CCMH
CENTER FOR COLLEGIATE MENTAL HEALTH

2025

ANNUAL REPORT

bringing science and practice together.

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2025 Report Introduction

The 2025 Annual Report summarizes data contributed to CCMH during the 2024–2025 academic year, beginning July 1, 2024 and closing on June 30, 2025. De-identified data were contributed by 209 college and university counseling centers, describing 162,187 unique college students seeking mental health treatment, 4,694 clinicians, and 1,114,255 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 permission from their institution (e.g., Institutional Review Board) to participate in client-level data contribution to CCMH. Although CCMH maintains membership of over 800 institutional counseling centers, only a percentage of these institutions participate in clientlevel data contribution. However, all counseling center members contribute center-level data for research.

REMINDERS FROM PRIOR REPORTS

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

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

- **2022** – CCMH explored how counseling centers contribute to the academic mission of institutions by examining the risk and protective factors associated with voluntary withdrawal from school during services. The study found that students who identified as a freshman/first-year status with elevated levels of academic distress paired with a history of psychiatric hospitalization were 48% more likely to withdraw from school during treatment than clients without these factors. Protective factors that reduce the risk of withdrawal were also identified: improvement of Depression, Generalized/Social Anxiety, Academic Distress, and overall distress symptoms during counseling services. Most notably, when students experience a decrease in Academic Distress during counseling while concurrently participating in an extracurricular activity, they were 50% less likely to withdraw from school. These findings suggest when students improve during counseling, they are more likely to persist in school. Institutions should be aware of the critical role college counseling centers play in the academic success of college students.
- **2023** – CCMH investigated if experiences of self-reported discrimination or unfair treatment based on six identities are associated with mental health concerns and symptom improvement at college counseling centers. Findings revealed a strong relationship between discrimination and increased general distress, social isolation, and suicidal thoughts at the beginning of treatment. Counseling centers were shown to effectively treat clients with experiences of discrimination, as they demonstrated commensurate improvement in symptoms of distress, social isolation, and suicidal ideation during services as students with no discrimination. However, clients who reported discrimination consistently ended treatment with higher average levels of distress, demonstrating a persistent outcome disparity. These findings highlight the critical role college counseling centers serve in supporting the Diversity, Equity, Inclusion, and Belonging (DEIB) goals that are a priority for many institutions. Institutions and leaders who prioritize and value mental health and wellness must simultaneously support DEIB initiatives to close the disparities in mental health symptoms and treatment outcomes among students who face identity-based discrimination.
- **2024** – CCMH examined college students with a history of suicidal or self-injurious behaviors (S/SIB) receiving counseling center services. Compared to students without such histories, these students entered treatment with more severe distress and complex co-occurring concerns, used more specialized services (e.g., case management, psychiatry), and experienced more critical events (e.g., self-harm or suicide attempts) during care. Despite these challenges, counseling centers were highly effective, as students with S/SIB showed significant reductions in distress and suicidal ideation. However, these students still ended treatment with higher distress than peers without S/SIB. These findings highlight the essential role of counseling centers in suicide prevention and campus safety. Institutions can strengthen this impact by investing in integrated care models that combine psychological treatment, psychiatric services, case management, and collaboration with campus partners (e.g., Title IX, Dean of Students, Financial Aid, Disability Services) to better support at-risk students and promote academic success.

2025 HIGHLIGHTS

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

Financial insecurity is a critical societal problem that has significant implications for higher education. While difficulty meeting basic needs can lead to a wide range of consequences for college students, there has been limited research thus far that has examined these impacts in a national sample of clients receiving care at counseling centers. In this year's special section, CCMH explored the prevalence rates of various types of financial insecurity, followed by an investigation of how students with one or more financial insecurities, compared to those without, differed by employment, engagement in extracurricular activities, and psychological distress. The findings revealed that students who were older, fifth year or higher undergraduates, or the first generation in their family to attend college disclosed considerably higher rates of financial insecurity. Additionally, financially insecure students, on average, worked more, were less involved in campus activities, and experienced higher levels of psychological distress.

These findings underscore the importance of assessing financial insecurity at the beginning of services at counseling centers, which can help clinicians develop case conceptualizations, treatment plans, and recommendations that effectively address areas of basic needs and associated distress. While financial insecurities are connected to

acute psychological symptoms that counseling centers can effectively support, deprivation of basic needs is not a mental health diagnosis. In fact, it is a microcosm of a larger societal problem of equity and access that needs to be acknowledged and confronted, which requires the cooperative efforts of college counseling centers, external departments, institutional leadership, and local partnerships. Reductions in budgets and resources that impede the delivery of financial health initiatives at institutions could have deleterious and compounding consequences for students' basic needs that are essential to succeeding academically. Thus, investments in supportive mechanisms, including the counseling center and collaborative case management services, belonging and inclusion initiatives, departments that work with populations that are more likely to report financial insecurity (e.g., adult learners, first-generation students), and other adjunctive support services that fulfill basic needs (e.g., financial aid, dean of students, financial literacy services, food pantries, housing and residence life, disability services), are vital to promote student success.

OTHER 2025 HIGHLIGHTS

- Rates of prior counseling and psychotropic medication usage continued to increase over the past year and are at their highest levels since this data was first collected in 2012.
- History of counseling continued to be the mental health history item with the largest 12-year increase: over 64% of students entered services with prior counseling.
- After a period of annual increases between 2012 and 2023, history of trauma slightly declined in the past two years, however, it has increased overall during the past 12 years, rising from 37.5% in 2012 to 44.2% this past year.
- Prior to the onset of the COVID-19 pandemic in 2020, many of the threat-to-self variables were increasing, which was followed by an immediate slight decline in these variables. However, since 2020–2021, the proportion of students with histories of threat-to-self characteristics has generally remained stable, with some variables demonstrating minor annual increases (histories of non-suicidal self-injury and suicide attempts) and others displaying marginal declines (serious suicidal ideation over the past month). Of note, in 2024–2025, the prevalence rates for histories of non-suicidal self-injury (29.2%) and suicide attempt(s) (11.3%) reached their highest levels since this data has been collected.
- All areas of self-reported distress remained relatively unchanged or slightly declined over the past year. This included areas that were previously increasing, such as Generalized and Social Anxiety. Social Anxiety continued to display the greatest 15-year change across all areas of distress.
- Although it remained flat this past year, Anxiety continues to be the most common presenting concern, with 64.9% of clients experiencing anxiety as assessed by clinicians. Relationship problem (specific) continued to show an upward trend as a top concern since 2020, while Trauma remained largely unchanged after reaching its highest level in 2022–2023.
- After the onset of the COVID-19 pandemic in 2020, CCMH began collecting data on the mode of counseling service delivery, which included in-person, video, audio, or text. From 2020 to 2025, the percentage of students who received exclusive in-person individual counseling services increased from 1.7% to 68.0%, and the proportion of those who were solely provided video care declined from 96.1% to 10.3%. For the past four years (2021–2024), the proportion of students who received hybrid care (combination of in-person and video) ranged from 20% to 25%.

Clinical Load Index

BACKGROUND OF THE CLI

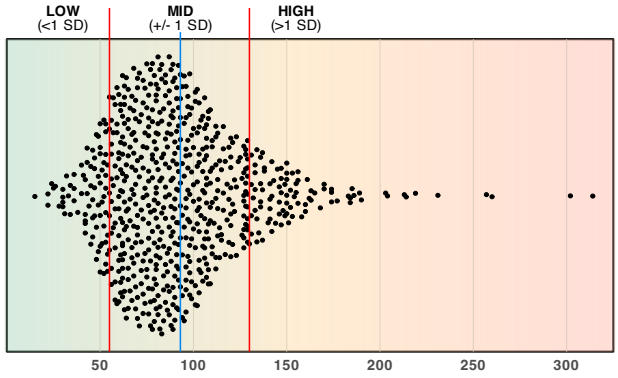
The Clinical Load Index (CLI) was developed in 2018–2019 by the Center for Collegiate Mental Health (CCMH), with support from the International Accreditation of Counseling Services (IACS) and the Association of University and College Counseling Center Directors (AUCCCD). The CLI was designed to provide a more accurate and consistently comparable supply-demand metric that describes the landscape of staffing levels. 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. 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). 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.

2024–2025 CLI DISTRIBUTION

To accompany this Annual Report, CCMH updated the CLI distribution based on new data from 676 CCMH member college counseling centers during the 2024–2025 Academic Year (7/1/2024 to 6/30/2025). Complete details about the 2024–2025 CLI (and an interactive tool to calculate your CLI) can be found on the CLI page of the CCMH website. The following describes the CLI distribution for 2024–2025:

- N = 676
- Range = 15-314
- Mean = 93
- Median = 87.5
- Standard Deviation = 37
- Zones
  - Low: Less than 55
  - Mid: Between 55 and 130
  - High: Greater than 130



Students with Financial Insecurity: Prevalence and Associations with Employment, Extracurricular Activities, and Psychological Distress

Financial insecurity, defined as having insufficient resources to maintain an adequate standard of living and the anxiety associated with this, is a pervasive societal problem (Richiardi & He, 2020). According to the United States Department of Agriculture (USDA), 13.5% of U.S. households (47.4 million people) experienced food insecurity in 2023. Some aspects of financial insecurity are also increasing, as the rate of homelessness in the U.S. went up 18% from 2023–2024, with a total of 771,480 impacted individuals (The 2024 Annual Homelessness Assessment Report to Congress).

Limited access to basic needs also affects students attending institutions of higher education. In fact, the National Center for Education Statistics (NCES) discovered that 22.6% of undergraduates and 12.2% of graduate students reported food insecurity in the past 30 days. Moreover, the same study revealed 8% of undergraduates and 4.6% of graduate students experienced homelessness within the last month. Beyond food and housing insecurities, the findings highlighted the existence of general financial stress, where 18% of undergraduate students indicated they could not pay $500 if they encountered an unexpected financial need in the next month. Based on these data, it is no surprise that 42% of college/university provosts have indicated food and housing insecurities are a substantial threat to student safety and well-being (Inside Higher Education, 2025).

Unmet basic needs can lead to a wide array of consequences for college students, including long work hours that potentially interfere with academics, fewer opportunities to participate in campus activities, and increased psychological distress (Cadaret & Bennett, 2019; Ryu & Fan, 2023). However, there has been limited research thus far that has examined these impacts in a national sample of students seeking treatment at college counseling centers. Given the well-documented serious and complex mental health concerns frequently treated at counseling centers, it is critical to evaluate how financial concerns affect students receiving care. Thus, on July 1, 2023, CCMH began investigating a broad range of financial insecurities by implementing the following Yes/No questions as part of the Standardized Data Set (SDS) – Client Information form:

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

- Enough food to eat
- Housing/utilities
- Basic transportation needs
- Necessary medical care
- Educational materials

Students who marked, "Yes," to any of the above items were considered to be experiencing financial insecurity. In the current investigation, CCMH used the financial insecurity item to answer the questions below:

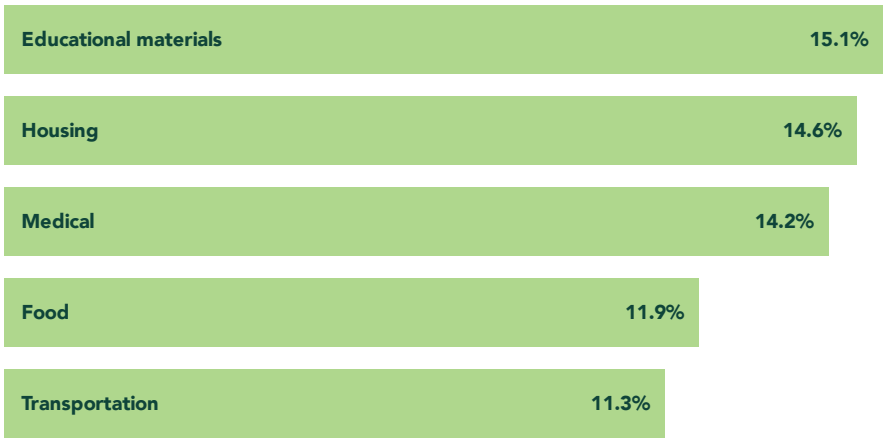
1. What is the prevalence of financial insecurity:
    - overall?
    - across centers?
    - within various age groups?
    - by academic year?
    - by first-generation status?
2. Do clients with financial insecurity, compared to those without, differ by:
    - engagement in extracurricular activities?
    - employment status?
    - levels of psychological distress?

Data related to financial insecurity, academic year, and first-generation status were collected from the CCMH Standardized Data Set (SDS) – Client Information form, while symptoms of psychological distress within the past two weeks were assessed using the Counseling Center Assessment of Psychological Symptoms (CCAPS). Both of these self-report tools are typically completed when students initiate services at college counseling centers. Data for the current Annual Report include 100,727 students who were treated at 110 different college counseling centers from 2023 to 2025.

PREVALENCE OF FINANCIAL INSECURITY

Overall

A total of 25.4% of students (approximately 25,500) reported one or more areas of current financial insecurity. Specific insecurity types were endorsed between 11.3% and 15.1%, with educational materials as the most prevalent and transportation as the least.



Across Centers

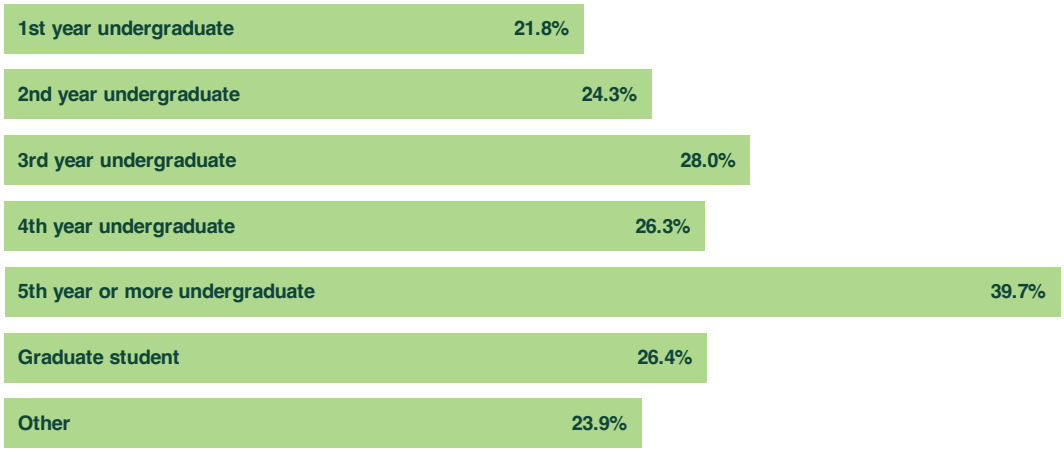
While a quarter of students nationally reported financial insecurity, rates varied substantially across centers. In most centers, 15% to 45% of students experienced difficulty meeting their basic needs.

Age

Older students were more likely to report financial insecurity. Those 30 years of age or older were the most likely to report insecurity (38.1%), while those ages 18-19 were the least likely (20.3%).

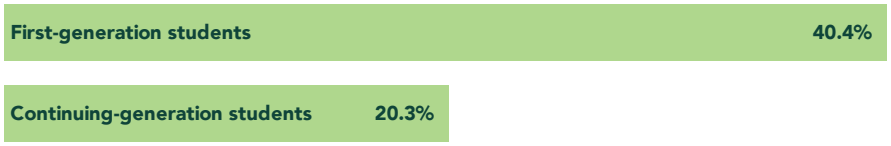
Academic Status

The prevalence of financial insecurity was generally similar between the various undergraduate and graduate academic statuses, ranging from 21.8% to 28.0%. However, undergraduates in their 5th year and beyond reported substantially higher rates of challenges affording basic needs (39.7%).



First-generation status

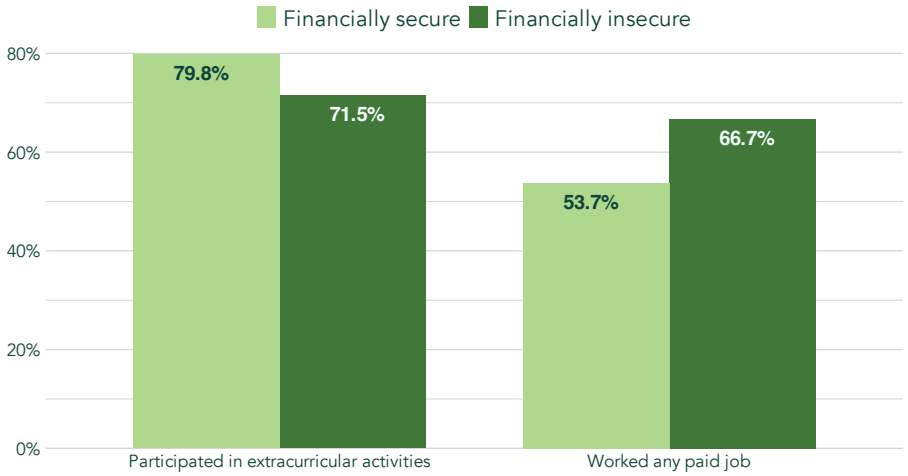
Students who identified as the first generation in their family to attend college reported a notably higher rate of financial insecurity (40.4%) compared to continuing-generation students (20.3%).



COMPARISONS OF STUDENTS WITH AND WITHOUT FINANCIAL INSECURITY

Employment and Activities

Students with financial insecurity, comparatively, were more likely to be employed, but they were less likely to participate in extracurricular activities. Additional analyses revealed 41.1% of students with financial insecurity worked extended hours (15+ hours per week) versus 25.8% of those without any insecurities.



Levels of distress

Students with financial insecurity versus those without reported more severe psychological symptoms within the past two weeks. There were small differences in Depression, Generalized Anxiety, Social Anxiety, Academic Distress, Eating Concerns, and General Distress, while a moderate difference was observed in Family Distress. There was a negligible difference in Substance Use symptoms between students with and without financial insecurity.

SUMMARY

Findings

Financial insecurity is a critical societal problem that has significant implications for higher education. While unmet basic needs can lead to a wide range of consequences for college students, there has been limited research thus far that has examined these impacts in a national sample of treatment-seeking students. Thus, an exploration of the prevalence rates of various types of financial insecurity was conducted, followed by an investigation of how students with one or more financial insecurities, compared to those without, differed by employment, engagement in extracurricular activities, and psychological distress.

The findings revealed that students who were older, fifth year or higher undergraduates, or the first generation in their family to attend college disclosed considerably higher rates of financial insecurity. Additionally, financially insecure students, comparatively, were more likely to have current employment, work extended hours, and report higher levels of psychological distress. However, students with financial insecurity were less likely to participate in extracurricular activities.

These findings underscore the importance of assessing financial insecurity at the outset of services at college counseling centers. Difficulty meeting basic needs is associated with a variety of concurrent circumstances (e.g., more employment and less extracurricular engagement) and elevated psychological symptoms. Providers should be especially cognizant of financial concerns among students who are adult learners, first generation to attend college, and participating in an extended course of undergraduate studies. We encourage clinicians of multiple disciplines (e.g., therapists, case managers, psychiatric providers) to use information gained during their assessment to develop case conceptualizations, treatment plans, and recommendations that effectively address areas of financial insecurity. For example, awareness of financial difficulties can help providers better understand the factors that contribute to clients' concerns, identify and refer them to adjunctive services that increase access to financial or basic needs resources, and provide necessary psychological care to help them cope with the distress associated with financial insecurity and mental health concerns. Finally, at the center level, counseling centers may consider developing policies and practices that directly address financial insecurities, such as creating a food pantry at the center, extending services for those with financial hardship who might need additional care, and establishing streamlined referrals to external departments and agencies that can efficiently fulfill the unmet needs.

While financial insecurities are associated with acute psychological distress, it is evident, given the range of associated stressors and experiences, that the support systems needed to address this widespread problem extend beyond the scope of counseling services. The findings from this investigation underscore the importance of counseling centers forming intentional partnerships with external departments and local agencies to fulfill basic needs that are essential for survival, equity, personal growth, and success. Moreover, it is critical for institutions to strengthen programs that commonly support specific populations, particularly adult learners, those with more extended undergraduate careers (five years or more), and first-generation college students. Additionally, students with financial insecurity might have reduced access to a collegiate community due to employment demands coupled with reduced participation in extracurricular activities. One of the key priorities of many colleges/universities is intentionally promoting engagement in communities and experiences, which is associated with positive outcomes for well-being and academic success. Therefore, it is imperative for institutions to be proactive, creative, and considerate in efforts to develop equitable experiences of community and belonging within this population of students who may be navigating a different collegiate experience than those who are financially secure.

Additional considerations

It is important to note several considerations related to the current findings. The association discovered between financial insecurity and psychological distress was correlational. Thus, while this data is consistent with prior research and theory suggesting that financial insecurity leads to psychological distress, this relationship could be due to other factors. As one example, the difference in the CCAPS Family Distress subscale between financially secure and insecure students could be due to family difficulties that limit financial support from caregivers rather than financial insecurity itself causing increases in Family Distress. Additionally, while 25.3% of students seen at counseling centers nationally reported one or more areas of financial insecurity, the prevalence significantly varied across individual centers: at the majority of centers, between 15% and 45% of students reported unmet basic needs. Therefore, it is important for centers to examine their local data to determine how these findings might inform their services, including identifying which student groups are most likely to report financial insecurity (e.g., those with various combinations of educational, psychological, or identity-related characteristics). Given the variability in financial insecurity rates between centers, further studies should investigate institutional characteristics associated with frequencies of unmet basic needs. Finally, this investigation did not further

explore how the specific insecurity types (i.e., Enough food to eat, Housing/utilities, Basic transportation needs, Necessary medical care, Educational materials) are associated with employment, activity engagement, and psychological distress. While many students with financial insecurity report multiple areas of unmet basic needs, further exploration could determine if specific insecurity types are differentially associated with stressors, experiences, or symptoms.

Conclusions

Over a quarter of students treated at college counseling centers nationally initiate services with one or more areas of financial insecurity. On average, students with difficulty meeting basic needs work more, are less involved in campus activities, and experience higher levels of psychological distress. While financial insecurities are associated with acute psychological symptoms that counseling centers can effectively support, deprivation of basic needs is not a mental health diagnosis. Rather, the fact that students with financial insecurity report more severe symptoms likely reflects the expected distress associated with significant financial difficulties. Effectively addressing financial insecurity requires the cooperative efforts of college counseling centers, external departments, institutional leadership, and local partnerships. Without these partnerships and institutional support, unmet basic needs are likely to persist. For example, reductions in budgets that impede the delivery of financial aid or work study initiatives at institutions could have deleterious and compounding consequences for students' basic needs that are essential to succeeding academically. Thus, investments in supportive mechanisms, including the counseling center and collaborative case management services, belonging and inclusion programs, departments that work with populations with a high prevalence of financial insecurity (e.g., adult learners, first-generation students), and other adjunctive support services that fulfill basic needs (e.g., financial aid, dean of students, financial literacy services, food pantries, housing and residence life, disability services) are vital to promote student success.

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Annual Trends

MENTAL HEALTH TRENDS

As of this report, CCMH has generated 15 annual data sets (2010–2011 through 2024–2025), 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.

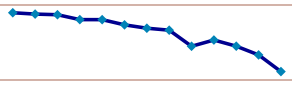
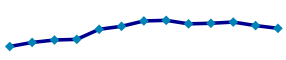
Data Sets

The table below summarizes the amount of data contributed to CCMH over the past 15 academic years. It is important to note the annual changes in number of clients merely reflect an increase in data that has been contributed by counseling centers and not an increase in utilization of counseling center services.

Year	Number of Centers	Number of Clients
2010–2011	97	82,611
2011–2012	120	97,012
2012–2013	132	95,109
2013–2014	140	101,027
2014–2015	139	100,736
2015–2016	139	150,483
2016–2017	147	161,014
2017–2018	152	179,964
2018–2019	163	207,818
2019–2020	153	185,440
2020–2021	180	153,233
2021–2022	180	190,907
2022–2023	195	185,114
2023–2024	213	173,536
2024–2025	209	162,187

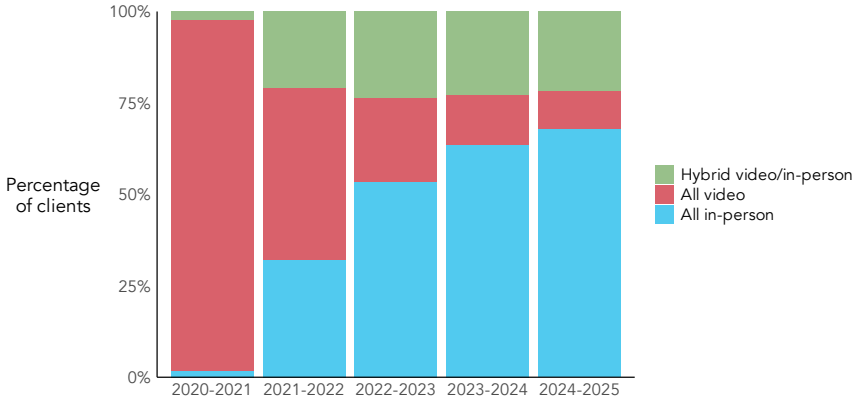
Mental Health Trends (2012–2025)

Several mental health history trends shifted in 2024–2025. Rates of prior counseling and psychotropic medication usage continued to increase and currently are at their highest levels since this data was collected in 2012. Past counseling is the mental health history item with the largest 13-year increase: over 64.4% of students entered services with prior counseling. After a period of annual increases between 2012 and 2023, history of trauma slightly declined in the past two years. Prior to the onset of the COVID-19 pandemic in 2020, many of the threat-to-self variables were increasing, which was succeeded by an immediate slight decline in these variables. However, since 2020–2021,the proportion of students with histories of threat-to-self characteristics has generally remained stable, with some variables demonstrating slight annual increases (histories of non-suicidal self-injury and suicide attempts) and others displaying marginal declines (serious suicidal ideation over the past month). Of note, in 2024–2025, the prevalence rates for histories of non-suicidal self-injury (29.2%) and suicide attempt(s) (11.3%) reached their highest levels since this data was collected. Threat to others (considered or intentionally caused serious injury to another) has shown minimal to no changes over the past several years. Notably, alcohol use variables have decreased over the past 13 years, with binge drinking decreasing by an actual rate of 15.6%.

Item	13-Year Change	2012–2025	Lowest	Highest	2024–2025
Prior Treatment					
Counseling	+16.6%		47.8%	64.4%	64.4%
Medication	+7.5%		32.4%	39.9%	39.9%
Hospitalization	0.0%		8.0%	10.3%	10.1%
Threat-to-Self					
Non-Suicidal Self-Injury	+6.2%		23.0%	29.2%	29.2%
Serious Suicidal Ideation	+4.1%		30.1%	36.9%	34.1%
Serious Suicidal Ideation (last month)	-1.7%		5.3%	8.2%	5.3%
Suicide Attempt(s)	+2.7%		8.7%	11.3%	11.3%
Some Suicidal Ideation (past 2 weeks)	-1.5%		32.5%	39.6%	32.5%
Threat-to-Others					
Considered causing serious physical injury to another person	-5.1%		5.2%	11.2%	6.1%
Intentionally caused serious injury to another person	-2.0%		1.2%	3.4%	1.4%
Traumatic Experiences					
Had unwanted sexual contact(s) or experience(s)	+6.6%		18.9%	27.4%	25.6%
Experienced harassing, controlling, and/or abusive behavior	+3.6%		32.8%	39.6%	36.9%
Experienced traumatic event	+6.7%		37.5%	46.8%	44.2%
Drug and Alcohol					
Felt the need to reduce alcohol/drug use	-2.2%		24.8%	27.5%	24.8%
Others concerned about alcohol/drug use	-4.8%		12.7%	17.6%	12.7%
Treatment for alcohol/drug use	-2.7%		1.7%	4.4%	1.7%
Binge drinking	-15.6%		25.9%	41.5%	25.9%
Marijuana use	+3.1%		19.1%	26.0%	23.9%

MODE OF SERVICE TRENDS

After the onset of COVID-19 in 2020, CCMH began collecting data on the mode of counseling service delivery, which included in-person, video, audio, or text. The figure below highlights the changes in the mode of services from 2020 to 2025. Audio and text were excluded from the analyses due to their relative infrequent usage across the years. From 2020 to 2025, the percentage of students who received exclusive in-person services increased from 1.7% to 68.0%, and the proportion of those who were solely provided video care declined from 96.1% to 10.3%. For the past four years (2021–2025), the proportion of students who received hybrid care (combination of in-person and video) ranged from 20 to 25%.



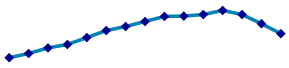
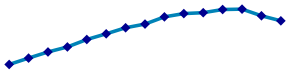
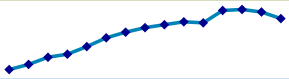
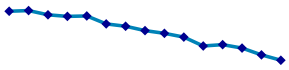
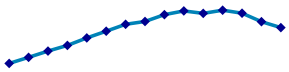
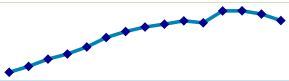
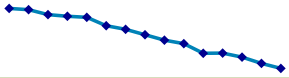
CCAPS TRENDS

All CCAPS Subscale scores continued to remain relatively flat or slightly decline over the past year. This included areas that were previously increasing until the 2021 to 2024 time period, such as Depression, Generalized Anxiety, and Social Anxiety. After the onset of the COVID-19 pandemic, Academic Distress notably increased in 2020–21, however it has since receded, and declined to slightly below pre- pandemic levels. Social Anxiety continued to demonstrate the greatest 15-year change across all CCAPS subscales, although it has slightly decreased from its highest level in 2023–2024.

CCAPS Trends: Average Subscale Scores (2010 to 2025)

All CCAPS Subscale scores remained relatively flat or slightly declined over the past year. This included areas that were previously increasing, such as Generalized and Social Anxiety. Academic Distress continues to recede from the substantial elevation after the onset of the COVID-19 pandemic in 2020, returning this year to pre- pandemic levels. Social Anxiety continued to display the greatest 14-year change across all CCAPS subscales, although it has decreased slightly from its highest value.

CCAPS Trends (2010–2025)

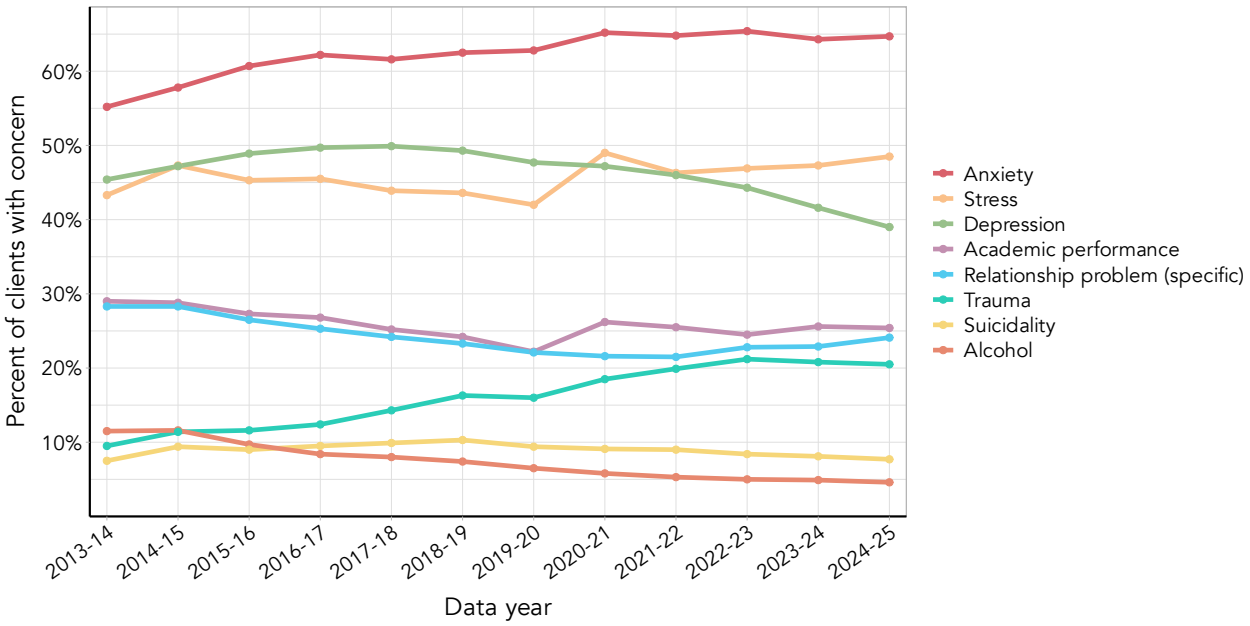
Item	15-Year Change	2010–2025	Lowest	Highest	2024–2025
CCAPS-62					
Depression	+0.13		1.59	1.84	1.72
Generalized Anxiety	+0.23		1.61	1.91	1.85
Social Anxiety	+0.27		1.82	2.14	2.09
Academic Distress	-0.01		1.84	2.05	1.84
Eating Concerns	+0.10		1.00	1.12	1.10
Frustration/Anger	-0.08		0.96	1.04	0.96
Substance Use	-0.26		0.51	0.77	0.51
Family Distress	+0.14		1.29	1.45	1.43
CCAPS-34					
Depression	+0.01		1.55	1.74	1.56
Generalized Anxiety	+0.19		1.77	2.05	1.96
Social Anxiety	+0.27		1.77	2.10	2.05
Academic Distress	-0.04		1.88	2.10	1.88
Eating Concerns	+0.08		0.94	1.07	1.03
Frustration/Anger	-0.13		0.80	0.93	0.80
Alcohol Use	-0.32		0.41	0.73	0.41
Distress Index	+0.06		1.65	1.83	1.72

CLICC TRENDS

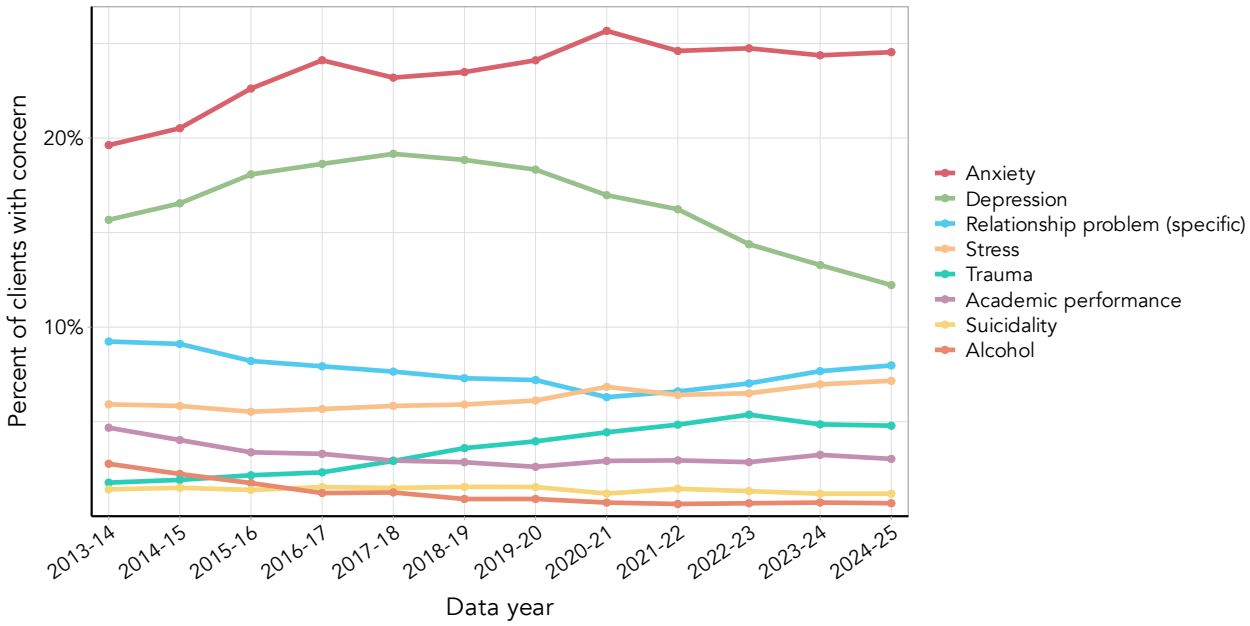
The Clinician Index of Client Concerns (CLICC) captures the presenting concerns of counseling center clients, as assessed by the clinician during an initial appointment. The CLICC includes 54 concerns and asks the clinician (a) to check all that apply and (b) to identify the "top concern" of those selected.

The graphs below display notable trends in the most frequently assessed CLICC items by clinicians. After steadily increasing since 2014–2015, Trauma as a general and top concern was relatively flat or somewhat decreased this past two years. Notably, relationship problem (specific) continued to show a slight upward trend as a top concern since 2020–2021. Anxiety has remained flat as both a general and top concern, while depression continued to decline in both areas.

CLICC Trends (Check All That Apply): Percentage of Clients with Each Concern from 2013 – 2025



CLICC Trends (Top Concern): Percentage of Clients with Each Concern from 2013 – 2025



Appointment Statistics

UTILIZATION

Data from 2024–2025 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 153,253 students across participating CCMH centers:

- The most common number of appointments per client per year is one.
- Clients averaged 5.77 total attended appointments of any kind, with a median of 4 appointments, and a range of 1-121 appointments.
- Clients averaged 5.17 attended Individual Treatment (initial clinical evaluations and individual counseling) appointments, with a median of 4 attended appointments, and a range of 1-120 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 21% of all appointments, averaging 24 appointments.
- 1% of clients accounted for 7% of all appointments, averaging 35 appointments.

ATTENDANCE

Out of 1,114,255 appointments, 75% were marked as attended.

Client Attendance	Frequency	Percent
Attended	837,834	75.3%
Center Closed	8,010	0.7%
Client Cancelled	52,737	4.7%
Client Cancelled Late	23,602	2.1%
Client No Show	81,443	7.3%
Client Rescheduled	60,205	5.4%
Counselor Cancelled	28,014	2.5%
Counselor Rescheduled	20,839	1.9%

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

Appointment Category	Total Sessions	Percent Attended
Individual psychotherapy/counseling	674,615	73.5%
Initial clinical evaluation	106,626	78.0%
Brief Screening or Walk-in	88,360	86.5%
Group – psychotherapy	75,657	64.5%
Psychiatric follow-up	33,971	73.7%
Case management	32,517	82.6%
Specialized individual treatment	8,500	74.4%
Couple's therapy	7,133	74.8%
Psychiatric evaluation	6,689	81.3%
Group – workshop	6,370	53.6%
Psychological Testing or Assessment	3,814	81.2%
Group – clinic	2,542	58.0%

APPOINTMENT LENGTH

Appointment length for all types of appointments was rounded up to the next 15-minute increment for 0 to 60 minutes and the next 30-minute mark for appointments 60 to 120 minutes in length. Over two thirds of appointments were 60 minutes. Only 7.5% of appointments were over 60 minutes in length.

Appointment Length (Minutes)	Frequency	Percent
15	45323	5.4%
30	105767	12.6%
45	40932	4.9%
60	583164	69.6%
90	53237	6.4%
120	9412	1.1%

APPOINTMENT MODE

Appointment mode information was provided for 547,897 attended appointments in 2024–2025.

Mode	Frequency	Percent
In person	406119	74.1%
Audio	29265	5.3%
Video	93580	17.1%
Text	18933	3.5%

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 108,500 students who sought care in 2024–2025.

	Business Days	Calendar Days
Brief Screening/Walk-In	1.50	2.05
Initial Clinical Evaluation	4.26	5.91

Approximately 34% of students were seen for their first appointment of the year on the same day it was scheduled, while 83% 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.

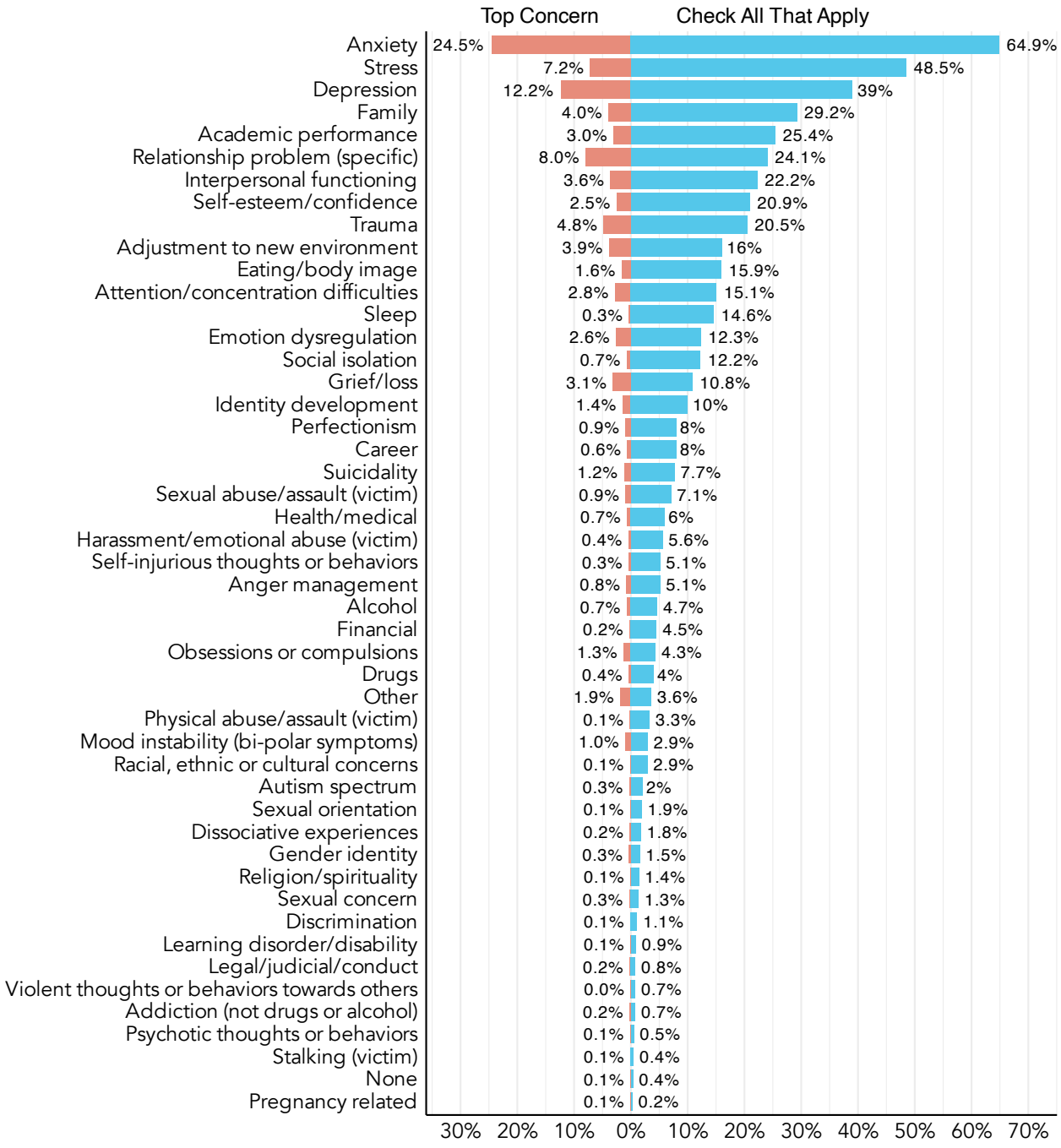
CLINICIAN INDEX OF CLIENT CONCERNS (CLICC)

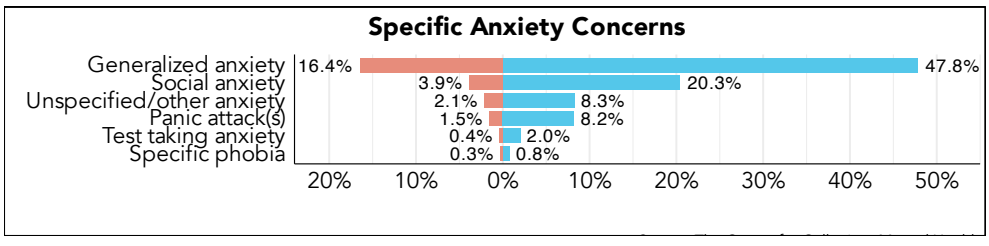
The CLICC was designed by CCMH to capture and facilitate reporting on the most common presenting concerns of counseling center clients, as assessed by the clinician during an initial appointment. The resulting data allows CCMH and individual centers to quickly and easily report on the most common client 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 55,728 clients during the 2024–2025 academic year. For each client, clinicians are asked to "check all that apply" from the list of CLICC concerns (as one client can have many concurrent concerns). The blue bars on the right portion of the graph illustrate the frequency of each concern regardless of how many other concerns a student experienced.

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

Collectively the two bars highlight the proportion of clients who were experiencing each concern (check all that apply) and the proportion for which the specific concern was the primary problem (top concern). For example, while many clients experienced sleep as concern (14.6%), it was the top concern for substantially fewer clients (0.3%). On the other hand, 24.1% of clients had Relationship problem (specific) endorsed as a concern, but a relatively higher proportion (8%) had it endorsed as their top concern. The Anxiety category is displayed broken out into the specific types of anxiety below the primary figure.


Top Concern
Check All That Apply
Anxiety 24.5% 64.9%
Stress 7.2% 48.5%
Depression 12.2% 39%
Family 4.0% 29.2%
Academic performance 3.0% 25.4%
Relationship problem (specific) 8.0% 24.1%
Interpersonal functioning 3.6% 22.2%
Self-esteem/confidence 2.5% 20.9%
Trauma 4.8% 20.5%
Adjustment to new environment 3.9% 16%
Eating/body image 1.6% 15.9%
Attention/concentration difficulties 2.8% 15.1%
Sleep 0.3% 14.6%
Emotion dysregulation 2.6% 12.3%
Social isolation 0.7% 12.2%
Grief/loss 3.1% 10.8%
Identity development 1.4% 10%
Perfectionism 0.9% 8%
Career 0.6% 8%
Suicidality 1.2% 7.7%
Sexual abuse/assault (victim) 0.9% 7.1%
Health/medical 0.7% 6%
Harassment/emotional abuse (victim) 0.4% 5.6%
Self-injurious thoughts or behaviors 0.3% 5.1%
Anger management 0.8% 5.1%
Alcohol 0.7% 4.7%
Financial 0.2% 4.5%
Obsessions or compulsions 1.3% 4.3%
Drugs 0.4% 4%
Other 1.9% 3.6%
Physical abuse/assault (victim) 0.1% 3.3%
Mood instability (bi-polar symptoms) 1.0% 2.9%
Racial, ethnic or cultural concerns 0.1% 2.9%
Autism spectrum 0.3% 2%
Sexual orientation 0.1% 1.9%
Dissociative experiences 0.2% 1.8%
Gender identity 0.3% 1.5%
Religion/spirituality 0.1% 1.4%
Sexual concern 0.3% 1.3%
Discrimination 0.1% 1.1%
Learning disorder/disability 0.1% 0.9%
Legal/judicial/conduct 0.2% 0.8%
Violent thoughts or behaviors towards others 0.0% 0.7%
Addiction (not drugs or alcohol) 0.2% 0.7%
Psychotic thoughts or behaviors 0.1% 0.5%
Stalking (victim) 0.1% 0.4%
None 0.1% 0.4%
Pregnancy related 0.1% 0.2%
30% 20% 10% 0% 10% 20% 30% 40% 50% 60% 70%

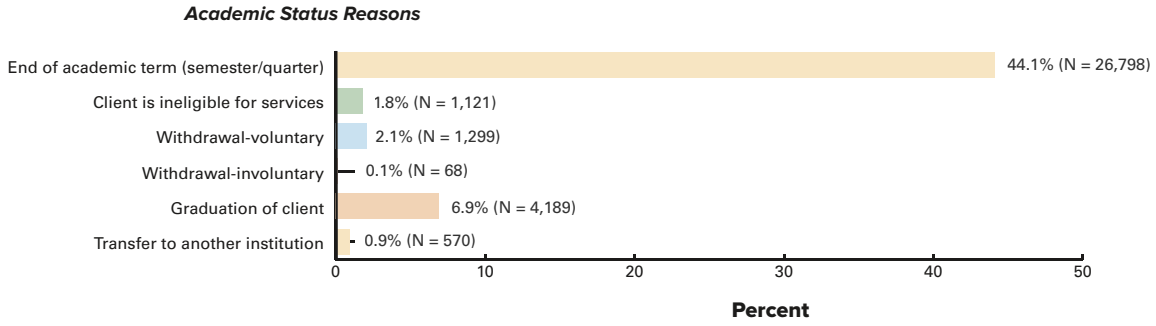

Specific Anxiety Concerns
Generalized anxiety 16.4% 47.8%
Social anxiety 3.9% 20.3%
Unspecified/other anxiety 2.1% 8.3%
Panic attack(s) 1.5% 8.2%
Test taking anxiety 0.4% 2.0%
Specific phobia 0.3% 0.8%
20% 10% 0% 10% 20% 30% 40% 50%

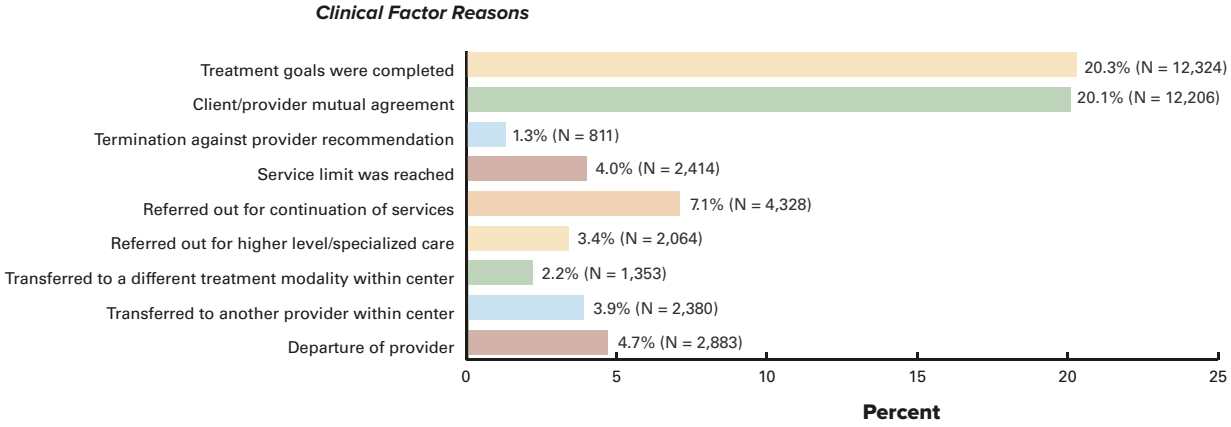
CASE CLOSURE FORM

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.

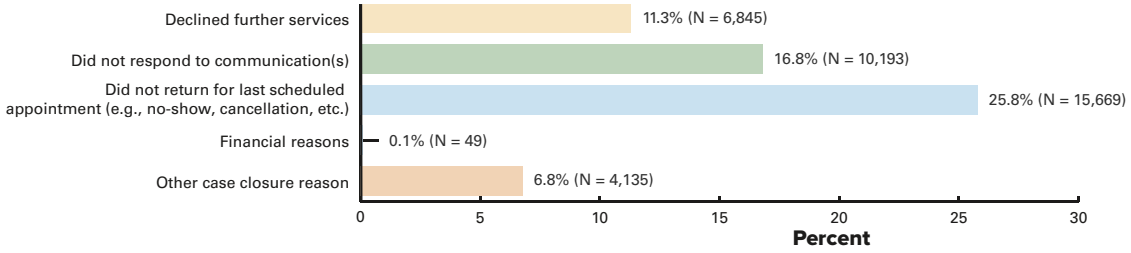
Reasons for Closure of Case

This graph describes the frequency of various reasons why services ended for students who received treatment during the 2024–2025 academic year (N = 60,767). Of note, the top most endorsed reasons were ending of the academic term (44.1%), followed by the client not returning for their last appointment (25.8%), client/provider mutual agreement (20.1%), and treatment goals being completed (20.3%).

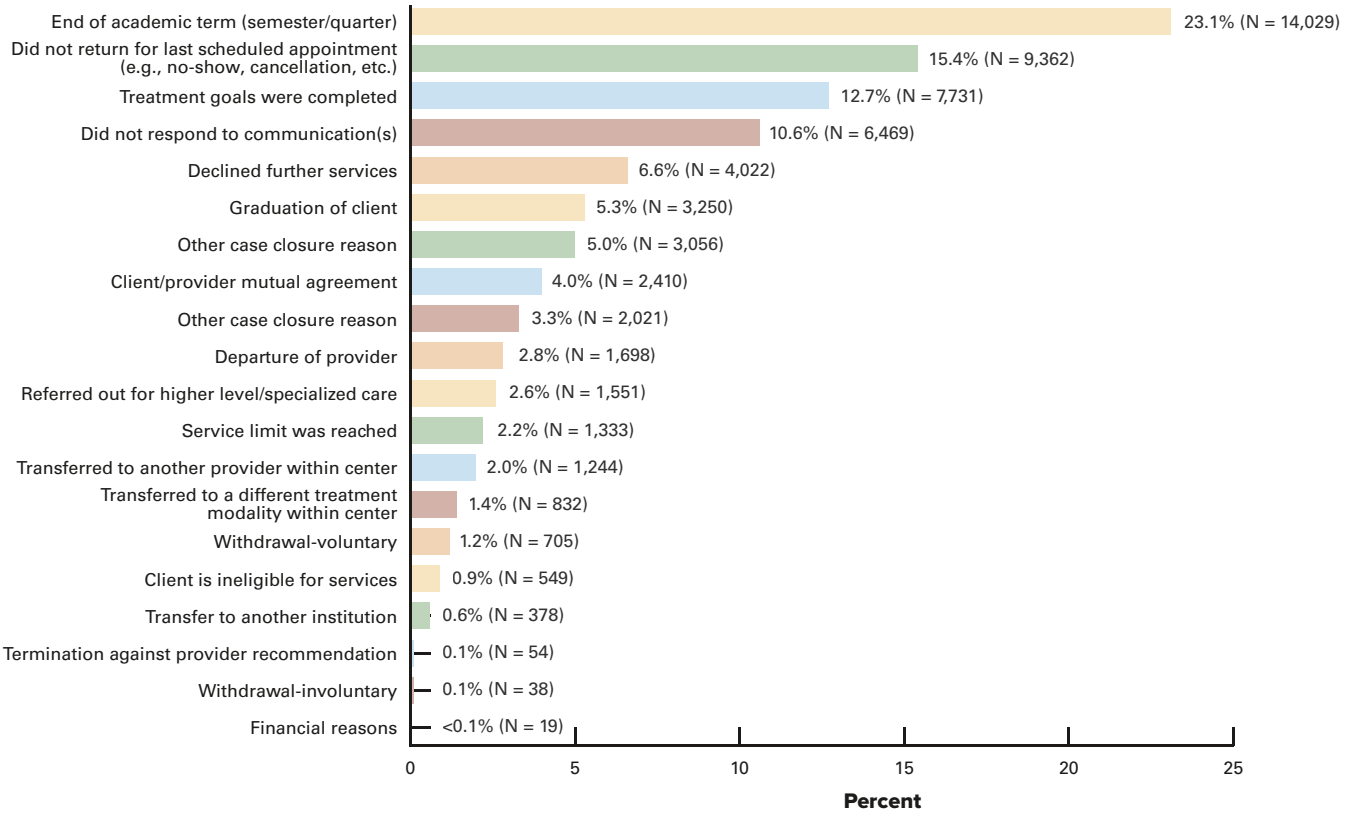




Client Factor Reasons

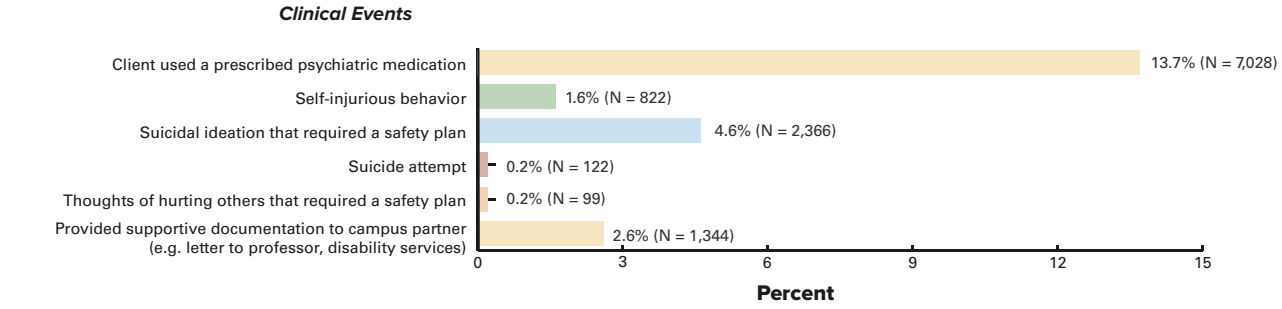


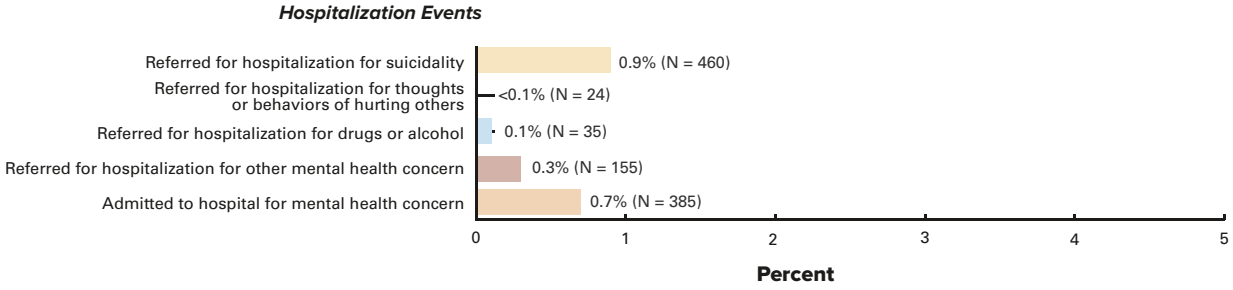
Top Case Closure Reason

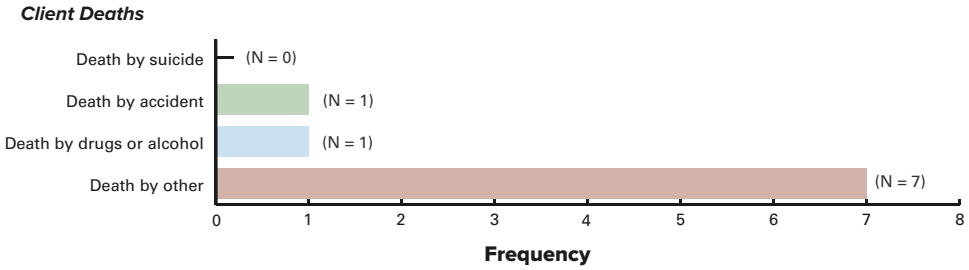


Case Events

This graph describes the frequency of significant events occurring during a course of services for students during the 2024–2025 academic year (N= 51,481).







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
22.01	4.23	18-60

What is your gender identity?

SDS 88 (N = 93,051)	Frequency	Percent
Woman	57,062	61.3%
Transgender woman	631	0.7%
Man	30,549	32.8%
Transgender man	926	1.0%
Non-binary	2,905	3.1%
Self-identify	978	1.1%

What was your sex at birth?

SDS 90 (N = 25,771)	Frequency	Percent
Female	16,627	64.5%
Male	9,132	35.4%
Intersex	12	<0.1%

Do you consider yourself to be:

SDS 91 (N = 85,928)	Frequency	Percent
Asexual	2,369	2.8%
Bisexual	12,197	14.2%
Gay	2,354	2.7%
Heterosexual/Straight	57,209	66.6%
Lesbian	2,669	3.1%
Pansexual	2,671	3.1%
Queer	3,030	3.5%
Questioning	2,454	2.9%
Self-identify	975	1.1%

What is your race/ethnicity?

SDS 1095 (N = 71,121)	Frequency	Percent
African American/Black	8,806	12.4%
American Indian or Alaska Native	1,038	1.5%
Asian American/Asian	10,786	15.2%
Hispanic/Latino/a/e	10,192	14.3%
Middle Eastern/North African	1,521	2.1%
Native Hawaiian or Pacific Islander	458	0.6%
White	46,920	66.0%
Self-identify (please specify)	750	1.1%

12.0% of clients endorsed multiple race/ethnicity options.

What is your country of origin?

Country	Frequency
United States	76,549
India	2,535
China	1,802
Mexico	630
Bangladesh	439
Korea, Republic of	392
Nigeria	375
Iran, Islamic Republic of	356
Canada	313
Pakistan	295
Puerto Rico	280
Brazil	279
Colombia	274

Country	Frequency
Vietnam	274
Philippines	233
Nepal	232
United Kingdom	230
Venezuela	206
Taiwan	170
Peru	156
Ghana	150
Jamaica	149
Germany	145
Russian Federation	141
Turkey	134
Guatemala	130

Country	Frequency
Egypt	126
United States Minor Outlying Islands	126
Dominican Republic	122
Cuba	117
Spain	110
Japan	108
Kenya	108
Ethiopia	101
Saudi Arabia	99
Haiti	95
Ecuador	92

Countries with less than 90 (0.1%) individuals:

Afghanistan; Aland Islands; Albania; Algeria; American Samoa; Andorra; Angola; Antarctica; Antigua and Barbuda; Argentina; Armenia; Aruba; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Barbados; Belarus; Belgium; Belize; Benin; Bermuda; Bhutan; Bolivia; Bosnia and Herzegovina; Botswana; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; 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; Fiji; Finland; France; French Polynesia; Gabon; Gambia; Georgia; Greece; Grenada; Guam; Guinea; Guyana; Honduras; Hong Kong; Hungary; Iceland; Indonesia; Iraq; Ireland; Israel; Italy; Jordan; Kazakhstan; 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; Malta; Marshall Islands; Mauritania; Mauritius; Micronesia, Federated States of; Moldova, Republic of; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Netherlands; Netherlands Antilles; New Zealand; Nicaragua; Niger; Niue; Northern Mariana Islands; Norway; Oman; Palau; Palestinian Territory; Panama; Paraguay; Pitcairn; Poland; Portugal; Romania; Rwanda; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Samoa; Senegal; Serbia; 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; Ukraine; United Arab Emirates; Uruguay; Uzbekistan; Virgin Islands, British; Virgin Islands, U.S.; Yemen; Zambia; Zimbabwe

Are you an international student?

SDS 32 (N = 97,284)	Frequency	Percent
No	88,446	90.9%
Yes	8,838	9.1%

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

SDS 56 (N = 95,196)	Frequency	Percent
No	70,564	74.1%
Yes	24,632	25.9%

Current academic status:

SDS 1037 (N = 81,040)	Frequency	Percent
1st year undergraduate	19,060	23.5%
2nd year undergraduate	16,977	20.9%
3rd year undergraduate	16,184	20.0%
4th year undergraduate	11,347	14.0%
5th year or more undergraduate	2,678	3.3%
Graduate student	12,730	15.7%
Professional degree student	1,248	1.5%
Non-student	81	0.1%
High-school student taking college classes	14	<0.1%
Non-degree student	161	0.2%
Faculty or staff	98	0.1%
Other (please specify)	462	0.6%

Graduate or professional degree program:

SDS 39 (N = 27,753)	Frequency	Percent
Post-Baccalaureate	2,306	8.3%
Masters	4,730	17.0%
Doctoral degree	2,882	10.4%
Law	837	3.0%
Medical	874	3.1%
Pharmacy	249	0.9%
Dental	153	0.6%
Veterinary Medicine	285	1.0%
Not applicable	13,889	50.0%
Other (please specify)	1,548	5.6%

What year are you in your graduate/professional program?

SDS 41 (N = 16,015)	Frequency	Percent
1	6,486	40.5%
2	3,855	24.1%
3	2,525	15.8%
4	2,403	15.0%
5+	746	4.7%

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

SDS 46 (N = 89,629)	Frequency	Percent
No	74,056	82.6%
Yes	15,573	17.4%

Where do you currently live?

SDS 1042 (N = 53,965)	Frequency	Percent
On-campus	22,662	42.0%
Off-campus	30,948	57.3%
I do not live in one stable, secure residence	160	0.3%
Other (please specify)	195	0.4%

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

SDS 44 (N = 85,251)	Frequency	Percent
Alone	12,558	14.7%
Spouse, partner, or significant other	7,806	9.2%
Roommates	55,269	64.8%
Children	1,549	1.8%
Parent(s) or guardian(s)	11,709	13.7%
Family (other)	4,983	5.8%
Other	1,051	1.2%

Relationship status:

SDS 33 (N = 92,752)	Frequency	Percent
Single	55,876	60.2%
Serious dating or committed relationships	32,393	34.9%
Civil union, domestic partnership, or equivalent	380	0.4%
Married	3,447	3.7%
Divorced	292	0.3%
Separated	327	0.4%
Widowed	37	<0.1%

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

SDS 48 (N = 47,206)	Frequency	Percent
None	14,656	31.0%
Occasional participation	10,577	22.4%
One regularly attended activity	8,120	17.2%
Two regularly attended activities	6,738	14.3%
Three or more regularly attended activities	7,115	15.1%

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

SDS 1151 (N = 65,271)	Frequency	Percent
No	60,293	92.4%
Yes	4,978	7.6%

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

SDS 1152 (N = 66,021)	Frequency	Percent
No	54,956	83.2%
Yes	11,065	16.8%

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

SDS 1153 (N = 65,210)	Frequency	Percent
No	62,412	95.7%
Yes	2,798	4.3%

Are you a member of a social fraternity or sorority?

SDS 117 (N = 31,753)	Frequency	Percent
No	27,894	87.8%
Yes	3,859	12.2%

Religious or Spiritual Preference:

SDS 97 (N = 84,103)	Frequency	Percent
Agnostic	13,550	16.1%
Atheist	8,115	9.6%
Buddhist	688	0.8%
Catholic	11,296	13.4%
Christian	26,406	31.4%
Hindu	1,961	2.3%
Jewish	1,418	1.7%
Muslim	2,047	2.4%
No preference	15,876	18.9%
Self-identify	2,746	3.3%

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

SDS 36 (N = 70,179)	Frequency	Percent
Very important	11,870	16.9%
Important	14,835	21.1%
Neutral	23,336	33.3%
Unimportant	10,709	15.3%
Very unimportant	9,429	13.4%

How would you describe your financial situation right now?

SDS 57 (N = 83,321)	Frequency	Percent
Always stressful	9,734	11.7%
Often stressful	16,946	20.3%
Sometimes stressful	29,824	35.8%
Rarely stressful	19,106	22.9%
Never stressful	7,711	9.3%

How would you describe your financial situation while growing up?

SDS 58 (N = 58,130)	Frequency	Percent
Always stressful	6,181	10.6%
Often stressful	9,132	15.7%
Sometimes stressful	14,314	24.6%
Rarely stressful	16,481	28.4%
Never stressful	12,022	20.7%

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

SDS 1055 (N = 71,730)	Frequency	Percent
0	29,599	41.3%
1-5	4,692	6.5%
6-10	8,325	11.6%
11-15	7,377	10.3%
16-20	9,874	13.8%
21-25	4,394	6.1%
26-30	2,533	3.5%
31-35	1,301	1.8%
36-40	1,856	2.6%
40+	1,779	2.5%

Are you a member of ROTC?

SDS 51 (N = 59,085)	Frequency	Percent
No	58,516	99.0%
Yes	569	1.0%

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

SDS 98 (N = 95,036)	Frequency	Percent
No	93,698	98.6%
Yes	1,338	1.4%

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

SDS 53 (N = 1,004)	Frequency	Percent
No	602	60.0%
Yes	402	40.0%

MENTAL HEALTH HISTORY ITEMS

Attended counseling for mental health concerns:

SDS 01 (N = 94,957)	Frequency	Percent
Never	33,801	35.6%
Prior to college	25,152	26.5%
After starting college	17,722	18.7%
Both	18,282	19.3%

Taken a prescribed medication for mental health concerns:

SDS 02 (N = 93,471)	Frequency	Percent
Never	56,146	60.1%
Prior to college	10,173	10.9%
After starting college	12,314	13.2%
Both	14,838	15.9%

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 = 98,572)	Frequency	Percent
Never	88,586	89.9%
1 time	6,584	6.7%
2-3 times	2,551	2.6%
4-5 times	428	0.4%
More than 5 times	423	0.4%

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

SDS 65 (N = 9,516)	Frequency	Percent
Within the last 2 weeks	565	5.9%
Within the last month	308	3.2%
Within the last year	1,579	16.6%
Within the last 1-5 years	4,482	47.1%
More than 5 years ago	2,582	27.1%

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

SDS 72 (N = 98,267)	Frequency	Percent
Never	69,588	70.8%
1 time	5,045	5.1%
2-3 times	7,845	8.0%
4-5 times	2,903	3.0%
More than 5 times	12,886	13.1%

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

SDS 73 (N = 27,499)	Frequency	Percent
Never	2	<0.1%
Within the last 2 weeks	2,706	9.8%
Within the last month	1,991	7.2%
Within the last year	5,390	19.6%
Within the last 1-5 years	11,006	40.0%
More than 5 years ago	6,404	23.3%

Seriously considered attempting suicide (how many times):

SDS 74 (N = 97,466)	Frequency	Percent
Never	64,223	65.9%
1 time	11,533	11.8%
2-3 times	12,169	12.5%
4-5 times	2,566	2.6%
More than 5 times	6,975	7.2%

Seriously considered attempting suicide (the last time):

SDS 75 (N = 31,564)	Frequency	Percent
Never	3	<0.1%
Within the last 2 weeks	2,995	9.5%
Within the last month	2,167	6.9%
Within the last year	5,712	18.1%
Within the last 1-5 years	13,860	43.9%
More than 5 years ago	6,827	21.6%

Made a suicide attempt (how many times):

SDS 76 (N = 97,352)	Frequency	Percent
Never	86,307	88.7%
1 time	6,877	7.1%
2-3 times	3,222	3.3%
4-5 times	432	0.4%
More than 5 times	514	0.5%

Made a suicide attempt (the last time):

SDS 77 (N = 10,730)	Frequency	Percent
Never	1	<0.1%
Within the last 2 weeks	246	2.3%
Within the last month	198	1.8%
Within the last year	1,065	9.9%
Within the last 1-5 years	5,034	46.9%
More than 5 years ago	4,186	39.0%

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

SDS 78 (N = 97,050)	Frequency	Percent
Never	91,091	93.9%
1 time	1,917	2.0%
2-3 times	2,198	2.3%
4-5 times	428	0.4%
More than 5 times	1,416	1.5%

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

SDS 79 (N = 5,601)	Frequency	Percent
Never	2	<0.1%
Within the last 2 weeks	673	12.0%
Within the last month	547	9.8%
Within the last year	1,238	22.1%
Within the last 1-5 years	2,063	36.8%
More than 5 years ago	1,078	19.2%

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

SDS 80 (N =96,370)	Frequency	Percent
Never	95,047	98.6%
1 time	644	0.7%
2-3 times	446	0.5%
4-5 times	77	0.1%
More than 5 times	156	0.2%

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

SDS 81 (N = 1,245)	Frequency	Percent
Never	1	0.1%
Within the last 2 weeks	40	3.2%
Within the last month	52	4.2%
Within the last year	184	14.8%
Within the last 1-5 years	422	33.9%
More than 5 years ago	546	43.9%

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

SDS 82 (N = 94,816)	Frequency	Percent
Never	70,540	74.4%
1 time	11,716	12.4%
2-3 times	8,161	8.6%
4-5 times	1,399	1.5%
More than 5 times	3,000	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 = 23,217)	Frequency	Percent
Within the last 2 weeks	487	2.1%
Within the last month	575	2.5%
Within the last year	3,782	16.3%
Within the last 1-5 years	10,348	44.6%
More than 5 years ago	8,025	34.6%

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

SDS 84 (N = 95,279)	Frequency	Percent
Never	60,167	63.1%
1 time	6,350	6.7%
2-3 times	7,876	8.3%
4-5 times	2,272	2.4%
More than 5 times	18,614	19.5%

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

SDS 85 (N = 33,003)	Frequency	Percent
Never	1	<0.1%
Within the last 2 weeks	2,487	7.5%
Within the last month	2,189	6.6%
Within the last year	6,884	20.9%
Within the last 1-5 years	13,724	41.6%
More than 5 years ago	7,718	23.4%

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

SDS 86 (N = 91,201)	Frequency	Percent
Never	50,920	55.8%
1 time	13,576	14.9%
2-3 times	14,209	15.6%
4-5 times	3,040	3.3%
More than 5 times	9,456	10.4%

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

SDS 87 (N = 37,765)	Frequency	Percent
Never	1	<0.1%
Within the last 2 weeks	2,729	7.2%
Within the last month	2,116	5.6%
Within the last year	7,456	19.7%
Within the last 1-5 years	15,645	41.4%
More than 5 years ago	9,818	26.0%

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

SDS 99 (N = 71,683)	Frequency	Percent
Childhood physical abuse	8,256	11.5%
Childhood sexual abuse	6,128	8.5%
Childhood emotional abuse	20,526	28.6%
Physical attack (e.g., mugged, beaten up, shot, stabbed, threatened with a weapon)	4,119	5.7%
Sexual violence (rape or attempted rape, sexually assaulted, stalked, abused by intimate partner, etc.)	12,552	17.5%
Military combat or war zone experience	294	0.4%
Kidnapped or taken hostage	394	0.5%
Serious accident, fire, or explosion (e.g., an industrial, farm, car, plane, or boating accident)	3,715	5.2%
Terrorist attack	160	0.2%
School/mass shooting	1,296	1.8%
Sextortion (e.g., threat or experience of having sexual content released)	2,666	3.7%
Near drowning	2,937	4.1%
Diagnosed with life threatening illness	1,210	1.7%
Natural disaster (e.g., flood, quake, hurricane, etc.)	2,192	3.1%
Imprisonment or torture	225	0.3%
Animal attack	1,237	1.7%
Other (please specify)	8,657	12.1%

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

SDS 66 (N = 89,353)	Frequency	Percent
Never	67,173	75.2%
1 time	7,030	7.9%
2-3 times	8,538	9.6%
4-5 times	1,630	1.8%
More than 5 times	4,982	5.6%

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

SDS 67 (N = 21,162)	Frequency	Percent
Never	2	<0.1%
Within the last 2 weeks	5,817	27.5%
Within the last month	3,912	18.5%
Within the last year	6,592	31.2%
Within the last 1-5 years	4,205	19.9%
More than 5 years ago	634	3.0%

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

SDS 68 (N = 89,605)	Frequency	Percent
Never	78,189	87.3%
1 time	4,491	5.0%
2-3 times	4,196	4.7%
4-5 times	826	0.9%
More than 5 times	1,903	2.1%

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

SDS 69 (N = 10,808)	Frequency	Percent
Within the last 2 weeks	1,898	17.6%
Within the last month	1,735	16.1%
Within the last year	3,750	34.7%
Within the last 1-5 years	2,851	26.4%
More than 5 years ago	574	5.3%

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

SDS 70 (N = 95,248)	Frequency	Percent
Never	93,624	98.3%
1 time	1,174	1.2%
2-3 times	291	0.3%
4-5 times	50	0.1%
More than 5 times	109	0.1%

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

SDS 71 (N = 1,511)	Frequency	Percent
Never	1	0.1%
Within the last 2 weeks	143	9.5%
Within the last month	114	7.5%
Within the last year	354	23.4%
Within the last 1-5 years	583	38.6%
More than 5 years ago	316	20.9%

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 = 43,660)	Frequency	Percent
None	29,728	68.1%
Once	6,392	14.6%
Twice	4,184	9.6%
3 to 5 times	2,685	6.1%
6 to 9 times	494	1.1%
10 or more times	177	0.4%

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

SDS 1096 (N = 74,096))	Frequency	Percent
None	56,413	76.1%
Once	4,036	5.4%
Twice	3,075	4.2%
3 to 5 times	4,277	5.8%
6 to 9 times	2,211	3.0%
10 or more times	4,084	5.5%

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

SDS 22 (N = 70,401)	Frequency	Percent
Strongly disagree	7,529	10.7%
Somewhat disagree	11,405	16.2%
Neutral	12,107	17.2%
Somewhat agree	22,162	31.5%
Strongly agree	17,198	24.4%

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 = 70,778)	Frequency	Percent
Strongly disagree	4,030	5.7%
Somewhat disagree	7,868	11.1%
Neutral	14,119	19.9%
Somewhat agree	27,432	38.8%
Strongly agree	17,329	24.5%

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

SDS 60 (N = 89,555)	Frequency	Percent
No	76,952	85.9%
Yes	12,603	14.1%

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 = 12,227)	Frequency	Percent
Difficulty hearing	385	3.1%
Difficulty seeing	323	2.6%
Difficulty speaking or language impairment	121	1.0%
Mobility limitation/orthopedic impairment	444	3.6%
Traumatic brain injury	243	2.0%
Specific learning disabilities	1,538	12.6%
ADD or ADHD	6,360	52.0%
Autism spectrum disorder	1,292	10.6%
Cognitive difficulties or intellectual disability	484	4.0%
Health impairment/condition, including chronic conditions	1,611	13.2%
Psychological or psychiatric condition	3,501	28.6%
Other	1,746	14.3%

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

SDS 111-116 (N = 54,686)	Frequency	Percent
Disability	1,583	2.9%
Gender	4,974	9.2%
Nationality/County of Origin	2,054	3.8%
Race/Ethnicity/Culture	4,653	8.6%
Religion	1,793	3.3%
Sexual Orientation	3,008	5.6%

19.7% of clients endorsed discrimination related to at least one identity.

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

SDS 119-123 (N = 60,001)	Frequency	Percent
Enough food to eat	7,399	12.4%
Housing/utilities	9,104	15.3%
Basic transportation needs	6,923	11.7%
Necessary medical care	8,806	14.8%
Educational materials (books, technology)	9,207	15.5%

26.2% of clients endorsed financial insecurity in at least one area.

How often do you feel that you lack companionship?

SDS 124 (N = 41,511)	Frequency	Percent
Hardly ever	11,147	26.9%
Some of the time	20,172	48.6%
Often	10,192	24.6%

How often do you feel left out?

SDS 125 (N = 41,598)	Frequency	Percent
Hardly ever	11,075	26.6%
Some of the time	20,546	49.4%
Often	9,977	24.0%

How often do you feel isolated from others?

SDS 126 (N = 41,605)	Frequency	Percent
Hardly ever	9,204	22.1%
Some of the time	19,070	45.8%
Often	13,331	32.0%

COVID IMPACT ITEMS

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

SDS 102 (N = 56,901)	Frequency	Percent
No	52,689	96.1%
Yes	2,152	3.9%

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, 74% of students endorsed at least one impacted area impacted by COVID-19, and 62% endorsed multiple areas being affected.

SDS 100 (N = 56,901)	Frequency	Percent
Mental health	26,906	47.3%
Academics	25,936	45.6%
Loneliness or isolation	23,510	41.3%
Motivation or focus	20,884	36.7%
Missed experiences or opportunities	20,521	36.1%
Relationships (Significant other, friends, family)	11,742	20.6%
Financial	9,910	17.4%
Career/Employment	8,105	14.2%
Health concerns (self)	7,487	13.2%
Health concerns (others)	6,754	11.9%
Grief/loss of someone	6,132	10.8%
Food or housing insecurity	2,920	5.1%
Discrimination/Harassment	1,252	2.2%
Other (please specify)	623	1.1%

How many times have you had COVID-19?

SDS 103 (N = 16,597)	Frequency	Percent
1 time	5,764	34.7%
2-3 times	5,386	32.5%
4-5 times	501	3.0%
More than 5 times	98	0.6%
I don't think I've had COVID-19	4,848	29.2%

PROVIDER DATA

The Standardized Data Set includes some basic demographic information about providers (clinicians) at participating counseling centers. The 2024–2025 data set represents 2,062 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	1,495	72.8%
Transgender woman	5	0.2%
Man	477	23.2%
Transgender man	6	0.3%
Non-binary	50	2.4%
Prefer not to answer	21	1.0%

Age

N	Mean	Mode
1,854	38.9	29

Race/Ethnicity

	Frequency	Percent
African-American/Black	193	13.5%
American Indian or Alaskan Native	13	0.9%
Asian American/Asian	121	8.5%
White	888	62.1%
Hispanic/Latino/a	119	8.3%
Native Hawaiian or Pacific Islander	6	0.4%
Multi-racial	69	4.8%
Prefer not to answer	13	0.9%
Other	8	0.6%

Highest Degree (descending sort)

	Frequency	Percent
Doctor of Philosophy	400	19.6%
Master of Arts	363	17.8%
Master of Social Work	357	17.5%
Master of Science	317	15.6%
Doctor of Psychology	230	11.3%
Master of Education	100	4.9%
Bachelor of Science	74	3.6%
Bachelor of Arts	69	3.4%
Other	41	2.0%
Doctor of Medicine	36	1.8%
Education Specialist	15	0.7%
Doctor of Education	13	0.6%
Doctor of Osteopathy	9	0.4%
Nursing (e.g. RN, RNP, PNP)	8	0.4%
Doctor of Social Work	4	0.2%

Highest Degree-Discipline (descending sort)

	Frequency	Percent
Clinical Psychology	474	23.5%
Counseling Psychology	399	19.8%
Social Work	378	18.8%
Mental Health Counseling/Clinical Mental Health Counseling	353	17.5%
Other	136	6.7%
Counselor Education	135	6.7%
Psychiatry	47	2.3%
Marriage and Family Therapist	46	2.3%
Nursing	19	0.9%
Higher Education	12	0.6%
Educational Psychology	11	0.5%
Community Psychology	5	0.2%
Health Education	1	0.0%

Are you licensed under your current degree?

	Frequency	Percent
Yes	1,516	75.2%
No	500	24.8%

Position Type (descending sort)

	Frequency	Percent
Professional staff member	1,516	74.1%
Master's level trainee	146	7.1%
Doctoral level trainee (not an intern)	79	3.9%
Pre-doctoral intern	153	7.5%
Post-doctoral level (non-psychiatric)	54	2.6%
Psychiatric resident	21	1.0%
Other (please specify)	78	3.8%

CENTER DATA

The information below describes the 778 colleges and universities that renewed membership or became CCMH members for the 2024–2025 academic year.

Utilization: The total number of students with at least 1 attended appointment between July 1st and June 30th. The average utilization is 834.

	Frequency	Percent
under 151	70	10.4%
151-200	49	7.2%
201-300	74	10.9%
301-350	34	5.0%
351-400	32	4.7%
401-500	81	12.0%
501-600	46	6.8%
601-700	40	5.9%
701-850	47	7.0%
851-1000	27	4.0%
1001-1200	32	4.7%
1201-1500	36	5.3%
1501-2000	45	6.7%
2001-3000	35	5.2%
3001+	28	4.1%

Percent Utilization: The proportion (%) of enrolled/eligible students who attended at least 1 appointment in the counseling center between July 1st and June 30th. The average percent utilization was 10.1%.

	Frequency	Percent
less than 5%	157	23.2%
5-7%	122	18.0%
7-10%	148	21.9%
10-12%	64	9.5%
12-15%	57	8.4%
15-20%	59	8.7%
20-30%	50	7.4%
more than 30%	19	2.8%

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 202.

	Frequency	Percent
48 or less (0-2 Standardized Counselors)	63	9.3%
49-72 (2-3 Standardized Counselors)	72	10.7%
73-96 (3-4 Standardized Counselors)	70	10.4%
97-120 (4-5 Standardized Counselors)	84	12.4%
121-144 (5-6 Standardized Counselors)	54	8.0%
145-168 (6-7 Standardized Counselors)	46	6.8%
169-192 (7-8 Standardized Counselors)	50	7.4%
193-240 (7-9 Standardized Counselors)	55	8.1%
241-312 (9-13 Standardized Counselors)	51	7.5%
313-432 (13-18 Standardized Counselors)	59	8.7%
over 433 (18+ Standardized Counselors)	72	10.7%

Does your center have an APA accredited doctoral internship program?

	Frequency	Percent
No	625	80.3%
Yes	153	19.7%

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

	Frequency	Percent
No	603	77.5%
Yes	175	22.5%

Is the director of your center a member of AUCCCD?

	Frequency	Percent
No	165	21.2%
Yes	613	78.8%

CLINICAL CHARACTERISTICS

Does your center have session limits for individual counseling?

	Frequency	Percent
No	513	65.9%
Yes	265	34.1%

Routine individual counseling appointments usually occur weekly.

	Frequency	Percent
No	391	50.3%
Yes	387	49.7%

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

	Frequency	Percent
No	591	76.0%
Yes	187	24.0%

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

	Frequency	Percent
No	591	76.0%
Yes	187	24.0%

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

	Frequency	Percent
No	442	56.8%
Yes	336	43.2%

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

	Frequency	Percent
No	274	35.2%
Yes	504	64.8%

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
No	469	60.3%
Yes	309	39.7%

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

	Frequency	Percent
No	654	84.1%
Yes	124	15.9%

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

	Frequency	Percent
No	36	28.3%
Yes	91	71.7%

Do your students pay out-of-pocket for individual counseling?

	Frequency	Percent
No, students do not pay for individual counseling sessions	729	93.7%
Yes, but students only pay after a certain number of sessions	18	2.3%
Yes, some students pay depending on insurance	7	0.9%
Yes, all students pay for all individual counseling sessions	5	0.6%
Other	19	2.4%

THIRD-PARTY VENDORS

Does your center have a contract with a third-party vendor for individual counseling?

	Frequency	Percent
No	467	60.0%
Yes	311	40.0%

Does your center have a contract with a third-party vendor for psychiatric services?

	Frequency	Percent
No	624	80.2%
Yes	154	19.8%

Does your center have a contract with a third-party vendor for intensive outpatient services?

	Frequency	Percent
No	727	93.4%
Yes	51	6.6%

Does your center have a contract with a third-party vendor for peer support?

	Frequency	Percent
No	654	84.1%
Yes	124	15.9%

Does your center have a contract with a third-party vendor for coaching?

	Frequency	Percent
No	752	96.7%
Yes	26	3.3%

Does your center have a contract with a third-party vendor for crisis services?

	Frequency	Percent
No	410	52.7%
Yes	368	47.3%

Does your center have a contract with a third-party vendor for referral services?

	Frequency	Percent
No	671	86.2%
Yes	107	13.8%

Does your center have a contract with a third-party vendor for mental health screening?

	Frequency	Percent
No	712	91.5%
Yes	66	8.5%

Does your center have a contract with a third-party vendor for training?

	Frequency	Percent
No	771	99.1%
Yes	7	0.9%

INSTITUTIONAL DATA

Data for the 2024–2025 CCMH data set has been contributed by 778 colleges and universities that hold membership with CCMH. Demographics for these institutions are listed below.

Institutional Enrollment: The total number of students enrolled at the institution who are eligible for services. The average enrollment is 12,766.

	Frequency	Percent
under 1,501	78	11.5%
1,501–2,500	90	13.3%
2,501–5,000	114	16.9%
5,001–7,500	70	10.4%
7,501–10,000	57	8.4%
10,001–15,000	83	12.3%
15,001–20,000	50	7.4%
20,001–25,000	38	5.6%
25,001–30,000	28	4.1%
30,001–35,000	18	2.7%
35,001–45,000	26	3.8%
45,001+	24	3.6%

Public or Private

	Frequency	Percent
Combined	3	0.4%
Private	312	40.1%
Public	463	59.5%

Type of institution (Check all)

	Frequency	Percent
4-year College/University	691	89%
Religious-Affiliated School	54	7%
2-year College/University	51	7%
Community College	46	6%
Health Professional School	39	5%
STEM Institution	33	4%
Other	28	4%
Historically Black College/ University (HBCU)	12	2%
Creative Focus	11	1%
Tribal	1	0%

Location of Campus

	Frequency	Percent
Canada	11	1.4%
International	18	2.3%
Midwest (IA, IL, IN, MI, MN, MT, ND, NE, OH, SD, WI)	160	20.6%
Northeast (CT, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VA, VT, WV)	265	34.1%
South (AL, AR, FL, GA, KS, KY, LA, MO, MS, NC, NM, NV, OK, SC, TN, TX)	206	26.5%
West (AK, AZ, CA, CO, HI, ID, OR, UT, WA, WY)	118	15.2%

Athletic Division

	Frequency	Percent
Division I	279	35.9%
Division II	129	16.6%
Division III	214	27.5%
None	156	20.1%

Contact Information

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