CCMH
CENTER FOR COLLEGIATE MENTAL HEALTH

2023 ANNUAL REPORT

bringing science and practice together.

PennState Student Affairs | Center for Collegiate Mental Health

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Acknowledgements

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- Association for University and College Counseling Center Directors (AUCCCD)
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2023 Report Introduction

The 2023 Annual Report summarizes data contributed to CCMH during the 2022-2023 academic year, beginning July 1, 2022 and closing on June 30, 2023. De-identified data were contributed by 195 college and university counseling centers, describing 185,114 unique college students seeking mental health treatment, 4,817 clinicians, and 1,259,380 appointments.

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 800 institutional counseling centers, only a percentage of these institutions participate in client-level data contribution. However, all counseling center members contribute center-level research data.

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 in 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 drop out of 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 supporting the academic success of college students.

2023 HIGHLIGHTS

In this year's Annual Report, CCMH investigated if experiences of 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. In fact, experiences of discrimination demonstrated associations with symptoms equivalent to most clinical variables that have been historically collected by clinicians (i.e., history of suicide attempts, history of counseling). Moreover, counseling centers were shown to effectively treat student 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, students who reported discrimination consistently ended treatment with higher average levels of distress, demonstrating a persistent outcome disparity.

The current 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. College counseling centers can effectively support students with experiences of discrimination; however, addressing the psychological symptoms are only a piece of the solution. DEIB informed support services (e.g., cultural centers, identity-based programs) are vital to buffer the impact of discrimination experiences, provide education/professional development to the campus community, and initiate advocacy to remedy societal sources of discrimination are also critical. It is imperative for institutions to understand the close connection between DEIB and mental health. Institutions and leaders who prioritize and value mental health and wellness must simultaneously support DEIB initiatives in order to close the disparities in mental health symptoms and treatment outcomes among students who face identity-based discrimination.

OTHER 2023 HIGHLIGHTS

- 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 11-year increase: over 61% of students entered services with prior counseling. Notably, history of trauma demonstrated the second largest rise: approximately 47% of students who initiated services endorsed a history of trauma.
- Threat-to-self characteristics slightly increased in 2022-2023 for some variables (histories of non-suicidal self-injury and suicide attempts) but continued to be endorsed at levels lower than the top rates reported before the onset of COVID-19. Threat-to-others symptoms remained unchanged in 2022-2023 from the prior year.
- Social Anxiety continued to display the greatest 13-year change across all CCAPS subscales. Of the areas that notably increased after the onset of COVID-19 (Social Anxiety, Academic Distress, Eating Concerns, and Family Distress), only Academic Distress appears to be receding, with Social Anxiety and Family Distress continuing to increase slightly and Eating Concerns flattening.
- Although it remained unchanged in the past year, Anxiety continues to be the most common presenting concern identified by therapists. Most notably, after steady declines in previous years, Relationship problem (specific) is now showing an upward trend as a top concern, while Trauma as a general and top concern has continued to increase since 2014-2015, which is consistent with student clients' self-report.

Clinical Load Index

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. 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?" This reframe helps centers and institutions better align messaging regarding current service capabilities based on staffing levels with partner and institutional expectations of those services. 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).

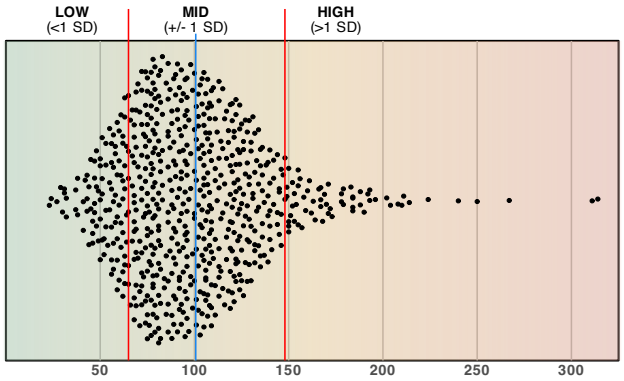
CLI scores can be conceptually thought of as the "average annual caseload" for a "standardized counselor" within a counseling center, or the average number of clients a typical full-time counselor would see in a year at that center. Because of the standardized/annual/aggregate nature of CLI scores, the 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.

2022-2023 CLI DISTRIBUTION

To accompany this Annual Report, CCMH updated the CLI distribution based on new data from 654 CCMH member institutions during the 2022-2023 Academic Year (7/1/2022 to 6/30/2023). Complete details about the 2022-2023 CLI (and an interactive tool to calculate your CLI) can be found on the CLI page of the CCMH website. After data were received from 735 member centers, CCMH staff carefully audited hundreds of centers via phone and email to confirm/adjust data for accuracy. A total of 81 centers were excluded due to missing data, incomplete audits, or unique/temporary staffing situations. The following describes the CLI distribution for 2022-2023:

- N = 654
- Range = 23-314
- Mean = 101
- Median = 96
- Standard Deviation = 38
- Zones:
  - Low: Less than 62
  - Mid: Between 62 and 139
  - High: Greater than 139



Student Experiences of Discrimination and Mental Health

After the murder of George Floyd on May 25, 2020, and the national reckoning that ensued, CCMH immediately began to explore ways students could share recent experiences of discrimination when they seek services at college counseling centers. This initiative was deemed critical by the collective collegiate mental health community given the CCMH measures at the time did not adequately capture experiences of discrimination from the student's perspective, and there was cautious optimism this awareness raising effort would help clinicians more effectively comprehend the contextual environments of students and enhance the support services they provide. Moreover, research emphasizing that discrimination is connected to increased mental health distress, social isolation, and suicidality (Oh et al., 2018; Paradies et al., 2015) further highlighted the need for this endeavor.

After one year of piloting questions to address this goal, CCMH officially implemented the following Yes/No questions as part of the National Standardized Data Set (SDS) – Client Information form on July 1, 2021: "In the past 6 months, have you experienced discrimination or unfair treatment due to any of the following parts of your identity? (Disability, Gender, Nationality/Country of Origin, Race/Ethnicity/Culture, Religion, Sexual Orientation)."

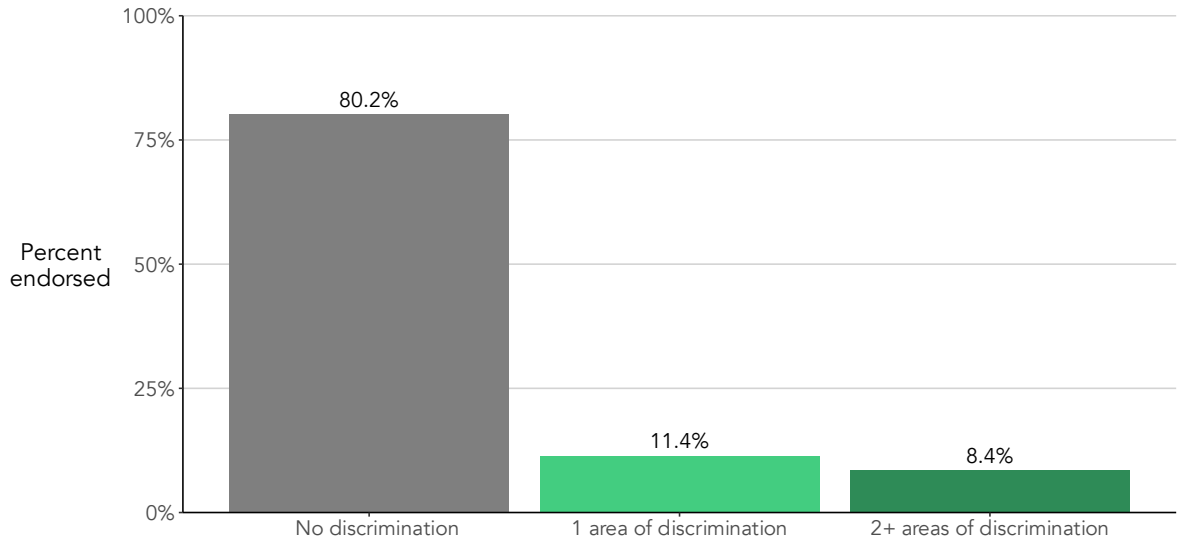
It should be clearly understood at the outset that the experience of discrimination is not a mental health diagnosis. Discrimination is a societal problem that needs to be addressed, and concurrently, it is essential to assess how these experiences are associated with mental health concerns. The 2023 Annual Report specifically investigated if discrimination or unfair treatment based on any of the six identities described above is associated with mental health symptoms and how college counseling centers support students who have experienced discrimination.

The following questions were explored:

1. Are student's experiences of discrimination associated with higher baseline levels of general distress, social isolation, and suicidal ideation?
2. Compared to other clinical variables that are routinely gathered at the beginning of treatment (e.g., history of suicide attempts, prior treatment), what is the strength of the relationship between discrimination and presenting symptoms of general distress, social isolation, and suicidal ideation?
3. Do students with experiences of discrimination demonstrate improvement in general distress, social isolation, and suicidal ideation during college counseling services that is comparable to clients who do not report discrimination?

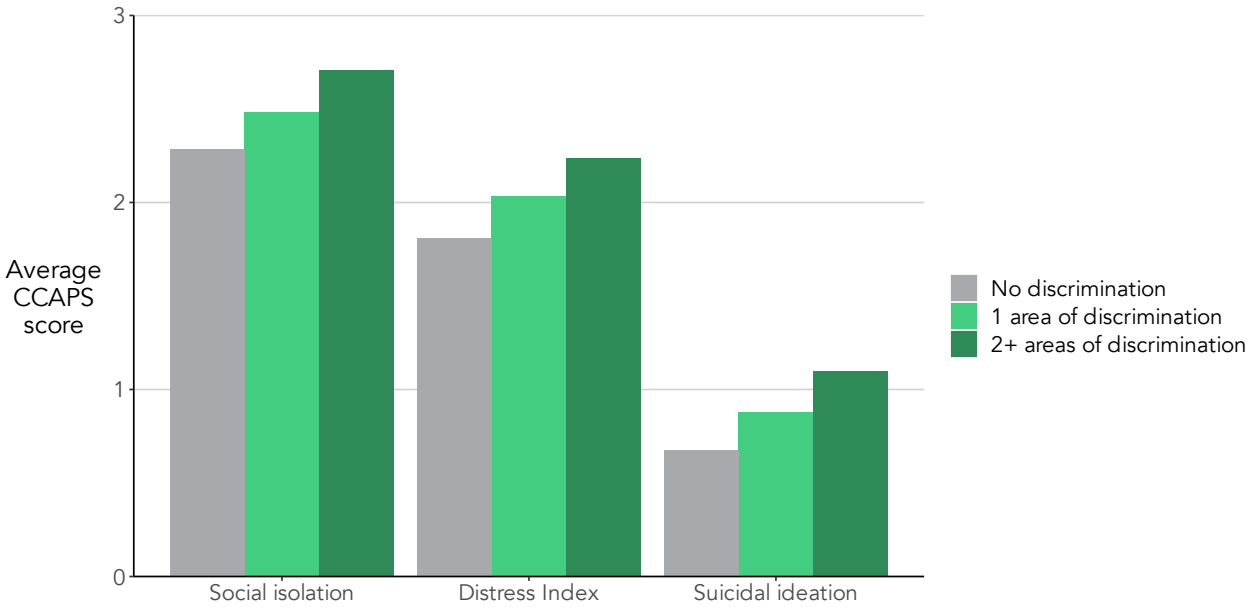
Data related to discrimination were collected from the CCMH Standardized Data Set (SDS) – Client Information form, while general distress, social isolation, and suicidal ideation was assessed using the Counseling Center Assessment of Psychological Symptoms (CCAPS) measure. Both of these self-report tools are typically implemented when students initiate services at college counseling centers nationally. Additionally, the CCAPS is commonly administered throughout treatment to monitor progress.

Data for the current Annual Report include 78,432 students who were treated at 85 different college counseling centers nationally. Overall, 19.8% of all students disclosed experiencing discrimination in the past six months based on 1 or more identities when they entered counseling services, while 8.4% reported discrimination in multiple (2+) identity areas.



DISCRIMINATION AND GENERAL DISTRESS, SOCIAL ISOLATION, AND SUICIDALITY

CCMH explored if students who share experiences of discrimination demonstrate higher levels of general distress, social isolation, and suicidal ideation compared to clients who do not report discrimination. Students who acknowledged discrimination based on 1 or multiple (2+) identities within the past six months reported substantially higher general distress, social isolation, and suicidal thoughts at the outset of counseling services. Furthermore, if students experienced multiple areas of discrimination, they displayed greater levels of distress, isolation, and suicidal ideation than students with either no discrimination or only 1 area.



DISCRIMINATION COMPARED TO TRADITIONAL CLINICAL HISTORY VARIABLES

Clinicians traditionally have been trained to gather specific information regarding a client's clinical history when they enter treatment. Among other things, this typically includes an assessment of prior mental health treatment, risk-related variables (i.e., suicidal behavior), and trauma. Information pertaining to a client's clinical history provides valuable data that typically corresponds with their level of presenting distress and informs the subsequent treatment plan.

In the current Annual Report, CCMH examined how experiences of discrimination compare to these traditional clinical history variables in terms of their association with general distress, social isolation, and suicidal ideation. These comparisons should be interpreted with the understanding that discrimination is not a mental health problem. Rather, they are presented to illustrate how recent discrimination may impact a client's presenting symptoms in comparison to clinical variables that providers have been trained to routinely collect. Specifically, we examined the following clinical history variables:

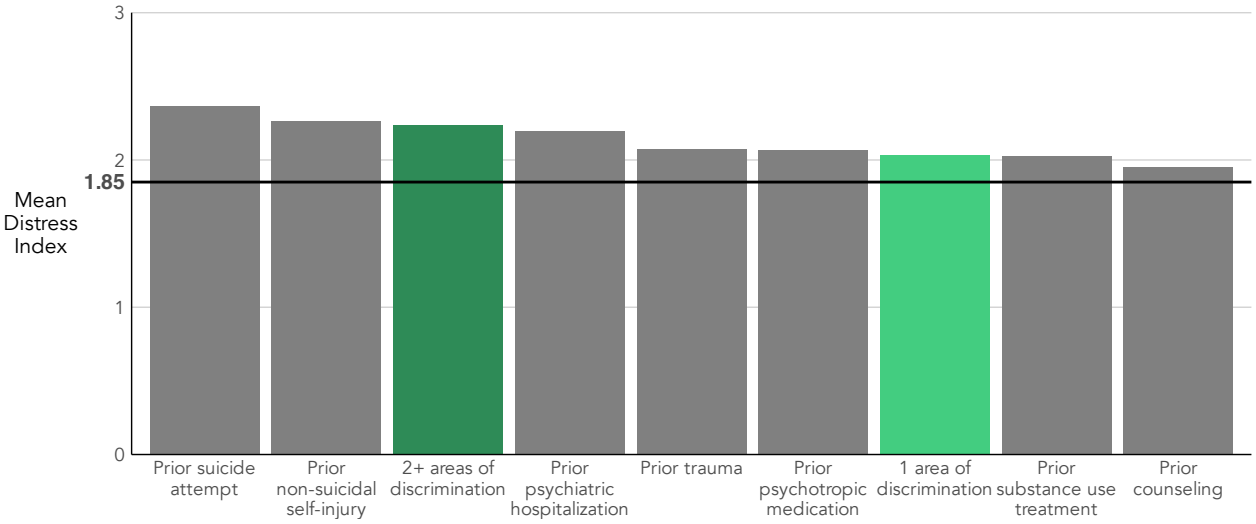
- Prior counseling or therapy
- Prior substance use treatment
- Prior psychotropic medication
- Prior psychiatric hospitalization
- History of trauma
- History of non-suicidal self-injury
- History of suicide attempt(s)

When students complete the SDS Client Information form at the outset of treatment, there are a wide range of responses they can provide, including endorsing any combination of the clinical history variables and types of discrimination. Thus, these items are not mutually exclusive, where a client could endorse both clinical history and discrimination experiences, either of these variables, or none of them.

The symptom levels for students who endorsed any clinical history variables and/or discrimination were compared to the average rate of distress, social isolation, and suicidal ideation reported by clients when they begin college counseling services. This average level is indicated by the bold horizontal line within each figure. As expected, the rates of distress for every traditional clinical history variable were higher than the average, which clearly demonstrates the increased risk for elevated symptoms when students have a history of prior mental health treatment, trauma, and suicidal behavior. In the subsequent sections, levels of general distress, social isolation, and suicidal ideation were compared between clients who disclosed discrimination based on 1 or multiple (2+) identities and those who reported a history of the aforementioned key clinical variables.

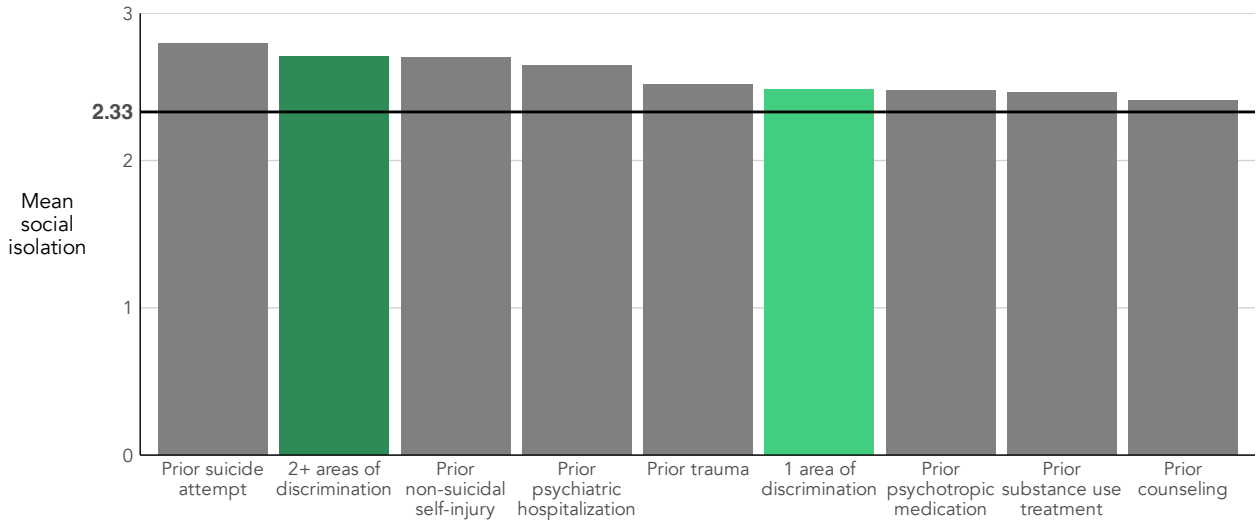
General Distress

Similar to the historical clinical variables, students who experienced discrimination, notated by the green shaded bars, endorsed similar levels of general distress as students who disclosed prior mental health treatment, trauma, or threat-to-self behaviors. In particular, students who reported multiple (2+) areas of discrimination within the past six months displayed nearly the highest association to general distress, comparable to those with a history of a psychiatric hospitalization, non-suicidal self-injury, and a suicide attempt.



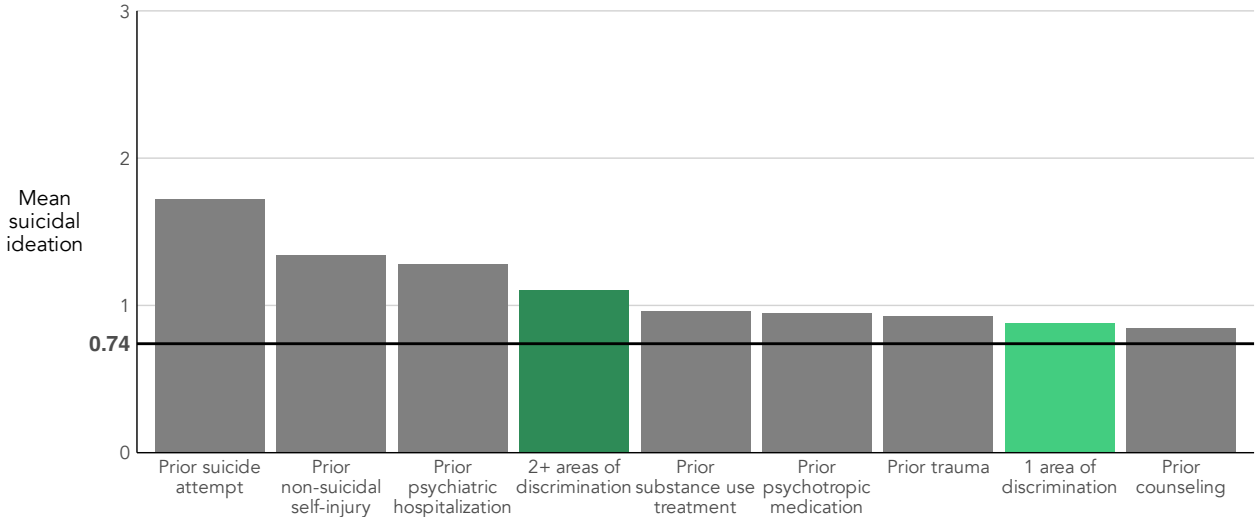
Social Isolation

Having a history of either 1 or multiple (2+) areas of discrimination was associated with elevated levels of social isolation. In fact, students who reported 2 or more areas of discrimination endorsed nearly the same level of social isolation as those who reported a past suicide attempt.



Suicidal Ideation

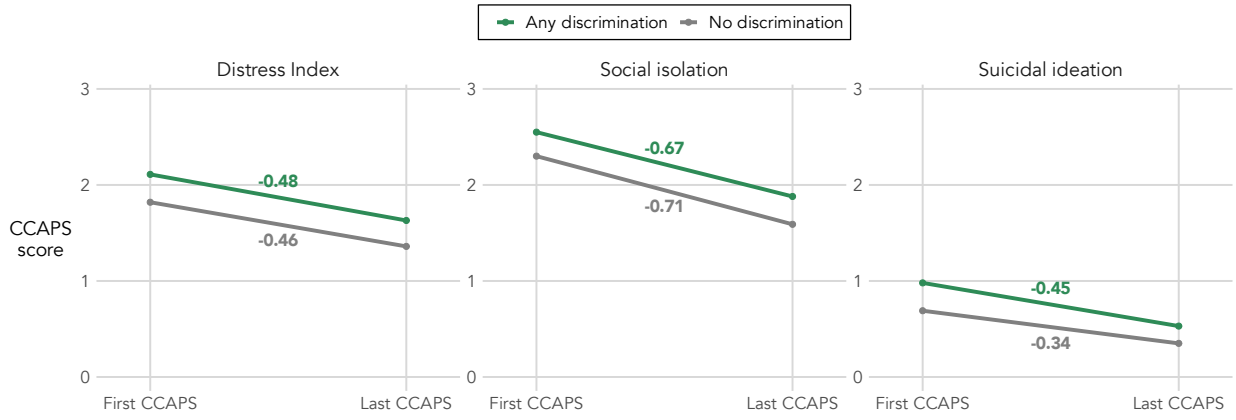
Students who experienced either 1 or multiple (2+) areas of discrimination disclosed suicidal ideation at similar levels to those who endorsed most of the other mental health history items. However, students who reported a prior suicide attempt had the highest rate of suicidal ideation.



COUNSELING CENTERS' ROLE IN SUPPORTING STUDENTS WITH EXPERIENCES OF DISCRIMINATION

Improvement in general distress, social isolation, and suicidal ideation (i.e., change between first and last administrations of the CCAPS) was compared between students who did and did not report discrimination. The changes were examined for all students, regardless of their level of symptoms at the beginning of treatment. The slope of the lines connecting first and last CCAPS administrations represents total improvement on that subscale, where steeper lines indicate more change. The numbers above or below each line indicate the average raw change in symptoms for each area of distress. Clients with experiences of discrimination began treatment (first administration) with higher levels of general distress, social isolation, and suicidal thoughts and showed similar improvement in all of these symptoms during counseling services compared to clients who did not indicate discrimination.

Despite notable improvement on each outcome (general distress, social isolation, and suicidal thoughts), students who disclosed discrimination still ended services (last administration) with considerably higher levels of distress than those who did not report discrimination. This outcome gap highlights the need for institutions to invest in and prioritize additional support services for students with discriminatory experiences.



SUMMARY

In the current 2023 Annual Report, CCMH investigated if experiences of discrimination or unfair treatment based on six identities are associated with mental health concerns and symptom improvement at college counseling centers. While we emphasized that discrimination is not a mental health diagnosis and rather a societal problem, this inquiry was considered critical given the findings could potentially assist clinicians in conceptualizing the environmental contexts that impact their clients and inform the support services delivered at college counseling centers, as well as the broader institutions.

The findings revealed that discrimination was strongly related to increased general distress, social isolation, and suicidal ideation, which was compounded when students disclosed multiple areas of discrimination. In fact, experiences of discrimination demonstrated associations with elevated symptoms equivalent to most historical clinical variables (i.e., history of suicide attempts, history of counseling) that clinicians have been trained to assess for decades. Moreover, counseling centers were shown to effectively treat clients with discrimination, as they, compared to students with no discrimination, demonstrated comparable improvement in symptoms of distress, social isolation, and suicidal ideation during services. While these findings highlight that counseling centers play an essential role in supporting students with recent discrimination, these clients consistently ended treatment with higher levels of distress, highlighting a persistent disparity in distress, social isolation, and suicidal ideation.

The findings underscore the critical function of gathering information pertaining to identity-based discrimination at the beginning of treatment. Although discrimination is not a mental health problem, it provides vital environmental and contextual information that is clearly associated with more severe mental health symptoms. Additionally, awareness and further assessment related to these experiences can potentially help clinicians better understand their clients in context, enhance the culturally affirmative support they provide during counseling services, advocate for their clients, and identify adjunctive services that might help students self-advocate and directly address their experiences of discrimination at the individual and systemic levels.

It is important to note several considerations related to the current findings. The strong association that was discovered between discrimination and mental health symptoms was correlational, and therefore causation between these variables can not be inferred. Additionally, the SDS item that inquires about discrimination neither specifies the source(s) of the discrimination nor the frequency of the experiences. Thus, it is unknown if the discrimination was experienced within the collegiate community or elsewhere, and how often it occurred. Finally, the current report did not specifically explore experiences of discrimination within various diverse demographic groups. In future investigations, it might be helpful to further assess the frequency and sources of discrimination, as well as the potential differential impacts of the various types of discrimination within specific identity groups. Nevertheless, this report provides a broad overview of the negative effects of discrimination, which emphasizes the importance of support services to address these affects at the individual and systemic levels of an institution.

The current 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. Students who have discrimination experiences are substantially more likely to report severe mental health symptoms, and college counseling services help these students feel less distressed, isolated, and suicidal. While counseling centers are effective in supporting DEIB initiatives in this manner, students who have experienced discrimination consistently end services with notably higher levels of distress than students without discrimination, creating an outcome gap or disparity. College counseling centers can effectively support these students; however, addressing the psychological symptoms is only a piece of the solution. Adjunctive DEIB informed support services (e.g., cultural centers, identity-based programs) are also essential to buffer the impact of discrimination, provide education/professional development to the campus community, and initiate advocacy to remedy campus and broader societal sources of discrimination. It is imperative for institutions to understand the close connection between DEIB and mental health. Institutions and leaders who prioritize and value mental health and wellness must concurrently support DEIB initiatives in order to reduce the disparities in mental health symptoms and treatment outcomes among students who face identity-based discrimination.

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- Pottschmidt, N.R., Janis, R. A., Scofield, B. E., Cummins, A. L., Carney, D. M., Davis, K. A., Kilcullen, J. R., Tan, H. M., Castonguay, L. G., & Locke, B. D. (2023) **Impacts of the COVID-19 pandemic on treatment-seeking college students.** *Cogent Mental Health,* 2(1), doi.org/10.1080/28324765.2023.2211633
- Pérez-Rojas, A. E., Bartholomew, T.T., Lockard, A.J., & Kocon, J. A. (2023). **Psychotherapy outcomes with Latinx clients attending Hispanic-serving institutions and predominantly White institutions.** *Journal of Counseling Psychology, 70*(4), 341–351. doi.org/10.1037/cou0000669
- Davis, K. A., Zhao F., Janis, R. A., Castonguay, L. G., Hayes, J. A., Scofield, B. E. (2023). **Therapeutic alliance and clinical outcomes in teletherapy and in-person psychotherapy: A noninferiority study during the COVID-19 pandemic.** *Psychotherapy Research, 1*(12). doi.org/10.1080/10503307.2023.2229505
- Rallis, B.A., Petrovich, J., Scofield, B.E., Kim, S., & Locke, B.D. (2022). **A comparison of treatment response between college students with and without suicide risk at university counseling centers.** *Cogent Mental Health, 1*(1), doi.org/10.1080/28324765.2023.2169583
- Xiao, H., Castonguay, L.G., Hayes, J.A., Janis, R.A., Locke, B.D. (2022). **Reconstructing dropout: Building from multiple definitions, therapist effects, and center effects.** *Psychotherapy Research, 33*(2), 146-157. doi.org/10.1080/10503307.2022.2082897

Annual Trends

MENTAL HEALTH TRENDS

As of this report, CCMH has generated 13 annual data sets (2010-2011 through 2022-2023), making it possible to examine numerous years 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 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

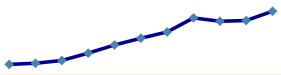
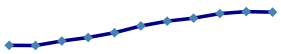
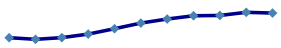
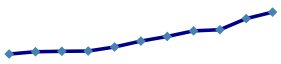
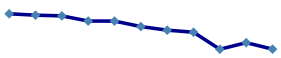
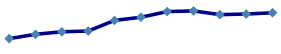
The table below summarizes the amount of data contributed to CCMH over the past 13 academic years. It is important to note the annual changes in number of clients merely reflect an increase in data that has been contributed by counseling centers and not an increase in utilization of counseling center 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

Mental Health Trends (2012 to 2023)

Several mental health history trends continued to shift in 2022-2023. 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 collected in 2012. History of counseling continued to be the mental health history item with the largest 11-year increase: over 61% of students entered services with prior counseling. Notably, history of trauma demonstrated the second largest rise: approximately 47% of students who initiated services endorsed a history of trauma. A closer examination of the specific traumatic events reported by students revealed that childhood emotional abuse and sexual violence primarily accounted for the 11-year increase. The rates of students with histories of threat-to-self characteristics slightly increased in 2022-2023 for some variables (histories of non-suicidal self-injury and suicide attempts) but continued to be endorsed at levels below the highest rates reported before the onset of COVID-19. Threat-to-others characteristics remained unchanged in 2022-2023 from the prior year.

Mental Health Trends (2012–2023)

Item	11-Year Change	2012-2023	Lowest	Highest	2022–2023
Prior Treatment					
Counseling	+13.3%		47.8%	61.1%	61.1%
Medication	+5.1%		32.4%	37.5%	37.5%
Hospitalization	-0.9%		8.0%	10.3%	9.2%
Threat-to-Self					
Non-Suicidal Self-Injury	+5.4%		23.0%	29.1%	28.4%
Serious Suicidal Ideation	+4.4%		30.1%	36.9%	34.4%
Serious Suicidal Ideation (last month)	-0.6%		6.1%	8.2%	6.3%
Suicide Attempt(s)	+2.0%		8.7%	10.9%	10.6%
Some Suicidal Ideation (past 2 weeks)	+1.9%		33.9%	39.6%	35.9%
Threat-to-Others					
Considered causing serious physical injury to another person	-5.2%		5.2%	11.2%	6.0%
Intentionally caused serious injury to another person	-2.0%		1.2%	3.4%	1.4%
Traumatic Experiences					
Had unwanted sexual contact(s) or experience(s)	+8.3%		18.9%	27.4%	27.3%
Experienced harassing, controlling, and/or abusive behavior	+6.2%		32.8%	39.6%	39.4%
Experienced traumatic event	+9.3%		37.5%	46.8%	46.8%
Drug and Alcohol					
Felt the need to reduce alcohol/drug use	-0.9%		25.6%	27.5%	26.2%
Others concerned about alcohol/drug use	-4.0%		13.0%	17.6%	13.5%
Treatment for alcohol/drug use	-2.6%		1.7%	4.4%	1.8%
Binge drinking	-8.9%		32.6%	41.5%	32.6%
Marijuana use	+4.8%		19.1%	26.0%	25.5%

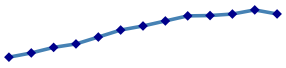
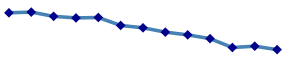
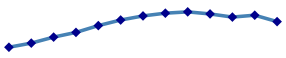
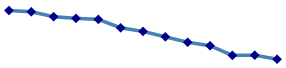
CCAPS TRENDS

The Counseling Center Assessment of Psychological Symptoms (CCAPS) is a multidimensional assessment and routine outcome monitoring instrument used by counseling centers who are members of CCMH. 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 upon entry to counseling services as indicated by the CCAPS subscales.

CCAPS Trends: Average Subscale Scores (2010 to 2023)

Generalized Anxiety marginally increased in 2022-2023, while Depression slightly decreased. Of the areas that notably increased after the onset of COVID-19 (Social Anxiety, Academic Distress, Eating Concerns, and Family Distress), only Academic Distress appears to be receding, with Social Anxiety and Family Distress continuing to increase slightly and Eating Concerns flattening. Social Anxiety continued to display the greatest 13-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." It is possible that the long-term increase in Social Anxiety is related to increasing levels of isolation, social comparison commonly experienced on social media, or more recently the transition back to more traditional in-person academic experiences after the widespread year of remote instruction in 2020-2021, which led to students abruptly encountering more stress inducing social situations.

CCAPS Trends (2010–2023)

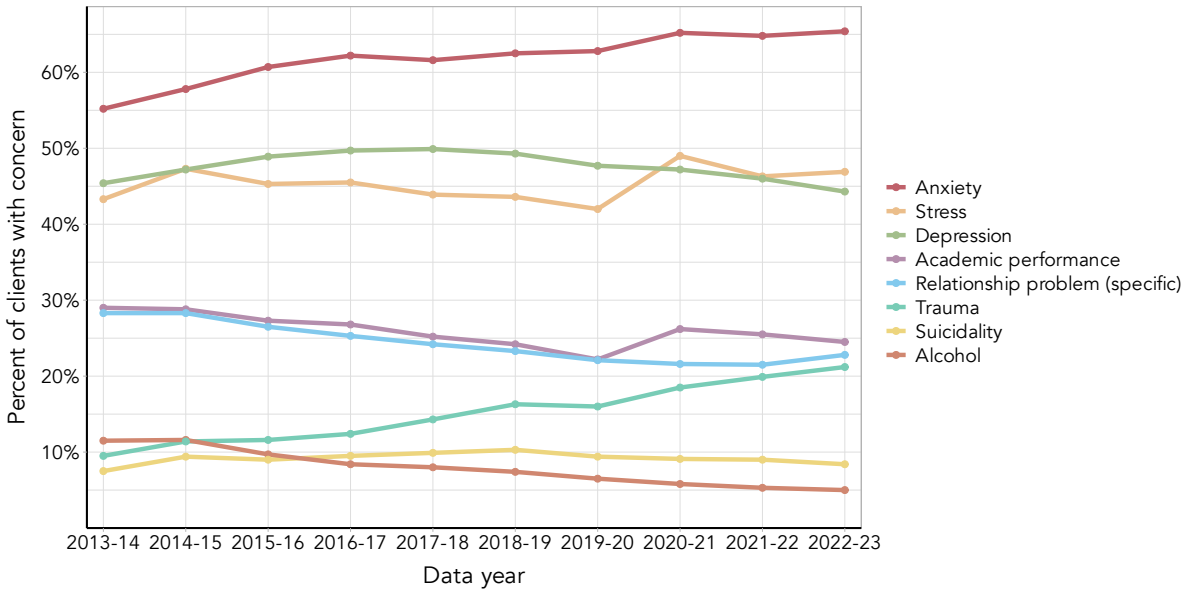
Item	13-Year Change	2010-2023	Lowest	Highest	2022–2023
CCAPS-62					
Depression	+0.23		1.59	1.84	1.82
Generalized Anxiety	+0.29		1.61	1.91	1.91
Social Anxiety	+0.32		1.82	2.14	2.14
Academic Distress	+0.08		1.85	2.05	1.93
Eating Concerns	+0.11		1.00	1.12	1.11
Frustration/Anger	-0.06		0.96	1.04	0.99
Substance Use	-0.20		0.57	0.77	0.57
Family Distress	+0.16		1.29	1.45	1.45
CCAPS-34					
Depression	+0.14		1.55	1.74	1.69
Generalized Anxiety	+0.27		1.77	2.05	2.03
Social Anxiety	+0.33		1.77	2.10	2.10
Academic Distress	+0.05		1.92	2.10	1.98
Eating Concerns	+0.11		0.94	1.07	1.06
Frustration/Anger	-0.11		0.80	0.93	0.82
Alcohol Use	-0.26		0.47	0.73	0.47
Distress Index	+0.15		1.65	1.83	1.80

CLICC TRENDS

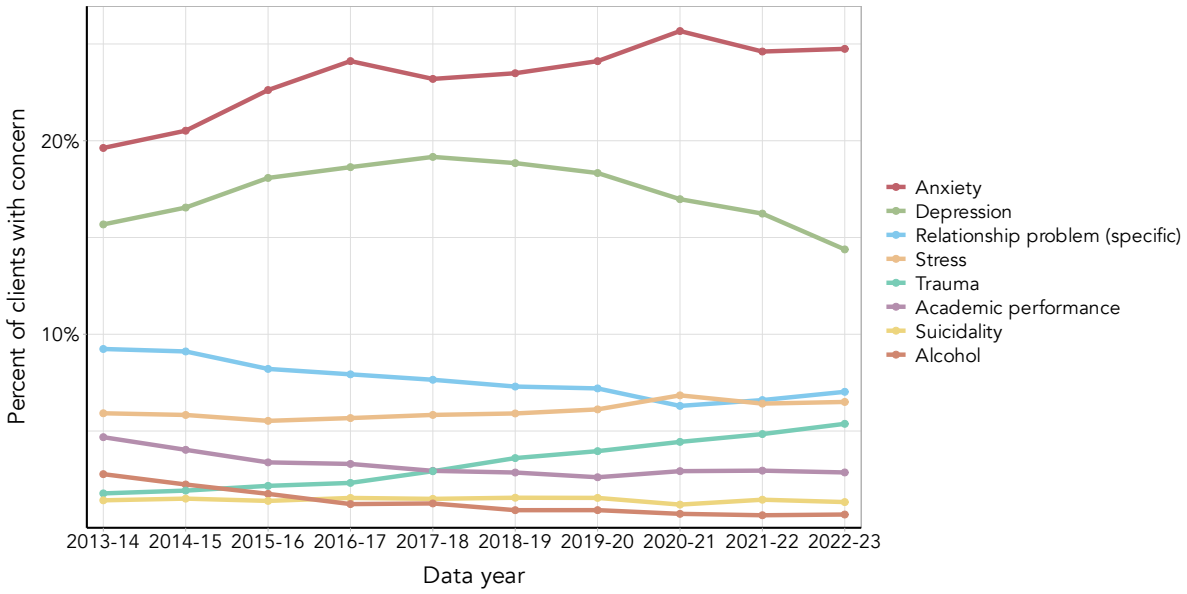
The Clinician Index of Client Concerns (CLICC) captures the presenting concerns of counseling center clients, as assessed by the clinician during an initial appointment. The CLICC includes 54 concerns and asks the clinician (a) to check all that apply and (b) to identify the "top concern" of those selected.

The graphs below display notable trends in the most frequently assessed CLICC items by clinicians. While Anxiety was relatively flat, Depression continued to decrease slightly both as a general (check all that apply) and top concern. After steady declines in previous years, Relationship problem (specific) is now showing an upward trend as a top concern. Most notably, Trauma as a general and top concern has continued to increase since 2014-2015, which is consistent with student clients' self-report on the SDS.

CLICC Trends (Check All That Apply): Percentage of Clients with Each Concern from 2013–2023



CLICC Trends (Top Concern): Percentage of Clients with Each Concern from 2013–2023



Appointment Statistics

UTILIZATION

Data from 2022-2023 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 175,624 students across participating CCMH centers:

- The most common number of appointments per client per year is one.
- Clients averaged 5.7 total attended appointments of any kind, with a median of 4 appointments, and a range of 1-135 appointments.
- Clients averaged 4.89 attended *Individual Treatment* (initial clinical evaluations and individual counseling) appointments, with a median of 3 attended appointments, and a range of 1-94 attended appointments.
- 20% of clients accounted for 56% of all appointments, averaging 15 appointments.
- 10% of clients accounted for 37% of all appointments, averaging 19 appointments.
- 5% of clients accounted for 24% of all appointments, averaging 24 appointments.
- 1% of clients accounted for 7% of all appointments, averaging 36 appointments.

ATTENDANCE

Out of 1,259,380 appointments, 76% were marked as attended.

Client Attendance	Frequency	Percent
Attended	952,543	75.8%
Center Closed	6,819	0.5%
Client Cancelled	59,024	4.7%
Client Cancelled Late	24,715	2.0%
Client No Show	95,291	7.6%
Client Rescheduled	63,905	5.1%
Counselor Cancelled	30,536	2.4%
Counselor Rescheduled	23,678	1.9%

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

Appointment Category	Total Sessions	Percent Attended
Individual psychotherapy/counseling	700,759	73.7%
Initial clinical evaluation	119,552	80.3%
Brief Screening or Walk-in	102,965	87.3%
Group – psychotherapy	101,293	64.0%
Psychiatric follow-up	48,113	74.4%
Case management	46,985	82.1%
Group – workshop	12,518	50.8%
Specialized individual treatment	10,549	76.9%
Couple's therapy	8,489	73.8%
Psychiatric evaluation	8,386	80.0%
Group – clinic	4,710	59.4%
Psychological Testing or Assessment	3,839	81.6%

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. Approximately two-thirds of appointments were 60 minutes. Only 8.4% of appointments were over 60 minutes in length.

Appointment Length (Minutes)	Frequency	Percent
15	56,881	6.0%
30	143,740	15.1%
45	39,750	4.2%
60	631,753	66.3%
90	68,467	7.2%
120	11,953	1.3%

APPOINTMENT MODE

Appointment mode information (In person, Video, Audio, or Text) was provided for 554,263 attended appointments in 2022-2023. The frequency of in person appointments increased from 2% in 2020-2021 to 60% in 2022-2023, while video appointments declined from 83% in 2020-2021 to 29% in 2022-2023.

Mode	Frequency	Percent
In person	334,338	60.3%
Audio	31,669	5.7%
Video	162,146	29.3%
Text	26,110	4.7%

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 126,388 students who sought care in 2022-2023.

	Business Days	Calendar Days
Brief Screening/Walk-In	1.54	2.12
Initial Clinical Evaluation	4.35	6.04

Approximately 35% of students were seen for their first appointment of the year on the same day it was scheduled, while 81% 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)

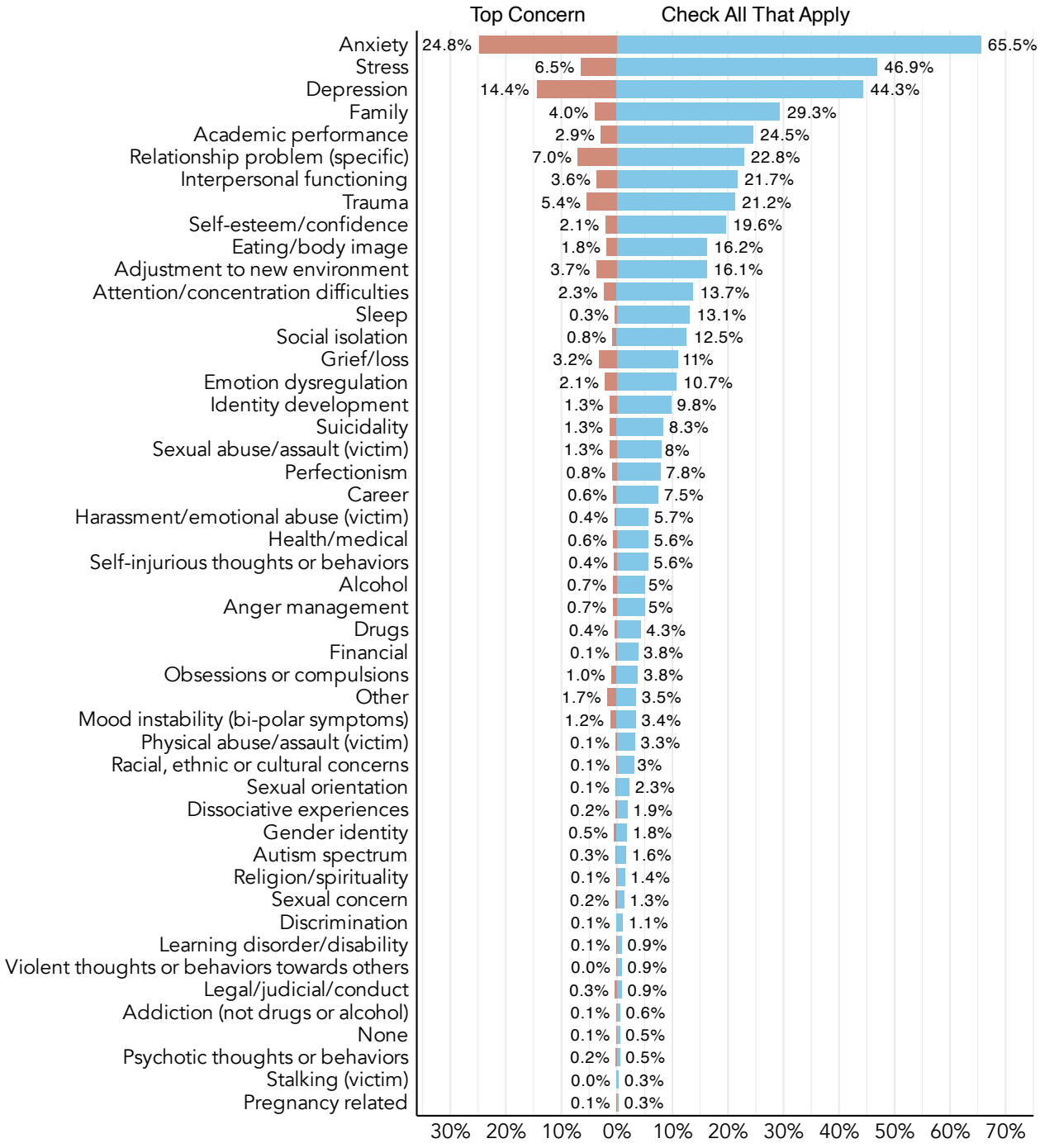
The CLICC was designed by CCMH to capture and facilitate reporting on the most common presenting concerns of counseling center clients, as assessed by the clinician during an initial appointment The resulting data allows CCMH and individual centers to quickly and easily report on the most common client 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.

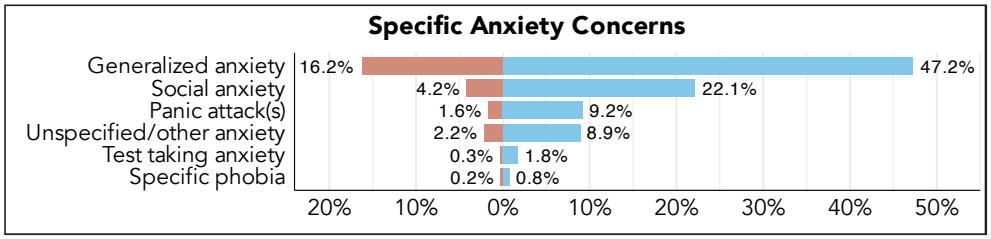
The graph on the next page illustrates the presenting concerns of 64,945 clients during the 2022-2023 academic year. For each client, clinicians are asked to "check all that apply" from the list of CLICC concerns (as one client can have many concurrent concerns). The blue bars on the right portion of 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 (13.1%), it was the top concern for far fewer clients (0.3%). On the other hand, 22.8% of clients had Relationship problem (specific) endorsed as a concern, but a higher percent (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



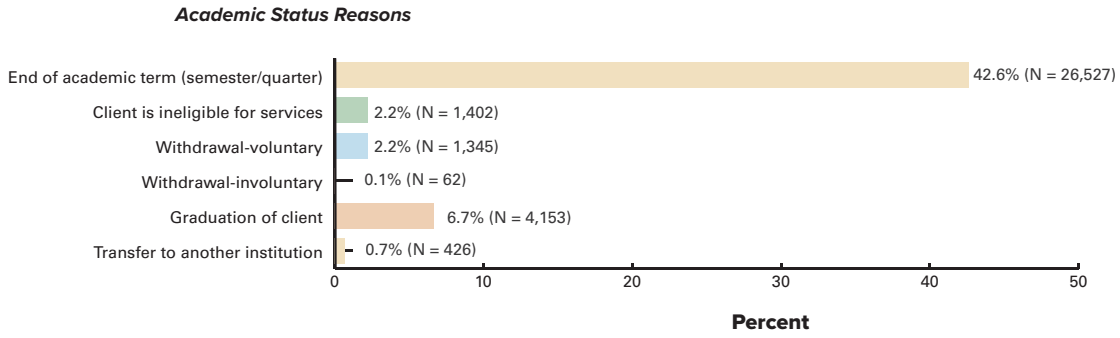


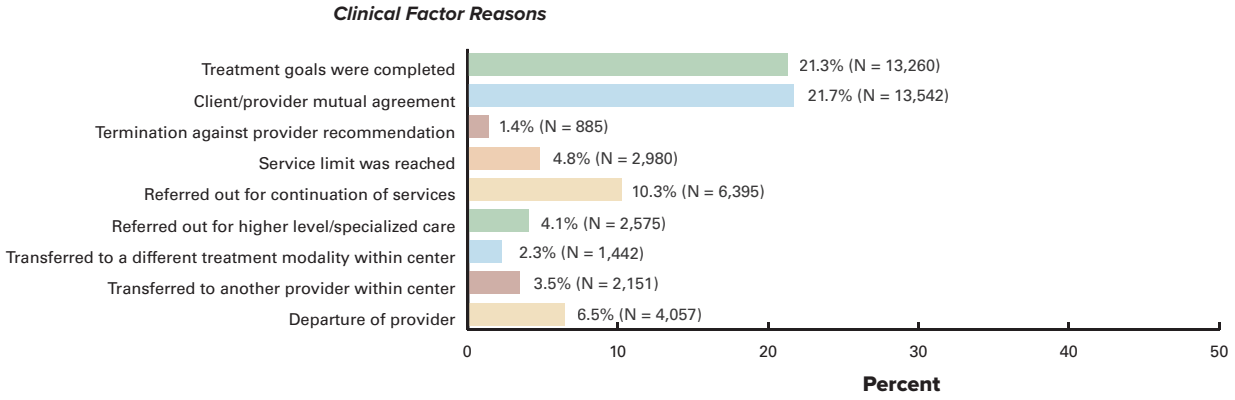
CASE CLOSURE FORM

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.

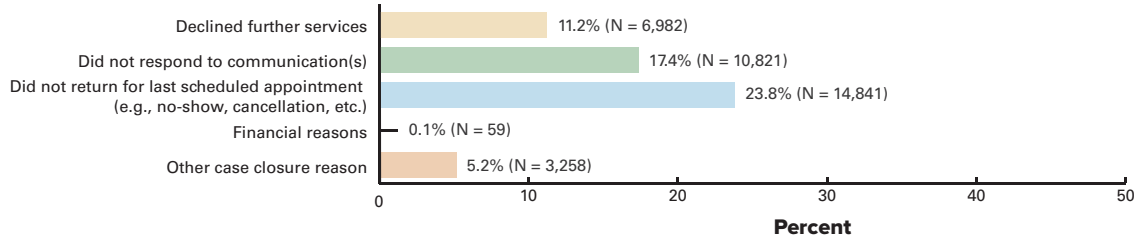
Reasons for Closure of Case

This graph describes the frequency of various reasons why services ended for students who received treatment during the 2022-2023 academic year (N = 62,328). Of note, the top most endorsed reasons were the ending of the academic term (42.6%), followed by the client not returning for their last appointment (23.8%), client/provider mutual agreement (21.7%), and treatment goals being completed (21.3%).

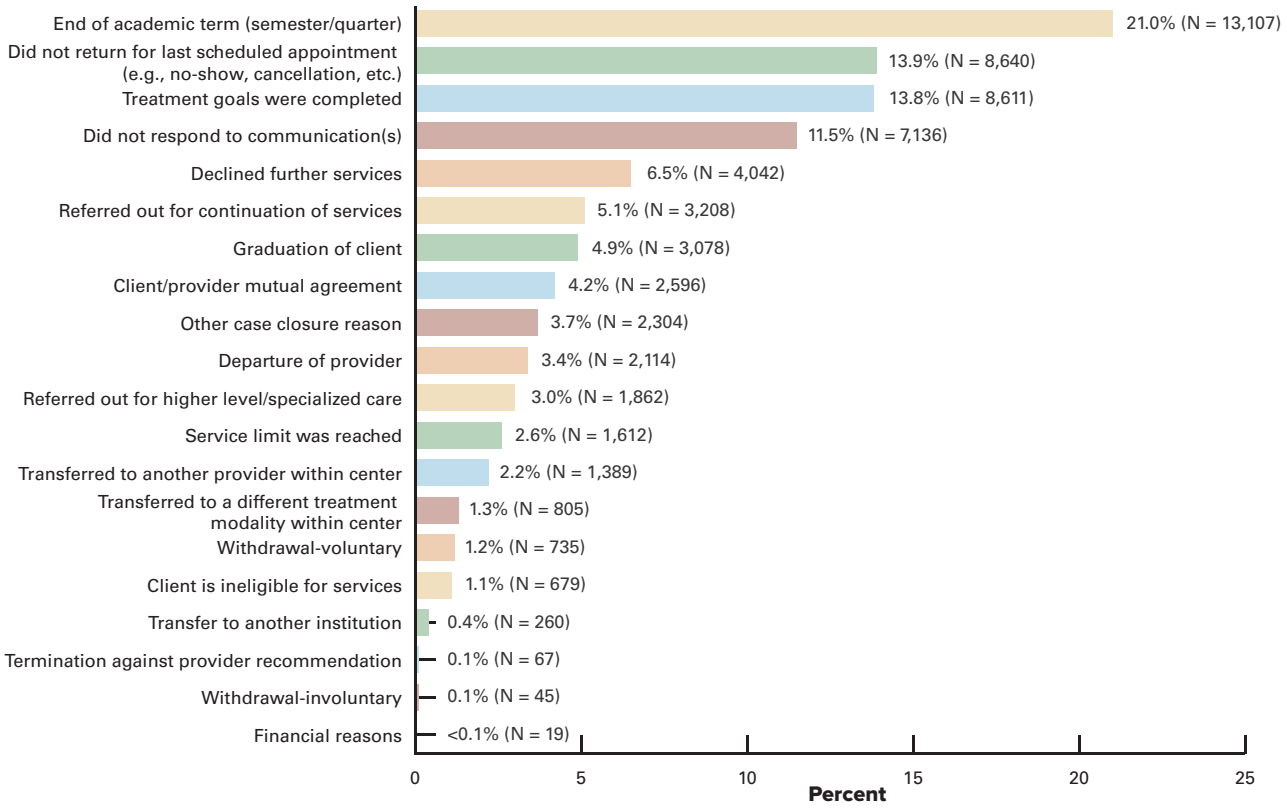




Client Factor Reasons

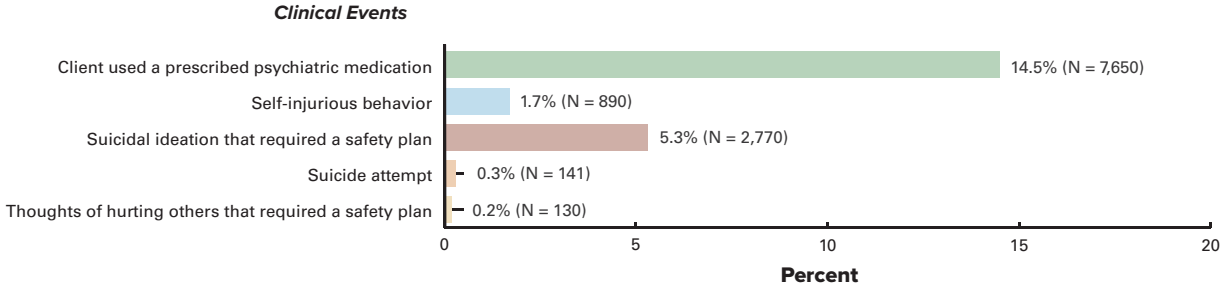


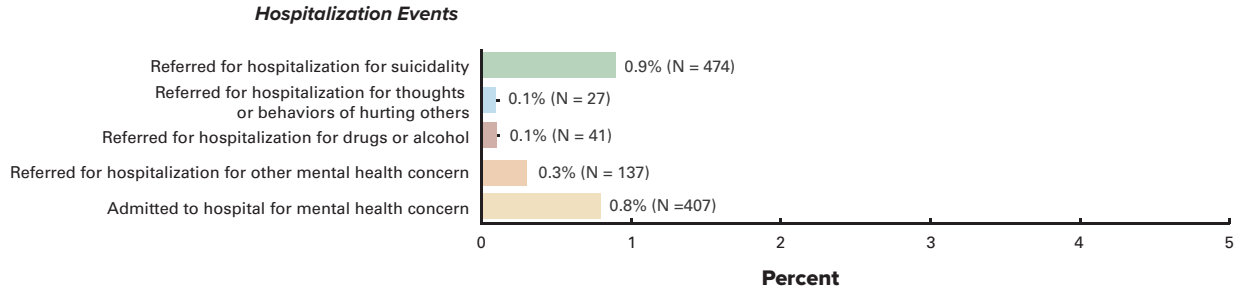
Top Case Closure Reason

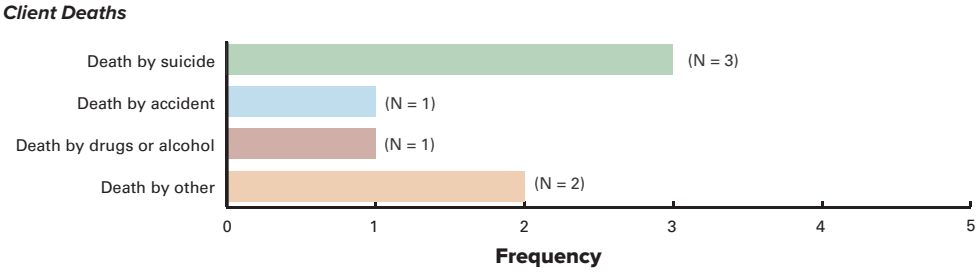


Case Events

This graph describes the frequency of significant events occurring during a course of services for students during the 2022-2023 academic year (N = 52,711).







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
22.07	4.13	18-60

What is your gender identity?

SDS 88 (N = 114,543)	Frequency	Percent
Woman	70,772	61.8%
Transgender woman	591	0.5%
Man	37,198	32.5%
Transgender man	754	0.7%
Non-binary	4,042	3.5%
Self-identify	1,186	1.0%

What was your sex at birth?

SDS 90 (N = 26,516)	Frequency	Percent
Female	17,478	65.9%
Male	9,035	34.1%
Intersex	3	<0.1%

Do you consider yourself to be:

SDS 91 (N = 107,156)	Frequency	Percent
Asexual	2,845	2.7%
Bisexual	15,349	14.3%
Gay	2,893	2.7%
Heterosexual/Straight	71,505	66.7%
Lesbian	2,558	2.4%
Pansexual	3,375	3.1%
Queer	3,615	3.4%
Questioning	3,793	3.5%
Self-identify	1,223	1.1%

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

SDS 93 (N = 12,103)	Frequency	Percent
Only with men	4,985	41.2%
Mostly with men	1,345	11.1%
About the same number of men and women	414	3.4%
Mostly with women	413	3.4%
Only with women	2,972	24.6%
I have not had sexual experiences	1,974	16.3%

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

SDS 94 (N = 17,173)	Frequency	Percent
Only attracted to women	4,493	26.2%
Mostly attracted to women	1,364	7.9%
Equally attracted to women and men	1,868	10.9%
Mostly attracted to men	2,411	14.0%
Only attracted to men	6,125	35.7%
Not sure	600	3.5%
I do not experience sexual attraction	312	1.8%

What is your race/ethnicity?

SDS 95 (N = 115,175)	Frequency	Percent
African American/Black	11,426	9.9%
American Indian or Alaskan Native	635	0.6%
Asian American/Asian	13,852	12.0%
Hispanic/Latino/a	13,164	11.4%
Native Hawaiian or Pacific Islander	243	0.2%
Multi-racial	5,855	5.1%
White	68,144	59.2%
Self-identify	1,856	1.6%

What is your country of origin?

Country	Frequency
United States	95,810
India	3,116
China	2,524
Mexico	764
Korea, Republic of	581
Nigeria	427
Iran, Islamic Republic of	415
Canada	410
Bangladesh	400
Colombia	356
Puerto Rico	346
Philippines	341
Brazil	328

Country	Frequency
Vietnam	319
Pakistan	304
Venezuela	290
United Kingdom	279
Taiwan	250
Russian Federation	241
Peru	198
Germany	168
Egypt	167
Nepal	164
Jamaica	157
Dominican Republic	155
Japan	151

Country	Frequency
Ghana	147
Haiti	143
Saudi Arabia	142
United States Minor Outlying Islands	142
Turkey	135
Cuba	132
Guatemala	132
Ecuador	126
Spain	121
Afghanistan	117
Italy	115
Ukraine	110

Countries with less than 110 (0.1%) individuals:

Aland Islands; Albania; Algeria; American Samoa; Angola; Anguilla; Antarctica; Antigua and Barbuda; Argentina; Armenia; Aruba; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Barbados; Belarus; Belgium; Belize; Benin; Bermuda; Bhutan; Bolivia; Bosnia and Herzegovina; Botswana; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Cape Verde; Cayman Islands; Central African Republic; Chad; Chile; Congo; Congo, The Democratic Republic of the; Costa Rica; Cote D'ivoire; Croatia; Cyprus; Czech Republic; Denmark; Djibouti; Dominica; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; French Guiana; French Polynesia; Gabon; Gambia; Georgia; Gibraltar; Greece; Greenland; Grenada; Guadeloupe; Guam; Guinea; Guyana; Honduras; 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; Lesotho; Liberia; Libyan Arab Jamahiriya; Lithuania; Luxembourg; Macedonia, The Former Yugoslav Republic of; Madagascar; Malawi; Malaysia; Maldives; Mali; Marshall Islands; Martinique; Mauritania; Mauritius; Mayotte; Micronesia, Federated States of; Moldova, Republic of; Mongolia; Montenegro; Montserrat; Morocco; Mozambique; Myanmar; Namibia; Nauru; 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; Saint Vincent and the Grenadines; Samoa; Senegal; Serbia; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Somalia; South Africa; Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Tanzania, United Republic of; Thailand; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkmenistan; Turks and Caicos Islands; Uganda; United Arab Emirates; Uruguay; Uzbekistan; Virgin Islands, British; Virgin Islands, U.S.; Yemen; Zambia; Zimbabwe

Are you an international student?

SDS 32 (N = 118,980)	Frequency	Percent
No	108,323	91.0%
Yes	10,657	9.0%

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

SDS 56 (N = 114,530)	Frequency	Percent
No	86,989	76.0%
Yes	27,541	24.0%

Current academic status:

SDS 1037 (N = 78,295)	Frequency	Percent
1st year undergraduate	18,745	23.9%
2nd year undergraduate	15,177	19.4%
3rd year undergraduate	15,100	19.3%
4th year undergraduate	11,330	14.5%
5th year or more undergraduate	3,143	4.0%
Graduate student	12,825	16.4%
Professional degree student	1,262	1.6%
Non-student	86	0.1%
High-school student taking college classes	10	<0.1%
Non-degree student	158	0.2%
Faculty or staff	64	0.1%
Other (please specify)	395	0.5%

Graduate or professional degree program:

SDS 39 (N = 36,828)	Frequency	Percent
Post-Baccalaureate	2,915	7.9%
Masters	6,048	16.4%
Doctoral degree	3,934	10.7%
Law	930	2.5%
Medical	1,038	2.8%
Pharmacy	280	0.8%
Dental	159	0.4%
Veterinary Medicine	435	1.2%
Not applicable	18,902	51.3%
Other (please specify)	2,187	5.9%

What year are you in your graduate/professional program?

SDS 41 (N = 21,425)	Frequency	Percent
1	8,188	38.2%
2	5,428	25.3%
3	3,411	15.9%
4	3,193	14.9%
5+	1,205	5.6%

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

SDS 46 (N = 110,132)	Frequency	Percent
No	90,360	82.0%
Yes	19,772	18.0%

What kind of housing do you currently have?

SDS 42 (N = 85,993)	Frequency	Percent
On-campus residence hall/apartment	33,333	38.8%
On/off campus fraternity/sorority house	1,337	1.6%
On/off campus co-operative house	803	0.9%
Off-campus apartment/house	49,599	57.7%
Other (please specify)	921	1.1%

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

SDS 44 (N = 101,770)	Frequency	Percent
Alone	14,214	14.0%
Spouse, partner, or significant other	9,918	9.7%
Roommates	67,598	66.4%
Children	1,935	1.9%
Parent(s) or guardian(s)	11,242	11.0%
Family (other)	5,581	5.5%
Other	1,271	1.2%

Relationship status:

SDS 33 (N = 112,713)	Frequency	Percent
Single	68,548	60.8%
Serious dating or committed relationships	38,542	34.2%
Civil union, domestic partnership, or equivalent	494	0.4%
Married	4,298	3.8%
Divorced	357	0.3%
Separated	428	0.4%
Widowed	46	<0.1%

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

SDS 48 (N = 58,614)	Frequency	Percent
None	20,536	35.0%
Occasional participation	13,208	22.5%
One regularly attended activity	9,708	16.6%
Two regularly attended activities	7,630	13.0%
Three or more regularly attended activities	7,532	12.9%

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

SDS 1151 (N = 84,104)	Frequency	Percent
No	77,767	92.5%
Yes	6,337	7.5%

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

SDS 1152 (N = 84,454)	Frequency	Percent
No	71,427	84.6%
Yes	13,027	15.4%

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

SDS 1153 (N = 83,696)	Frequency	Percent
No	80,420	96.1%
Yes	3,276	3.9%

Are you a member of a social fraternity or sorority?

SDS 117 (N = 30,025)	Frequency	Percent
No	26,336	87.7%
Yes	3,689	12.3%

Religious or Spiritual Preference:

SDS 97 (N = 102,663)	Frequency	Percent
Agnostic	17,455	17.0%
Atheist	10,623	10.3%
Buddhist	856	0.8%
Catholic	12,931	12.6%
Christian	28,990	28.2%
Hindu	2,329	2.3%
Jewish	2,005	2.0%
Muslim	2,297	2.2%
No preference	21,503	20.9%
Self-identify	3,674	3.6%

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

SDS 36 (N = 80,989)	Frequency	Percent
Very important	11,584	14.3%
Important	15,835	19.6%
Neutral	27,755	34.3%
Unimportant	13,670	16.9%
Very unimportant	12,145	15.0%

How would you describe your financial situation right now?

SDS 57 (N = 97,800)	Frequency	Percent
Always stressful	11,969	12.2%
Often stressful	19,752	20.2%
Sometimes stressful	34,950	35.7%
Rarely stressful	22,500	23.0%
Never stressful	8,629	8.8%

How would you describe your financial situation while growing up?

SDS 58 (N = 69,576)	Frequency	Percent
Always stressful	7,638	11.0%
Often stressful	11,055	15.9%
Sometimes stressful	17,012	24.5%
Rarely stressful	19,505	28.0%
Never stressful	14,366	20.6%

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

SDS 1055 (N = 85,859)	Frequency	Percent
0	35,113	40.9%
1-5	5,440	6.3%
6-10	9,790	11.4%
11-15	8,974	10.5%
16-20	11,797	13.7%
21-25	5,340	6.2%
26-30	3,191	3.7%
31-35	1,621	1.9%
36-40	2,305	2.7%
40+	2,288	2.7%

Are you a member of ROTC?

SDS 51 (N = 67,143)	Frequency	Percent
No	66,533	99.1%
Yes	610	0.9%

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

SDS 98 (N = 115,212)	Frequency	Percent
No	113,694	98.7%
Yes	1,518	1.3%

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

SDS 53 (N = 1,229)	Frequency	Percent
No	788	64.1%
Yes	441	35.9%

MENTAL HEALTH HISTORY ITEMS

Attended counseling for mental health concerns:

SDS 01 (N = 112,646)	Frequency	Percent
Never	43,763	38.9%
Prior to college	26,764	23.8%
After starting college	22,667	20.1%
Both	19,452	17.3%

Taken a prescribed medication for mental health concerns:

SDS 02 (N = 112,455)	Frequency	Percent
Never	70,287	62.5%
Prior to college	10,342	9.2%
After starting college	15,953	14.2%
Both	15,873	14.1%

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 (N = 117,955)	Frequency	Percent
Never	107,121	90.8%
1 time	7,314	6.2%
2-3 times	2,693	2.3%
4-5 times	438	0.4%
More than 5 times	389	0.3%

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

SDS 65 (N = 10,401)	Frequency	Percent
Within the last 2 weeks	729	7.0%
Within the last month	374	3.6%
Within the last year	1,986	19.1%
Within the last 1-5 years	4,692	45.1%
More than 5 years ago	2,620	25.2%

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

SDS 72 (N = 115,761)	Frequency	Percent
Never	82,875	71.6%
1 time	6,179	5.3%
2-3 times	9,171	7.9%
4-5 times	3,372	2.9%
More than 5 times	14,164	12.2%

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

SDS 73 (N = 31,820)	Frequency	Percent
Within the last 2 weeks	3,454	10.9%
Within the last month	2,650	8.3%
Within the last year	7,084	22.3%
Within the last 1-5 years	11,429	35.9%
More than 5 years ago	7,203	22.6%

Seriously considered attempting suicide (how many times):

SDS 74 (N = 113,355)	Frequency	Percent
Never	74,345	65.6%
1 time	13,596	12.0%
2-3 times	14,457	12.8%
4-5 times	2,851	2.5%
More than 5 times	8,106	7.2%

Seriously considered attempting suicide (the last time):

SDS 75 (N = 37,500)	Frequency	Percent
Never	2	<0.1%
Within the last 2 weeks	4,029	10.7%
Within the last month	3,162	8.4%
Within the last year	7,940	21.2%
Within the last 1-5 years	15,535	41.4%
More than 5 years ago	6,832	18.2%

Made a suicide attempt (how many times):

SDS 76 (N = 113,636)	Frequency	Percent
Never	101,543	89.4%
1 time	7,572	6.7%
2-3 times	3,536	3.1%
4-5 times	486	0.4%
More than 5 times	499	0.4%

Made a suicide attempt (the last time):

SDS 77 (N = 11,801)	Frequency	Percent
Within the last 2 weeks	376	3.2%
Within the last month	264	2.2%
Within the last year	1,504	12.7%
Within the last 1-5 years	5,570	47.2%
More than 5 years ago	4,087	34.6%

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

SDS 78 (N = 112,991)	Frequency	Percent
Never	106,227	94.0%
1 time	2,309	2.0%
2-3 times	2,492	2.2%
4-5 times	428	0.4%
More than 5 times	1,535	1.4%

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

SDS 79 (N = 6,409)	Frequency	Percent
Never	3	<0.1%
Within the last 2 weeks	762	11.9%
Within the last month	650	10.1%
Within the last year	1,583	24.7%
Within the last 1-5 years	2,250	35.1%
More than 5 years ago	1,161	18.1%

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

SDS 80 (N = 112,281)	Frequency	Percent
Never	110,692	98.6%
1 time	789	0.7%
2-3 times	527	0.5%
4-5 times	87	0.1%
More than 5 times	186	0.2%

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

SDS 81 (N = 1,523)	Frequency	Percent
Within the last 2 weeks	63	4.1%
Within the last month	63	4.1%
Within the last year	214	14.1%
Within the last 1-5 years	517	33.9%
More than 5 years ago	666	43.7%

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 = 112,082)	Frequency	Percent
Never	81,513	72.7%
1 time	14,926	13.3%
2-3 times	10,205	9.1%
4-5 times	1,671	1.5%
More than 5 times	3,767	3.4%

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 = 29,379)	Frequency	Percent
Never	2	<0.1%
Within the last 2 weeks	688	2.3%
Within the last month	806	2.7%
Within the last year	5,614	19.1%
Within the last 1-5 years	13,473	45.9%
More than 5 years ago	8,796	29.9%

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

SDS 84 (N = 113,715)	Frequency	Percent
Never	68,902	60.6%
1 time	7,921	7.0%
2-3 times	9,997	8.8%
4-5 times	2,833	2.5%
More than 5 times	24,062	21.2%

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

SDS 85 (N = 42,314)	Frequency	Percent
Never	1	<0.1%
Within the last 2 weeks	3,403	8.0%
Within the last month	3,195	7.6%
Within the last year	9,457	22.3%
Within the last 1-5 years	17,401	41.1%
More than 5 years ago	8,857	20.9%

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

SDS 86 (N = 109,824)	Frequency	Percent
Never	58,476	53.2%
1 time	17,936	16.3%
2-3 times	18,212	16.6%
4-5 times	3,706	3.4%
More than 5 times	11,494	10.5%

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

SDS 87 (N = 48,450)	Frequency	Percent
Within the last 2 weeks	3,774	7.8%
Within the last month	3,034	6.3%
Within the last year	10,577	21.8%
Within the last 1-5 years	19,612	40.5%
More than 5 years ago	11,453	23.6%

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

SDS 99 (N = 39,553)	Frequency	Percent
Childhood physical abuse	7,849	19.8%
Childhood sexual abuse	5,889	14.9%
Childhood emotional abuse	21,350	54.0%
Physical attack (e.g., mugged, beaten up, shot, stabbed, threatened with a weapon)	4,093	10.3%
Sexual violence (rape or attempted rape, sexually assaulted, stalked, abused by intimate partner, etc.)	14,013	35.4%
Military combat or war zone experience	260	0.7%
Kidnapped or taken hostage	386	1.0%
Serious accident, fire, or explosion (e.g., an industrial, farm, car, plane, or boating accident)	3,845	9.7%
Terrorist attack	220	0.6%
Near drowning	3,167	8.0%
Diagnosed with life threatening illness	1,305	3.3%
Natural disaster (e.g., flood, quake, hurricane, etc.)	1,867	4.7%
Imprisonment or torture	258	0.7%
Animal attack	1,213	3.1%
Other (please specify)	10,348	26.2%

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

SDS 66 (N = 106,448)	Frequency	Percent
Never	78,605	73.8%
1 time	9,240	8.7%
2-3 times	10,744	10.1%
4-5 times	1,968	1.8%
More than 5 times	5,891	5.5%

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

SDS 67 (N = 27,031)	Frequency	Percent
Never	1	<0.1%
Within the last 2 weeks	7,714	28.5%
Within the last month	5,267	19.5%
Within the last year	8,473	31.3%
Within the last 1-5 years	4,818	17.8%
More than 5 years ago	758	2.8%

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

SDS 68 (N = 106,385)	Frequency	Percent
Never	92,024	86.5%
1 time	5,797	5.4%
2-3 times	5,282	5.0%
4-5 times	992	0.9%
More than 5 times	2,290	2.2%

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

SDS 69 (N = 13,887)	Frequency	Percent
Never	2	<0.1%
Within the last 2 weeks	2,652	19.1%
Within the last month	2,271	16.4%
Within the last year	4,995	36.0%
Within the last 1-5 years	3,304	23.8%
More than 5 years ago	663	4.8%

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

SDS 70 (N = 111,093)	Frequency	Percent
Never	109,122	98.2%
1 time	1,441	1.3%
2-3 times	334	0.3%
4-5 times	61	0.1%
More than 5 times	135	0.1%

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

SDS 71 (N = 1,880)	Frequency	Percent
Within the last 2 weeks	182	9.7%
Within the last month	98	5.2%
Within the last year	461	24.5%
Within the last 1-5 years	765	40.7%
More than 5 years ago	374	19.9%

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 = 86,533)	Frequency	Percent
None	58,293	67.4%
Once	13,201	15.3%
Twice	8,140	9.4%
3 to 5 times	5,550	6.4%
6 to 9 times	951	1.1%
10 or more times	398	0.5%

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

SDS 1096 (N = 97,277)	Frequency	Percent
None	72,445	74.5%
Once	5,516	5.7%
Twice	4,304	4.4%
3 to 5 times	5,812	6.0%
6 to 9 times	3,005	3.1%
10 or more times	6,195	6.4%

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

SDS 22 (N = 82,146)	Frequency	Percent
Strongly disagree	9,504	11.6%
Somewhat disagree	13,904	16.9%
Neutral	14,141	17.2%
Somewhat agree	26,148	31.8%
Strongly agree	18,449	22.5%

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 = 82,504)	Frequency	Percent
Strongly disagree	5,127	6.2%
Somewhat disagree	9,929	12.0%
Neutral	15,896	19.3%
Somewhat agree	32,500	39.4%
Strongly agree	19,052	23.1%

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

SDS 60 (N = 111,913)	Frequency	Percent
No	98,819	88.3%
Yes	13,094	11.7%

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 = 12,853)	Frequency	Percent
Difficulty hearing	408	3.2%
Difficulty seeing	317	2.5%
Difficulty speaking or language impairment	139	1.1%
Mobility limitation/orthopedic impairment	470	3.7%
Traumatic brain injury	299	2.3%
Specific learning disabilities	1,674	13.0%
ADD or ADHD	6,395	49.8%
Autism spectrum disorder	1,077	8.4%
Cognitive difficulties or intellectual disability	519	4.0%
Health impairment/condition, including chronic conditions	1,551	12.1%
Psychological or psychiatric condition	3,869	30.1%
Other	1,861	14.5%

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 = 50,561)	Frequency	Percent
Disability	1,380	2.8%
Gender	5,166	10.3%
Nationality/County of Origin	1,872	3.7%
Race/Ethnicity/Culture	4,613	9.2%
Religion	1,351	2.7%
Sexual Orientation	3,026	6.0%

COVID IMPACT ITEMS

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

SDS 102 (N = 106,917)	Frequency	Percent
No	93,555	91.8%
Yes	8,338	8.2%

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, 85% of students endorsed at least one impacted area impacted by COVID-19, and 77% endorsed multiple areas being affected.

SDS 100 (N = 106,917)	Frequency	Percent
Mental health	64,125	60.0%
Academics	58,219	54.5%
Loneliness or isolation	56,365	52.7%
Motivation or focus	53,806	50.3%
Missed experiences or opportunities	52,040	48.7%
Relationships (Significant other, friends, family)	31,341	29.3%
Financial	27,127	25.4%
Career/Employment	25,046	23.4%
Health concerns (self)	20,843	19.5%
Health concerns (others)	19,927	18.6%
Grief/loss of someone	14,438	13.5%
Food or housing insecurity	7,310	6.8%
Discrimination/Harassment	2,974	2.8%
Other (please specify)	1,068	1.0%

How many times have you had COVID-19?

SDS 103 (N = 21,708)	Frequency	Percent
1 time	9,789	45.1%
2-3 times	4,194	19.3%
4-5 times	155	0.7%
More than 5 times	21	0.1%
I don't think I've had COVID-19	7,549	34.8%

PROVIDER DATA

The Standardized Data Set includes some basic demographic information about providers (clinicians) at participating counseling centers. The 2022-2023 data set represents 1,997 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	1,420	71.4%
Transgender woman	6	0.3%
Man	495	24.9%
Transgender man	9	0.5%
Non-binary	42	2.1%
Prefer not to answer	16	0.8%

Age

N	Mean	Mode
1,804	39.1	32

Race/Ethnicity

	Frequency	Percent
African-American/Black	251	12.7%
American Indian or Alaskan Native	11	0.6%
Asian American/Asian	159	8.0%
White	1,281	64.7%
Hispanic/Latino/a	138	7.0%
Native Hawaiian or Pacific Islander	6	0.3%
Multi-racial	91	4.6%
Prefer not to answer	17	0.9%
Other	27	1.4%

Highest Degree (descending sort)

	Frequency	Percent
Doctor of Philosophy	457	23.1%
Master of Arts	340	17.2%
Master of Social Work	306	15.4%
Master of Science	301	15.2%
Doctor of Psychology	243	12.3%
Master of Education	90	4.5%
Bachelor of Science	65	3.3%
Doctor of Medicine	44	2.2%
Bachelor of Arts	42	2.1%
Other	32	1.6%
Doctor of Osteopathy	17	0.9%
Education Specialist	16	0.8%
Nursing (e.g. RN, RNP, PNP)	15	0.8%
Doctor of Education	11	0.6%
Doctor of Social Work	3	0.2%

Highest Degree-Discipline (descending sort)

	Frequency	Percent
Clinical Psychology	526	26.7%
Counseling Psychology	447	22.7%
Social Work	320	16.2%
Mental Health Counseling/Clinical Mental Health Counseling	294	14.9%
Other	131	6.6%
Counselor Education	98	5.0%
Psychiatry	56	2.8%
Marriage and Family Therapist	51	2.6%
Nursing	21	1.1%
Higher Education	13	0.7%
Educational Psychology	10	0.5%
Health Education	2	0.1%
Community Psychology	1	0.1%

Are you licensed under your current degree?

	Frequency	Percent
Yes	1,442	73.2%
No	529	26.8%

Position Type (descending sort)

	Frequency	Percent
Professional staff member	1,434	72.1%
Master's level trainee	125	6.3%
Doctoral level trainee (not an intern)	72	3.6%
Pre-doctoral intern	187	9.4%
Post-doctoral level (non-psychiatric)	71	3.6%
Psychiatric resident	19	1.0%
Other (please specify)	81	4.1%

CENTER DATA

The information below describes the 735 colleges and universities that renewed membership or became CCMH members for the 2022-2023 academic year.

Utilization: The total number of students with at least 1 attended appointment between July 1st and June 30th. The average utilization is 895.

	Frequency	Percent
under 151	56	8.6%
151-200	39	6.0%
201-300	71	10.9%
301-350	36	5.5%
351-400	29	4.4%
401-500	73	11.2%
501-600	52	8.0%
601-700	29	4.4%
701-850	53	8.1%
851-1000	30	4.6%
1001-1200	35	5.4%
1201-1500	39	6.0%
1501-2000	45	6.9%
2001-3000	37	5.7%
3001+	30	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 11.0%.

	Frequency	Percent
less than 5%	106	16.2%
5-7%	127	19.4%
7-10	137	20.9%
10-12%	75	11.5%
12-15%	71	10.9%
15-20%	51	7.8%
20-30%	71	10.9%
more than 30%	16	2.4%

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 199.

	Frequency	Percent
48 or less (0-2 Standardized Counselors)	44	6.7%
49-72 (2-3 Standardized Counselors)	85	13.0%
73-96 (3-4 Standardized Counselors)	74	11.3%
97-120 (4-5 Standardized Counselors)	69	10.6%
121-144 (5-6 Standardized Counselors)	56	8.6%
145-168 (6-7 Standardized Counselors)	60	9.2%
169-192 (7-8 Standardized Counselors)	34	5.2%
193-240 (7-9 Standardized Counselors)	62	9.5%
241-312 (9-13 Standardized Counselors)	53	8.1%
313-432 (13-18 Standardized Counselors)	54	8.3%
over 433 (18+ Standardized Counselors)	63	9.6%

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

	Frequency	Percent
No	578	78.6%
Yes	157	21.4%

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

	Frequency	Percent
No	565	76.9%
Yes	170	23.1%

Is the director of your center a member of AUCCCD?

	Frequency	Percent
No	137	18.6%
Yes	598	81.4%

THIRD-PARTY CONTRACTED VENDORS

Does your center have a contract with a third-party vendor for individual counseling (i.e., Mantra, TimelyMD, UWill, Talkspace)?

	Frequency	Percent
No	493	67.1%
Yes	242	32.9%

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

	Frequency	Percent
No	580	78.9%
Yes	155	21.1%

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

	Frequency	Percent
No	729	99.2%
Yes	6	0.8%

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

	Frequency	Percent
No	624	84.9%
Yes	111	15.1%

Does your center have a contract with a third-party vendor for wellness (i.e., WellTrack Boost, TAO, Calm, HeadSpace)?

	Frequency	Percent
No	511	69.5%
Yes	224	30.5%

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

	Frequency	Percent
No	705	95.9%
Yes	30	4.1%

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

	Frequency	Percent
No	337	45.9%
Yes	398	54.1%

Does your center have a contract with a third-party vendor for referral services (i.e., ThrivingCampus, Shrink Space, WellTrack Connect)?

	Frequency	Percent
No	569	77.4%
Yes	166	22.6%

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

	Frequency	Percent
No	631	85.9%
Yes	104	14.1%

CLINICAL CHARACTERISTICS

Does your center have session limits for individual counseling?

	Frequency	Percent
No	461	62.7%
Yes	274	37.3%

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

	Frequency	Percent
No	532	72.4%
Yes	203	27.6%

We have regular extended hours (open until at least 7-8pm on some weekdays and/or weekend hours).

	Frequency	Percent
False	608	82.7%
True	127	17.3%

Routine individual counseling appointments usually occur weekly.

	Frequency	Percent
False	347	47.2%
True	388	52.8%

We retain the most severe and chronic cases and do not routinely refer them to external services.

	Frequency	Percent
False	532	72.4%
True	203	27.6%

We retain almost all students who seek services and do not routinely refer them to external services.

	Frequency	Percent
False	298	40.5%
True	437	59.5%

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

	Frequency	Percent
False	535	72.8%
True	200	27.2%

We have some form of "counselor on duty" during business hours.

	Frequency	Percent
False	121	16.5%
True	613	83.5%

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

	Frequency	Percent
False	388	52.9%
True	346	47.1%

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

	Frequency	Percent
False	577	78.5%
True	158	21.5%

Staff are expected to have a specified number of attended appointment hours per week (i.e., not just scheduled appointments).

	Frequency	Percent
False	613	83.4%
True	122	16.6%

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

	Frequency	Percent
False	448	61.0%
True	287	39.0%

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

	Frequency	Percent
False	263	35.8%
True	472	64.2%

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	422	57.4%
True	313	42.6%

INSTITUTIONAL DATA

Institutional Enrollment: The total number of students enrolled at the institution who are eligible for services. The average enrollment is 11,719.

	Frequency	Percent
under 1,501	78	11.9%
1,501-2,500	82	12.5%
2,501-5,000	116	17.7%
5,001-7,500	68	10.4%
7,501-10,000	63	9.6%
10,001-15,000	72	11.0%
15,001-20,000	53	8.1%
20,001-25,000	37	5.7%
25,001-30,000	21	3.2%
30,001-35,000	18	2.8%
35,001-45,000	25	3.8%
45,001+	21	3.2%

Public or Private

	Frequency	Percent
Combined	3	0.4%
Private	303	41.2%
Public	429	58.4%

Type of institution (Check all)

	Frequency	Percent
4-year College/University	661	90%
Religious-Affiliated School	47	6%
2-year College/University	42	6%
Health Professional School	37	5%
Community College	34	5%
STEM Institution	34	5%
Other	20	3%
Creative Focus	13	2%
Historically Black College/ University (HBCU)	6	1%
Tribal	1	0%

Location of Campus

	Frequency	Percent
Canada	11	1.5%
International	14	1.9%
Midwest (IA, IL, IN, MI, MN, MT, ND, NE, OH, SD, WI)	158	21.5%
Northeast (CT, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VA, VT, WV)	249	33.9%
South (AL, AR, FL, GA, KS, KY, LA, MO, MS, NC, NM, NV, OK, SC, TN, TX)	187	25.5%
West (AK, AZ, CA, CO, HI, ID, OR, UT, WA, WY)	115	15.7%

Athletic Division

	Frequency	Percent
Division I	262	35.6%
Division II	116	15.8%
Division III	206	28.0%
None	151	20.5%

Contact Information

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