More than 5 times	2,010	2.1%

Others have expressed concern about your alcohol or drug use (the last time):

SDS 69 (N = 12,057)	Frequency	Percent
Never	3	<0.1%
Within the last 2 weeks	2,185	18.1%
Within the last month	1,924	16.0%
Within the last year	4,450	36.9%
Within the last 1-5 years	2,924	24.3%
More than 5 years ago	571	4.7%

Received treatment for alcohol or drug use (how many times):

SDS 70 (N = 101,110)	Frequency	Percent
Never	99,372	98.3%
1 time	1,249	1.2%
2-3 times	332	0.3%
4-5 times	40	<0.1%
More than 5 times	117	0.1%

Received treatment for alcohol or drug use (the last time):

SDS 71 (N = 1,622)	Frequency	Percent
Never	1	0.1%
Within the last 2 weeks	149	9.2%
Within the last month	106	6.5%
Within the last year	411	25.3%
Within the last 1-5 years	647	39.9%
More than 5 years ago	308	19.0%

Think back over the last two weeks. How many times have you had five or more drinks in a row (for males) OR four or more drinks in a row (for females)? (A drink is a bottle of beer, a glass of wine, a wine cooler, a shot glass of liquor, or a mixed drink):

SDS 19 (N = 72,986)	Frequency	Percent
None	50,860	69.7%
Once	10,589	14.5%
Twice	6,308	8.6%
3 to 5 times	4,172	5.7%
6 to 9 times	669	0.9%
10 or more times	388	0.5%

Think back over the last two weeks. How many times have you used marijuana?

SDS 1096 (N = 84,638)	Frequency	Percent
None	63,826	75.4%
Once	4,670	5.5%
Twice	3,581	4.2%
3 to 5 times	4,974	5.9%
6 to 9 times	2,482	2.9%
10 or more times	5,105	6.0%

Please indicate how much you agree with the statement: "I get the emotional help and support I need from my family":

SDS 22 (N = 73,952)	Frequency	Percent
Strongly disagree	8,010	10.8%
Somewhat disagree	12,078	16.3%
Neutral	12,665	17.1%
Somewhat agree	23,506	31.8%
Strongly agree	17,693	23.9%

Please indicate how much you agree with the statement: "I get the emotional help and support I need from my social network (e.g., friends, acquaintances)":

SDS 23 (N = 73,691)	Frequency	Percent
Strongly disagree	4,286	5.8%
Somewhat disagree	8,634	11.7%
Neutral	14,526	19.7%
Somewhat agree	28,719	39.0%
Strongly agree	17,526	23.8%

Are you registered with the office for disability services on this campus as having a documented and diagnosed disability?

SDS 60 (N = 102,135)	Frequency	Percent
No	88,695	86.8%
Yes	13,440	13.2%

If you selected "Yes" for the previous question, please indicate which category of disability you are registered for (check all that apply):

SDS 1061 (N = 13,066)	Frequency	Percent
Difficulty hearing	400	3.1%
Difficulty seeing	330	2.5%
Difficulty speaking or language impairment	124	0.9%
Mobility limitation/orthopedic impairment	466	3.6%
Traumatic brain injury	271	2.1%
Specific learning disabilities	1,584	12.1%
ADD or ADHD	6,730	51.5%
Autism spectrum disorder	1,266	9.7%
Cognitive difficulties or intellectual disability	479	3.7%
Health impairment/condition, including chronic conditions	1,569	12.0%
Psychological or psychiatric condition	3,933	30.1%
Other	1,849	14.2%

In the past 6 months, have you experienced discrimination or unfair treatment due to any of the following parts of your identity?

SDS 111-116 (N = 54,750)	Frequency	Percent
Disability	1,665	3.1%
Gender	5,473	10.1%
Nationality/County of Origin	2,068	3.8%
Race/Ethnicity/Culture	4,661	8.6%
Religion	1,745	3.2%
Sexual Orientation	3,246	6.0%

20.6% of clients endorsed discrimination related to at least one identity.

Are you unable to pay for or are you having great difficulty paying for any of the following?

SDS 119-123 (N = 53,289)	Frequency	Percent
Enough food to eat	6,650	12.6%
Housing/utilities	8,139	15.4%
Basic transportation needs	6,240	11.8%
Necessary medical care	7,711	14.6%
Educational materials (books, technology)	8,364	15.8%

26.5% of clients endorsed financial insecurity in at least one area.

COVID IMPACT ITEMS

Are your reasons for seeking services in any way related to the COVID-19 pandemic and related events?

SDS 102 (N = 84,103)	Frequency	Percent
No	76,495	94.8%
Yes	4,172	5.2%

Which area(s) of your life have been negatively impacted by COVID-19? (check all that apply)

When asked to endorse negative impacts from COVID-19, 79% of students endorsed at least one impacted area impacted by COVID-19, and 68% endorsed multiple areas being affected.

SDS 100 (N = 84,103)	Frequency	Percent
Mental health	43,847	52.1%
Academics	41,297	49.1%
Loneliness or isolation	38,366	45.6%
Motivation or focus	35,058	41.7%
Missed experiences or opportunities	34,695	41.3%
Relationships (Significant other, friends, family)	20,152	24.0%
Financial	16,576	19.7%
Career/Employment	14,457	17.2%
Health concerns (self)	13,161	15.6%
Health concerns (others)	11,916	14.2%
Grief/loss of someone	9,763	11.6%
Food or housing insecurity	4,528	5.4%
Discrimination/Harassment	1,998	2.4%
Other (please specify)	1,018	1.2%

How many times have you had COVID-19?

SDS 103 (N = 20,663)	Frequency	Percent
1 time	8,239	39.9%
2-3 times	5,622	27.2%
4-5 times	370	1.8%
More than 5 times	58	0.3%
I don't think I've had COVID-19	6,374	30.8%

PROVIDER DATA

The Standardized Data Set includes some basic demographic information about providers (clinicians) at participating counseling centers. The 2023-2024 data set represents 2,033 unique providers. Answer totals may vary by question since some counseling centers do not gather this data on providers or a provider may choose not to answer one or more questions.

Gender

	Frequency	Percent
Woman	1,496	73.9%
Transgender woman	2	0.1%
Man	460	22.7%
Transgender man	7	0.3%
Non-binary	38	1.9%
Prefer not to answer	21	1.0%

Age

N	Mean	Mode
1,829	39	31

Race/Ethnicity

	Frequency	Percent
African-American/Black	280	13.9%
American Indian or Alaskan Native	12	0.6%
Asian American/Asian	163	8.1%
White	1,258	62.5%
Hispanic/Latino/a	160	8.0%
Native Hawaiian or Pacific Islander	5	0.2%
Multi-racial	95	4.7%
Prefer not to answer	14	0.7%
Other	25	1.2%

Highest Degree (descending sort)

	Frequency	Percent
Doctor of Philosophy	428	21.4%
Master of Arts	363	18.1%
Master of Social Work	341	17.0%
Master of Science	315	15.7%
Doctor of Psychology	220	11.0%
Master of Education	86	4.3%
Bachelor of Arts	58	2.9%
Bachelor of Science	56	2.8%
Doctor of Medicine	40	2.0%
Other	38	1.9%
Education Specialist	16	0.8%
Nursing (e.g. RN, RNP, PNP)	15	0.7%
Doctor of Education	12	0.6%
Doctor of Osteopathy	10	0.5%
Doctor of Social Work	5	0.2%

Highest Degree-Discipline (descending sort)

	Frequency	Percent
Clinical Psychology	484	24.3%
Counseling Psychology	425	21.3%
Social Work	364	18.3%
Mental Health Counseling/Clinical Mental Health Counseling	333	16.7%
Other	133	6.7%
Counselor Education	102	5.1%
Psychiatry	53	2.7%
Marriage and Family Therapist	42	2.1%
Nursing	22	1.1%
Higher Education	13	0.7%
Educational Psychology	10	0.5%
Health Education	6	0.3%
Community Psychology	4	0.2%

Are you licensed under your current degree?

	Frequency	Percent
Yes	1,486	74.6%
No	505	25.4%

Position Type (descending sort)

	Frequency	Percent
Professional staff member	1,460	72.3%
Master's level trainee	159	7.9%
Doctoral level trainee (not an intern)	68	3.4%
Pre-doctoral intern	179	8.9%
Post-doctoral level (non-psychiatric)	56	2.8%
Psychiatric resident	14	0.7%
Other (please specify)	83	4.1%

CENTER DATA

The information below describes the 789 colleges and universities that renewed membership or became CCMH members during the 2023-2024 academic year.

Utilization: The total number of students with at least 1 attended appointment between July 1st and June 30th. The average utilization is 828.

	Frequency	Percent
under 151	72	10.3%
151-200	48	6.9%
201-300	79	11.4%
301-350	39	5.6%
351-400	37	5.3%
401-500	73	10.5%
501-600	60	8.6%
601-700	36	5.2%
701-850	53	7.6%
851-1000	21	3.0%
1001-1200	37	5.3%
1201-1500	30	4.3%
1501-2000	48	6.9%
2001-3000	31	4.5%
3001+	32	4.6%

Percent Utilization: The proportion (%) of enrolled/eligible students who attended at least 1 appointment in the counseling center between July 1st and June 30th. The average percent utilization was 10.2%.

	Frequency	Percent
less than 5%	147	21.1%
5-7%	118	17.0%
7-10	168	24.1%
10-12%	69	9.9%
12-15%	73	10.5%
15-20%	48	6.9%
20-30%	59	8.5%
more than 30%	14	2.0%

Clinical Capacity: The total number of contracted/expected clinical hours for a typical/busy week when the center is fully staffed (not including case management and psychiatric services). One Standardized Counselor represents one block of 24 clinical hours per week. The average clinical capacity is 201.

	Frequency	Percent
48 or less (0-2 Standardized Counselors)	58	8.3%
49-72 (2-3 Standardized Counselors)	82	11.8%
73-96 (3-4 Standardized Counselors)	76	10.9%
97-120 (4-5 Standardized Counselors)	85	12.2%
121-144 (5-6 Standardized Counselors)	73	10.5%
145-168 (6-7 Standardized Counselors)	45	6.5%
169-192 (7-8 Standardized Counselors)	31	4.5%
193-240 (7-9 Standardized Counselors)	59	8.5%
241-312 (9-13 Standardized Counselors)	60	8.6%
313-432 (13-18 Standardized Counselors)	63	9.1%
over 433 (18+ Standardized Counselors)	64	9.2%

Does your center have an APA accredited doctoral internship program?

	Frequency	Percent
No	626	79.3%
Yes	163	20.7%

Is your counseling center currently accredited by IACS (International Accreditation of Counseling Services)?

	Frequency	Percent
No	614	77.8%
Yes	175	22.2%

Is the director of your center a member of AUCCCD?

	Frequency	Percent
No	166	21.0%
Yes	623	79.0%

Does your center have session limits for individual counseling?

	Frequency	Percent
False	480	64.2%
True	268	35.8%

Does your center use an annual contracting process to define each staff member's responsibilities, including the number of clinical hours?

	Frequency	Percent
False	539	72.1%
True	209	27.9%

THIRD-PARTY CONTRACTED VENDORS

Does your center have a contract with a third-party vendor for individual counseling (e.g., Mantra Health, TimelyCare, UWill, Talkspace, BetterMynd, TELUS)?

	Frequency	Percent
No	457	61.1%
Yes	291	38.9%

Were students required to receive a referral from the counseling center before beginning individual counseling with the contracted third-party vendor?

	Frequency	Percent
No	245	83.3%
Yes	49	16.7%

Does your center have a contract with a third-party vendor for psychiatric services (e.g., Mantra Health, TimelyCare)?

	Frequency	Percent
No	612	81.8%
Yes	136	18.2%

Does your center have a contract with a third-party vendor for intensive outpatient services (e.g., Charlie Health)?

	Frequency	Percent
No	713	95.3%
Yes	35	4.7%

Does your center have a contract with a third-party vendor for peer support (e.g., TogetherAll, TalkLife, TalkCampus)?

	Frequency	Percent
No	627	83.8%
Yes	121	16.2%

Does your center have a contract with a third-party vendor for coaching (e.g., Ginger, Mantra Health)?

	Frequency	Percent
No	733	98.0%
Yes	15	2.0%

Does your center contract with any of the following vendors for crisis/after hours (e.g., ProtoCall)?

	Frequency	Percent
No	387	51.7%
Yes	361	48.3%

Does your center have a contract with a third-party vendor for referral services (e.g., Thriving Campus, WellTrack Connect)?

	Frequency	Percent
No	631	84.4%
Yes	117	15.6%

Does your center have a contract with a third-party vendor for mental health screening (e.g., MindWise)?

	Frequency	Percent
No	680	90.9%
Yes	68	9.1%

Does your center have a contract with a third-party vendor for training feedback (e.g., Lyssn)?

	Frequency	Percent
No	738	98.7%
Yes	10	1.3%

Does your center have a contract with a third-party vendor for another purpose not listed?

	Frequency	Percent
No	696	93.0%
Yes	52	7.0%

CLINICAL CHARACTERISTICS

Routine individual counseling appointments usually occur weekly.

	Frequency	Percent
False	372	49.7%
True	376	50.3%

After-hours crisis services are primarily handled by counseling center staff (i.e., not by a 3rd party such as ProtoCall).

	Frequency	Percent
False	567	75.8%
True	181	24.2%

Staff are required to provide a specified number of initial contacts each week (e.g., triage, intake, crisis).

	Frequency	Percent
False	446	59.6%
True	302	40.4%

Staff are required to absorb a specified number of new clients into their caseload per week (regardless of current caseload).

	Frequency	Percent
False	598	79.9%
True	150	20.1%

We have one or more staff who focus on community referrals (e.g., case/care manager, referral coordinator).

	Frequency	Percent
False	442	59.1%
True	306	40.9%

A student's first clinical contact is usually a full (45-60 min) assessment.

	Frequency	Percent
False	279	37.3%
True	469	62.7%

Clinicians in our center regularly engage in remote work (i.e., working from home on a scheduled basis as opposed to occasionally working from home as needed).

	Frequency	Percent
False	440	58.8%
True	308	41.2%

Our campus police/public safety uses a co-responder model (i.e. a mental health worker goes with or instead of campus police/ public safety to respond to crisis or mental health calls).

	Frequency	Percent
False	631	84.4%
True	117	15.6%

In our co-responder model, the mental health worker is a counseling center employee.

	Frequency	Percent
False	36	30.8%
True	81	69.2%

INSTITUTIONAL DATA

Institutional Enrollment: The total number of students enrolled at the institution who are eligible for services. The average enrollment is 11,583.

	Frequency	Percent
under 1,501	83	11.9%
1,501-2,500	79	11.4%
2,501-5,000	138	19.8%
5,001-7,500	71	10.2%
7,501-10,000	66	9.5%
10,001-15,000	81	11.6%
15,001-20,000	49	7.0%
20,001-25,000	37	5.3%
25,001-30,000	26	3.7%
30,001-35,000	17	2.4%
35,001-45,000	23	3.3%
45,001+	26	3.7%

Public or Private

	Frequency	Percent
Combined	2	0.3%
Private	322	40.8%
Public	465	58.9%

Type of institution (Check all)

	Frequency	Percent
4-year College/University	704	89%
Religious-Affiliated School	56	7%
2-year College/University	48	6%
Community College	43	5%
Health Professional School	41	5%
STEM Institution	36	5%
Other	25	3%
Creative Focus	12	2%
Historically Black College/ University (HBCU)	12	2%
Tribal	1	0%

Location of Campus

	Frequency	Percent
Northeast (CT, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VA, VT, WV)	275	34.9%
South (AL, AR, FL, GA, KS, KY, LA, MO, MS, NC, NM, NV, OK, SC, TN, TX)	200	25.4%
Midwest (IA, IL, IN, MI, MN, MT, ND, NE, OH, SD, WI)	159	20.2%
West (AK, AZ, CA, CO, HI, ID, OR, UT, WA, WY)	124	15.7%
Canada	10	1.3%
Other international	20	2.5%

Athletic Division

	Frequency	Percent
Division I	279	35.4%
Division II	130	16.5%
Division III	218	27.6%
None	162	20.5%

Contact Information

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