Center for Collegiate Mental Health

(CCMH)

2020 ANNUAL REPORT

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Acknowledgements

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2020 Report Introduction

All 602 CCMH member college and university counseling centers provided baseline center-level research data for the 2020 Annual Report special section. Additionally, 153 of these CCMH members contributed de-identified client data, describing 185,440 unique college students seeking mental health treatment, 3,890 clinicians, and 1,395,685 appointments. The 2020 Annual Report summarizes client data contributed to CCMH during the 2019-2020 academic year, beginning July 1, 2019 and closing on June 30, 2020.

The following are critical to understand when reading this report:

1. **This report describes college students receiving mental health services, NOT the general college student population.**
2. **Year-to-year changes in the number of students 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, then contributed to CCMH.
4. The number of clients will vary by question due to variations in clinical procedure and implementation of CCMH data forms.
5. Counseling centers are required to receive Institutional Review Board (IRB) approval at their institution to participate in client-level data contribution to CCMH. Although CCMH maintains membership of over 600 institutional counseling centers, only a percentage of these institutions participate in client-level data contribution. However, all counseling center members contribute baseline center-level research data.

2020 CHANGES

Mental Health Trends: Prior to this year, mental health trends used data from 2010-2011 onwards. However, the wording and response format changed in 2012-2013 for several domains included in the trends (Prior Treatment, Threat to Self, Threat to Others, Traumatic Experiences, and Drug and Alcohol). This produced an immediate shift in some of the trends that made them more difficult to interpret. Thus, for the current year, CCMH analyzed eight-year trends from 2012-2013 to the present using only the data reported from items with identical wording/response formats.

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 HIGHLIGHTS

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

The CLI, first released in the Fall of 2019, can be conceptually thought of as the "average annual caseload" for a "standardized counselor" within a counseling center. The CLI was designed to provide a more accurate and consistently comparable metric that describes the landscape of staffing levels rather than offering a single recommendation.

The 2020 Annual Report built on this foundation with two additional goals: (1) replicate, update, and expand the 2017-2018 CLI distribution to represent more colleges and universities, and (2) evaluate differences in counseling center practices between centers at the low and high ends of the CLI distribution.

Findings demonstrated the following:

- **Low CLI Centers** are more likely to be at smaller institutions and provide full-length assessments at the outset of services as well as ongoing weekly counseling that produces more improvement in symptoms. These centers are much less likely to run out of treatment capacity during periods of high demand.
- **High CLI Centers** are more likely to be at larger institutions and implement clinical systems that maximize efficiency in an effort to serve the masses while limiting access to weekly individual therapy. Case Management services and referrals to external treatment services are much more common at these centers. Treatment provided is more likely to be diluted (decreased dosage and scheduled farther apart) and produce less improvement in symptoms.

These results can fundamentally alter the way colleges and universities understand and plan for mental-health services through the careful and transparent alignment of service goals, clinical practices, and funding. As a result, the CLI helps 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?"

Other 2020 Highlights

- Lifetime history of counseling continued to increase, with approximately 60% of students seeking services reporting prior mental health treatment. In 2012-2013, this number was under 48%.
- The lifetime prevalence rates of "threat-to-self" characteristics (non-suicidal self-injury, serious suicidal ideation, and suicide attempts) were relatively stable compared to the prior year, suggesting that this long-standing area of growth may be slowing.
- Lifetime experience of traumatic events continued to show mild increases for the past six to eight years.
- Anxiety and depression continued to be the most common presenting concerns assessed by clinicians.
- Depression showed a mild decrease as a "check all" and "top concern", whereas Anxiety revealed a slight increase as a "top concern." Notably, while Trauma increased the prior six years, and particularly from 2016-2017 to 2018-2019, as both a "check all" and "top concern", it only slightly increased as a "top concern" in the past year.

2020 Annual Report Special Section

INTRODUCTION

Beginning in 1980, the staffing guidance for counseling centers focused on a recommended ratio of staff-to-enrolled-students of 1 staff member per 1750 enrolled students, which was later adjusted to a recommended range of 1:1000 or 1:1500, depending on local factors. While this ratio continues to be critical in defining broad staffing expectations, counseling centers and their institutions have become more diverse over the last 50 years and have been increasingly in need of a more accurate, comparable, and flexible metric. The ratio has also struggled to provide useful guidance because it was not designed to account for the immense variation in student utilization rates (percentage of the student body served ranges from <1% to >40% per year) and clinical hours per staff member that have evolved over the last several decades.

To address these problems, 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 metric that describes the landscape of staffing levels associated with particular clinical outcomes (i.e. treatment dosages and distress change). As a result, 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?" The importance of this shift will be made clear in this report.

UNDERSTANDING THE CLI

The CLI was first released in the Fall of 2019 (based on FY 17-18 data), which described 432 institutions, with CLI scores ranging from 37 to 308 and a mean of 118. This year's 2020 Annual Report describes the updated 2018-2019 CLI distribution representing 567 institutions with scores ranging from 30 to 310 and a mean of 120. Complete information about the development and utilization of the CLI, along with the interactive CLI tool for calculating your CLI and downloading a custom report, can be found online at (https://ccmh.psu.edu/clinical-load-index-cli). In brief, the CLI is calculated using two numbers from the same 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).

CLI scores can be conceptually thought of as the "average annual caseload" for a "standardized counselor" within a counseling center. Because of the standardized/annual/aggregate nature of CLI scores, the following guidelines should be observed:

1. CLI scores should never be used to compare/evaluate individual counselors.
2. 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 and allows institutions to align service goals with staffing levels.
3. The CLI does not include psychiatry or dedicated case-management because these are still 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.
4. The CLI does not describe expenses related to the administration of a counseling center or staffing related to different center missions (e.g., comprehensive counseling center, training center, integrated, etc.).

The 2018 and 2019 CCMH Annual Reports described a number of key findings related to the CLI that are worth mentioning. Specifically:

- 2018: Clinical models emphasizing dedicated treatment hours for each student were associated with higher dosages of treatment and better outcomes (symptom reduction).
- 2019: Lower CLIs were found to be associated with higher average dose of treatment (more sessions, spaced more closely together) and better treatment outcomes (symptom reduction).

NEW FOR 2020: UPDATING THE CLI DISTRIBUTION

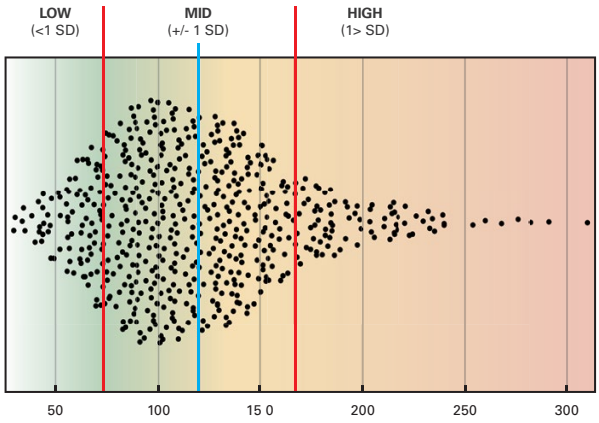
The development of the 2017-2018 CLI represented a successful "proof of concept" effort to create a parsimonious and carefully calibrated metric that describes the distribution of counseling center staffing levels in a useful manner. In addition, last year's report established initial validity of the CLI by demonstrating that lower scores were associated with increased treatment dosage and reduction in distress. The 2020 Annual Report builds on this foundation with two additional goals: (1) replicate, update, and expand the CLI distribution to represent more colleges and universities, and (2) evaluate differences in counseling center practices between centers at the low and high zones of the CLI distribution.

2018-2019 CLI Distribution

To accompany this Annual Report, CCMH updated the CLI based on new data from 602 CCMH member institutions during the 2018-2019 Academic Year (7/1/2018 to 6/30/2019). The 2019-2020 year was not used due to the unique and temporary impact of COVID-19. Complete details about the 2018-2019 CLI (and an interactive tool to calculate your CLI) can be found online (https://ccmh.psu.edu/clinical-load-index-cli). After data were received from 602 member centers, CCMH staff carefully audited hundreds of centers via phone and email to confirm/adjust data for accuracy. A total

of 35 centers were excluded due to incomplete audits or unique/temporary staffing situations. The following describes the CLI distribution for 2018-2019, which was nearly identical to the data collected from 2017-2018:

- N = 567 (from 602 submitted)
- Minimum = 30
- Maximum = 310
- Mean = 120
- Median = 114
- Standard Deviation = 47
- Zones:
  - Low: 30 to 72
  - Mid: 73 to 167
  - High: 168 to 310



NEW FOR 2020: COUNSELING CENTER CHARACTERISTICS AND THE CLI

With the 2018-2019 CLI replication/expansion complete, the next step is to begin a longer-term process of clarifying the relationship between CLI scores and counseling center practices. This process will effectively anchor the ends of the CLI distribution in useful clinical service descriptions so that institutions can gradually work to align their service goals with their staffing levels. To advance this goal, CCMH worked with the CCMH Advisory Board to develop a preliminary list of 40 true/false "counseling center characteristics" that were then gathered during the annual CCMH member registration/ renewal research process.

Given the novelty of this exploration, several points are worth keeping in mind. First, standardized counseling center practices based on staffing levels have not been systematically implemented over the last 50 years and therefore it is assumed that the relationship between characteristics and the CLI will be imprecise. Indeed, this lack of consistency between staffing levels and clinical practices has been problematic in the field and is part of the reason the CLI was developed. In other words, a practice that aligns well with the clinical resources of a center with a Low CLI center may also be found in a High CLI center because guidance was not available at the time of implementation. Additionally, in this first assessment of characteristics/practices alongside CLI scores, it is important to understand that a common characteristic (overall or for a particular CLI zone) is not necessarily a "best practice". As the field gradually develops agreement about which service goals are appropriate for a given CLI zone, best practices will also be defined. Even at that future point, real world implementation of any specific practice will be multi-determinant and vary from institution to institution.

Counseling Center Characteristics and CLI Zones

Table 1 provides an overview of counseling center characteristics and CLI scores examined in this study. Before reviewing the table, readers should understand the following terms:

- **Characteristic**: 40 True/False counseling center characteristics and practices.
- **True/False (N/%)**: The rate that a characteristic was marked True or False in both count and percentage (rounded to the hearest whole number) for the total sample of 567 centers.
  - *The overall prevalence for any given characteristic is the "True" column.*
- **% Low, Mid, and High**: The percentage of centers indicating True for a characteristic within a given CLI zone. As a reminder, CLI zones are defined as:
  - **Low**: <1 SD below the mean (30 to 72)
  - **Mid**: Mean +/- 1 SD (73 to 167)
  - **High**: >1 SD above the mean (168 to 310)
- **High/Low % Difference:** *The table is sorted by this column,* the absolute difference in percent frequency for each characteristic between Low and High CLI zones. Characteristics at the top (dark green) demonstrated the greatest difference in percentage frequency whereas characteristics towards the bottom (very light green) demonstrated the

smallest differences. The * indicates that the characteristic is more common within a center in the Low CLI zone compared to the High zone.

- **High/Low Ratio**: The ratio of percent frequency between High/Low CLI centers. Characteristics with dark red shading demonstrated the highest ratio differences. (Example: If a characteristic is present in 10% of Low centers and 30% of High centers, it would have a 3.0 ratio, or in other words, is 3x more likely in a High center than a Low center.)

Table 1: Counseling Center Characteristics ordered by High/Low % Absolute Difference

Characteristic	TRUE	FALSE	% True (Low)	% True (Mid)	% True (High)	High/Low % Diff	High/Low Ratio
4. Routine individual counseling appointments usually occur weekly*	293 (52%)	274 (48%)	83%	49%	34%	50%	2.50
5. Routine individual counseling appointments are usually scheduled bi-weekly or more (e.g., every 2 or 3 weeks)	322 (57%)	245 (43%)	27%	60%	69%	41%	2.51
22. Staff are required to provide a specified number of initial contacts each week (e.g., triage, intake, crisis)	269 (47%)	298 (53%)	19%	52%	55%	36%	2.87
40. We have 1 or more staff who focus on community referrals (e.g., Case/Care Manager, Referral Coordinator)	218 (38%)	349 (62%)	19%	40%	51%	32%	2.69
29. We use some form of appointment reminders (e.g., text, email, phone)	466 (82%)	101 (18%)	65%	84%	92%	26%	1.40
23. Staff are required to take on a specific number of new clients per week (regardless of current caseload)	114 (20%)	453 (80%)	5%	21%	30%	25%	6.35
37. Staff receive a reduction in required clinical hours when they assume administrative and/or supervisory responsibilities	435 (77%)	132 (23%)	63%	78%	85%	22%	1.35
20. We provide drop-in group workshops (e.g., anxiety, depression)	316 (56%)	251 (44%)	49%	54%	70%	21%	1.43
30. We charge a fee for at least some no-shows and/or cancellations	148 (26%)	419 (74%)	12%	28%	33%	21%	2.73
15. We offer some kind of online self-help service (e.g., Welltrack, SilverCloud)	219 (39%)	348 (61%)	32%	38%	49%	17%	1.52
21. After-hours crisis services are primarily handled by counseling center staff (i.e., not by a 3rd party such as ProtoCall)*	222 (39%)	345 (61%)	43%	41%	27%	16%	1.61
9. A student's first clinical contact is usually a full (45-60 min) assessment *	347 (61%)	220 (39%)	75%	59%	59%	16%	1.27
19. We provide a drop-in consultation service for students (e.g., Let's Talk)	271 (48%)	296 (52%)	36%	50%	51%	15%	1.43
13. Students are routinely offered other services (e.g., workshop, online self-help, Let's Talk) before individual counseling	173 (31%)	394 (69%)	19%	32%	34%	15%	1.77
27. The leadership at our institution expects the counseling center to retain almost all students who seek services*	225 (40%)	342 (60%)	44%	41%	30%	14%	1.45
12. We provide some form of online service to help students locate off-campus providers and referrals	298 (53%)	269 (47%)	49%	51%	63%	14%	1.29
14. We provide some form of group counseling (process, psychoeducational, support)	486 (86%)	81 (14%)	74%	88%	87%	13%	1.18
31. During the busiest time of the year, we decrease or eliminate community education/outreach activities	271 (48%)	296 (52%)	31%	52%	44%	13%	1.43
17. Our staff provide some amount of tele-counseling services	382 (67%)	185 (33%)	61%	68%	73%	13%	1.21

Characteristic	TRUE	FALSE	% True (Low)	% True (Mid)	% True (High)	High/Low % Diff	High/Low Ratio
8. A student's first clinical contact is usually a brief (5-30 min) assessment (e.g., triage, screening)	236 (42%)	331 (58%)	31%	44%	43%	12%	1.39
10. We routinely retain the most severe and chronic cases internally*	245 (43%)	322 (57%)	38%	48%	27%	11%	1.43
28. The leadership at our institution does not allow us to use a waiting list for individual counseling	85 (15%)	482 (85%)	8%	15%	20%	11%	2.37
34. Some students are not eligible for some individual counseling services (e.g., part-time)	144 (25%)	423 (75%)	20%	25%	31%	11%	1.55
35. We have some "session limits" for individual counseling (e.g., per student, semester, year)	243 (43%)	324 (57%)	38%	43%	48%	10%	1.25
11. We routinely refer the most severe and chronic cases to outside providers	331 (58%)	236 (42%)	65%	53%	74%	9%	1.14
33. We charge a fee for at least some attended counseling appointments	55 (10%)	512 (90%)	4%	10%	13%	9%	3.58
2. A student can routinely schedule and attend a first clinical contact (triage or intake) within 1 week*	456 (80%)	111 (20%)	88%	79%	79%	9%	1.11
18. The institution has a contract with a 3rd party tele-counseling service that is available to at least some of the students	121 (21%)	446 (79%)	15%	22%	23%	8%	1.50
32. During the busiest time of the year, we decrease or eliminate non-clinical activities	255 (45%)	312 (55%)	33%	48%	41%	7%	1.22
38. We provide dedicated work-time for staff development/training activities at least 2 times annually	500 (88%)	67 (12%)	81%	90%	88%	7%	1.09
26. There is a local inpatient psychiatric hospital available for students if needed*	501 (88%)	66 (12%)	92%	88%	86%	6%	1.06
36. Staff are provided dedicated time outside the clinical hour to complete notes/reports	497 (88%)	70 (12%)	83%	88%	88%	5%	1.06
25. There is a local intensive outpatient service (IOP) available for students if needed*	406 (72%)	161 (28%)	79%	70%	73%	5%	1.08
1. We have some regular extended hours (open until at least 7-8pm on weekdays OR weekend hours)	161 (28%)	406 (72%)	25%	29%	29%	4%	1.16
39. We provide dedicated work-time for staff case-consultation on a weekly or bi-weekly basis	516 (91%)	51 (9%)	86%	93%	88%	3%	1.03
7. Routine individual counseling appointments are usually 20-30 minutes	20 (4%)	547 (96%)	2%	3%	6%	3%	2.44
16. We have some kind of online mental health-screening tool	368 (65%)	199 (35%)	62%	66%	64%	2%	1.03
6. Routine individual counseling appointments are usually 45-60 minutes*	562 (99%)	5 (1%)	100%	99%	98%	2%	1.02
3. Students are routinely placed on a waiting list prior to individual counseling*	99 (17%)	468 (83%)	15%	18%	15%	0%	1.02
24. We have some form of "counselor on duty" during the business hours	438 (77%)	129 (23%)	80%	76%	80%	0%	1.01

Discussion: Describing High vs. Low CLI Zones

Table 1 describes the prevalence of 40 counseling center characteristics and illustrates how these characteristics vary between Low, Mid, and High CLI zones. Results are complex and can be examined from many perspectives moving forward. However, the primary goal of this analysis is to begin the process of describing differences between High vs. Low zones to maximize the contrast between groups (i.e., anchoring the endpoints). Prevalence for Mid-CLI centers is also available. The top nine characteristics in Table 2 below accurately predicted whether a center was in the High or Low CLI zone at least 60% of the time:

Table 2: Counseling Center Characteristics predicting Low vs. High CLI Zones

Characteristic	CLI Zone
4. Routine individual counseling appointments usually occur weekly*	Low
5. Routine individual counseling appointments are usually scheduled bi-weekly or more (e.g., every 2 or 3 weeks)	High
22. Staff are required to provide a specified number of initial contacts each week (e.g., triage, intake, crisis)	High
40. We have 1 or more staff who focus on community referrals (e.g., Case/Care Manager, Referral Coordinator)	High
29. We use some form of appointment reminders (e.g., text, email, phone)	High
23. Staff are required to take on a specific number of new clients per week (regardless of current caseload)	High
37. Staff receive a reduction in required clinical hours when they assume administrative and/or supervisory responsibilities	High
20. We provide drop-in group workshops (e.g., anxiety, depression)	High
30. We charge a fee for at least some no-shows and/or cancellations	High

While the characteristics listed in Table 2 are notable for their ability to predict whether a center had a CLI score within the High or Low zones, it is also possible to determine their increased likelihood between the zones. This approach of linking characteristics to CLI zones also identified nine characteristics in Table 3 below that were at least twice as likely to occur between the High and Low CLI zones. With this approach, it is important to note that some items are uncommon, even rare, but do in fact differentiate zones. (Items that were also a Predictive Characteristic in Table 2 are noted as well.)

Table 3: Counseling Center Characteristics ordered by High/Low Ratio

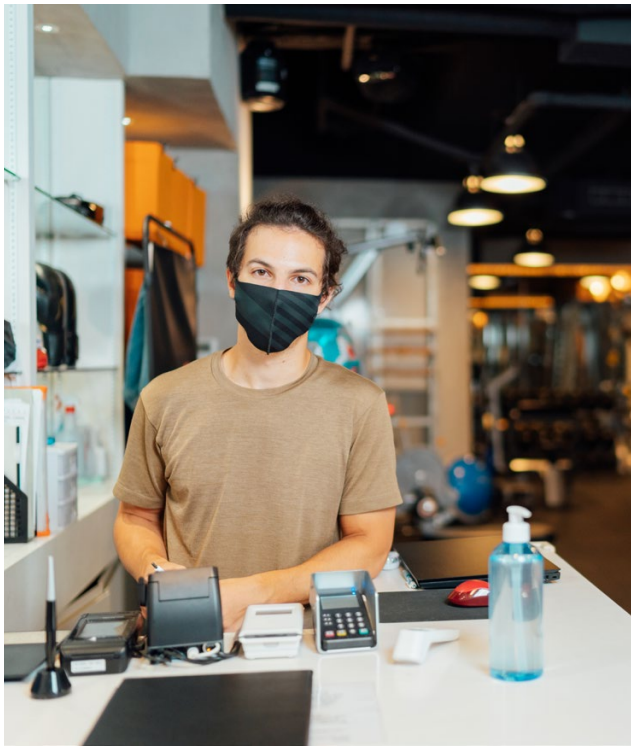
Characteristic	Ratio	More likely CLI Zone	Overall Prevalence	Predictive
23. Staff are required to take on a specific number of new clients per week (regardless of current caseload)	6.35	High	20%	Yes
33. We charge a fee for at least some attended counseling appointments	3.58	High	10%	--
22. Staff are required to provide a specified number of initial contacts each week (e.g., triage, intake, crisis)	2.87	High	47%	Yes
30. We charge a fee for at least some no-shows and/or cancellations	2.73	High	26%	Yes
40. We have 1 or more staff who focus on community referrals (e.g., Case/Care Manager, Referral Coordinator)	2.69	High	38%	Yes
5. Routine individual counseling appointments are usually scheduled bi-weekly or more (e.g., every 2 or 3 weeks)	2.51	High	57%	Yes
4. Routine individual counseling appointments usually occur weekly*	2.50	Low	52%	Yes
7. Routine individual counseling appointments are usually 20-30 minutes	2.44	High	4%	--
28. The leadership at our institution does not allow us to use a waiting list for individual counseling	2.37	High	15%	--

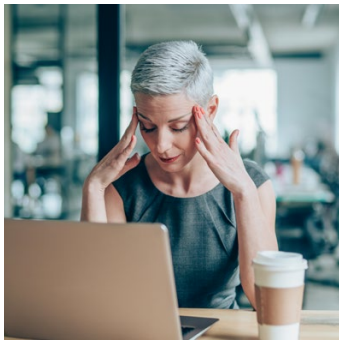
Common Shared Characteristics

While Table 3 differentiates practices between High and Low CLI zones, results also indicated that some characteristics are common across all CLI zones. Although this means they are not useful in differentiating between zones, they are notable for being routinely implemented in counseling centers more generally. Again, it is important to emphasize that a common characteristic across CLI zones does not necessarily represent a "best practice." The following nine characteristics in Table 4 were endorsed at by at least 70% of centers in all three CLI zones (sorted by overall prevalence):

Table 4: Counseling Center Characteristics common across all CLI Zones sorted by Overall Prevalence

Characteristic	Overall %	Low %	Mid %	High %
6. Routine individual counseling appointments are usually 45-60 minutes*	99%	100%	99%	98%
39. We provide dedicated work-time for staff case-consultation on a weekly or bi-weekly basis	91%	86%	93%	88%
38. We provide dedicated work-time for staff development/training activities at least 2 times annually	88%	81%	90%	88%
36. Staff are provided dedicated time outside the clinical hour to complete notes/reports	88%	83%	88%	88%
26. There is a local inpatient psychiatric hospital available for students if needed*	88%	92%	88%	86%
14. We provide some form of group counseling (process, psychoeducational, support)	86%	74%	88%	87%
2. A student can routinely schedule and attend a first clinical contact (triage or intake) within 1 week*	80%	88%	79%	79%
24. We have some form of "counselor on duty" during the business hours	77%	80%	76%	80%
25. There is a local intensive outpatient service (IOP) available for students if needed*	72%	79%	70%	73%





SUMMARY OF CLI ZONES AND CHARACTERISTICS

This year's annual report describes the updated 2018-2019 CLI distribution using data from 567 counseling centers and takes the first step in determining how counseling center characteristics vary by CLI zone. While the results presented herein are preliminary, they do begin to describe the characteristics and practices of centers within the CLI distribution that can gradually evolve and become more specific and prescriptive over time. This, in turn, will help institutions better align aspirational service goals (e.g., student experiences) with resource allocation (clinical staffing levels) and stakeholder expectations when seeking services. This approach will allow institutions to be transparent with stakeholders about the opportunities and limitations of the service model they have funded, which will, in turn, enable counseling centers to strategically adjust operations to match resource levels and transparently communicate about services offered and the existing limitations while also allowing for variation among institutions and centers.

The results presented above are complex and represent a first attempt to articulate and measure a set of characteristics that have not been well defined or systematically implemented over time. In order to provide more useful descriptions of the CLI zones, the following thematic descriptions have been developed by integrating (a) the results presented above, (b) findings from the 2019 Annual Report, and (c) anecdotal/qualitative information gathered during the auditing process. *Enormous variability exists among institutions and counseling centers and these descriptions are intended as broad brush strokes that allow for locally unique factors and approaches.*

Low CLI Centers (30 to 72)

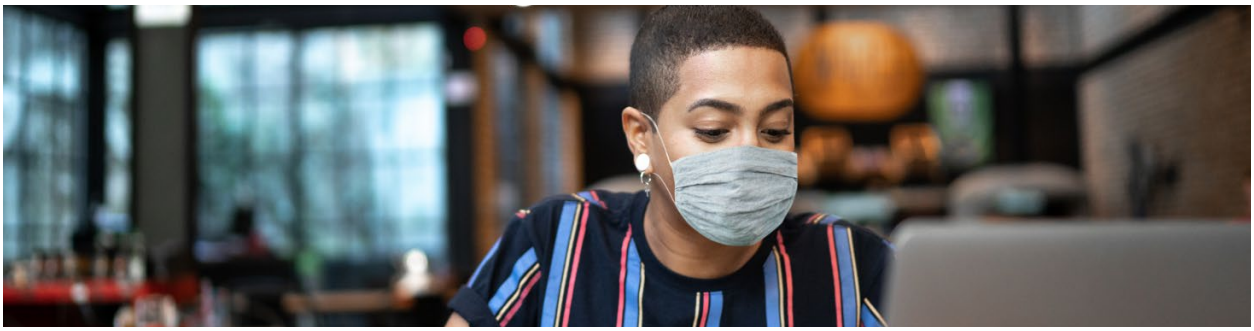
Centers in this zone are more likely to be at smaller institutions and more likely to embody traditional counseling center services involving full-length assessments as a first point of contact followed by ongoing individual counseling. Students served in Low CLI centers are the most likely to receive weekly individual counseling, more appointments that are scheduled closer together, and experience more symptom reduction during treatment. Wait for routine counseling services tends to be minimal and individual counseling is likely to be the primary mode of treatment. Centers in this zone will tend to be more operationally flexible and less likely to implement controlled scheduling practices. Institutional leadership may expect the center to "take care" of all students seeking services rather than referring them out, and centers are much more likely to be able to serve most students who seek help. Centers with the lowest CLI scores may never run out of capacity during the year. Work stress is more likely to center around the expectation to serve all students without limits.

Mid CLI Centers (73 to 167)

Most centers in our sample fall in this zone and are therefore the most diverse in terms of operations and service characteristics. In general, as a center moves from the low to high ends of the Mid CLI zone they will gradually accumulate characteristics of centers managing greater demand with limited supply. These centers will tend to fill up relatively quickly for individual counseling each semester and are increasingly likely to struggle with demand exceeding supply as the CLI increases. Mid CLI centers will be unable to provide as much individual weekly therapy as Low CLI centers. As centers transition from low to high ends of the Mid CLI zone they are likely to implement an increasing number of "demand management strategies", including operational oversight of staff schedules, engaging in efficiency efforts (appointment reminders, treatment limits), shifting from traditional intakes to brief screenings, diversifying treatment options, providing Case Management, and offering a disproportionate amount of "rapid-access" services compared to routine treatment. Centers that have gradually moved toward the high end of this zone without commensurate changes to stakeholder expectations may be under considerable operational stress. Work stress for centers in this zone is likely to be caused by the powerful reality of demand exceeding supply and the corresponding experience of being unable to fully treat students in need. Centers at the high end of this zone are very likely to place limits on the length of individual treatment through a variety of of approaches and deliver a broader range of (or stepped approach to) treatments as a result, resulting in increasingly complex systems and offerings.

High CLI Centers (168+)

Centers in this zone will vary depending on the actual size of the center and the institution (e.g., a large public university with many employees vs. a community college with one staff member). However, these centers are generally more likely to be at larger institutions and to implement clinical systems that maximize efficiency while also clearly limiting access to weekly individual therapy, if it is available at all. Operationally, these centers are more likely to implement a variety of oversight mechanisms that manage staff schedules (e.g., requiring a particular number of intakes or absorbing a specific number of clients per week) and are much more likely to use techniques, such as appointment reminders, dedicated administrative time, short session lengths, and fees to help maximize resources. These centers may be under pressure (as



a result of the demand/supply imbalance) to get students in quickly — but are also the most likely to provide diluted treatment, that is associated with less symptom reduction (poorer outcomes). Centers are more likely to prioritize "rapid-access" services over "treatment"— and have increased crisis intervention demands that require external resources to help manage after-hours. In general, centers in this zone will be managing very high demand that consistently exceeds supply and thus are more likely to provide a range of treatment options for students. Diluted treatment (spreading appointments out, limiting the number of appointments, shortening appointment lengths), limits on eligibility for care, and other scope-of-service limitations will be common. Centers across this zone may struggle to, or be unable to, provide weekly individual counseling and will be constantly seeking ways to manage demand and improve efficiency. Those at the highest end of this zone may need to focus almost entirely on rapid-access, crisis stabilization, and external referrals. Work stress in this zone, especially the high-end, will likely be focused on a near constant level of excessive demand for services by students in high levels of distress paired with the inability to provide treatment on site. Some centers may need to focus primarily on triage/referral services.

Note regarding the vulnerability of small centers: The process of developing the CLI and auditing hundreds of centers highlighted a particular vulnerability that should be noted with small centers. The loss of 1 staff member in a small center can have a massive impact on that center's ability to provide the same level of services. While this seems self-evident, the CLI effectively illustrates the magnitude of the impact. For example, a center that serves 180 students per year with a weekly clinical capacity of 55 hours would have a CLI of approximately 78, a Low CLI that is well below average. If that same center lost 1 staff member responsible for 24 hours of service capacity, the CLI would immediately jump from 78 to 138 (a Mid CLI that is above average) – resulting in the need for an almost immediate shift in clinical services (e.g., longer waits, session limits, and external referrals if possible). This example highlights the fact that small centers with unstable staffing may need to monitor their CLI more regularly in order to routinely align stakeholder expectations. It also speaks to the potential utility of aiming for a lower CLI that can withstand staffing changes mid-stream.

CONCLUSIONS AND NEXT STEPS

One of the most well documented trends in higher education over the last 20 years is the dramatic increase in the number of students being referred to and seeking mental health services, which have not been scaled equivalently. CCMH has clearly documented (see Annual Reports 2015-2019) that this long-term trend is causing counseling centers services to shift away from traditional and effective treatment towards short-term crisis support and diluted treatment (fewer/shorter appointments spaced farther apart). This trend has caused distress for nearly all stakeholders and misplaced assertions of the collegiate mental health "crisis" as colleges and universities have struggled to chart a clear path forward. Widely divergent approaches have been explored ranging from the idea that the demand for mental health services will never be met (and ergo we should not try), while others have attempted to provide professional services to every student who steps forward using various methods.

What has been missing throughout this time is an accurate and consistent metric for evaluating the clinical capacities of counseling centers and a theoretical structure to align these capacities with the service goals of the institution. This year's 2020 Annual Report offers new information to advance these discussions in the form of the 2018-2019 CLI distribution and the first descriptions of counseling center characteristics and practices that are most common for each CLI zone. This new information can be used to fundamentally shift the way that colleges and universities understand and plan for mental-health services through the careful and transparent alignment of service goals, clinical practices, and funding. The following three steps are recommended based on this new information:

1. **Track your CLI**: counseling centers are strongly encouraged to consistently and accurately track the necessary information to calculate their CLI (utilization and clinical capacity) on an annual basis. Ideally, counseling centers will also contribute this information to CCMH to improve the size and representation of the CLI distribution.
2. **Define institutional service goals**: institutional leaders, stakeholders, and counseling center leadership should review the CLI zone descriptions and collaboratively define the mental-health service goals, experiences, and related limits they would like their students to have when seeking services.
3. **Seek alignment**: institutional leaders, stakeholders, and counseling center leadership should then work to align the desired institutional service goals/limits with appropriate staffing/funding levels (e.g., an aspirational CLI). These service goals/limits can then be transparently and consistently communicated to all stakeholders and adjusted over time. For example, an institution might have been communicating to stakeholders (via tours or admissions) that students can typically receive weekly counseling with minimal wait times. However, if the counseling center has a CLI of 175, it will be difficult to routinely offer quick access to weekly counseling. To fix this, institutional service goals, stakeholder expectations, and counseling center resources will need to be aligned so that everyone holds the same expectations.

In brief, the CLI and service-goal alignment framework offered in this report provide institutions with new tools and information to intentionally and transparently align their desired clinical service goals/experiences with appropriate resource allocations that are sufficient to achieve those goals, adjust resource allocations over time to maintain the service goals, and/or change the service goals (and limits) in the face of changes to funding. For example, a Low CLI may be most desirable for those institutions that prioritize the provision of on-campus, effective/complete mental-health treatment with minimal limits. A Mid CLI (and the many limits that come with it) may be appropriate for many other institutions and acceptable to their stakeholders who are seeking to provide a limited amount of care the greatest number of those in need. Finally, a High CLI might be acceptable as a first step towards providing basic mental-health services (crisis intervention and referral) with very clearly communicated limits regarding ongoing care (assuming that outside resources exist).

Recent CCMH Publications

- Carney, D., Castonguay, L.G., Janis, R.A., Scofield, B.E, Hayes, J.A., & Locke, B.D. (2021). Center effects: Counseling center variables as predictors of psychotherapy outcomes. *The Counseling Psychologist*
- Ghosh, A., Nileksela, C., Parham, A., & Janis, R. (2020). Investigating factorial invariance of the Counseling Center Assessment of Psychological Symptoms – 34 (CCAPS-34) with military and non-military students. *Measurement and Evaluation in Counseling and Development,* 1-14. https://doi.org/10.1080/07481756.2020.1745649
- Hayes, J.A., Petrovich, J., Janis, R.A., Yang, Y., Castonguay, L.G., & Locke, B.D. (2020). Suicide among college students in psychotherapy: Individual predictors and latent classes. *Journal of Counseling Psychology, 67,* 104-114. https://doi.org/10.1037/cou0000384
- Kilcullen, J.R., Castonguay, L.G., Janis, R.A., Hallquist, M.N., Hayes, J.A., & Locke B. D. (in press). Predicting future courses of psychotherapy within a grouped LASSO framework. *Psychotherapy Research, 31*, 63-77.
- McAleavey, A.A, Castonguay, L.G., Hayes, J.A., Locke, B.D. (in press). Multilevel vs single level factor analysis. Differentiating within-person and between-person variability using the CCAPS-34. *Journal of Consulting and Clinical Psychology*
- Niileksela, C.R., Ghosh, A., & Janis, R.A. (in press). Dynamic relationships among changes in anxiety and depression during counseling. *The Journal of Counseling Psychology*
- Youn, S.J., Castonguay, L.G., McAleavey, A.A., Nordberg, S.S., Hayes, J.A., & Locke, B.D. (2020). Sensitivity to change of the Counseling Center Assessment of Psychological Symptoms-34. *Measurement and Evaluation in Counseling and Development, 52*, 75-88. https://doi.org/10.1080/07481756.2019.1691459

Annual Trends

MENTAL HEALTH TRENDS

As of this report, CCMH has generated 10 annual data sets (2010-2011 through 2019-2020), making it possible to examine a decade of trends among college students seeking mental health services. To examine 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 prior versions of the SDS for specifics. Specifically, the wording and response format for many items changed in 2012-2013, resulting in a larger change in response rate to some items after that year. Because of this change and immediate shift in some of the trends thereafter, CCMH modified the trend analyses to include data from 2012-2013 to the current year using only the information reported from items with identical wording/response formats.

Data Sets

The below table summarizes the amount of data contributed to CCMH over the past 10 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	# of Institutions	# 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

Mental Health Trends (2012–2020)

Item	8-Year Change	2012-2020	Lowest	Highest	2019–2020
Prior Treatment					
Counseling	+11.6%		47.8%	59.5%	59.5%
Medication	+3.7%		32.4%	36.1%	36.1%
Hospitalization	-0.2%		9.5%	10.3%	9.9%
Threat to Self					
Non-Suicidal Self-Injury	+6.1%		23.0%	29.1%	29.1%
Serious Suicidal Ideation	+6.9%		30.1%	36.9%	36.9%
Serious Suicidal Ideation (last month)	+0.8%		6.4%	8.2%	7.8%
Suicide Attempt(s)	+2.2%		8.7%	10.9%	10.9%
Some Suicidal Ideation (past 2 weeks)	+4.6%		33.9%	39.6%	38.5%
Threat to Others					
Considered causing serious physical injury to another person	-4.1%		7.1%	11.2%	7.1%
Intentionally caused serious injury to another person	-1.8%		1.6%	3.4%	1.6%
Traumatic Experiences					
Had unwanted sexual contact(s) or experience(s)	+6.8%		18.9%	25.8%	25.8%
Experienced harassing, controlling, and/or abusive behavior	+5.5%		32.8%	38.7%	38.7%
Experienced traumatic event	+11.7%		31.0%	42.6%	42.6%
Drug and Alcohol					
Felt the need to reduce alcohol/drug use	+0.4%		26.7%	27.5%	27.4%
Others concerned about alcohol/drug use	-2.3%		15.2%	17.6%	15.2%
Treatment for alcohol/drug use	-2.1%		2.3%	4.4%	2.3%
Binge drinking	-4.6%		36.9%	41.5%	36.9%
Marijuana use	+5.2%		19.1%	26.0%	26.0%

CCAPS TRENDS

The Counseling Center Assessment of Psychological Symptoms (CCAPS) is a multidimensional assessment and outcome-monitoring instrument used by CCMH counseling centers. The frequency and clinical timing of CCAPS administration varies by counseling center. Students respond to the items on a five-point Likert scale from 0 (*not at all like me*) to 4 (*extremely like me*). The following charts provide information regarding trends in student self-reported distress upon entry to counseling services as indicated by the CCAPS subscales.

Trends: Average Subscale Scores (2010 to 2020)

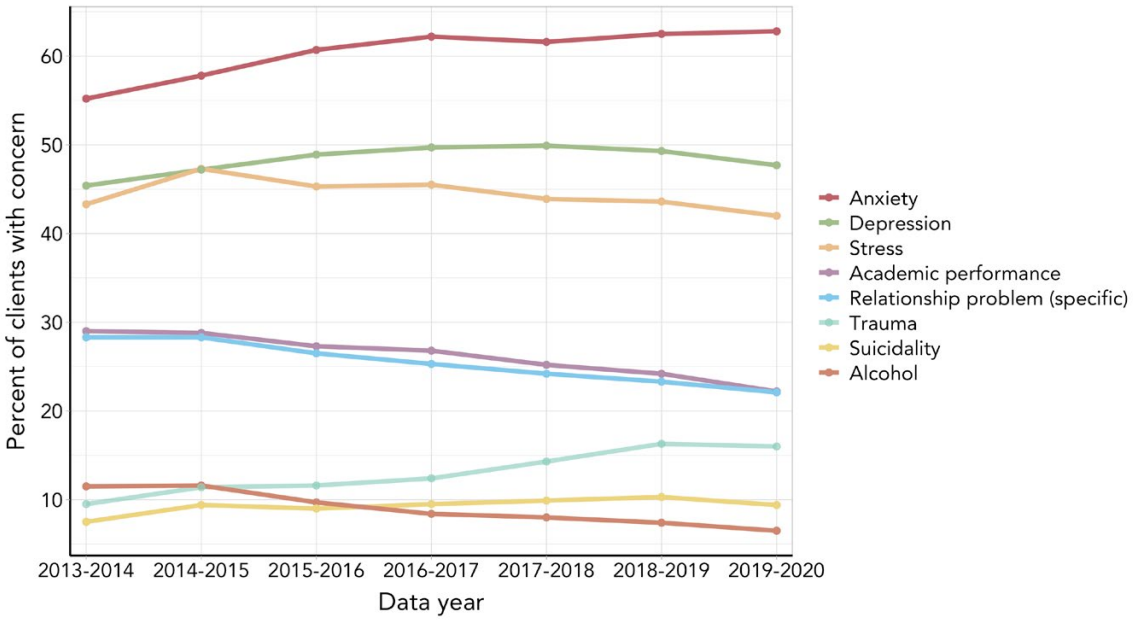
Item	10-Year Change	2010-2020	Lowest	Highest	2019–2020
CCAPS-62					
Depression	+0.22		1.59	1.82	1.82
Generalized Anxiety	+0.27		1.61	1.88	1.88
Social Anxiety	+0.25		1.82	2.07	2.07
Academic Distress	+0.02		1.85	1.89	1.87
Eating Concerns	+0.06		1.00	1.06	1.06
Hostility	-0.07		0.97	1.04	0.97
Substance Use	-0.14		0.63	0.77	0.63
Family Distress	+0.08		1.29	1.38	1.38
CCAPS-34					
Depression	+0.18		1.55	1.74	1.73
Generalized Anxiety	+0.28		1.77	2.05	2.05
Social Anxiety	+0.27		1.77	2.05	2.05
Academic Distress	+0.01		1.92	1.97	1.93
Eating Concerns	+0.06		0.94	1.00	1.00
Hostility	-0.12		0.81	0.93	0.81
Alcohol Use	-0.19		0.54	0.73	0.54
Distress Index	+0.15		1.65	1.80	1.80

CLICC TRENDS

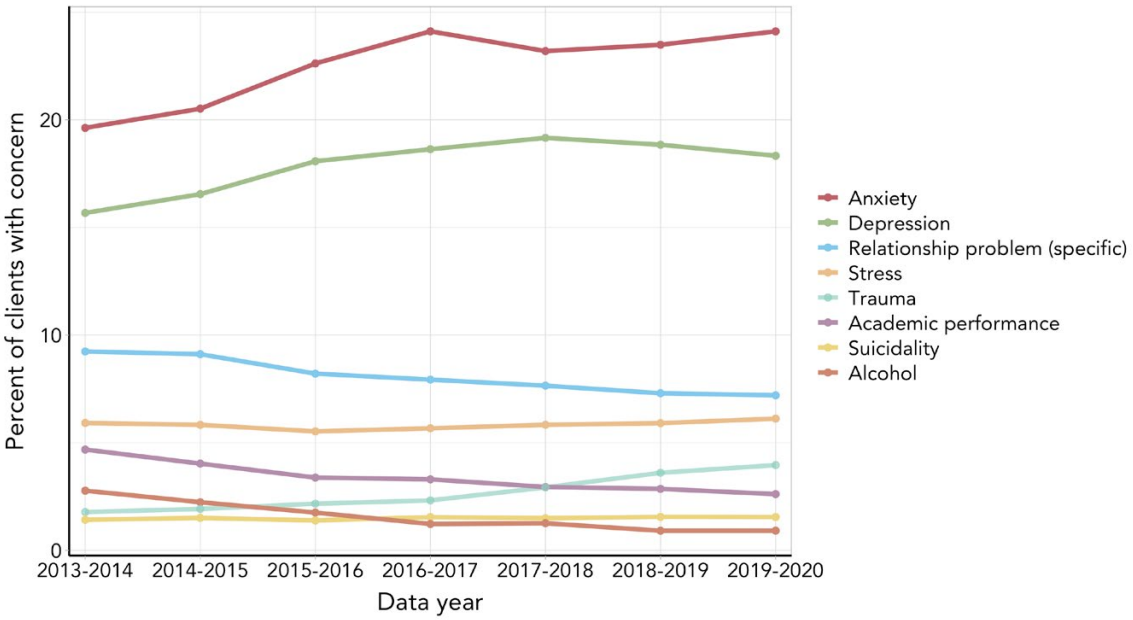
The Clinician Index of Client Concerns (CLICC) captures the presenting concerns of counseling center clients, as assessed by the clinician during an initial appointment. The CLICC includes 54 concerns and asks the clinician (a) to check all that apply and (b) to identify the "top concern" of those selected.

The graphs below display notable trends in some of the CLICC items. All concerns generally demonstrated minimal to no change from 2018-2019 to 2019-2020. While Depression showed a mild decrease as a "check all" and "top concern," Anxiety revealed a faint increase as a "top concern." Notably, Trauma increased the prior six years, and particularly from 2016-2017 to 2018-2019, as both a "check all" and "top concern" but only slightly increased as a "top concern" in the past year.

CLICC Trends (Check All That Apply): Percentage of Clients with Each Concern from 2013–2020



CLICC Trends (Top Concern): Percentage of Clients with Each Concern from 2013–2020



Counseling Center Resource Utilization by Students

Data from 2019-2020 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 172,199 students across participating CCMH centers:

- The most common number of appointments per client per year is one.
- Clients averaged 5.44 total attended appointments of any kind, with a median of 3 appointments, and a range of 1-145 appointments.
- Clients averaged 4.35 attended *Individual Treatment* (initial clinical evaluations and individual counseling) appointments, with a median of 3 attended appointments, and a range of 1-71 attended appointments.
- 20% of clients accounted for 60% of all appointments, averaging 14 appointments.
- 10% of clients accounted for 37% of all appointments, averaging 20 appointments.
- 5% of clients accounted for 25% of all appointments, averaging 24 appointments.
- 1% of clients accounted for 7% of all appointments, averaging 37 appointments.
- 10 clients utilized a total of 1,018 appointments.

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)

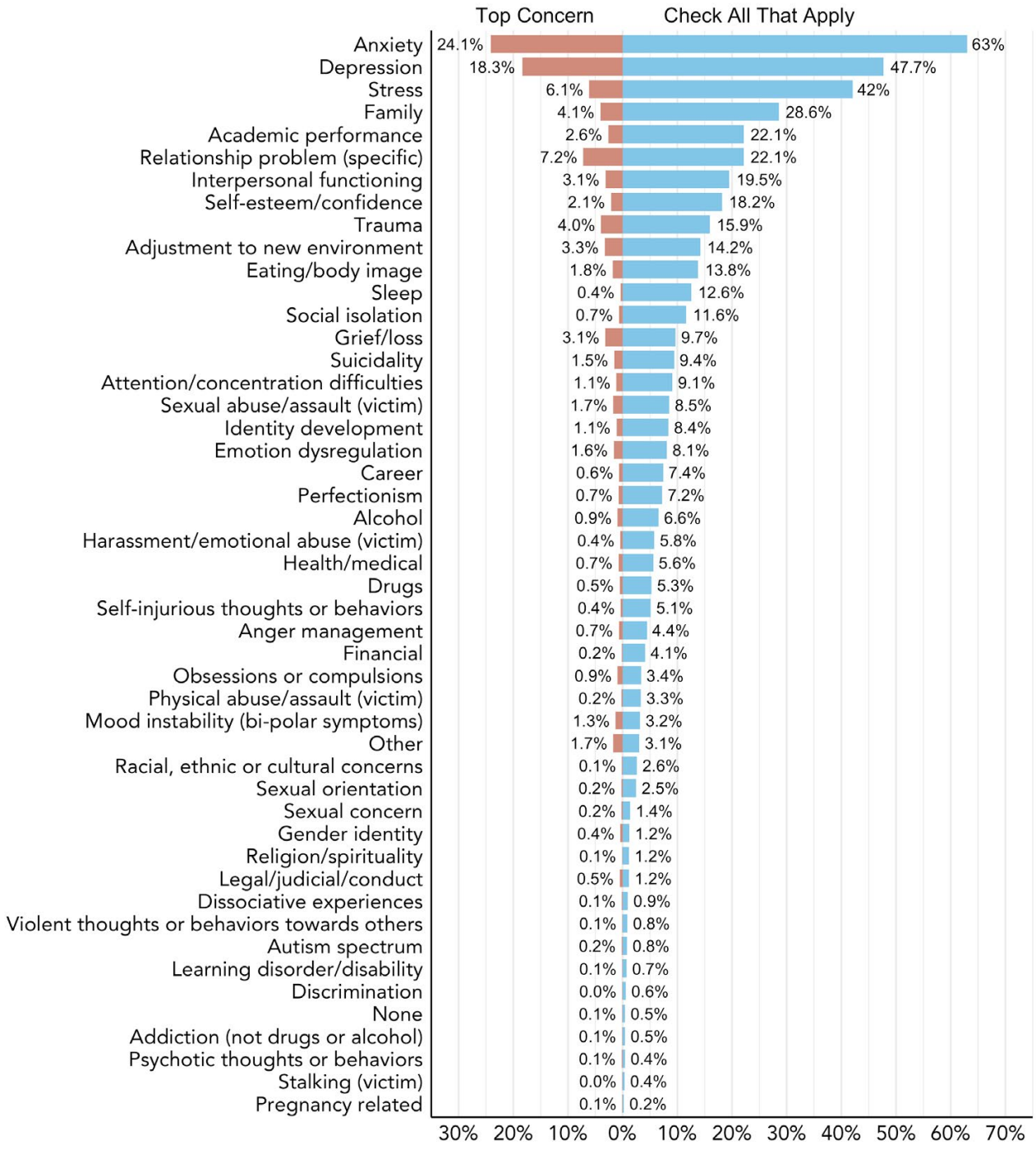
The CLICC was designed by CCMH to capture and facilitate reporting on the most common presenting concerns of counseling center clients, as assessed by the clinician during an initial appointment. The resulting data allows individual centers and CCMH to quickly and easily report on the most common client concerns in addition to supporting a wide array of research. The CLICC includes 54 concerns, and starting 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.

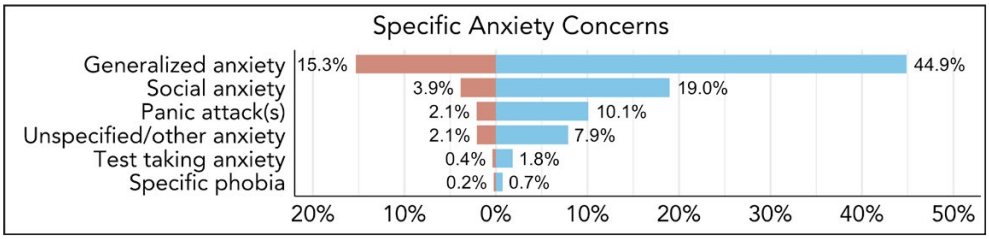
The graph on the next page illustrates the presenting concerns of 71,609 clients during the 2019-2020 academic year. For each client, clinicians are asked to "check all that apply" from the list of CLICC concerns (as one client can have many concurrent concerns). The blue bars on the right portion of 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.

Taken together, the two bars highlight the proportion of clients who were experiencing each concern in general (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 a concern, it was the *top* concern for far fewer clients. On the other hand, few clients had Relationship problem (specific) endorsed as a concern, but of those clients, a higher proportion 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



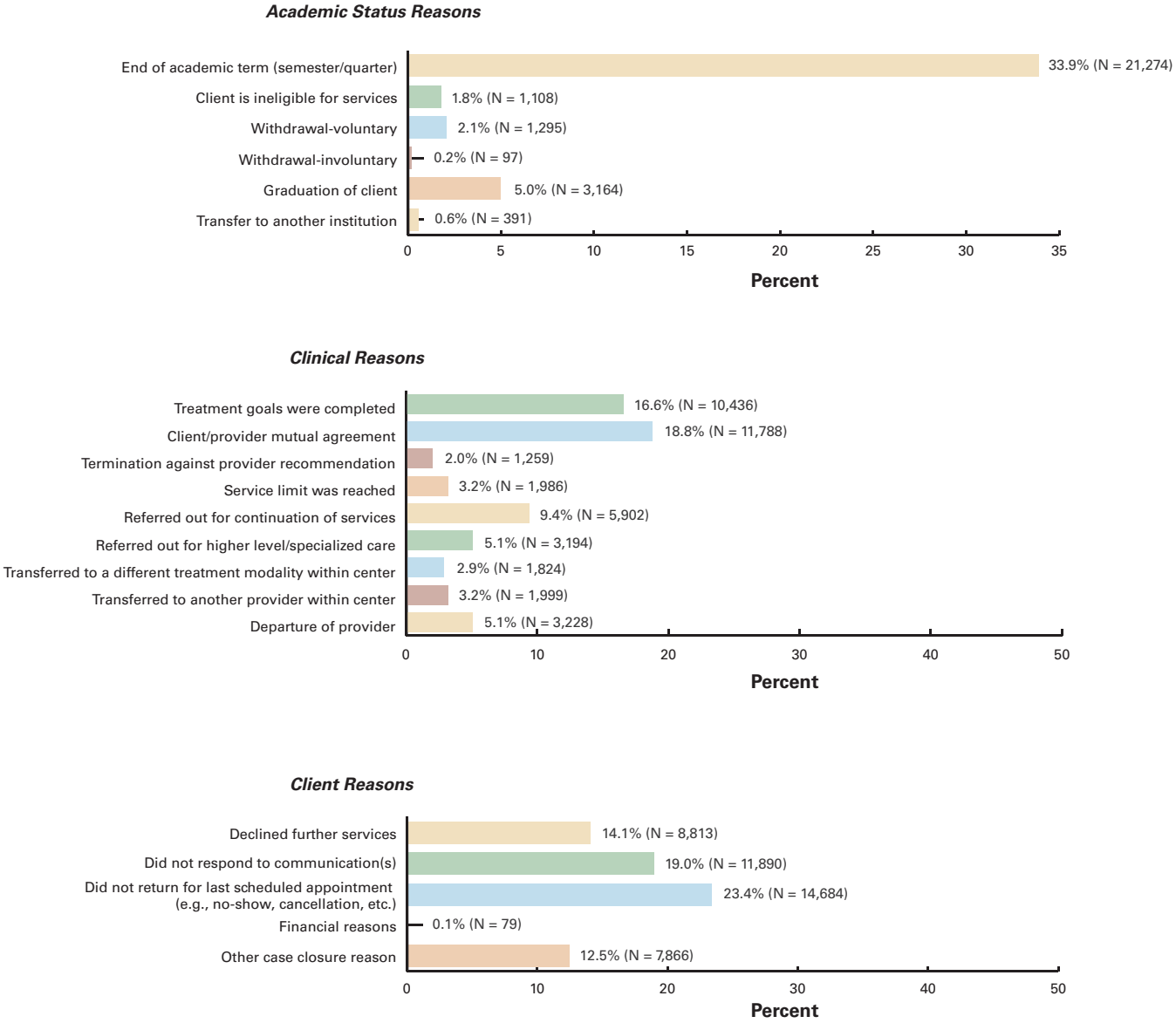


CASE CLOSURE FORM

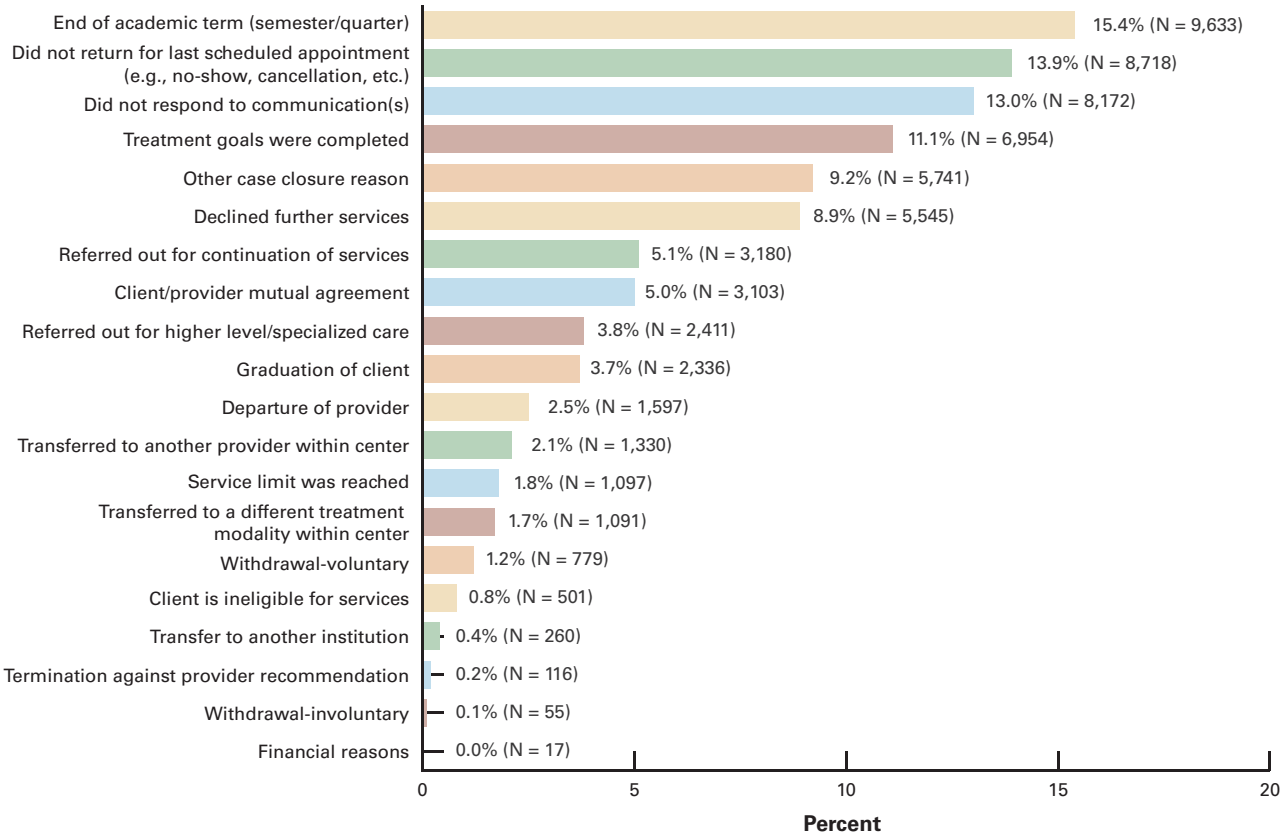
The Case Closure Form captures a wide array of reasons (academic, clinical, and client factors) why services ended, as well as significant events that might have occurred during the course of a student's services. Clinicians are asked to complete this form following the end of their service provision 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 2019-2020 academic year (N = 62,704). The top two most endorsed reasons for ending of services were the timing of the academic term, followed by the client not returning for their last appointment. Notably, the category "Other case closure reason" was more frequent this year than last year, with 2,866 responses mentioning "COVID" or "Coronavirus."

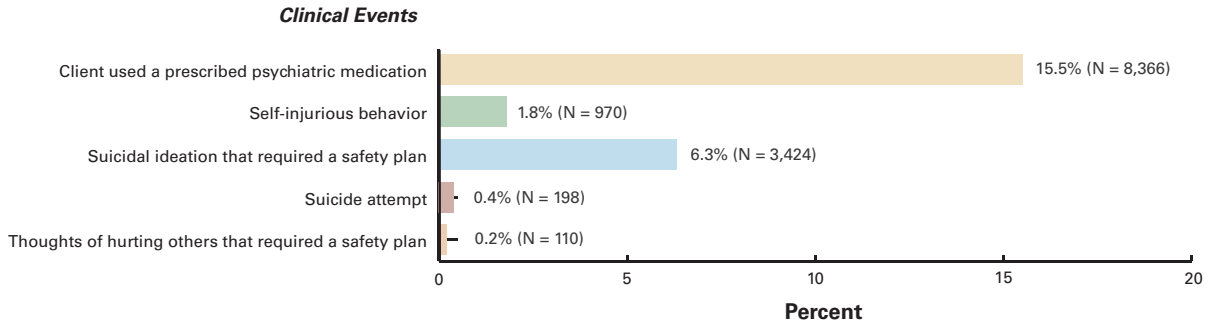


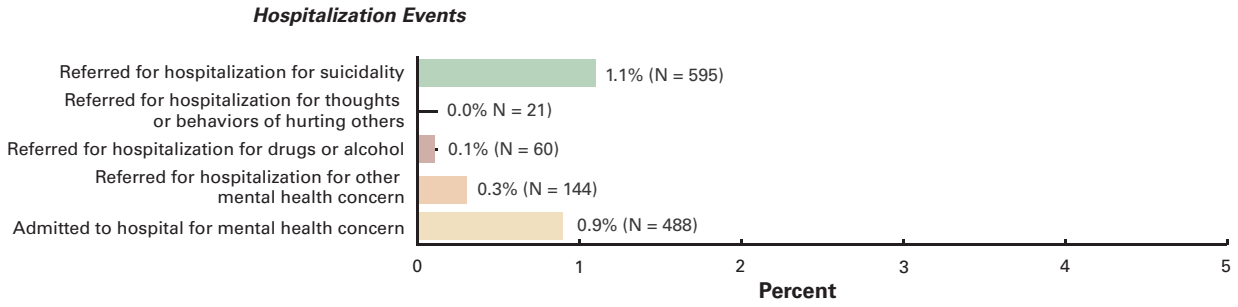
Top Case Closure Reason

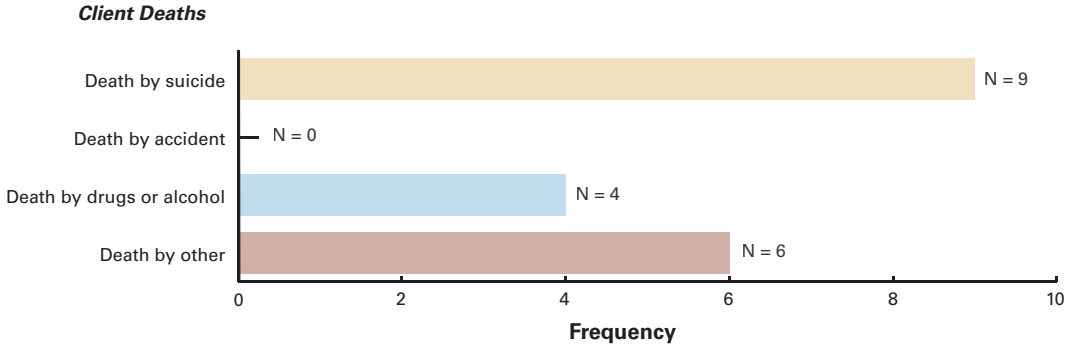


Case Events

This graph describes the frequency of significant events occurring during a course of services for students during the 2019-2020 academic year (*N*= 54,044).







CLIENT DEMOGRAPHIC INFORMATION

The Standardized Data Set (SDS) for client demographic information contains numerous different questions, and the tables below include the item text and number. The SDS has "core" or required items and a larger number of optional items that are typically asked of students seeking services. Because counseling centers vary in the types of questions they ask, the total number of responses varies by question.

Client age

Mean	SD	Range
21.87	3.9	18-60

What is your gender identity?

SDS 88	Frequency	Percent
Woman	78,308	64.8%
Man	39,429	32.6%
Transgender	998	0.8%
Self-identify	2,033	1.7%

What was your sex at birth?

SDS 90	Frequency	Percent
Female	14,465	66.2%
Male	7,359	33.7%
Intersex	11	0.1%

Do you consider yourself to be:

SDS 91	Frequency	Percent
Heterosexual/Straight	85,893	74.7%
Lesbian	2,436	2.1%
Gay	3,265	2.8%
Bisexual	15,456	13.4%
Questioning	4,124	3.6%
Self-identify	3,784	3.3%

Since puberty, with whom have you had sexual experience(s)?

SDS 93	Frequency	Percent
Only with men	5,486	44.8%
Mostly with men	1,338	10.9%
About the same number of men and women	378	3.1%
Mostly with women	378	3.1%
Only with women	2,742	22.4%
I have not had sexual experiences	1,926	15.7%

People are different in their sexual attraction to other people. Which best describes your current feelings? Are you:

SDS 94	Frequency	Percent
Only attracted to women	3,599	24.7%
Mostly attracted to women	971	6.7%
Equally attracted to women and men	1,228	8.4%
Mostly attracted to men	2,303	15.8%
Only attracted to men	5,935	40.8%
Not sure	355	2.4%
I do not experience sexual attraction	166	1.1%

What is your race/ethnicity?

SDS 95	Frequency	Percent
African American/Black	11,720	9.6%
American Indian or Alaskan Native	619	0.5%
Asian American/Asian	10,849	8.9%
Hispanic/Latino/a	11,574	9.5%
Native Hawaiian or Pacific Islander	241	0.2%
Multi-racial	6,231	5.1%
White	79,078	64.7%
Self-identify	1,848	1.5%

What is your country of origin?

Country	Frequency
United States	101,177
China	2,056
India	1,618
Mexico	765
Republic of Korea	456
Colombia	402
Puerto Rico	395
Canada	389
Brazil	366
Philippines	288

Country	Frequency
Islamic Republic of Iran	287
United Kingdom	280
Pakistan	264
Vietnam	257
Nigeria	256
Venezuela	254
Bangladesh	238
Russian Federation	204
Peru	177
Germany	171

Country	Frequency
Saudi Arabia	166
Jamaica	149
Japan	140
Taiwan	140
Ecuador	138
Cuba	129
Nepal	128
Egypt	127
Turkey	121

Countries with less than 116 (0.1%) individuals:

Afghanistan, Aland Islands, Albania, Algeria, American Samoa, Angola, Anguilla, Antigua and Barbuda, Argentina, Armenia, Aruba, Australia, Austria, Azerbaijan, Bahamas, Bahrain, Barbados, Belarus, Belgium, Belize, Benin, Bermuda, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, British Virgin Islands, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Cayman Islands, Central African Republic, Chad, Chile, Congo, Costa Rica, Cote D'ivoire, Croatia, Cyprus, Czech Republic, Democratic People's Republic of Korea, Denmark, Djibouti, Dominica, Dominican Republic, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Federated States of Micronesia, Fiji, Finland, France, French Guiana, Gabon, Gambia, Georgia, Ghana, Greece, Grenada, Guadeloupe, Guam, Guatemala, Guinea, Guyana, Haiti, Heard Island and Mcdonald Islands, Honduras, Hong Kong, Hungary, Iceland, Indonesia, Iraq, Ireland, Isle of Man, Israel, Italy, Jersey, Jordan, Kazakhstan, Kenya, Kuwait, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lebanon, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Macao, Madagascar, Malawi, Malaysia, Mali, Malta, Marshall Islands, Mauritania, Mauritius, Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Netherlands, Netherlands Antilles, New Zealand, Nicaragua, Niger, Northern Mariana Islands, Norway, Oman, Palestinian Territory, Panama, Paraguay, Pitcairn, Poland, Portugal, Qatar, Republic of Moldova, Reunion, Romania, Rwanda, Saint Helena, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Samoa, Senegal, Serbia, Sierra Leone, Singapore, Slovakia, Slovenia, Somalia, South Africa, Spain, Sri Lanka, Sudan, Suriname, Swaziland, Sweden, Switzerland, Syrian Arab Republic, Tajikistan, Thailand, The Democratic Republic of the Congo, The Former Yugoslav Republic of Macedonia, Togo, Trinidad and Tobago, Tunisia, Turkmenistan, Turks and Caicos Islands, U.S. Virgin Islands, Uganda, Ukraine, United Arab Emirates, United Republic of Tanzania, United States Minor Outlying Islands, Uruguay, Uzbekistan, Yemen, Zambia, Zimbabwe

Are you an international student?

SDS 32	Frequency	Percent
No	110,453	93.8%
Yes	7,248	6.2%

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

SDS 56	Frequency	Percent
No	88,848	77.1%
Yes	26,391	22.9%

Current academic status:

SDS 37	Frequency	Percent
Freshman/First-year	25,978	21.0%
Sophomore	25,345	20.5%
Junior	27,291	22.0%
Senior	25,736	20.8%
Graduate/Professional degree student	18,094	14.6%
Non-student	170	0.1%
High-school student taking college classes	16	<0.1%
Non-degree student	263	0.2%
Faculty or staff	79	0.1%
Other (please specify)	913	0.7%

Graduate or professional degree program:

SDS 39	Frequency	Percent
Post-Baccalaureate	3,040	8.0%
Masters	5,398	14.2%
Doctoral degree	3,181	8.4%
Law	924	2.4%
Medical	1,008	2.7%
Pharmacy	249	0.7%
Dental	89	0.2%
Veterinary Medicine	380	1.0%
Not applicable	22,041	57.9%
Other (please specify)	1,726	4.5%

What year are you in your graduate/professional program?

SDS 41	Frequency	Percent
1	6,783	36.4%
2	4,536	24.3%
3	2,867	15.4%
4	3,295	17.7%
5+	1,176	6.3%

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

SDS 46	Frequency	Percent
No	96,157	82.2%
Yes	20,828	17.8%

What kind of housing do you currently have?

SDS 42	Frequency	Percent
On-campus residence hall/ apartment	37,807	36.6%
On/off campus fraternity/sorority house	1,905	1.8%
On/off campus co-operative house	952	0.9%
Off-campus apartment/house	61,314	59.4%
Other (please specify)	1,259	1.2%

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

SDS 44	Frequency	Percent
Alone	13,307	12.6%
Spouse, partner, or significant other	9,998	9.5%
Roommates	72,645	68.9%
Children	1,866	1.8%
Parent(s) or guardian(s)	10,481	9.9%
Family (other)	5,292	5.0%
Other	1,378	1.3%

Relationship status:

SDS 33	Frequency	Percent
Single	72,946	61.5%
Serious dating or committed relationships	39,999	33.7%
Civil union, domestic partnership, or equivalent	437	0.4%
Married	4,396	3.7%
Divorced	355	0.3%
Separated	386	0.3%
Widowed	39	<0.1%

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

SDS 48	Frequency	Percent
None	20,711	32.1%
Occasional participation	13,564	21.0%
One regularly attended activity	11,905	18.4%
Two regularly attended activities	9,581	14.8%
Three or more regularly attended activities	8,767	13.6%

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

SDS 1151	Frequency	Percent
No	82,443	92.1%
Yes	7,110	7.9%

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

SDS 1152	Frequency	Percent
No	76,313	85.2%
Yes	13,306	14.8%

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

SDS 1153	Frequency	Percent
No	85,146	96.5%
Yes	3,101	3.5%

Religious or Spiritual Preference:

SDS 97	Frequency	Percent
Agnostic	16,566	15.2%
Athiest	9,950	9.2%
Buddhist	896	0.8%
Catholic	15,320	14.1%
Christian	35,028	32.2%
Hindu	1,329	1.2%
Jewish	2,405	2.2%
Muslim	1,990	1.8%
No preference	21,705	20.0%
Self-identify	3,554	3.3%

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

SDS 36	Frequency	Percent
Very important	13,023	15.4%
Important	18,000	21.3%
Neutral	27,546	32.7%
Unimportant	13,428	15.9%
Very unimportant	12,339	14.6%

How would you describe your financial situation right now?

SDS 57	Frequency	Percent
Always stressful	13,049	12.8%
Often stressful	21,471	21.1%
Sometimes stressful	36,088	35.4%
Rarely stressful	22,637	22.2%
Never stressful	8,656	8.5%

How would you describe your financial situation while growing up?

SDS 58	Frequency	Percent
Always stressful	7,617	10.5%
Often stressful	11,118	15.3%
Sometimes stressful	17,476	24.1%
Rarely stressful	21,048	29.0%
Never stressful	15,281	21.1%

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

SDS 1055	Frequency	Percent
0	37,955	41.5%
1-5	5,412	5.9%
6-10	10,669	11.7%
11-15	9,862	10.8%
16-20	12,234	13.4%
21-25	5,828	6.4%
26-30	3,619	4.0%
31-35	1,689	1.8%
36-40	1,983	2.2%
40+	2,224	2.4%

Are you a member of ROTC?

SDS 51	Frequency	Percent
No	70,749	99.0%
Yes	747	1.0%

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

SDS 98	Frequency	Percent
No	119,042	98.6%
Yes	1,694	1.4%

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

SDS 53	Frequency	Percent
No	916	69.4%
Yes	404	30.6%

MENTAL HEALTH HISTORY ITEMS

Attended counseling for mental health concerns:

SDS 01	Frequency	Percent
Never	47,885	40.5%
Prior to college	26,581	22.5%
After starting college	24,275	20.5%
Both	19,422	16.4%

Taken a prescribed medication for mental health concerns:

SDS 02	Frequency	Percent
Never	74,641	63.9%
Prior to college	10,838	9.3%
After starting college	16,051	13.7%
Both	15,242	13.1%

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	Frequency	Percent
Never	109,107	90.1%
1 time	8,156	6.7%
2-3 times	3,098	2.6%
4-5 times	426	0.4%
More than 5 times	354	0.3%

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

SDS 65	Frequency	Percent
Never	4	<0.1%
Within the last 2 weeks	771	6.6%
Within the last month	449	3.9%
Within the last year	2,479	21.4%
Within the last 1-5 years	5,320	45.8%
More than 5 years ago	2,584	22.3%

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

SDS 72	Frequency	Percent
Never	86,317	70.9%
1 time	6,851	5.6%
2-3 times	9,994	8.2%
4-5 times	3,536	2.9%
More than 5 times	15,071	12.4%

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

SDS 73	Frequency	Percent
Never	20	0.1%
Within the last 2 weeks	3,801	11.1%
Within the last month	2,642	7.7%
Within the last year	7,123	20.8%
Within the last 1-5 years	12,532	36.7%
More than 5 years ago	8,058	23.6%

Seriously considered attempting suicide (how many times):

SDS 74	Frequency	Percent
Never	77,237	63.1%
1 time	15,626	12.8%
2-3 times	16,763	13.7%
4-5 times	3,521	2.9%
More than 5 times	9,280	7.6%

Seriously considered attempting suicide (the last time):

SDS 75	Frequency	Percent
Never	24	0.1%
Within the last 2 weeks	5,642	13.0%
Within the last month	3,917	9.0%
Within the last year	9,609	22.2%
Within the last 1-5 years	16,989	39.2%
More than 5 years ago	7,188	16.6%

Made a suicide attempt (how many times):

SDS 76	Frequency	Percent
Never	108,205	89.1%
1 time	8,439	7.0%
2-3 times	3,785	3.1%
4-5 times	467	0.4%
More than 5 times	507	0.4%

Made a suicide attempt (the last time):

SDS 77	Frequency	Percent
Never	4	<0.1%
Within the last 2 weeks	493	3.8%
Within the last month	307	2.4%
Within the last year	1,821	14.1%
Within the last 1-5 years	6,184	47.9%
More than 5 years ago	4,113	31.8%

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

SDS 78	Frequency	Percent
Never	110,910	92.9%
1 time	2,913	2.4%
2-3 times	3,124	2.6%
4-5 times	574	0.5%
More than 5 times	1,924	1.6%

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

SDS 79	Frequency	Percent
Never	9	0.1%
Within the last 2 weeks	1,156	14.1%
Within the last month	900	11.0%
Within the last year	2,032	24.9%
Within the last 1-5 years	2,752	33.7%
More than 5 years ago	1,321	16.2%

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

SDS 80	Frequency	Percent
Never	117,028	98.4%
1 time	940	0.8%
2-3 times	642	0.5%
4-5 times	119	0.1%
More than 5 times	219	0.2%

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

SDS 81	Frequency	Percent
Never	1	0.1%
Within the last 2 weeks	71	3.9%
Within the last month	92	5.0%
Within the last year	312	17.0%
Within the last 1-5 years	618	33.8%
More than 5 years ago	736	40.2%

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	Frequency	Percent
Never	88,219	74.2%
1 time	16,273	13.7%
2-3 times	9,427	7.9%
4-5 times	1,541	1.3%
More than 5 times	3,394	2.9%

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	Frequency	Percent
Never	13	<0.1%
Within the last 2 weeks	872	3.0%
Within the last month	915	3.1%
Within the last year	5,682	19.5%
Within the last 1-5 years	13,434	46.0%
More than 5 years ago	8,257	28.3%

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

SDS 84	Frequency	Percent
Never	73,543	61.3%
1 time	9,336	7.8%
2-3 times	10,479	8.7%
4-5 times	2,807	2.3%
More than 5 times	23,861	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	Frequency	Percent
Never	14	<0.1%
Within the last 2 weeks	3,867	8.9%
Within the last month	3,245	7.5%
Within the last year	10,059	23.2%
Within the last 1-5 years	17,802	41.0%
More than 5 years ago	8,430	19.4%

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

SDS 86	Frequency	Percent
Never	65,998	57.4%
1 time	19,847	17.3%
2-3 times	16,873	14.7%
4-5 times	3,084	2.7%
More than 5 times	9,191	8.0%

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

SDS 87	Frequency	Percent
Never	7	<0.1%
Within the last 2 weeks	3,924	8.4%
Within the last month	2,849	6.1%
Within the last year	10,384	22.3%
Within the last 1-5 years	18,364	39.5%
More than 5 years ago	10,981	23.6%

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

SDS 99	Frequency	Percent
Childhood physical abuse	6,021	17.7%
Childhood sexual abuse	5,057	14.9%
Childhood emotional abuse	16,297	48.0%
Physical attack (e.g., mugged, beaten up, shot, stabbed, threatened with a weapon)	3,792	11.2%
Sexual violence (rape or attempted rape, sexually assaulted, stalked, abused by intimate partner, etc.)	11,962	35.2%
Military combat or war zone experience	252	0.7%
Kidnapped or taken hostage	343	1.0%
Serious accident, fire, or explosion (e.g., an industrial, farm, car, plane, or boating accident)	3,571	10.5%
Terrorist attack	195	0.6%
Near drowning	2,888	8.5%
Diagnosed with life threatening illness	1,074	3.2%
Natural disaster (e.g., flood, quake, hurricane, etc.)	1,534	4.5%
Imprisonment or torture	251	0.7%
Animal attack	1,076	3.2%
Other (please specify)	8,351	24.6%

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

SDS 66	Frequency	Percent
Never	81,394	72.6%
1 time	10,686	9.5%
2-3 times	12,108	10.8%
4-5 times	2,053	1.8%
More than 5 times	5,944	5.3%

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

SDS 67	Frequency	Percent
Never	4	<0.1%
Within the last 2 weeks	8,422	28.3%
Within the last month	5,683	19.1%
Within the last year	9,421	31.7%
Within the last 1-5 years	5,376	18.1%
More than 5 years ago	817	2.7%

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

SDS 68	Frequency	Percent
Never	95,078	84.8%
1 time	6,942	6.2%
2-3 times	6,355	5.7%
4-5 times	1,093	1.0%
More than 5 times	2,672	2.4%

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

SDS 69	Frequency	Percent
Never	3	<0.1%
Within the last 2 weeks	3,351	20.5%
Within the last month	2,748	16.8%
Within the last year	5,722	35.0%
Within the last 1-5 years	3,767	23.1%
More than 5 years ago	739	4.5%

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

SDS 70	Frequency	Percent
Never	115,401	97.7%
1 time	1,965	1.7%
2-3 times	531	0.4%
4-5 times	70	0.1%
More than 5 times	137	0.1%

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

SDS 71	Frequency	Percent
Never	4	0.2%
Within the last 2 weeks	182	7.0%
Within the last month	147	5.7%
Within the last year	643	24.8%
Within the last 1-5 years	1,127	43.5%
More than 5 years ago	486	18.8%

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	Frequency	Percent
None	57,730	63.1%
Once	15,043	16.4%
Twice	9,473	10.4%
3 to 5 times	7,124	7.8%
6 to 9 times	1,285	1.4%
10 or more times	792	0.9%

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

SDS 1096	Frequency	Percent
None	78,407	74.0%
Once	6,377	6.0%
Twice	4,665	4.4%
3 to 5 times	6,310	6.0%
6 to 9 times	3,331	3.1%
10 or more times	6,838	6.5%

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

SDS 22	Frequency	Percent
Strongly disagree	8,722	10.4%
Somewhat disagree	13,412	16.0%
Neutral	13,375	16.0%
Somewhat agree	27,597	33.0%
Strongly agree	20,623	24.6%

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	Frequency	Percent
Strongly disagree	5,246	6.3%
Somewhat disagree	10,282	12.4%
Neutral	15,202	18.3%
Somewhat agree	33,059	39.8%
Strongly agree	19,225	23.2%

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

SDS 60	Frequency	Percent
No	108,528	90.0%
Yes	12,008	10.0%

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

SDS 1061	Frequency	Percent
Difficulty hearing	410	3.3%
Difficulty seeing	367	3.0%
Difficulty speaking or language impairment	144	1.2%
Mobility limitation/orthopedic impairment	495	4.0%
Traumatic brain injury	350	2.8%
Specific learning disabilities	1,568	12.7%
ADD or ADHD	5,255	42.4%
Autism spectrum disorder	760	6.1%
Cognitive difficulties or intellectual disability	518	4.2%
Health impairment/condition, including chronic conditions	1,401	11.3%
Psychological or psychiatric condition	3,908	31.5%
Other	1,983	16.0%

PROVIDER DATA

The Standardized Data Set includes some basic demographic information about providers (clinicians) at participating counseling centers. The 2019-2020 data set represents 3,889 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
Male	462	26.5%
Female	1,253	71.9%
Transgender	11	0.6%
Prefer not to answer	16	0.9%

Age

N	Mean	Mode
1,588	40.1	31

Race/Ethnicity

	Frequency	Percent
African-American/Black	192	11.1%
American Indian or Alaskan Native	5	0.3%
Asian American/Asian	134	7.7%
White	1,181	68.1%
Hispanic/Latino/a	117	6.7%
Native Hawaiian or Pacific Islander	4	0.2%
Multi-racial	63	3.6%
Prefer not to answer	7	0.4%
Other	31	1.8%

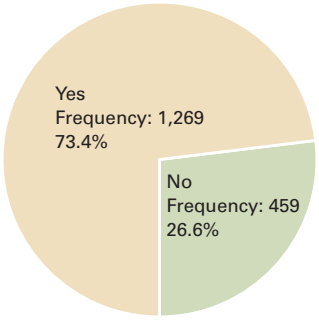
Highest Degree (descending sort)

	Frequency	Percent
Doctor of Philosophy	531	30.6%
Master of Arts	312	18.0%
Doctor of Psychology	226	13.0%
Master of Social Work	213	12.3%
Master of Science	204	11.7%
Master of Education	68	3.9%
Bachelor of Arts	48	2.8%
Bachelor of Science	41	2.4%
Doctor of Medicine	34	2.0%
Other	27	1.6%
Nursing (e.g. RN, RNP, PNP)	12	0.7%
Education Specialist	10	0.6%
Doctor of Education	6	0.3%
Doctor of Osteopathy	4	0.2%
Doctor of Social Work	1	0.1%

Highest Degree-Discipline (descending sort)

	Frequency	Percent
Counseling Psychology	510	29.6%
Clinical Psychology	504	29.2%
Social Work	220	12.8%
Mental Health Counseling/Clinical Mental Health Counseling	170	9.9%
Other	119	6.9%
Counselor Education	91	5.3%
Psychiatry	39	2.3%
Marriage and Family Therapist	32	1.9%
Nursing	17	1.0%
Higher Education	10	0.6%
Educational Psychology	7	0.4%
Community Psychology	5	0.3%
Health Education	1	0.1%

Are you licensed under your current degree?



Position Type (descending sort)

	Frequency	Percent
Professional staff member	1,261	72.4%
Master's level trainee	77	4.4%
Doctoral level trainee (not an intern)	79	4.5%
Pre-doctoral intern	171	9.8%
Post-doctoral level (non-psychiatric)	71	4.1%
Psychiatric resident	3	0.2%
Other (please specify)	79	4.5%

CENTER INFORMATION

The information below describes the 153 colleges and universities that contributed data to the 2019-2020 CCMH data set.

Does your counseling center currently have an APA accredited pre-doctoral training program?

	Frequency	Percent
Yes	58	38.4%
No	93	61.6%

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

	Frequency	Percent
Yes	74	49.3%
No	76	50.7%

Which services are integrated with your counseling center? (check all that apply)

	Frequency	Percent
Career services	8	5.3%
Disability services	6	4.0%
Drug and alcohol	37	24.5%
Employee assistance	2	1.3%
Learning services	5	3.3%
Health services	16	10.6%
Testing services	17	11.3%
Other	17	11.3%

What psychiatric services are provided by your center?

	Frequency	Percent
None	56	37.8%
Part time, in house	51	34.5%
Full time, in house	20	13.5%
Part time, off campus consultant	12	8.1%
Other	9	6.1%

Does your center have an annual individual psychotherapy limit?

	Frequency	Percent
Yes	55	36.4%
No	96	63.6%

If you answered "yes" to session limit, please enter your individual psychotherapy session limit.

	Frequency	Percent
0	1	1.9%
6	1	1.9%
7	1	1.9%
8	3	5.6%
9	1	1.9%
10	9	16.7%
12	25	46.3%
14	1	1.9%
15	4	7.4%
16	3	5.6%
18	1	1.9%
20	3	5.6%
24	1	1.9%

Check each service for which you charge a standard fee. (Don't check services that are initially free–e.g., first 8 sessions.)

	Frequency	Percent
Psychiatric evaluation (initial meeting)	24	15.9%
Psychiatric follow-up (ongoing client)	24	15.9%
Other	18	11.9%
Formal assessment: Psychological	17	11.3%
Formal assessment: Career	12	7.9%
Individual counseling	10	6.6%
Group counseling	8	5.3%
Formal assessment: Disability	8	5.3%
Intake	4	2.6%

INSTITUTIONAL DATA

Data for the 2019-2020 CCMH data set has been contributed by 153 colleges and universities that hold membership with CCMH. Demographics for these institutions are listed below.

	Frequency	Percent
Type of Institution		
Private	51	33.6%
Public	98	64.5%
Combined	3	2.0%
Location of Campus		
Midwest (IA, IL, IN, MI, MN, MT, ND, OH, WI)	36	23.7%
Northeast (CT, DE, MA, MD, ME, NJ, NY, PA, VA, VT)	41	27.0%
South (AL, AR, FL, GA, KY, LA, MO, MS, NC, NV, OK, SC, TN, TX)	59	38.8%
West (CA, CO, ID, OR, UT, WA)	16	10.5%
Enrollment		
Under 1,500	3	2.5%
1,501-2,500	11	9.1%
2,501-5,000	12	9.9%
5,001-7,500	9	7.4%
7,501-10,000	9	7.4%
10,001-15,000	18	14.9%
15,001-20,000	16	13.2%
20,001-25,000	13	10.7%
25,001-30,000	7	5.8%
30,001-35,000	10	8.3%
35,001-40,000	5	4.1%
40,001-50,000	6	5.0%
50,001 and over	2	1.7%

	Frequency	Percent
Athletic Division		
None	9	6.1%
Division I	88	59.5%
Division II	27	18.2%
Division III	24	16.2%
Grade Scale		
0-4	146	96.1%
1-5	2	1.3%
0-100	2	1.3%
Other	2	1.3%

Contact Information

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