CCMH
CENTER FOR COLLEGIATE MENTAL HEALTH

2022

ANNUAL REPORT

bringing science and practice together.

PennState Student Affairs | Center for Collegiate Mental Health

Table of Contents

Acknowledgements 2
Business Team at Penn State University 2
Advisory Board (2021–2022 and 2022–2023) 3
Recommended Citation 3
Contact Information 3
2022 Report Introduction 4
- Reminders from Prior Reports 4
- 2022 Highlights 5
- Other 2022 Highlights 5

Clinical Load Index 6
- Background of the CLI 6
- 2021-2022 CLI Distribution 6
- Changes in the CLI Distribution from 2018-2019 to 2021-2022 7

Risks and Protective Factors for Withdrawal from School During Counseling Services 7
- Pre-treatment Client Factors Associated with Withdrawal During Treatment 8
  - Demographic factors 8
  - Chronic factors 9
  - Acute factors 9
  - Therapist assessed factors 10
  - Situational factors 10
  - Overall Examination of Pre-Treatment Client Factors Associated with Withdrawal from School 10
- Student Experiences in Counseling that Change the Risk of Withdrawal During Treatment 11
  - Treatment utilization 11
  - Symptom change 12
- Overall Analyses of Protective Factors that Reduce the Risk of Withdrawal from School 13
- Summary 13

Annual Trends 14
- Mental Health Trends 14
- CCAPS Trends 16
- CLICC Trends 18

Appointment Statistics 19
- Utilization 19
- Attendance 19
- Appointment Length 19
- Appointment Mode 20
- Wait Time for First Appointment 20

Standardized Data Set (SDS) 20
- Clinician Index of Client Concerns (CLICC) 20
- Case Closure Form 22
  - Reasons for Closure of Case 22
  - Case Events 24
- Discrimination Items 25
- Client Demographic Information 26
- Mental Health History Items 30
- COVID Impact Items 33
- Provider Data 34
- Center Data 35
- Institutional Data 37

Acknowledgements

The 2022 Annual Report was made possible by:

- Collaborative efforts of approximately 750 university and college counseling centers
- Association for University and College Counseling Center Directors (AUCCCD)
- Titanium Software, Inc.
- Penn State University Student Affairs
- Penn State University Counseling and Psychological Services

Business Team at Penn State University

CCMH STAFF:

EXECUTIVE DIRECTOR:
Brett E. Scofield, Ph.D.—Associate Director, Counseling and Psychological Services

ASSOCIATE DIRECTOR OF DATA SCIENCE:
Rebecca Janis, Ph.D.

PROJECT MANAGER:
Alaina Cummins, M.Ed.

DATA ANALYST:
Tyler White, M.A.

ADMINISTRATIVE ASSISTANT:
Jodi Williams

COUNSELING AND PSYCHOLOGICAL SERVICES:
Research Advisor
Henry Xiao, Ph.D.—Operations Coordinator, Staff Psychologist

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY, COUNSELING, AND SPECIAL EDUCATION:
Professors of Counselor Education
Jeffrey A. Hayes, Ph.D.
Kathleen Bieschke, Ph.D.

Doctoral Students in Counselor Education
Fanghui Zhao, M.A.

DEPARTMENT OF PSYCHOLOGY:
Professor of Clinical Psychology
Louis G. Castonguay, Ph.D.

Doctoral Students in Clinical Psychology
Ryan Kilcullen, M.S.
Katherine Davis, M.S.
Natalie Pottschmidt, M.S.
Hongjun Tan, M.S.

Advisory Board (2021–2022 and 2022–2023)

Bethany Rallis, Ph.D.—Research Coordinator, Cook Counseling Center, Virginia Tech

Mike Pietrus, Psy.D.—Director, Counseling Services, School of the Art Institute of Chicago

Ralph Piper, Ph.D.—Consultant, Counseling Center, Morgan State University

Rebbecca Estrada Lockwood, Ph.D.—Assistant Director of Clinical Services, Counseling and Psychological Services, University of Central Florida

Kimberly Gorman, Ph.D. (AUCCCD Liaison)—Director, Counseling and Psychological Services, Western Carolina University

BOARD MEMBERS BEGINNING MAY 2022:

David Erekson, Ph.D.—Associate Clinical Professor, Assistant Director of Research & Technology, Counseling and Psychological Services, Brigham Young University, Provo

Dan Elreda, Ph.D.—Assistant Director for Training, Student Health and Wellness, University of Virginia

Lisa Youngling Howard, M.D.—Director of Psychiatry, Associate Director, Counseling Services, Smith College

Justin Gibson, Ph.D.—Clinical Director, Student Health and Counseling Services, University of California, San Francisco

Christopher Leonard, Psy.D.—Director, Counseling Services, Wichita State University

Recommended Citation

Center for Collegiate Mental Health. (2023, January). *2022 Annual Report* (Publication No. STA 23-168)

*This version of the CCMH 2022 Annual Report was updated on 2/19/2024 to correct the 2012-2022 traumatic event mental health trend. The lowest value was previously reported as 31.0%, and the previous 10-year change was reported as +14.4%. This correction changed traumatic events from having the largest 10-year increase for the mental health history items to the third largest.

Contact Information

Center for Collegiate Mental Health
Penn State University
501 Student Health Center
University Park, PA 16802

Phone: 814-865-1419
Email: ccmh@psu.edu
Web: ccmh.psu.edu

2022 Report Introduction

The 2022 Annual Report summarizes data contributed to CCMH during the 2021-2022 academic year, beginning July 1, 2021 and closing on June 30, 2022. De-identified data were contributed by 180 college and university counseling centers, describing 190,907 unique college students seeking mental health treatment, 4,688 clinicians, and 1,287,775 appointments.

The following are critical to understand when reading this report:

1. **This report describes college students receiving services at counseling centers, 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 college 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 750 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 HIGHLIGHTS

In the current 2022 Annual Report, 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. This investigation was critical given the concerning national rates of "drop out" among college students.

CCMH examined if any information routinely collected when students enter counseling services was associated with leaving school during services. While several variables increased the risk, students who identified as freshman/first-year status with current elevated levels of academic distress and a history of a psychiatric hospitalization were 48% more likely to withdraw from school during treatment.

Additionally, several protective factors were discovered that reduce the risk of withdrawal from school, including improvement in Depression, Generalized/Social Anxiety, and overall distress symptoms during services. Most notably, when Academic Distress significantly decreased during counseling and students were concurrently participating in an extracurricular activity, they were 51% less likely to withdraw from school.

The current findings highlight the critical role college counseling centers serve in supporting the academic mission of institutions. When students improve during services at counseling centers, they are more likely to persist in school. Given counseling centers routinely work with students experiencing complex and diverse issues, both mental health and non-mental health related, it is essential for institutions to assess and strengthen their local offerings of academic, social, cultural, and mental health support services that ultimately reinforce student success.

OTHER 2022 HIGHLIGHTS

- While prior counseling demonstrated the largest 10-year increase of any mental health history item, experiences of trauma also notably increased with unwanted sexual contacts and general traumatic events demonstrating the second and third largest increases, respectively. A closer investigation of the specific traumatic events reported by students revealed that childhood emotional abuse and sexual violence primarily accounted for the 10-year increases, and the traumatic events were increasingly more likely to have occurred in the distant past (1-5 years and more than 5 years ago).
- Social Anxiety exceeded Generalized Anxiety as the CCAPS subscale with the largest 12-year increase. The Social Anxiety symptom that increased the most is "concerns that others do not like me."
- Academic Distress declined slightly in 2021-2022, however, it continues to be much higher than prior to the onset of the COVID-19 pandemic. Each item on the Academic Distress subscale increased, with the largest involving difficulty staying motivated in class.
- After 10 years of steadily decreasing, lifetime history of having considered causing serious injury to another person marginally increased from 5.3% during 2020-2021 to 5.7% during 2021-2022.
- Although it remained unchanged in the past year, Anxiety continues to be the most common presenting concern identified by therapists. While all concerns (check all and top) commonly assessed by therapists were flat or somewhat declined, trauma continued to increase in 2021-2022.

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 experiences do we want students to have when they seek counseling services?" This reframe helps centers and institutions better align messaging regarding current service capabilities based on staffing levels with stakeholder 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).

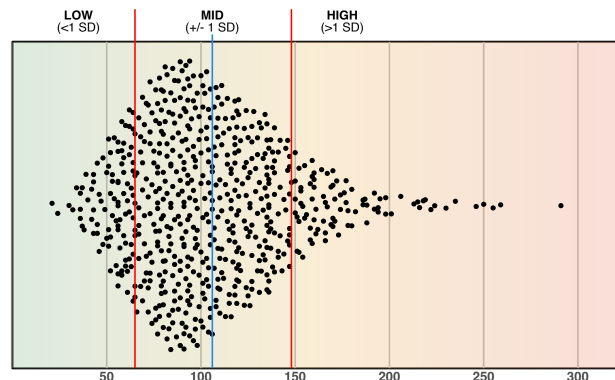
CLI scores can be conceptually thought of as the "average annual caseload" for a "standardized counselor" within a counseling center, or the average number of clients a typical full-time counselor would see in a year at that center. Because of the standardized/annual/aggregate nature of CLI scores, the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

- CLI scores should never be used to compare/evaluate individual counselors or assess how efficient a center is operating.
- 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 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.
- 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.).

2021-2022 CLI DISTRIBUTION

To accompany this Annual Report, CCMH updated the CLI distribution based on new data from 626 CCMH member institutions during the 2021-2022 academic year (7/1/2021 to 6/30/2022). Complete details about the 2021-2022 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 685 member centers, CCMH staff carefully audited hundreds of centers via phone and email to confirm/adjust data for accuracy. A total of 59 centers were excluded due to missing data, incomplete audits, or unique/temporary staffing situations. The following describes the CLI distribution for 2021-2022:

- N = 626
- Range = 21-291
- Mean = 106
- Median = 100
- Standard Deviation = 41
- Zones:
  - Low: 21 to 65
  - Mid: 66 to 147
  - High: 148 to 291



CHANGES IN THE CLI DISTRIBUTION FROM 2018-2019 TO 2021-2022

While the overall shape of the CLI distribution remained similar across the three years of measurement (2018-2019, 2020-2021, 2021-2022), the means, medians, ranges, and zones shifted. The reasons for the CLI changes in many centers were primarily driven by decreases in counseling center usage (utilization) followed secondarily by reductions in staffing levels (clinical capacity) that occurred after the onset of COVID-19. For example, from 2018-2019 to 2021-2022, 65% of centers experienced a decrease in utilization, while only 48% of centers reported a decrease in clinical capacity. Although a decline in utilization was demonstrated in the majority of centers, some centers did experience an increase in students served from 2018-2019 to 2021-2022.

Risks and Protective Factors for Withdrawal from School During Counseling Services

In the CCMH Annual Reports from 2019 to 2021, the relationship between counseling center "average annual caseloads" and client care was examined. Findings demonstrated that higher CLI scores or annual counselor caseloads corresponded with center practices focused on demand management strategies that maximize existing resources while limiting access to weekly individual therapy. Additionally, larger caseloads were associated with less improvement in symptoms and substantially lower treatment dosages (fewer appointments with more days between appointments), which affected all clients, on average, including those with critical safety and identity concerns often prioritized by institutions. The importance of investing in counseling services that are transparently advertised and aligned with the expressed mission of the institution was highlighted throughout the 2019, 2020, and 2021 Annual Reports.

The current 2022 Annual Report investigated how counseling centers contribute to the academic mission of institutions. Over the past decade, institutions of higher education have increasingly emphasized the importance of student retention and persistence given the alarming rates of students leaving school before completing their degrees. In fact, 29.4% of full-time college students, on average, "drop out" between their first and second years of college (Integrated Postsecondary Education Data System, IPEDS, 2020). Additionally, just over 50% of students receive their bachelor's degree within six years of matriculating to college. In some circumstances, withdrawing from school might be the only viable option for those experiencing critical problems, which can ultimately pave the way for successful short- and long-term outcomes. However, on many occasions, dropping out of college can cause numerous adverse social, psychological, financial, and professional consequences for students, families, and institutions. Thus, administrators within higher education have increasingly prioritized student retention, persistence, and degree success as part of their academic mission.

To date, most studies that have investigated the impact of counseling center usage on student retention are limited to examinations of single institutions. Using data from a national sample of college counseling centers, CCMH investigated the risk and protective factors associated with students' decision to voluntarily withdraw from school while receiving counseling services.

The following questions were explored:

1. When students initiate services at college counseling centers, what pre-treatment client factors are associated with withdrawal from the institution while receiving care?
2. Do students have experiences in counseling that modify the risk of withdrawal during services?

Data on voluntary withdrawal from school during counseling services was collected from the CCMH Case Closure Form, which clinicians complete following the end of their service provision with a student. The form measures 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. A total of 156,257 students from 95 counseling centers had Case Closure Forms completed from 2017 to 2022. Overall, 4,415 out of the 156,257 clients (2.8%) voluntarily withdrew from school while receiving any services at the counseling center. The average duration of treatment when students could have potentially left school was 85.7 days (12.2 weeks).

PRE-TREATMENT CLIENT FACTORS ASSOCIATED WITH WITHDRAWAL DURING TREATMENT

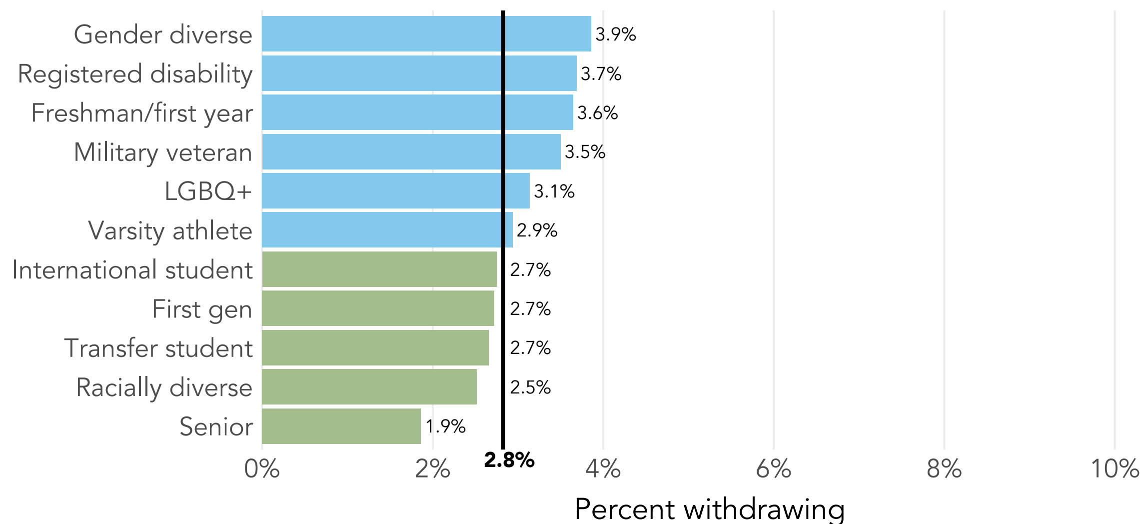
When students enter treatment at counseling centers nationally, information related to demographics, treatment history, current level of distress, clinician assessment of client concerns, and social supports is routinely gathered. CCMH explored if any of the following categories of pre-treatment variables were associated with withdrawal from school during services:

- Demographic (identity statuses)
- Chronic (treatment and safety-risk behavior history)
- Acute (current levels of distress)
- Therapist Assessed (presenting concerns assessed by clinicians)
- Situational (environmental stressors and protective factors)

In the subsequent sections, the withdrawal rates of students with each specific pre-treatment factor were compared to the average rate of 2.8%. If the frequencies were notably above the average withdrawal percentage of 2.8%, those variables were considered risk factors for leaving school. If the rates were substantially below the average, those factors were identified as protective factors that reduce the risk of dropping out.

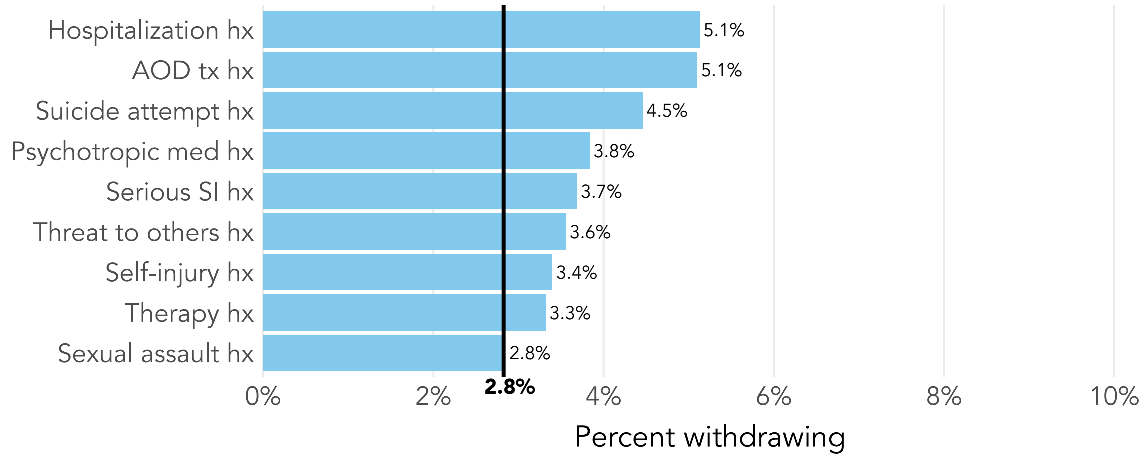
Demographic factors

Demographic and identity statuses were explored using the self-reported items from the Standardized Data Set (SDS). Several identity variables were associated with withdrawal rates above the average (2.8%), including clients with diverse gender identities (transgender, non-binary, self-identify) at 3.9%, those with a registered disability (3.7%), and freshman/first year students (3.6%). Conversely, seniors (1.9%) and students identifying as racially diverse (African American/Black, American Indian or Alaskan Native, Asian American/Asian, Hispanic/Latino/a, Native Hawaiian or Pacific Islander, Multi-racial, and Self-identify) at 2.5% were slightly less likely to withdraw from school than the average student.



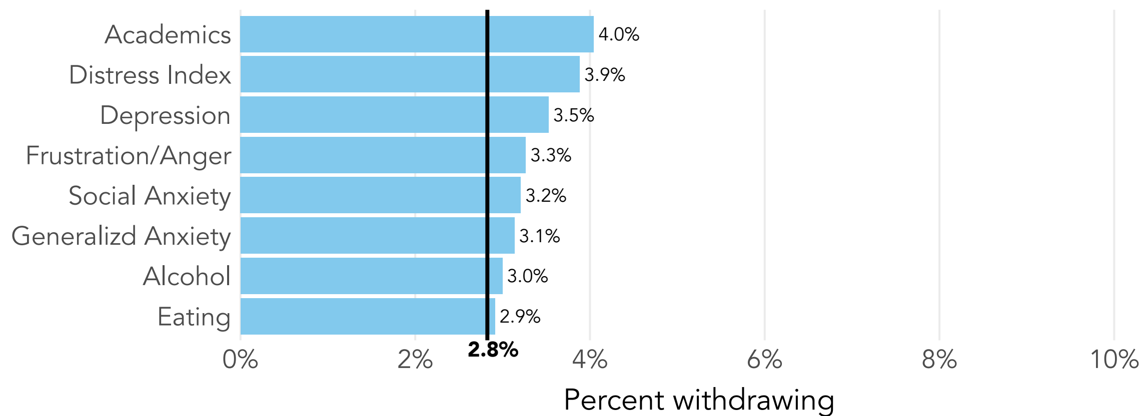
Chronic factors

Chronic factors were measured using self-reported mental health history items from the SDS. All variables, with the exception of sexual assault history, demonstrated higher rates of withdrawal compared to the average. The two strongest relationships were histories of a psychiatric hospitalization and alcohol/other drug (AOD) treatment, both of which had withdrawal rates (5.1%) of nearly twice the average student (2.8%).



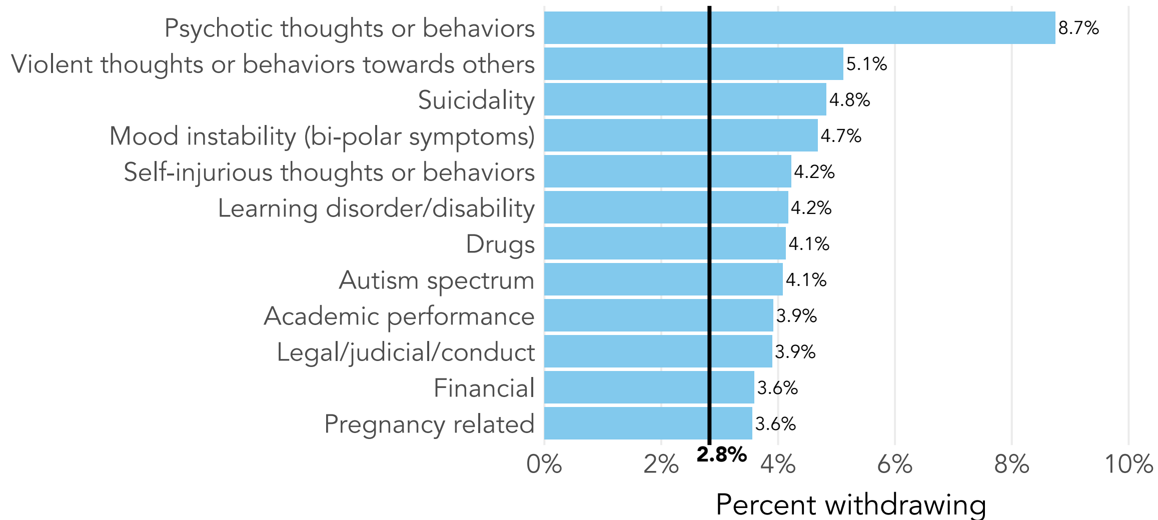
Acute factors

Symptoms of self-reported distress were evaluated using the Counseling Center Assessment of Psychological Symptoms (CCAPS), which measures eight areas of distress commonly experienced by college students. Elevated levels of distress in each area were related to slightly higher than average rates of leaving school. The strongest associations included Academic Distress (4.0%) and overall distress (3.9%), which both had higher rates of withdrawal than the average student (2.8%).



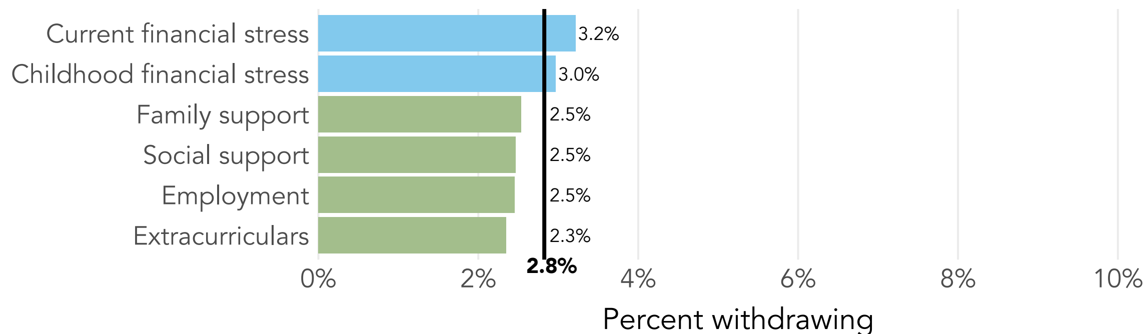
Therapist assessed factors

Presenting concerns assessed by therapists were measured using the Clinician Index of Client Concerns (CLICC). The primary problems associated with increased withdrawal rates from school were psychotic (8.7%) and violent (5.1%) thoughts/behaviors; however, it should be noted that both of these presenting concerns were rarely identified by therapists, occurring in less than 1.0% of clients. Other more commonly endorsed concerns that were related to leaving school were suicidality (4.8%) and mood instability (4.7%), both of which had higher rates than the average student (2.8%).



Situational factors

Situational factors were examined using the SDS. Most of the items demonstrated similar withdrawal rates to the average student in counseling (2.8%). However, involvement in an extracurricular activity (2.3%) and family/social support (2.5%) showed slightly lower rates than the average student (2.8%), which indicates these are protective factors that reduce the risk of leaving school.



Overall Examination of Pre-Treatment Client Factors Associated with Withdrawal from School

Given numerous pre-treatment client factors were related to withdrawal from school, CCMH collectively analyzed all variables to determine which ones are the most important factors associated with students voluntarily leaving school during counseling services.

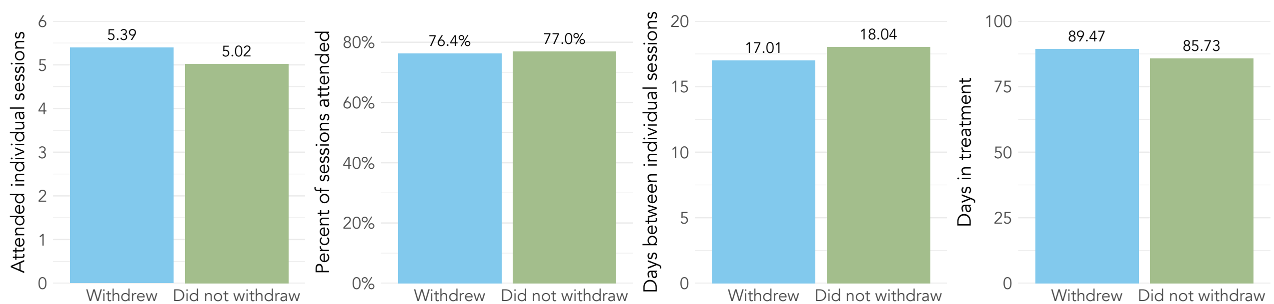
The results demonstrated that elevated Academic Distress, history of a psychiatric hospitalization, and identifying as a freshmen/first year student were the most important risk factors associated with withdrawal from school. When a student has these characteristics when they initiate treatment at counseling centers, they are 48% more likely to leave school during services. In terms of protective factors, involvement in an extracurricular activity is the most salient variable, which reduces the risk of withdrawal by 12%.

STUDENT EXPERIENCES IN COUNSELING THAT CHANGE THE RISK OF WITHDRAWAL DURING TREATMENT

CCMH examined students' experiences in counseling to determine if they alter the risk of dropping out of school during services. In the following sections, students who did and did not withdraw were compared based on treatment utilization and levels of symptom change during services.

Treatment utilization

Counseling center appointment data was used to examine differences in treatment utilization between those who did and did not leave school during counseling services. Students who withdrew attended slightly more individual counseling sessions, attended appointments at a somewhat lower rate, waited marginally less days in between appointments, and experienced a slightly longer duration of services. All differences were minimal, which highlights that students who withdrew demonstrated similar counseling utilization patterns as those who remained in school.

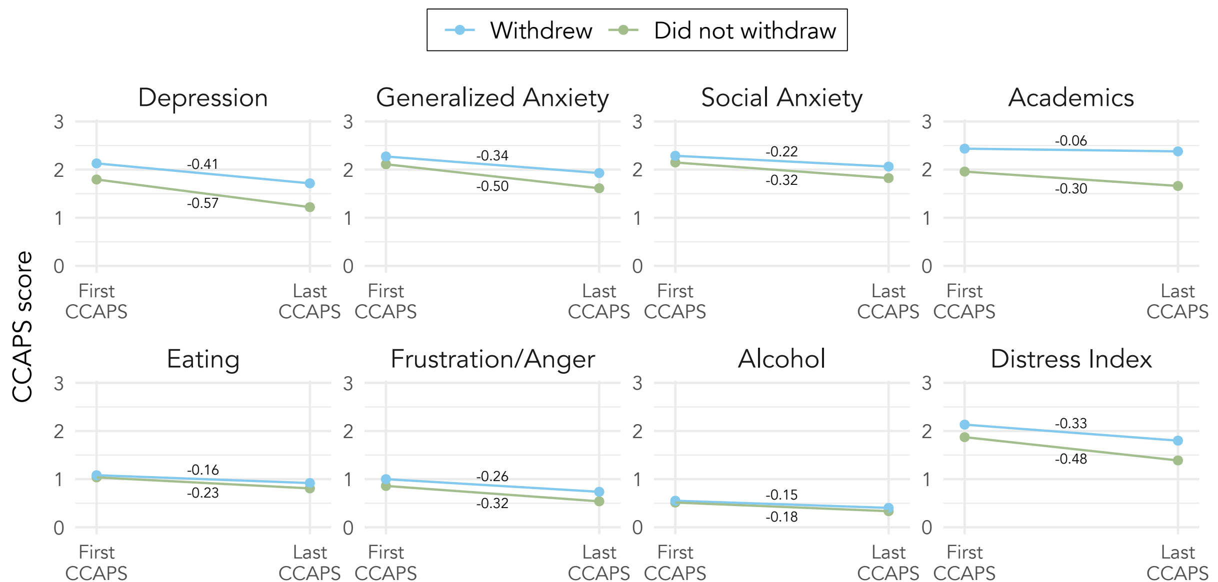


Symptom change

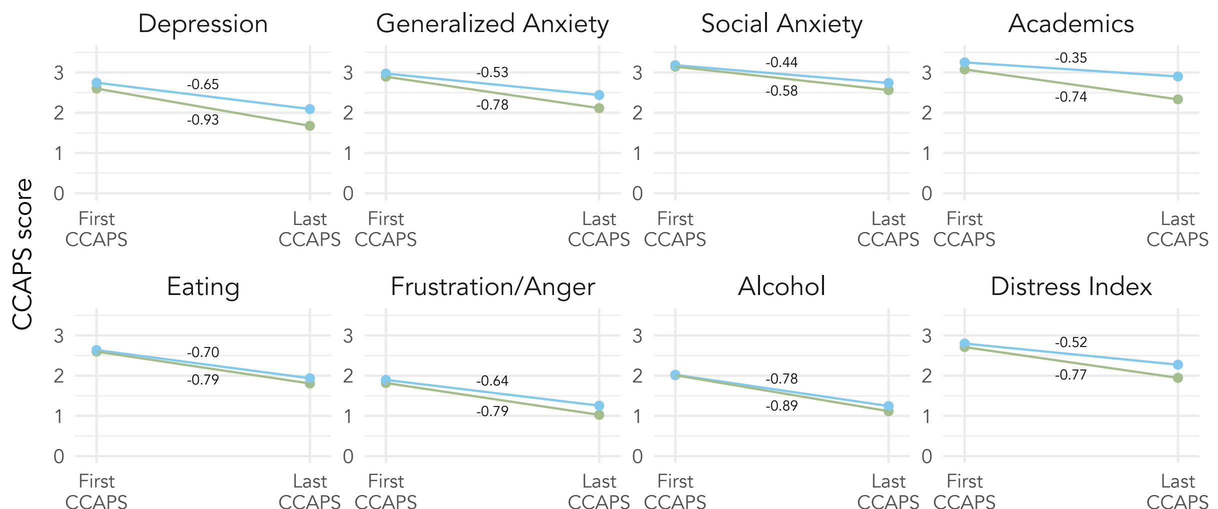
Symptom improvement (change in distress between first and last administrations) was compared between students who did and did not leave school during counseling services using the CCAPS.

CCMH initially examined the differences in symptom change for all students, regardless of their level of distress at the beginning of treatment. The slope of the lines connecting first and last CCAPS represents their total change on that subscale, where steeper lines indicate more change. Additionally, the numbers next to each line demonstrate the average raw change in symptoms for each area of distress.

The findings showed that clients who withdrew from school began treatment with higher levels of Academic Distress, Depression, Generalized Anxiety, Social Anxiety, Frustration/Anger, and overall distress. Furthermore, clients who persisted in school during treatment experienced more improvement in symptoms across all areas of distress. This was especially notable on the Academic Distress subscale, where clients who withdrew from school experienced essentially no change in symptoms compared to students who stayed in school.



CCMH next examined the differences in symptom change between students who withdrew and remained in school for only those who entered counseling services with elevated levels of distress. Students who persisted in school during counseling services experienced more improvement across all areas of distress. This was particularly evident for students who experienced symptom decreases in Academic Distress, Depression, Generalized Anxiety, Social Anxiety, and overall distress.



OVERALL ANALYSES OF PROTECTIVE FACTORS THAT REDUCE THE RISK OF WITHDRAWAL FROM SCHOOL

CCMH collectively analyzed all pre-treatment variables and experiences in counseling to determine which components are the most important protective factors associated with a reduced risk of voluntarily withdrawing from school during counseling services.

While there were several protective factors that decreased the risk, improvement in Academic Distress during treatment and involvement in an extracurricular activity were the most important variables. When students experience a significant decrease in Academic Distress symptoms coupled with concurrent involvement in an extracurricular activity, they are 51% less likely to withdraw from school during treatment.

SUMMARY

In the current 2022 Annual Report, CCMH explored how counseling centers support the academic mission of institutions by examining the risk and protective factors associated with students' decision to voluntarily withdraw from school during services. This investigation is critical given the concerning national rates of "drop out" among college students and the ensuing adverse consequences for students, families, and institutions.

CCMH explored if any information routinely collected when students enter counseling services was associated with leaving school during treatment. While numerous variables were discovered that increase the risk, students who identified as freshman/first-year status with current elevated levels of academic distress and a history of a psychiatric hospitalization were 48% more likely to withdraw from school during counseling than students without these characteristics. Additionally, several protective factors were associated with persistence in school, including improvement in Depression, Generalized/Social Anxiety, and overall distress symptoms during treatment. Most notably, when Academic Distress significantly decreased during counseling and students were simultaneously participating in an extracurricular activity, they were 51% less likely to withdraw from school than students without these qualities.

These findings demonstrate the multidimensional and diverse nature of risk/protective factors associated with students' choice to leave school during the course of counseling services. While many of the variables that affected the risk were primarily mental health related (e.g., elevated levels of distress, symptom change, chronicity of problems), other factors corresponded to academic concerns, transition, identity statuses, and social support systems. It is important for counseling center staff and other professionals who work closely with college students to be aware of the full range of characteristics associated with voluntary withdrawal from school, so they can be thoroughly evaluated, monitored, and addressed, if needed, while providing services. For many students with increased risk, this may involve a holistic approach to care, including targeting specific clinical issues in treatment (i.e., current levels of distress, chronicity of symptoms), while concurrently utilizing adjunctive support services commonly offered at institutions, such as student activities, peer support, multicultural services, disability resources, and academic services.

It is important to note several considerations related to the current findings. Withdrawal from school was only measured during the time span of services at the counseling centers (average of 12.2 weeks) and did not investigate academic outcomes that occurred after the termination of care (i.e., if the student returned to school). The overall base rate (2.8%) of withdrawal from school during counseling was relatively low, which makes it a challenging event to predict. Thus, students, on average, are still unlikely to leave school despite having any combination of these risk factors. Additionally, while counseling centers, in general, support the academic missions of institutions through student retention and persistence, withdrawal from school is not always a negative event and instead can lead to successful short- and long-term outcomes. In fact, there are many critical circumstances encountered by students where leaving school is the only reasonable option and opens the door for them to flourish at a later time, perhaps returning in the future to complete their degree. Moreover, many students enter counseling with complex needs that impact academic readiness, and consequently, clinicians need to have authentic and supportive conversations with students about their current situations, which occasionally may lead to the student deciding to leave school and better position themselves for a more optimistic pathway ahead.

The current findings highlight the critical role college counseling centers serve in supporting the academic mission of institutions. When students improve during treatment at counseling centers, they are more likely to remain in school. Furthermore, the results underscore that mental health services are only a portion of the larger comprehensive support systems needed to promote student success. Given counseling centers routinely work with students experiencing specialized

and diverse issues, both mental health and non-mental health related, it is important for institutions to evaluate and fortify their local offerings of academic, social, cultural, and mental health support services that ultimately reinforce the academic mission.

Annual Trends

MENTAL HEALTH TRENDS

As of this report, CCMH has generated 12 annual data sets (2010-2011 through 2021-2022), 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 the SDS Manual for details. Specifically, the wording for many items were modified in 2012, which led to greater changes in prevalence rates for some items after 2012.

Data Sets

The below table summarizes the amount of data contributed to CCMH over the past 12 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

Mental Health Trends (2012 to 2022)

Several mental health history trends continued to shift in 2021-2022. The rates of students with histories of threat-to-self characteristics rebounded in 2021-2022 but continued to be endorsed at levels lower than the top rates reported before the beginning of COVID-19. After 10 years of steadily decreasing, lifetime history of considered causing serious injury to another person marginally increased in 2021-2022. Rates of prior treatment (counseling, medication, hospitalization) showed a slight increase in the past year but remained below the highest levels that were reported just prior to the onset of the COVID-19 pandemic. While prior counseling demonstrated the largest 10-year increase of any mental health history item, experiences of trauma also notably increased with unwanted sexual contacts and general traumatic events demonstrating the second and third largest increases, respectively. A closer examination of the specific traumatic events reported by students revealed that childhood emotional abuse and sexual violence primarily accounted for the 10-year increase, and the traumatic events were increasingly more likely to have occurred in the distant past (1-5 years and more than 5 years ago).

Mental Health Trends (2012–2022)

Item	10-Year Change	2012-2022	Lowest	Highest	2021–2022
Prior Treatment					
Counseling	+11.0%		47.8%	59.5%	58.8%
Medication	+3.0%		32.4%	36.1%	35.4%
Hospitalization	-1.6%		8.0%	10.3%	8.5%
Threat-to-Self					
Non-Suicidal Self-Injury	+4.7%		23.0%	29.1%	27.7%
Serious Suicidal Ideation	+4.1%		30.1%	36.9%	34.2%
Serious Suicidal Ideation (last month)	-0.2%		6.1%	8.2%	6.8%
Suicide Attempt(s)	+1.4%		8.7%	10.9%	10.1%
Some Suicidal Ideation (past 2 weeks)	+2.7%		33.9%	39.6%	36.7%
Threat-to-Others					
Considered causing serious physical injury to another person	-5.5%		5.2%	11.2%	5.7%
Intentionally caused serious injury to another person	-2.1%		1.2%	3.4%	1.3%
Traumatic Experiences					
Had unwanted sexual contact(s) or experience(s)	+8.4%		18.9%	27.4%	27.4%
Experienced harassing, controlling, and/or abusive behavior	+6.3%		32.8%	39.6%	39.6%
Experienced traumatic event	+7.8%		37.5%	45.3%	45.3%
Drug and Alcohol					
Felt the need to reduce alcohol/drug use	-1.2%		25.6%	27.5%	25.9%
Others concerned about alcohol/drug use	-4.3%		13.0%	17.6%	13.3%
Treatment for alcohol/drug use	-2.7%		1.7%	4.4%	1.7%
Binge drinking	-7.2%		32.6%	41.5%	34.3%
Marijuana use	+4.4%		19.1%	26.0%	25.2%

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 figures provide information regarding trends in self-reported distress when students enter services at counseling centers, as indicated by the CCAPS subscales.

Both Depression and Generalized Anxiety slightly increased in 2021-2022, while Academic Distress and Eating Concerns slightly decreased and flattened respectively after substantial increases in 2020-2021. Family Distress continued to rise in the past year. Most notably, Social Anxiety increased considerably from the prior year and displayed the greatest 12-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 associated with expanding levels of isolation and social comparison processes commonly experienced through social media usage. Furthermore, the recent marked increase in Social Anxiety in the past year might be related to the shift from widespread remote learning environments in 2020-2021 to more traditional in-person academic experiences in 2021-2022, which led to students abruptly encountering more stress inducing social situations.

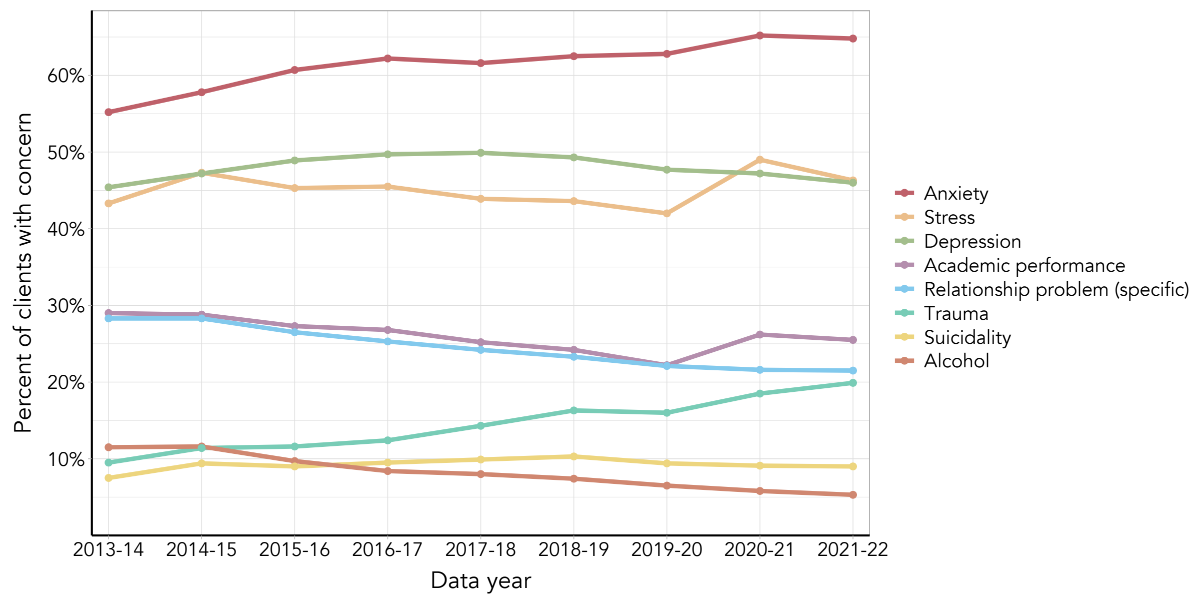
Trends: Average Subscale Scores (2010 to 2022)

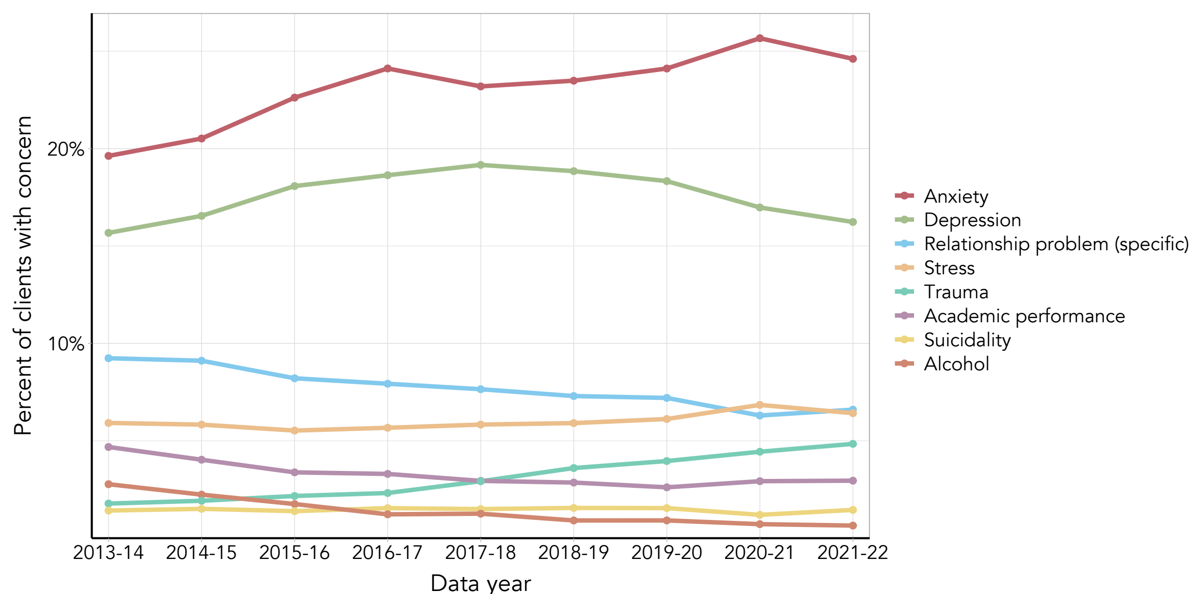
Item	12-Year Change	2010-2022	Lowest	Highest	2021–2022
CCAPS-62					
Depression	+0.25		1.59	1.84	1.84
Generalized Anxiety	+0.29		1.61	1.91	1.91
Social Anxiety	+0.31		1.82	2.13	2.13
Academic Distress	+0.15		1.85	2.05	2.00
Eating Concerns	+0.12		1.00	1.12	1.12
Frustration/Anger	-0.07		0.96	1.04	0.98
Substance Use	-0.18		0.58	0.77	0.59
Family Distress	+0.15		1.29	1.44	1.44
CCAPS-34					
Depression	+0.17		1.55	1.74	1.72
Generalized Anxiety	+0.28		1.77	2.05	2.05
Social Anxiety	+0.33		1.77	2.10	2.10
Academic Distress	+0.13		1.92	2.10	2.06
Eating Concerns	+0.12		0.94	1.07	1.06
Frustration/Anger	-0.12		0.80	0.93	0.81
Alcohol Use	-0.24		0.49	0.73	0.49
Distress Index	+0.18		1.65	1.83	1.83

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. While Anxiety demonstrated no change, Depression slightly decreased in 2021-2022. After markedly increasing in 2020-2021, Stress slightly declined, while Academic Performance remained flat in 2021-2022. Most notably, Trauma as a check all that apply and top concern has continued to increase since 2014-2015, which is consistent with students self-report on the SDS.





Appointment Statistics

UTILIZATION

Data from 2021-2022 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 180,984 students across participating CCMH centers:

- The most common number of appointments per client per year is one.
- Clients averaged 5.72 total attended appointments of any kind, with a median of 4 appointments, and a range of 1-157 appointments.
- Clients averaged 4.81 attended *Individual Treatment* (initial clinical evaluations and individual counseling) appointments, with a median of 3 attended appointments, and a range of 1-142 attended appointments.
- 20% of clients accounted for 56% of all appointments, averaging 15 appointments.
- 10% of clients accounted for 38% of all appointments, averaging 19 appointments.
- 5% of clients accounted for 23% of all appointments, averaging 25 appointments.
- 1% of clients accounted for 7% of all appointments, averaging 37 appointments.
- 10 clients utilized a total of 1,159 appointments.

ATTENDANCE

Out of 1,287,775 appointments, approximately 77% were marked as attended.

Client Attendance	Frequency	Percent
Attended	987,607	76.9%
Center Closed	5,034	0.4%
Client Cancelled	60,729	4.7%
Client Cancelled Late	23,337	1.8%
Client No Show	94,887	7.4%
Client Rescheduled	60,806	4.7%
Counselor Cancelled	27,973	2.2%
Counselor Rescheduled	24,541	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	701,685	74.7%
Initial clinical evaluation	124,197	81.8%
Group – psychotherapy	110,544	65.3%
Brief Screening or Walk-in	104,194	88.0%
Psychiatric follow-up	50,164	76.8%
Case management	42,415	81.5%
Group – workshop	11,537	56.3%
Specialized individual treatment	10,064	77.7%
Psychiatric evaluation	8,866	81.7%
Couple's therapy	8,022	74.8%
Group – clinic	6,866	53.9%
Psychological Testing or Assessment	3,755	81.7%

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 8.6% of appointments were over 60 minutes in length.

Appointment Length (Minutes)	Frequency	Percent
15	64,789	6.6%
30	146,269	14.8%
45	42,339	4.3%
60	649,015	65.7%
90	72,681	7.4%
120	12,514	1.3%

APPOINTMENT MODE

Appointment mode information (In person, Video, Audio, or Text) was provided for 553,997 attended appointments in 2021-2022. From 2020-2021 to 2021-2022, the frequency of in person appointments increased from 2% to 37%, while video appointments declined from 83% to 51%.

Mode	Frequency	Percent
In person	204,286	36.9%
Audio	35,659	6.4%
Video	284,618	51.4%
Text	29,434	5.3%

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 (abbreviated 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 133,392 students who sought care in 2021-2022.

	Business Days	Calendar Days
Brief Screening/Walk-In	1.77	2.44
Initial Clinical Evaluation	4.96	6.90

Approximately 34% of students were seen for their first appointment of the year on the same day it was scheduled, while 76% were seen within 5 business days or 7 calendar days.

Standardized Data Set (SDS)

The Standardized Data Set (SDS) is a collection 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 subsequent data allows centers to support a wide array of research as well as quickly and easily produce aggregate reports on the most common client concerns experienced at their specific center. The CLICC includes 54 concerns, and starting in July 2017, the category of "Anxiety" was expanded to include options for six specific types of anxiety, including Generalized, Social, Test Anxiety, Panic Attacks, Specific Phobias, and unspecified/other.

The graph on the next page illustrates the presenting concerns of 69,969 clients during the 2021-2022 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 were selected by clinicians.

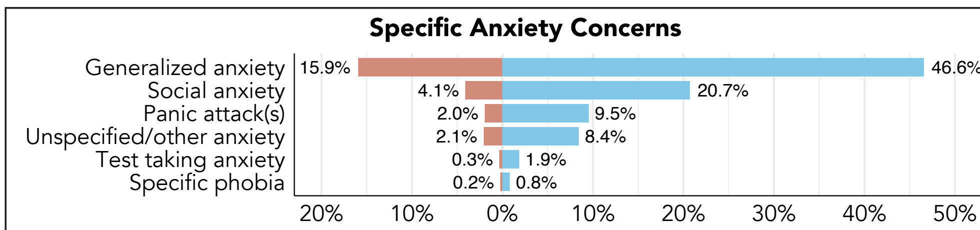
Clinicians are then asked to choose one primary concern from those selected (i.e., the top concern). The red bars on the left in the graph provide the frequency of each primary (top) concern.

Collectively the two bars highlight the proportion of clients who were experiencing each concern 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 general 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 according to the specific types of anxiety below the main graph.

CLICC Combined Top Concern and Check All That Apply

	Top Concern	Check All That Apply
Anxiety	24.6%	64.9%
Stress	6.4%	46.3%
Depression	16.2%	46%
Family	3.9%	29.3%
Academic performance	3.0%	25.5%
Relationship problem (specific)	6.6%	21.5%
Interpersonal functioning	3.2%	21%
Trauma	4.8%	19.9%
Self-esteem/confidence	2.0%	18.7%
Adjustment to new environment	3.6%	16.4%
Eating/body image	2.1%	16.1%
Attention/concentration difficulties	2.3%	14%
Sleep	0.3%	12.9%
Social isolation	0.8%	12.8%
Grief/loss	3.3%	11%
Emotion dysregulation	1.8%	9.2%
Identity development	1.2%	9.1%
Suicidality	1.4%	9.1%
Sexual abuse/assault (victim)	1.4%	8.5%
Perfectionism	0.8%	7.7%
Career	0.6%	7.6%
Harassment/emotional abuse (victim)	0.5%	6.2%
Health/medical	0.6%	5.9%
Self-injurious thoughts or behaviors	0.4%	5.7%
Alcohol	0.7%	5.3%
Anger management	0.6%	4.5%
Drugs	0.4%	4.2%
Financial	0.1%	3.5%
Obsessions or compulsions	0.9%	3.4%
Mood instability (bi-polar symptoms)	1.2%	3.3%
Physical abuse/assault (victim)	0.1%	3.2%
Racial, ethnic or cultural concerns	0.2%	3.1%
Other	1.5%	3%
Sexual orientation	0.2%	2.5%
Gender identity	0.4%	1.8%
Dissociative experiences	0.2%	1.6%
Sexual concern	0.2%	1.3%
Religion/spirituality	0.1%	1.3%
Autism spectrum	0.2%	1.2%
Discrimination	0.0%	1%
Legal/judicial/conduct	0.4%	0.9%
Violent thoughts or behaviors towards others	0.0%	0.8%
Learning disorder/disability	0.1%	0.8%
Addiction (not drugs or alcohol)	0.1%	0.5%
Psychotic thoughts or behaviors	0.1%	0.4%
None	0.2%	0.4%
Stalking (victim)	0.0%	0.4%
Pregnancy related	0.1%	0.3%

30% 20% 10% 0% 10% 20% 30% 40% 50% 60% 70%

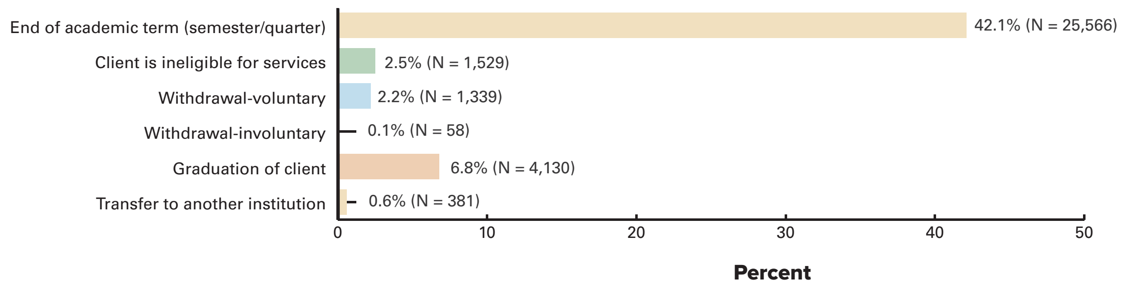


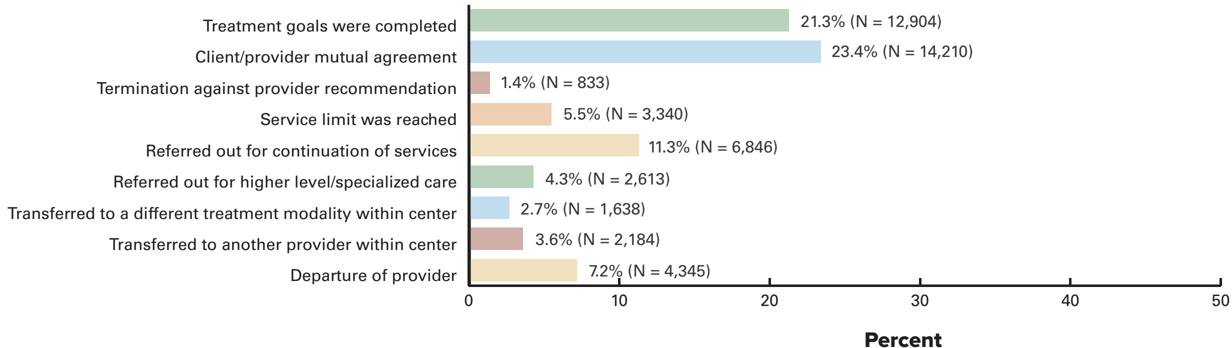
CASE CLOSURE FORM

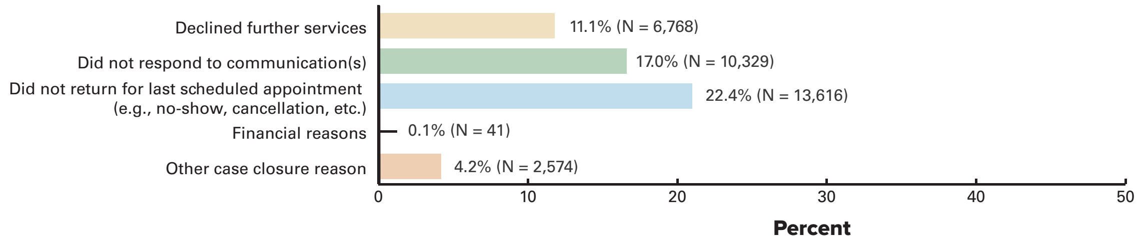
The Case Closure Form captures a wide array of reasons (academic, clinical, and client factors) why services ended, as well as significant events that might have occurred during the course of a student's services. Clinicians are asked to complete this form following the end of their service provision 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.

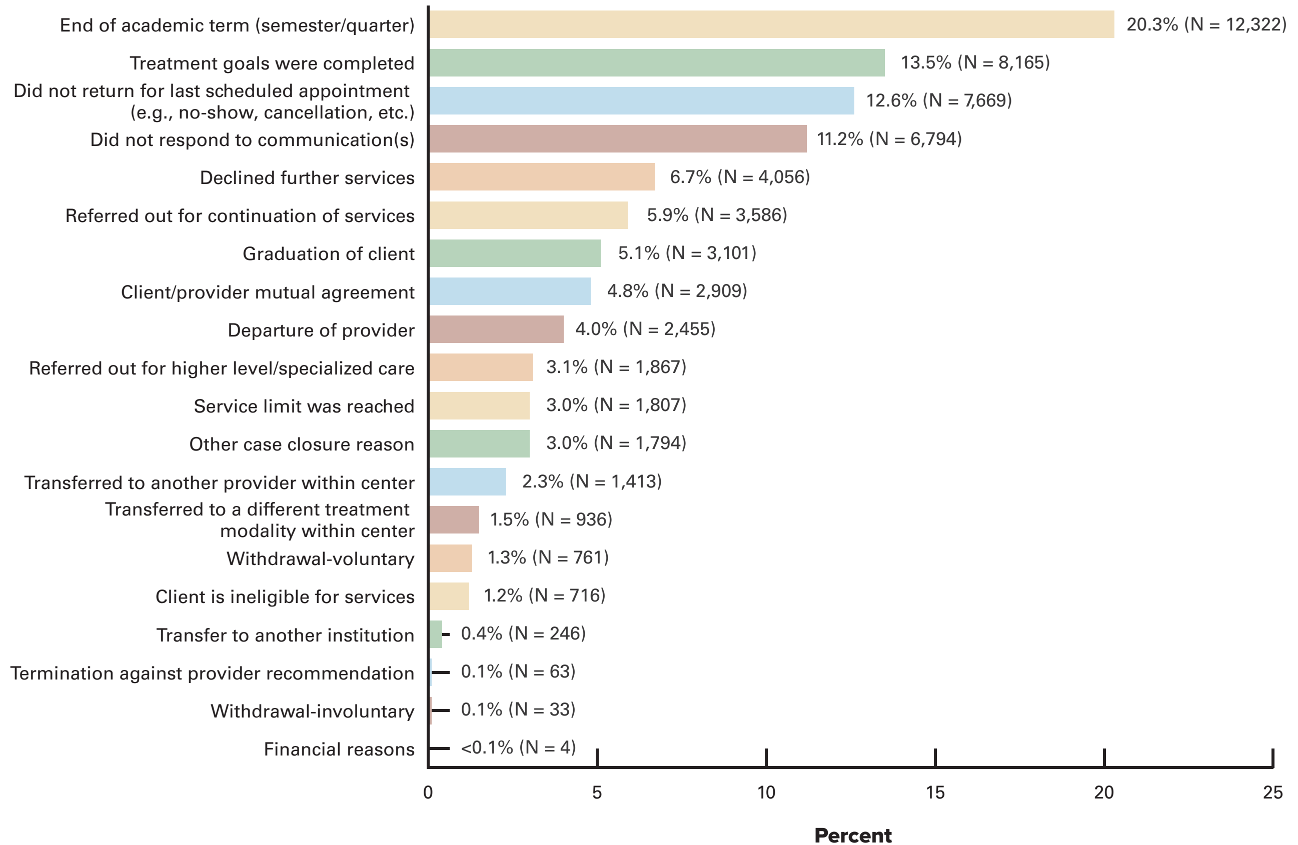
Reasons for Closure of Case

This graph describes the frequency of various reasons why services ended for students who received treatment during the 2021-2022 academic year (N = 60,721). Of note, the most common reasons for the cessation of services were the ending of the academic term, followed by client/provider mutual agreement, client not returning for last scheduled appointment, and treatment goals being completed.





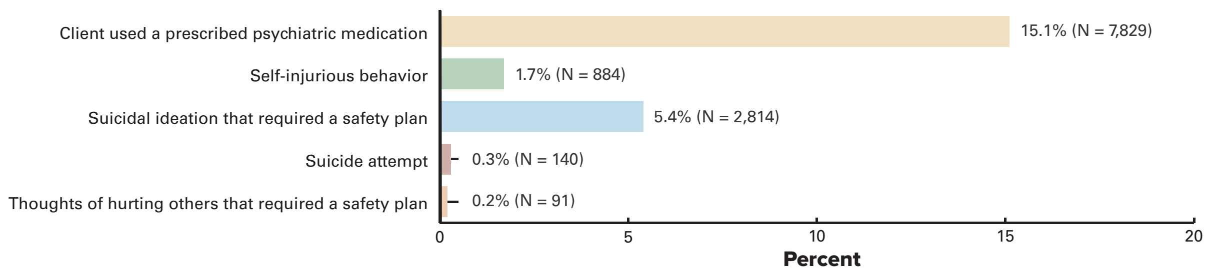


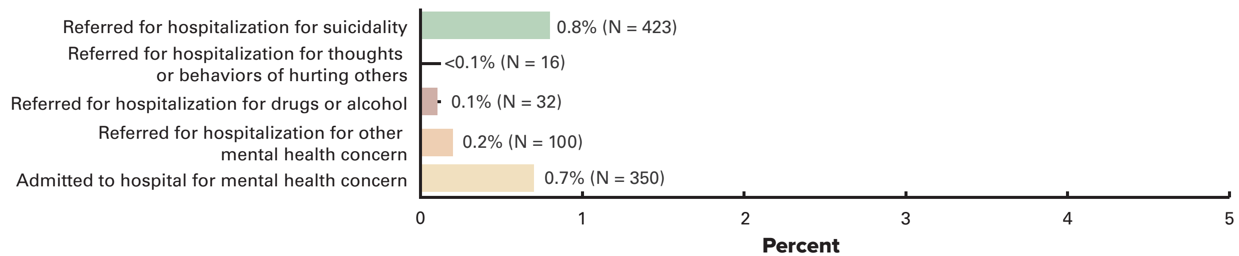


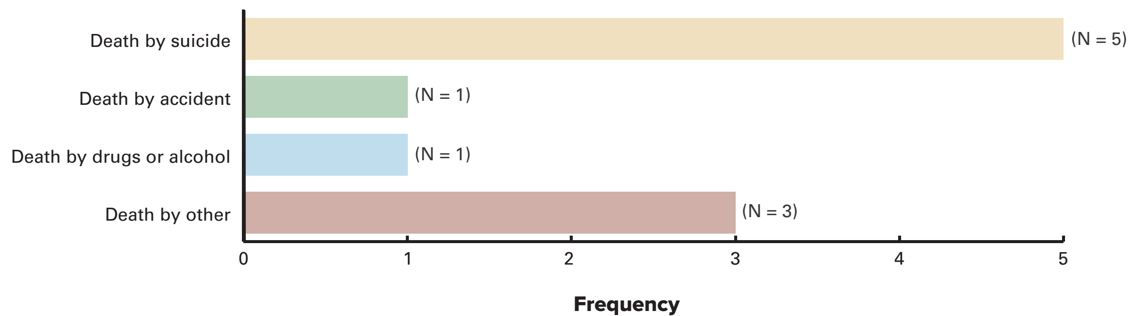
Top Case Closure Reason
End of academic term (semester/quarter)
20.3% (N = 12,322)
Treatment goals were completed
13.5% (N = 8,165)
Did not return for last scheduled appointment (e.g., no-show, cancellation, etc.)
12.6% (N = 7,669)
Did not respond to communication(s)
11.2% (N = 6,794)
Declined further services
6.7% (N = 4,056)
Referred out for continuation of services
5.9% (N = 3,586)
Graduation of client
5.1% (N = 3,101)
Client/provider mutual agreement
4.8% (N = 2,909)
Departure of provider
4.0% (N = 2,455)
Referred out for higher level/specialized care
3.1% (N = 1,867)
Service limit was reached
3.0% (N = 1,807)
Other case closure reason
3.0% (N = 1,794)
Transferred to another provider within center
2.3% (N = 1,413)
Transferred to a different treatment modality within center
1.5% (N = 936)
Withdrawal-voluntary
1.3% (N = 761)
Client is ineligible for services
1.2% (N = 716)
Transfer to another institution
0.4% (N = 246)
Termination against provider recommendation
0.1% (N = 63)
Withdrawal-involuntary
0.1% (N = 33)
Financial reasons
<0.1% (N = 4)
0
5
10
15
20
25
Percent

Case Events

This graph describes the frequency of significant events occurring during a course of services for students during the 2021-2022 academic year (*N* = 51,715).







DISCRIMINATION ITEMS

In 2021, CCMH added six new items to the SDS that assess whether students had experienced discrimination or unfair treatment due to any of six parts of their identity in the past six months.

Overall rates of endorsement

Overall, 19.4% of clients endorsed discrimination related to at least one identity.

SDS 111-116 (N = 36,068)	Frequency	Percent
Disability	839	2.3%
Gender	3,501	9.8%
Nationality/Country of Origin	1,100	3.1%
Race/Ethnicity/Culture	3,006	8.4%
Religion	841	2.4%
Sexual Orientation	1,996	5.6%

Rates of endorsement by corresponding identity

The tables below present the frequency and percent of clients within each identity who reported discrimination related to that specific identity status.

Prevalence of disability discrimination (SDS 111) within each registered disability status (SDS 60):

SDS 60 (N = 35,187)	Frequency	Percent
Not registered with disability services	340	1.1%
Registered with disability services	490	14.0%

Prevalence of gender discrimination (SDS 112) within each gender identity (SDS 88):

SDS 88 (N = 35,611)	Frequency	Percent
Woman	2,592	11.6%
Transgender woman	61	34.3%
Man	179	1.6%
Transgender man	110	49.8%
Non-binary	421	34.9%
Self-identify	114	27.9%

Prevalence of nationality/country of origin discrimination (SDS 113) within each international student status (SDS 32):

SDS 32 (N = 34,059)	Frequency	Percent
Domestic student	622	2.0%
International student	421	15.6%

Prevalence of racial/ethnic/cultural discrimination (SDS 114) within each race/ethnicity (SDS 95):

SDS 95 (N = 34,480)	Frequency	Percent
African American/Black	917	27.1%
American Indian or Alaskan Native	20	19.2%
Asian American/Asian	758	19.5%
Hispanic/Latino/a	508	13.0%
Native Hawaiian or Pacific Islander	12	19.0%
Multi-racial	299	17.5%
White	219	1.0%
Self-identify	110	19.8%

Prevalence of religious discrimination (SDS 115) within each religious or spiritual preference (SDS 97):

SDS 97 (N = 30,942)	Frequency	Percent
Agnostic	62	1.1%
Atheist	46	1.4%
Buddhist	12	3.9%
Catholic	64	1.5%
Christian	170	2.3%
Hindu	20	3.3%
Jewish	85	11.4%
Muslim	124	18.0%
No preference	51	0.7%
Self-identify	84	7.1%

Prevalence of sexual orientation discrimination (SDS 116) within each sexual orientation (SDS 91):

SDS 91 (N = 33,013)	Frequency	Percent
Asexual	76	9.4%
Bisexual	643	13.1%
Gay	286	30.8%
Heterosexual/Straight	100	0.5%
Lesbian	242	28.4%
Pansexual	170	16.9%
Queer	258	24.7%
Questioning	67	4.9%
Self-identify	50	13.7%

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. Because counseling centers vary in the types of questions they ask, the total number of responses varies by question.

Client Age

Mean	SD	Range
22.09	4.02	18-60

What is your gender identity?

SDS 88 (N = 122,536)	Frequency	Percent
Woman	77,511	63.3%
Transgender woman	522	0.4%
Man	38,940	31.8%
Transgender man	644	0.5%
Non-binary	3,708	3.0%
Self-identify	1,211	1.0%

What was your sex at birth?

SDS 90 (N = 28,590)	Frequency	Percent
Female	18,980	66.4%
Male	9,603	33.6%
Intersex	7	<0.1%

Do you consider yourself to be:

SDS 91 (N = 114,564)	Frequency	Percent
Asexual	2,775	2.4%
Bisexual	16,248	14.2%
Gay	3,173	2.8%
Heterosexual/Straight	77,493	67.6%
Lesbian	2,648	2.3%
Pansexual	3,189	2.8%
Queer	3,314	2.9%
Questioning	4,528	4.0%
Self-identify	1,196	1.0%

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

SDS 93 (N = 11,817)	Frequency	Percent
Only with men	5,037	42.6%
Mostly with men	1,262	10.7%
About the same number of men and women	387	3.3%
Mostly with women	361	3.1%
Only with women	2,801	23.7%
I have not had sexual experiences	1,969	16.7%

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

SDS 94 (N = 15,647)	Frequency	Percent
Only attracted to women	3,961	25.3%
Mostly attracted to women	1,200	7.7%
Equally attracted to women and men	1,708	10.9%
Mostly attracted to men	2,450	15.7%
Only attracted to men	5,504	35.2%
Not sure	551	3.5%
I do not experience sexual attraction	273	1.7%

What is your race/ethnicity?

SDS 95 (N = 123,907)	Frequency	Percent
African American/Black	11,931	9.6%
American Indian or Alaskan Native	650	0.5%
Asian American/Asian	14,059	11.3%
Hispanic/Latino/a	13,675	11.0%
Native Hawaiian or Pacific Islander	242	0.2%
Multi-racial	6,054	4.9%
White	75,335	60.8%
Self-identify	1,961	1.6%

What is your country of origin?

Country	Frequency
United States	102,539
India	2,414
China	2,408
Mexico	829
Korea, Republic of	614
Canada	435
Puerto Rico	420
Colombia	404
Philippines	381
Brazil	370
Nigeria	364
Bangladesh	343

Country	Frequency
Vietnam	333
Iran, Islamic Republic of	327
United Kingdom	313
Venezuela	295
Pakistan	291
Russian Federation	272
Taiwan	238
Jamaica	195
Peru	189
Turkey	182
Cuba	171
Germany	171

Country	Frequency
Haiti	164
Saudi Arabia	156
Japan	150
Egypt	136
Dominican Republic	134
United States Minor Outlying Islands	134
Nepal	132
Ecuador	131
Spain	130
Ghana	128
Indonesia	122

Countries with less than 120 (0.1%) individuals:
Afghanistan; Aland Islands; Albania; Algeria; American Samoa; Andorra; 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; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Cape Verde; Cayman Islands; Chad; Chile; Christmas Island; Comoros; 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 Polynesia; Gabon; Gambia; Georgia; Greece; Grenada; Guadeloupe; Guam; Guatemala; Guinea; Guinea-bissau; Guyana; Honduras; Hong Kong; Hungary; Iceland; Iraq; Ireland; Isle of Man; Israel; Italy; Jordan; Kazakhstan; Kenya; Kiribati; Korea, Democratic People's Republic of; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Lithuania; Luxembourg; Macao; Macedonia, The Former Yugoslav Republic of; Madagascar; Malawi; Malaysia; Mali; Marshall Islands; Martinique; Mauritania; Mauritius; Micronesia, Federated States of; Moldova, Republic of; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Netherlands; Netherlands Antilles; New Zealand; Nicaragua; Northern Mariana Islands; Norway; Oman; Palestinian Territory; Panama; Papua New Guinea; Paraguay; Poland; Portugal; Qatar; Romania; Rwanda; Saint Kitts and Nevis; Saint Lucia; 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; Timor-leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkmenistan; Turks and Caicos Islands; Tuvalu; Uganda; Ukraine; United Arab Emirates; Uruguay; Uzbekistan; Virgin Islands, British; Virgin Islands, U.S.; Wallis and Futuna; Western Sahara; Yemen; Zambia; Zimbabwe

Are you an international student?

SDS 32 (N = 124,851)	Frequency	Percent
No	115,234	92.3%
Yes	9,617	7.7%

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

SDS 56 (N = 120,064)	Frequency	Percent
No	92,501	77.0%
Yes	27,563	23.0%

Current academic status:

SDS 37 (N = 109,321)	Frequency	Percent
Freshman/First-year	23,300	21.3%
Sophomore	20,992	19.2%
Junior	24,011	22.0%
Senior	21,656	19.8%
Graduate/Professional degree student	18,103	16.6%
Non-student	184	0.2%
High-school student taking college classes	8	<0.1%
Non-degree student	196	0.2%
Faculty or staff	66	0.1%
Other (please specify)	805	0.7%

Graduate or professional degree program:

SDS 39 (N = 40,250)	Frequency	Percent
Post-Baccalaureate	3,050	7.6%
Masters	6,304	15.7%
Doctoral degree	3,995	9.9%
Law	945	2.3%
Medical	1,118	2.8%
Pharmacy	238	0.6%
Dental	107	0.3%
Veterinary Medicine	455	1.1%
Not applicable	22,028	54.7%
Other (please specify)	2,010	5.0%

What year are you in your graduate/professional program?

SDS 41 (N = 19,761)	Frequency	Percent
1	7,726	39.1%
2	4,717	23.9%
3	2,980	15.1%
4	3,141	15.9%
5+	1,197	6.1%

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

SDS 46 (N = 115,937)	Frequency	Percent
No	95,543	82.4%
Yes	20,394	17.6%

What kind of housing do you currently have?

SDS 42 (N = 102,390)	Frequency	Percent
On-campus residence hall/apartment	36,211	35.4%
On/off campus fraternity/sorority house	1,641	1.6%
On/off campus co-operative house	872	0.9%
Off-campus apartment/house	62,455	61.0%
Other (please specify)	1,211	1.2%

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

SDS 44 (N = 106,736)	Frequency	Percent
Alone	15,042	14.1%
Spouse, partner, or significant other	11,094	10.4%
Roommates	70,693	66.2%
Children	2,139	2.0%
Parent(s) or guardian(s)	11,092	10.4%
Family (other)	5,821	5.5%
Other	1,330	1.2%

Relationship status:

SDS 33 (N = 120,627)	Frequency	Percent
Single	73,412	60.9%
Serious dating or committed relationships	41,190	34.1%
Civil union, domestic partnership, or equivalent	469	0.4%
Married	4,797	4.0%
Divorced	346	0.3%
Separated	374	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 (N = 58,383)	Frequency	Percent
None	21,619	37.0%
Occasional participation	12,480	21.4%
One regularly attended activity	9,583	16.4%
Two regularly attended activities	7,257	12.4%
Three or more regularly attended activities	7,444	12.8%

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

SDS 1151 (N = 89,879)	Frequency	Percent
No	83,943	93.4%
Yes	5,936	6.6%

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

SDS 1152 (N = 90,067)	Frequency	Percent
No	77,475	86.0%
Yes	12,592	14.0%

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

SDS 1153 (N = 89,282)	Frequency	Percent
No	85,814	96.1%
Yes	3,468	3.9%

Religious or Spiritual Preference:

SDS 97 (N = 110,576)	Frequency	Percent
Agnostic	18,633	16.9%
Atheist	10,993	9.9%
Buddhist	989	0.9%
Catholic	13,910	12.6%
Christian	32,219	29.1%
Hindu	2,107	1.9%
Jewish	2,231	2.0%
Muslim	2,276	2.1%
No preference	23,079	20.9%
Self-identify	4,139	3.7%

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

SDS 36 (N = 83,147)	Frequency	Percent
Very important	12,040	14.5%
Important	16,470	19.8%
Neutral	28,114	33.8%
Unimportant	13,884	16.7%
Very unimportant	12,639	15.2%

How would you describe your financial situation right now?

SDS 57 (N = 102,946)	Frequency	Percent
Always stressful	11,079	10.8%
Often stressful	19,993	19.4%
Sometimes stressful	37,215	36.2%
Rarely stressful	24,995	24.3%
Never stressful	9,664	9.4%

How would you describe your financial situation while growing up?

SDS 58 (N = 70,239)	Frequency	Percent
Always stressful	7,610	10.8%
Often stressful	10,824	15.4%
Sometimes stressful	17,138	24.4%
Rarely stressful	19,940	28.4%
Never stressful	14,727	21.0%

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

SDS 1055 (N = 90,567)	Frequency	Percent
0	37,287	41.2%
1-5	5,556	6.1%
6-10	10,076	11.1%
11-15	9,312	10.3%
16-20	12,110	13.4%
21-25	5,891	6.5%
26-30	3,423	3.8%
31-35	1,787	2.0%
36-40	2,494	2.8%
40+	2,631	2.9%

Are you a member of ROTC?

SDS 51 (N = 68,241)	Frequency	Percent
No	67,624	99.1%
Yes	617	0.9%

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

SDS 98 (N = 121,718)	Frequency	Percent
No	120,152	98.7%
Yes	1,566	1.3%

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

SDS 53 (N = 1,237)	Frequency	Percent
No	811	65.6%
Yes	426	34.4%

MENTAL HEALTH HISTORY ITEMS

Attended counseling for mental health concerns:

SDS 01 (N = 120,639)	Frequency	Percent
Never	49,688	41.2%
Prior to college	26,588	22.0%
After starting college	24,800	20.6%
Both	19,563	16.2%

Taken a prescribed medication for mental health concerns:

SDS 02 (N = 120,656)	Frequency	Percent
Never	77,912	64.6%
Prior to college	10,260	8.5%
After starting college	17,107	14.2%
Both	15,377	12.7%

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 = 124,748)	Frequency	Percent
Never	114,179	91.5%
1 time	7,242	5.8%
2-3 times	2,601	2.1%
4-5 times	373	0.3%
More than 5 times	353	0.3%

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

SDS 65 (N = 10,258)	Frequency	Percent
Within the last 2 weeks	742	7.2%
Within the last month	389	3.8%
Within the last year	1,828	17.8%
Within the last 1-5 years	4,743	46.2%
More than 5 years ago	2,556	24.9%

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

SDS 72 (N = 122,025)	Frequency	Percent
Never	88,270	72.3%
1 time	6,183	5.1%
2-3 times	9,179	7.5%
4-5 times	3,596	2.9%
More than 5 times	14,797	12.1%

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

SDS 73 (N = 33,009)	Frequency	Percent
Never	3	<0.1%
Within the last 2 weeks	3,776	11.4%
Within the last month	2,838	8.6%
Within the last year	7,170	21.7%
Within the last 1-5 years	11,559	35.0%
More than 5 years ago	7,663	23.2%

Seriously considered attempting suicide (how many times):

SDS 74 (N = 119,484)	Frequency	Percent
Never	78,651	65.8%
1 time	14,039	11.7%
2-3 times	15,199	12.7%
4-5 times	3,119	2.6%
More than 5 times	8,476	7.1%

Seriously considered attempting suicide (the last time):

SDS 75 (N = 39,800)	Frequency	Percent
Never	1	<0.1%
Within the last 2 weeks	4,557	11.4%
Within the last month	3,584	9.0%
Within the last year	8,661	21.8%
Within the last 1-5 years	15,808	39.7%
More than 5 years ago	7,189	18.1%

Made a suicide attempt (how many times):

SDS 76 (N = 119,603)	Frequency	Percent
Never	107,508	89.9%
1 time	7,707	6.4%
2-3 times	3,506	2.9%
4-5 times	431	0.4%
More than 5 times	451	0.4%

Made a suicide attempt (the last time):

SDS 77 (N = 12,007)	Frequency	Percent
Within the last 2 weeks	391	3.3%
Within the last month	308	2.6%
Within the last year	1,552	12.9%
Within the last 1-5 years	5,513	45.9%
More than 5 years ago	4,243	35.3%

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

SDS 78 (N = 118,802)	Frequency	Percent
Never	111,995	94.3%
1 time	2,290	1.9%
2-3 times	2,557	2.2%
4-5 times	455	0.4%
More than 5 times	1,505	1.3%

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

SDS 79 (N = 6,589)	Frequency	Percent
Within the last 2 weeks	836	12.7%
Within the last month	662	10.0%
Within the last year	1,573	23.9%
Within the last 1-5 years	2,348	35.6%
More than 5 years ago	1,170	17.8%

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

SDS 80 (N = 117,717)	Frequency	Percent
Never	116,203	98.7%
1 time	768	0.7%
2-3 times	501	0.4%
4-5 times	78	0.1%
More than 5 times	167	0.1%

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

SDS 81 (N = 1,466)	Frequency	Percent
Never	1	0.1%
Within the last 2 weeks	49	3.3%
Within the last month	45	3.1%
Within the last year	216	14.7%
Within the last 1-5 years	509	34.7%
More than 5 years ago	646	44.1%

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

SDS 82 (N = 117,754)	Frequency	Percent
Never	85,473	72.6%
1 time	15,985	13.6%
2-3 times	10,697	9.1%
4-5 times	1,783	1.5%
More than 5 times	3,816	3.2%

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) (the last time):

SDS 83 (N = 31,222)	Frequency	Percent
Never	1	<0.1%
Within the last 2 weeks	786	2.5%
Within the last month	963	3.1%
Within the last year	5,571	17.8%
Within the last 1-5 years	14,858	47.6%
More than 5 years ago	9,043	29.0%

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

SDS 84 (N = 119,644)	Frequency	Percent
Never	72,272	60.4%
1 time	8,482	7.1%
2-3 times	10,331	8.6%
4-5 times	3,065	2.6%
More than 5 times	25,494	21.3%

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

SDS 85 (N = 44,947)	Frequency	Percent
Never	2	<0.1%
Within the last 2 weeks	3,784	8.4%
Within the last month	3,463	7.7%
Within the last year	10,183	22.7%
Within the last 1-5 years	18,484	41.1%
More than 5 years ago	9,031	20.1%

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

SDS 86 (N = 116,477)	Frequency	Percent
Never	63,686	54.7%
1 time	18,891	16.2%
2-3 times	18,726	16.1%
4-5 times	3,856	3.3%
More than 5 times	11,318	9.7%

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

SDS 87 (N = 50,431)	Frequency	Percent
Never	3	<0.1%
Within the last 2 weeks	3,886	7.7%
Within the last month	3,067	6.1%
Within the last year	10,937	21.7%
Within the last 1-5 years	20,469	40.6%
More than 5 years ago	12,069	23.9%

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

SDS 99 (N = 37,648)	Frequency	Percent
Childhood physical abuse	7,140	19.0%
Childhood sexual abuse	5,714	15.2%
Childhood emotional abuse	19,858	52.7%
Physical attack (e.g., mugged, beaten up, shot, stabbed, threatened with a weapon)	3,837	10.2%
Sexual violence (rape or attempted rape, sexually assaulted, stalked, abused by intimate partner, etc.)	13,427	35.7%
Military combat or war zone experience	241	0.6%
Kidnapped or taken hostage	343	0.9%
Serious accident, fire, or explosion (e.g., an industrial, farm, car, plane, or boating accident)	3,667	9.7%
Terrorist attack	196	0.5%
Near drowning	2,953	7.8%
Diagnosed with life threatening illness	1,205	3.2%
Natural disaster (e.g., flood, quake, hurricane, etc.)	1,857	4.9%
Imprisonment or torture	210	0.6%
Animal attack	1,130	3.0%
Other (please specify)	9,878	26.2%

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

SDS 66 (N = 110,109)	Frequency	Percent
Never	81,618	74.1%
1 time	9,479	8.6%
2-3 times	11,215	10.2%
4-5 times	1,959	1.8%
More than 5 times	5,838	5.3%

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

SDS 67 (N = 27,962)	Frequency	Percent
Never	4	<0.1%
Within the last 2 weeks	7,953	28.4%
Within the last month	5,319	19.0%
Within the last year	8,655	31.0%
Within the last 1-5 years	5,251	18.8%
More than 5 years ago	780	2.8%

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

SDS 68 (N = 110,177)	Frequency	Percent
Never	95,573	86.7%
1 time	6,049	5.5%
2-3 times	5,324	4.8%
4-5 times	962	0.9%
More than 5 times	2,269	2.1%

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

SDS 69 (N = 14,263)	Frequency	Percent
Within the last 2 weeks	2,700	18.9%
Within the last month	2,376	16.7%
Within the last year	4,944	34.7%
Within the last 1-5 years	3,559	25.0%
More than 5 years ago	684	4.8%

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

SDS 70 (N = 115,797)	Frequency	Percent
Never	113,838	98.3%
1 time	1,378	1.2%
2-3 times	393	0.3%
4-5 times	58	0.1%
More than 5 times	130	0.1%

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

SDS 71 (N = 1,894)	Frequency	Percent
Never	1	0.1%
Within the last 2 weeks	168	8.9%
Within the last month	95	5.0%
Within the last year	429	22.7%
Within the last 1-5 years	841	44.4%
More than 5 years ago	360	19.0%

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

SDS 19 (N = 90,969)	Frequency	Percent
None	59,799	65.7%
Once	14,228	15.6%
Twice	8,959	9.8%
3 to 5 times	6,427	7.1%
6 to 9 times	1,129	1.2%
10 or more times	427	0.5%

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

SDS 1096 (N = 103,164)	Frequency	Percent
None	77,161	74.8%
Once	5,765	5.6%
Twice	4,391	4.3%
3 to 5 times	6,236	6.0%
6 to 9 times	3,139	3.0%
10 or more times	6,472	6.3%

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

SDS 22 (N = 85,075)	Frequency	Percent
Strongly disagree	10,143	11.9%
Somewhat disagree	15,120	17.8%
Neutral	14,155	16.6%
Somewhat agree	27,364	32.2%
Strongly agree	18,293	21.5%

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 = 85,801)	Frequency	Percent
Strongly disagree	5,481	6.4%
Somewhat disagree	10,822	12.6%
Neutral	16,113	18.8%
Somewhat agree	34,147	39.8%
Strongly agree	19,238	22.4%

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

SDS 60 (N = 119,469)	Frequency	Percent
No	106,976	89.5%
Yes	12,493	10.5%

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 = 12,294)	Frequency	Percent
Difficulty hearing	365	3.0%
Difficulty seeing	299	2.4%
Difficulty speaking or language impairment	91	0.7%
Mobility limitation/orthopedic impairment	434	3.5%
Traumatic brain injury	281	2.3%
Specific learning disabilities	1,572	12.8%
ADD or ADHD	5,786	47.1%
Autism spectrum disorder	861	7.0%
Cognitive difficulties or intellectual disability	479	3.9%
Health impairment/condition, including chronic conditions	1,355	11.0%
Psychological or psychiatric condition	3,748	30.5%
Other	1,958	15.9%

COVID IMPACT ITEMS

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

SDS 102 (N = 123,865)	Frequency	Percent
No	97,927	83.4%
Yes	19,550	16.6%

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, 91% of students endorsed at least one impacted area impacted by COVID-19, and 85% endorsed multiple areas being affected.

SDS 100 (N = 123,865)	Frequency	Percent
Mental health	84979	68.6%
Academics	75982	61.3%
Motivation or focus	75738	61.1%
Loneliness or isolation	74363	60.0%
Missed experiences or opportunities	69388	56.0%
Relationships (Significant other, friends, family)	45759	36.9%
Career/Employment	38569	31.1%
Financial	37479	30.3%
Health concerns (others)	30755	24.8%
Health concerns (self)	30065	24.3%
Grief/loss of someone	18559	15.0%
Food or housing insecurity	9555	7.7%
Discrimination/Harassment	3780	3.1%
Other (please specify)	1223	1.0%

PROVIDER DATA

The Standardized Data Set includes some basic demographic information about providers (clinicians) at participating counseling centers. The 2021-2022 data set represents 1,831 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	1,330	73.1%
Transgender woman	4	0.2%
Man	440	24.2%
Transgender man	4	0.2%
Non-Binary	29	1.6%
Prefer not to answer	12	0.7%

Age

N	Mean	Mode
1,655	39.5	31

Race/Ethnicity

	Frequency	Percent
African-American/Black	246	13.6%
American Indian or Alaskan Native	7	0.4%
Asian American/Asian	142	7.9%
White	1,163	64.4%
Hispanic/Latino/a	130	7.2%
Native Hawaiian or Pacific Islander	4	0.2%
Multi-racial	70	3.9%
Prefer not to answer	17	0.9%
Other	28	1.5%

Highest Degree (descending sort)

	Frequency	Percent
Doctor of Philosophy	487	26.9%
Master of Arts	300	16.6%
Master of Social Work	269	14.9%
Doctor of Psychology	233	12.9%
Master of Science	231	12.8%
Master of Education	67	3.7%
Bachelor of Science	60	3.3%
Bachelor of Arts	51	2.8%
Doctor of Medicine	38	2.1%
Other	25	1.4%
Education Specialist	15	0.8%
Nursing (e.g. RN, RNP, PNP)	14	0.8%
Doctor of Osteopathy	10	0.6%
Doctor of Education	7	0.4%
Doctor of Social Work	1	0.1%

Highest Degree-Discipline (descending sort)

	Frequency	Percent
Clinical Psychology	496	27.8%
Counseling Psychology	450	25.2%
Social Work	286	16.0%
Mental Health Counseling/Clinical Mental Health Counseling	222	12.4%
Other	117	6.6%
Counselor Education	88	4.9%
Psychiatry	45	2.5%
Marriage and Family Therapist	38	2.1%
Nursing	20	1.1%
Higher Education	14	0.8%
Educational Psychology	7	0.4%
Community Psychology	2	0.1%
Health Education	1	0.1%

Are you licensed under your current degree?

	Frequency	Percent
Yes	1,318	72.9%
No	489	27.1%

Position Type (descending sort)

	Frequency	Percent
Professional staff member	1,313	72.4%
Master's level trainee	97	5.4%
Doctoral level trainee (not an intern)	67	3.7%
Pre-doctoral intern	174	9.6%
Post-doctoral level (non-psychiatric)	67	3.7%
Psychiatric resident	13	0.7%
Other (please specify)	82	4.5%

CENTER DATA

The information below describes the 685 colleges and universities who were CCMH members during the 2021-2022 academic year.

Utilization: The total number of students with at least 1 attended appointment between July 1st and June 30th. The average utilization is 976.

	Frequency	Percent
under 151	53	8.2%
151-200	39	6.0%
201-300	68	10.5%
301-350	40	6.2%
351-400	34	5.2%
401-500	57	8.8%
501-600	47	7.2%
601-700	40	6.2%
701-850	42	6.5%
851-1000	29	4.5%
1001-1200	41	6.3%
1201-1500	28	4.3%
1501-2000	39	6.0%
2001-3000	53	8.2%
3001+	40	6.2%

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 12.1%.

	Frequency	Percent
less than 5%	96	14.8%
5-7%	110	17.0%
7-10	138	21.3%
10-12%	81	12.5%
12-15%	71	11.0%
15-20%	56	8.6%
20-30%	70	10.8%
more than 30%	26	4.0%

Clinical Capacity: The total number of contracted/expected clinical hours for a typical/busy week when the center is fully staffed (not including case management and psychiatric services). One Standardized Counselor represents one block of 24 clinical hours per week. The average clinical capacity is 223.

	Frequency	Percent
48 or less (0-2 Standardized Counselors)	64	9.4%
49-72 (2-3 Standardized Counselors)	76	11.2%
73-96 (3-4 Standardized Counselors)	88	12.9%
97-120 (4-5 Standardized Counselors)	74	10.9%
121-144 (5-6 Standardized Counselors)	54	7.9%
145-168 (6-7 Standardized Counselors)	48	7.1%
169-192 (7-8 Standardized Counselors)	40	5.9%
193-240 (7-9 Standardized Counselors)	57	8.4%
241-312 (9-13 Standardized Counselors)	48	7.1%
313-432 (13-18 Standardized Counselors)	68	10.0%
over 433 (18+ Standardized Counselors)	63	9.3%

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

	Frequency	Percent
No	543	79.3%
Yes	142	20.7%

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

	Frequency	Percent
No	525	76.6%
Yes	160	23.4%

Is the director of your center a member of AUCCCD?

	Frequency	Percent
No	138	20.1%
Yes	547	79.9%

Does your center have session limits for individual counseling?

	Frequency	Percent
No	428	62.5%
Yes	257	37.5%

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

	Frequency	Percent
No	497	72.6%
Yes	188	27.4%

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

	Frequency	Percent
False	546	79.7%
True	139	20.3%

Routine individual counseling appointments usually occur weekly

	Frequency	Percent
False	313	45.7%
True	372	54.3%

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

	Frequency	Percent
False	464	67.7%
True	221	32.3%

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

	Frequency	Percent
False	277	40.4%
True	408	59.6%

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

	Frequency	Percent
False	485	70.8%
True	200	29.2%

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

	Frequency	Percent
False	97	14.2%
True	587	85.7%

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

	Frequency	Percent
False	377	55.0%
True	308	45.0%

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

	Frequency	Percent
False	537	78.4%
True	148	21.6%

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

	Frequency	Percent
False	548	80.0%
True	137	20.0%

Staff receive a reduction in required clinical hours when they assume administrative/managerial responsibilities

	Frequency	Percent
False	117	17.1%
True	568	82.9%

We count community education/outreach activities as direct clinical services

	Frequency	Percent
False	423	61.8%
True	262	38.2%

We count clinical supervision as direct clinical services

	Frequency	Percent
False	389	56.8%
True	296	43.2%

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

	Frequency	Percent
False	420	61.3%
True	265	38.7%

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

	Frequency	Percent
False	258	37.7%
True	427	62.3%

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	388	56.6%
True	297	43.4%

INSTITUTIONAL DATA

Information about institutions was contributed by 684 colleges and universities who were CCMH members during the 2021-2022 academic year.

Institutional Enrollment: The total number of students enrolled at the institution who are eligible for services. The average enrollment is 11,810.

	Frequency	Percent
under 1,501	76	11.1%
1,501-2,500	89	13.0%
2,501-5,000	124	18.1%
5,001-7,500	71	10.4%
7,501-10,000	69	10.1%
10,001-15,000	77	11.2%
15,001-20,000	53	7.7%
20,001-25,000	40	5.8%
25,001-30,000	20	2.9%
30,001-35,000	22	3.2%
35,001-45,000	22	3.2%
45,001+	22	3.2%

Public or Private

	Frequency	Percent
Combined	3	0.4%
Private	279	40.7%
Public	403	58.8%

Type of institution (Check all)

	Frequency	Percent
4-year College/University	615	90%
Religious-Affiliated School	40	6%
2-year College/University	36	5%
Health Professional School	33	5%
Community College	28	4%
STEM Institution	26	4%
Other	21	3%
Creative Focus	12	2%
Historically Black College/ University (HBCU)	6	1%
Tribal	1	0%

Location of Campus

	Frequency	Percent
Canada	8	1.2%
International	19	2.8%
Midwest (IA, IL, IN, MI, MN, MT, ND, NE, OH, SD, WI)	142	20.7%
Northeast (CT, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VA, VT, WV)	232	33.9%
South (AL, AR, FL, GA, KS, KY, LA, MO, MS, NC, NV, OK, SC, TN, TX)	179	26.1%
West (AK, AZ, CA, CO, HI, ID, OR, UT, WA, WY)	105	15.3%

Athletic Division

	Frequency	Percent
Division I	243	35.5%
Division II	106	15.5%
Division III	192	28.0%
None	144	21.0%

This publication is available in alternative media on request. Penn State is an equal opportunity, affirmative action employer, and is committed to providing employment opportunities to all qualified applicants without regard to race, color, religion, age, sex, sexual orientation, gender identity, national origin, disability or protected veteran status. U.Ed. STA 23-168 MPC S167071

Contact Information

Center for Collegiate Mental Health
Penn State University
501 Student Health Center
University Park, PA 16802

Phone: 814-865-1419
Email: ccmh@psu.edu
Web: ccmh.psu.edu

PennState