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Lived Experiences of Mental Health in Higher Education: A Comparative Analysis of Determinants to Supports and Services

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Due to increasing incidence of mental health challenges in college students and its relation to poorer student outcomes (e.g., recruitment, retention, graduation), higher education institutions have turned their attention toward the needs of students experiencing mental health challenges (Collins & Mowbray, 2005). In attempts to ameliorate poorer student outcomes, some states have investigated the impact of mental health on those enrolled in higher education as well as the needs for supports and services for those impacted (e.g., Oregon Higher Education Coordinating Commission [OHECC], Office of Academic Policy and Authorization, 2018). However, despite these initiatives, limited empirical research is available related to the lived experiences of individuals with mental health challenges in higher education settings; including the supports and barriers they may experience while navigating these complex settings. This study begins to address this knowledge gap by using qualitative content analysis to examine and compare key stakeholder lived experiences related to mental health challenges in higher education, including the similarities and differences regarding service and support needs, determinants to usage (support and barriers), and recommendations for future research and improving the continuum of care. Considerations for policy, practice, and future research are provided.

Public Policy Relevance Statement
In spite of the link between mental health challenges and poorer outcomes in higher education (recruitment, retention, graduation), there is a dearth of research on the contributing factors to successful outcomes, or lack thereof. This study expands the research base by identifying potential factors underpinning student outcomes, access to services, and participation in higher education settings. Ultimately these findings give light to a range of themes relevant to improving precision of interventions, supports, policies, and directions for future research.

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Students are entering college with identified mental health challenges at increasing rates (The Center for Collegiate Mental Health, 2018). Over the last 10 years, reports of severe anxiety and suicidal ideation have increased, with 19% of individuals age 18–25 reporting mental health challenges in 2008 compared to over 26% reporting these same concerns in 2018. In addition, students from underserved communities (e.g., individuals of color, individuals identifying as LGBTQIA+, and individuals with disabilities) are at increased risk of experiencing mental health challenges due to a variety of systemic and contextual factors

including discrimination and racism on both individual and systemic levels (Brown et al., 2016; Cree et al., 2020; Hunt et al., 2015; Williams, 2018; Woodford et al., 2012). These noted risks have led to organizations like The Steve Fund and Jed Foundation (2018) encouraging campuses and programs to account for the unique experiences of minority student populations when developing supports and services for mental health on college campuses.

While many higher education institutions have increased their services for students requiring mental health support, examining how these mental health supports are perceived by students and higher education personnel is under explored. Providing mental health supports for students is not only a critical need for individual campuses, on a national scale, but mental illness is also a public health issue. Among students on college campuses, suicide is the second leading cause of death (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018; Turner et al., 2013).

Impact of Mental Health Challenges on Student Outcomes

Mental health challenges also negatively impact student's daily functioning, school performance, and graduation rates. Research demonstrates that the quality of academic functioning is impaired when students experience mental health challenges, including lower grade point averages (Bruffaerts et al., 2018; Conley et al., 2015). Moreover, students who experience mental health challenges also experience threats to more distal outcomes, such as delayed graduation and an increased probability of dropping out of school (e.g., Hartley, 2010; Lipson & Eisenberg, 2018). Outside of school, individuals with mental health challenges may also experience negative occupational outcomes including missed work, reduced job performance, and unemployment (Haller et al., 2014).

Evidence for Addressing Mental Health in Higher Education

Although there is a significant body of research on mental health services and supports, research addressing mental health challenges in higher education is in its infancy, with prevention and intervention strategies still emerging (Bruffaerts et al., 2018; Conley et al., 2015; Pedrelli et al., 2015). From the dearth of literature available, certain practices that are successful outside of higher education demonstrate promise when implemented on campuses. According to the Association for University and College Counseling Center Directors, 69% of students reported campus counseling services helped with their academic performance and 65% believed these services helped reduce mental health related attrition (Leviness et al., 2018). Furthermore, recommendations from the Centers for Disease Control (CDC) and the National Association of School Psychologists (NASP) identified the public health or tiered approach as an optimal framework to adequately address mental and behavioral health needs in a range of settings (Centers for Disease Control and Prevention [CDC], 2020; National Association of School Psychologists [NASP], 2016). This includes a focus on tiered interventions including universal, targeted, and tertiary supports (David-Ferdon et al., 2016). Yet, in spite of these recommendations, there remains little guidance for mental health supports and interventions in higher education. Hence some states have recently begun to respond to this need via legislative initiatives. Guidance at a state or federal level for mental health prevention and intervention in higher education has received increasing attention. In 2016, the first known legislation specific to campus mental health was passed in the state of Washington with Senate Bill 1,138. Senate Bill 1,138 convened a task force to identify needs related to mental health and suicide prevention on university, community college, and technical program campuses (Task Force on Mental Health and Suicide Prevention in Higher Education, 2016). Two years later, the State of Oregon followed suit via Senate Bill 231 (which will be referred to as the Senate Bill) which also convened a task force of mental health experts and practicing professionals in higher education. The Senate Bill focused on investigating not only reported prevalence and community specific impacts but also specified an interest in gathering the lived experiences of students in Oregon's public higher education institutions regarding mental health (S.B. 231, 2017). This work also resulted in a formal report with recommendations to the state (Oregon Higher Education Coordinating Commission [OHECC], Office of Academic Policy and Authorization, 2018).

Determinants to Accessing Support

There are a variety of determinants (i.e., supports and barriers) that impact if and how students access services and supports related to mental health challenges. It is critical for the field of higher education to understand the mechanisms of these determinants in order to improve the implementation and sustainability of evidence-based practices on college campuses. According to the Healthy Minds Study in the Fall of 2020, 30% of students report they do not know, or are unsure of, how or where to seek professional help for mental or emotional health on their campus (Eisenberg et al., 2021). Eisenberg et al. (2012) suggested reducing barriers by increasing campus outreach (e.g., knowledge or stigma reduction campaigns) and gatekeeper training (i.e., training campus stakeholders to identify and refer students in need) as an important strategy. However, as more research emerges, it is critical to understand that each campus is unique and that a one-size fits all approach will not provide the appropriate infrastructure for meaningful and sustainable change (The Steve Fund and JED Foundation, 2018).

Studies on implementation of evidence-based interventions in health care indicate that less than 50% of interventions ever reach full scale use (Balas & Boren, 2000). This can be due to a disconnect between the intervention and the specific needs of the participant or community. Therefore, determining participant needs prior to choosing an intervention is foundational to improving use of effective interventions in real-world environments. However, this takes an understanding of what services are currently implemented, potential barriers and supports to using interventions, and gathering information on the specific needs of stakeholders to develop, implement, and sustain an effective system. Understanding not only the needs of stakeholders but also barriers to implementation of interventions becomes especially important when navigating complex issues and diverse populations, such as with mental health in higher education. Hence, there have been recent calls for more research surrounding the impacts of mental health on higher education experiences, including a need for enhanced understanding of facilitators and barriers to participation and successful outcomes (e.g., Brown, 2020; Bruffaerts et al., 2018).

The purpose of this study is to examine the experiences of both students and administrators in higher education, via qualitative content analysis, relative to accessing mental health supports and services that are foundational to improved student outcomes. In doing so, we compare the differences between these stakeholder groups and build on the prior policy-driven work by *the Oregon Task Force on Student Mental Health Support* (OHECC, 2018). Specifically, this study delves into qualitative data collected during activities directed by the Senate Bill under the Oregon Task Force on Mental Health. Limitations such as time constraints and a limited scope of work to fulfill the mission of the Senate Bill provided an opportunity for this new qualitative data analysis and discussion not reported previously. Specifically, this analysis was conducted to build upon the original work and identify overarching themes/essences, provide rich description of the data, and discuss findings in light of current research and issues. Analyzing the rich data through a research rather than policy lens allows for further empirical understanding on the issue of mental health challenges in higher education. This opportunity to analyze data and advance research, coupled with recent calls for using existing data when available to reduce subject risk and societal cost (Blair, 2016; Currie, 2013), provides both an ethical and empirical support for this research to address the following questions:

1. What are the common experiences of students and administrators relative to accessing supports and services for mental health in higher education, including an examination of the essence of these experiences?
2. What are the key differences in experiences of students and administrators relative to accessing supports and services for mental health in higher education settings including an examination of the essence of these differences?

Method

Qualitative content analysis utilizing a phenomenological lens guided development of the research questions, data collection, and analysis. A recent review of qualitative research by Raskind et al. (2019) identified that a specified methodological approach is often lacking in implementation and policy-driven research; thereby making this a unique contribution to the literature not only due to the focus of the research questions but also the use of a specified analytic qualitative method within a policy-related project. Qualitative content analysis is defined as "a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon, 2005, p. 1278). This ultimately allows for coding and analytic processes that meet the research questions of this study (Elo et al., 2014; Graneheim et al., 2017). Due to the direct link to the Senate Bill, the initial project was overseen and approved by the State department directing the work. For the secondary analysis project described and reported herein, internal review board (IRB) permissions were sought and determined exempt (IRB Protocol Number: 02122019.021). In the following section, methods are reported according to best practice guidelines for improving trustworthiness (i.e., findings are "worth paying attention to") of qualitative content analysis studies as developed by Elo et al. (2014). This work addresses Elo et al.'s recommended components related to trustworthiness and high-quality qualitative studies including: sampling, participants and unit of analysis, procedures for data collection, and the categorization and interpretation process (Elo et al., 2014). In addition, detailed information is provided in tables and figures herein for improved audit trail and transparency in our analytic process. The following reporting also was checked against the Consolidated Criteria for Reporting Qualitative Research—COREQ to ensure best practices in reporting (Tong et al., 2007).

Sampling

Due to the Senate Bill directive to understand student mental health experiences in higher education across a range of contexts and communities in Oregon (S.B. 231, 2017), a purposive sampling method was used. Specifically, participants were purposefully recruited from all higher education institutions throughout the state to ensure broad representation. In addition, snowball sampling was used within the higher education institutions for additional recruitment of students and administrators. Due to the individual differences and readily changing supports and services available within each unique higher education setting, it was necessary to have internal referrals within each higher education institutions in order to optimize contacts for the most knowledgeable administrators and student groups. In addition, snowball sampling was required to connect with general student populations experiencing mental health challenges as well as to connect with student groups identifying as under-represented populations (e.g., LGBTQIA+, disability support services, first generation students, etc.). Email was the primary mode of recruitment with some follow-up phone calls for reminders to the school contacts to distribute email messages for recruitment.

Participants

Participants included both students and administrators from higher education institutions throughout the state of Oregon. Inclusion criteria for the higher education intuitions and individual level participants were determined by the experts on the Governor appointed Task Force. General participant information is listed below. However, due to the specificity and sensitivity of interview questions and limited number of participants, more identifiable demographic data (e.g., age, sex, disability) were not collected on students and administrators. Participants received a $25 gift card for participation.

Higher Education Institutions. Inclusion criteria for higher education institutions included all 4-year and 2-year public higher education for a total of 24 possible institutions (7 public 4-year higher education institutions and 17 public community colleges). Private higher education institutions and trade schools were excluded due to limitations of funding, time constraints, and other mandates related to the Senate Bill. Recruitment resulted in representation from 18 institutions; of which 50% are identified as urban institutions, 45% rural, and 5% not designated to due location of the institution represented more than one locale.

Students. Inclusion criteria for student participants were: (a) enrollment (current or within 6 months or less of exit) in one of the state public higher education institutions at any level

(e.g., undergraduate, graduate, doctoral) and (b) self-identified as having experienced challenges related to mental health in higher education settings. In total, 25 students were recruited and participated in qualitative interviews and focus groups. All students who volunteered to participate in the study met inclusion criteria. Two interviews had to be rescheduled due to personal reasons of the student but no participants dropped out/all students completed their planned interview. For the three focus groups, all students who attended chose to participate after informed consent and remained for the full focus group/none dropped out.

Administrators. Inclusion criteria for administrators were: (a) professionals currently working in some administrative capacity with direct knowledge of mental health supports and services in their institution of higher education (e.g., university administrative staff) or (b) paid professionals hired by the higher education providing direct services (e.g., mental health counselors) for students related to mental health. A total of 12 administrators participated in qualitative interviews. All administrators who volunteered to participate in the study met inclusion criteria. No administrators dropped out/all administrators completed their planned interview.

Data Collection

The research team consisted of three PhD level researchers and two PhD candidates in their final year of study. All members of the research team had expertise/focused lines of research related to mental health across the lifespan. In addition, four of the research team members had background experience directly working in the field of education and/or health with populations experiencing mental health challenges in addition to experience working with low incidence and diverse populations. Three of the research team members identify as female and two identify as male. Their field experience included work as direct service providers, teachers, and program or state leaders. Years of experience in field-based work ranged from 2 to 15 years prior to their transition into focused research.

Four research team members (authors 1–4 of this manuscript) conducted the interviews. A total of 22 interviews and three focus groups were conducted across 18 public universities and community colleges throughout the state of Oregon. Participants did not know the researchers prior to the study. Ten students and 12 administrators participated in individual interviews. An additional 15 students participated across three focus groups for a total of 25 students and 12 administrators. Participants were informed that the intent of the study was to gain understanding about experiences of mental health in higher education including supports and barriers to education, services, and supports. Identical questions were used for both the interviews and focus groups. Interview participants were given the choice of either in-person or phone interviews in order to meet the needs of differing schedules and individual preferences for sharing information. Focus groups were conducted in-person on college or university campuses and were offered at times that student support groups for mental health already met to decrease participant burden and optimize potential participation. Only researchers and focus group participants were present for the focus groups. Interviews lasted between 30 and 60 min and focus groups lasted between 60 and 90 min. All participants were subjected to signed informed consent procedures. Qualitative interview data were gathered between September and November of 2018. Interviews were audio recorded and later transcribed verbatim by a professional transcriptionist, deidentified, and given a unique identifier. The key-code match was kept on a separate spread sheet in a separate file on a secure database only accessible to the researchers through secure digital access.

The research team went to extensive efforts to achieve data saturation within the time constraints. In data saturation studies, researchers have identified data saturation in as little as six participants and 92% of the time found data saturation to be achieved with 12 participants (Guest et al., 2006). Although these numbers are good guidelines, current best practice identifies that sample size in qualitative research should be determined not by a certain number of participants but by how "rich" and "thick" the data are and whether it has been triangulated and examined from multiple viewpoints to exhaust the data (Fusch & Ness, 2015). Hence, recruitment continued until repeating themes were noted, consistencies were identified through triangulation with quantitative data available, and there was representation of participants from universities and colleges across the state.

Materials and Measures

Interview questions were intentionally ordered to start with general open format questions followed by more directed questions to decrease potential bias from the interview questions themselves (Bevan, 2014). The interview questions were piloted with the research team prior to use to ensure that the process was understandable and that the protocol could be easily followed within timeframes. Interviews and focus groups were conducted by trained members of the research and facilitation team (authors one through four). All transcriptions were screened by the lead author to verify interviews met recommendations for ensuring trustworthiness of data (e.g., interviewers did not lead the participants and that interview protocols were followed; Creswell & Poth, 2018). Please see Supplemental Materials for sample interview questions.

Data Analysis

All transcripts were analyzed and coded using Atlas TI version 8.4.0 (Atlas TI, 2018). Also, best/recommended practices for coding of data according to recent scholarly publications on qualitative content analysis were used for guidance (e.g., full review of transcripts prior to inductive coding, bias reduction and self-reflection with reflexivity statement, iterative rounds of coding, and memoing—including brief field notes and code development; Elo et al., 2014; Erlingsson & Brysiewicz, 2017). As mentioned prior, qualitative content analysis was chosen due to its analytic processes that are in alignment with the aims of the research questions of this study which aimed to elucidate inductive essences, or the overarching themes of the data to garner new understanding (Elo et al., 2014; Graneheim et al., 2017). Data from the transcripts were initially examined to allow the emergence of student and administrator lived experiences on accessing mental health services in higher education institutions. Significant statements in the text were subsequently identified. These significant statements are referred to as "meaning units" and coded according to iteratively developed codes commonly identified by the first two authors (Elo et al., 2014; Erlingsson & Brysiewicz, 2017). Triangulation across coders (investigator triangulation) and data

sources (data triangulation with quantitative data obtained as part of the larger policy project) were used for validation. Consensus was used for any discrepancies in the coding process. Then, through iterative rounds of consensus and coding of the data, the authors developed a composite description of the phenomena, known as "essence" (Creswell & Poth, 2018) or "theme" (Erlingsson & Brysiewicz, 2017). Specifically, the first two authors used a process of consensus to derive from the initial codes the (a) the essence of shared barriers to services identified by both students and administrators and (b) the essence of differences between students and administrators in perceived barriers to services for mental health on college campuses. Both textural (e.g., the "what" that individuals experience) and structural (e.g., the "how" and "where" of experiences) elements were included in the review of inductive codes. Examining the essence or overarching theme of meaning units, codes, and categories is particularly important with complex or emerging topics (Graneheim et al., 2017). The following results are reported according to recommendations for qualitative content analysis (Elo et al., 2014) and reporting of inductive coding (Hannah & Lautsch, 2011). Please note that the terminology used in the results section and figures also follows recommendations by Elo et al. (2014). Essences are the overarching themes and in this reporting style are presented as a statement that conveys the meaning. Categories are one-to-three-word descriptions related to the essence. Codes are the sub-categories and meaning units are the quotes.

Results

Research Question 1: What are the *shared* experiences of students and administrators relative to accessing supports and services for mental health in higher education, including an examination of the essence of these lived experiences?

The analysis for this research project revealed that the shared needs and barriers related to accessing supports and services in higher education in Oregon centered around three categories: (a) systems level issues (e.g., ongoing systemic barriers or procedures that may prohibit access to services); (b) funding issues; and (c) contextual challenges (e.g., differing contexts impacting equitable access to mental health services). See also Figure 1 for the essences, categories, codes, and exemplar meaning units related to shared experiences for students and administrators. Figures are recommended as a mode in the reporting of qualitative content analysis results for conveying the complexity of findings in a succinct and translatable manner to support the validation process and increase understanding related to transferability (Elo et al., 2014).

Systems Level Issues

This theme/essence has been identified as, *Systems matter! Structures can enhance or inhibit access and participation—are we opening or closing doors?* Systems level barriers included identified needs related to: (a) screening and identification for mental health, (b) faculty and upper administrator awareness and support of issues related to mental health, and (c) procedural system barriers.

Screening and Identification

Interviews of both students and administrators identified a common need, early and universal screening for mental health challenges. One student stated, *I'm not seeing any universal screenings*. In addition, administrators relayed similar statements such as, *I think we probably lack in screenings* and *we don't have any wide-sweeping screenings of students*. However, one administrator described new extensive efforts focused on meeting this need for screening and universal supports on campus by using data to identify holes and gaps and beginning to improve their systems and supports. *I kind of look for gaps in our system based on the student voice and based on kind of what our data is showing we need to do better on.* They then went on to describe a range of universal supports they have implemented to meet the identified gaps such as messaging, training, and ongoing outreach. Hence, although screening and early identification were described as a need by administrators, there were some initiatives occurring in this area on university campuses in hopes of filling this gap in the near future.

Administrative Awareness and Support

Throughout the student interviews a recurring theme emerged: Students felt faculty and administration were less supportive than desired and attributed the barrier to lack of faculty and administration awareness on key mental health issues. One student stated, *but from what I've seen it's not just openly talked about enough in classrooms .... So I think that limits people getting help.* In this case, lack of acknowledgment that mental health challenges could impact a student's performance in class, shaped the student's perception that faculty may not be the best person to turn to for help. Another student identified similar needs, *I think a lot of it is we need to be training our professors and our staff to understand that like, students are humans too and these are the factors that might affect their work.*

Administrators also acknowledged that faculty needed additional mental health training and professional development. One mentioned, *faculty and staff training on supporting students uh [is needed], because students are basically saying that staff and faculty are not sensitive, they are not responsive.* Another administrator stated,

> Sometimes our faculty has been less involved as we would like them to be on certain um, early alert or support services because they sort of, you know, some of them I think have sort of that mindset that we're not a social service agency.

These administrators echoed the concern of the students. This emphasis on additional training demonstrates a common identified need for faculty understanding and support of students with mental health challenges.

Procedural Barriers

Another barrier identified by both students and administrators concerned campus policies and procedures ranging from departmental practices to campus-wide rules and regulations directly or indirectly related to access of mental health services. For example, one student commented on the procedures to make appointments at campus counseling centers, *we don't have any sort of like, online way to request an appointment so and it's kinda like, a barrier.*

Figure 1

Codes, Meaning Units, Categories, and Themes/Essence for Shared Experiences

Theme/ Essence [Category]	Systems matter! Structures can enhance or inhibit access and participation. Are we opening or closing doors?  [S = Systems level issues]	
	Equitable access to mental health services and supports is context related.  [C = Contextual issues]	
	Funding foundations. Money is the foundational pathway to access supports.  [F = Funding issues]	
Codes and Meaning Units	Need for early screening and identification [S]	*"I think we probably lack in screenings"* *"I'm not seeing any universal screenings"*
	Lack of faculty and administrator awareness [S]	*"There's huge barriers because there is a lack of um support for it [sic] with overall administration"* *"faculty and staff training on supporting students uh [is needed], because students are basically saying that staff and faculty are not sensitive, they are not responsive"*
	Systemic and procedural barriers [S]	*"It feels like everyone's kind of doing their own thing [six] and so I'd love to see that kind of like, tightened up and coordinated"* *"We don't have any sort of like, online way to request an appointment*"
	Long wait times/not enough service [F]	*"We often have to have students wait three weeks to get an appointment"* *"Each counselor only has like one free appointment slot for a crisis just seems kind of not good"*
	Lack of staff [F]	*"We do need more clinicians"* *"We only have one person that is a counselor…but she's really busy"*
	Stigma and discrimination [C]	"*there's still a lot of stigma around mental health"* *"…and the first and most significant barrier, which is true not only for students but for the general population, is the stigma associated with seeking help"*
	Supports needed for special populations [C]	*"When we think about underrepresented groups on campus, we don't really think about students in recovery much. There really aren't a lot of spaces that recognize the challenges they have."* *"I would say get more staff of color in those support services because as far as I'm aware we only have one, like, person of color who is working in the counseling services."*
	Lack of on-campus access to supports and services [C]	*"they [students] didn't feel comfortable going off campus to find the place and work with someone they didn't see as connected to the college"* "*we definitely need just a specific um, place to go on campus*."

Interestingly, multiple students commented on the way in which appointments were made trending toward the use of online management systems (e.g., web portals or apps) versus initiating a telephone call or scheduling in-person. Another area of concern was related to how service access is linked to particular funding streams and how a well-intended support, such as a scholarship, may move students into a new funding category and thereby may no longer be allowed access to needed mental health services. One student identified this as a significant concern stating,

> If I do receive one of those [scholarships], like the Diversity Scholarship, then I can't really like use the student support services and that like eliminates . . . my like therapy talks that I really need to like kind of stay in balance.

Administrators also mentioned procedural barriers including how the institution communicates with students and how students access services. One administrator commented on the need to change how communications on mental health are distributed across the campus population, *in order to change culture they need to be seeing these*

messages over and over again so it's difficult to reach our students because we're not allowed to message them directly. Due to their limited ability to connect with students directly, this administrator suggested for a more visible college-wide campaign of campus services while also reducing stigma. Another administrator reflected on the limited access to resources and the procedures for outsourcing services due to limitations of being in a rural community. The administrator reflects on the process;

> First, it's incredibly hard for them [students] to get in there and so for a student to come in, which is already a huge step in their journey towards recovery, and then to have to send them to another place [off campus], um that referral process. We lose some students in that referral process.

Without access to services on campus paired with federal privacy protection policies, this administrator had no ability to ensure that the students served would access the referred services, presenting a problem for the recovery process. Last, administrators also identified a need for more coordinated services and supports on the systems level. For example, *it feels like everyone's kind of doing their own thing [sic] and so I'd love to see that kind of like, tightened up and coordinated.*

Funding Issues

This theme/essence has been identified as, *Funding foundations … money is the foundational pathway to access and supports.* Specifically, funding issues and concerns were particularly salient throughout the student and administrator interviews. For example, students see a lack of funding as inadequate, especially when need is immediate, *I think funding um, just to have better like, resources for students to be able to tap into when it comes to scheduling and like, having additional like, crisis support, counseling would be extremely beneficial.* An administrator also emphasized the need for more readily available services, particularly during student episodes of crisis stating, *we often have to have students wait three weeks to get an appointment. There's also the crises that people go through that need help today, not three weeks from now.* Other consequences of lack of funding identified by students included dwindling resources for student groups, *funding for higher education is depleting and um, as it depletes so like funds for student organizations like Active Minds* [referring to less funding resources for their club to help promote positive mental health]. Some students more directly communicated about the impact of funding, *I think another issue would be money* and finally, *funding is always a huge issue*. Other students felt that their campus services were outdated (e.g., referring to the lack of updated technology previously stated).

Administrators also focused their attention on how funding issues impact the amount of student services available on campus. One administrator stated *I think funding um, just to have better like, resources for students to be able tap into when it comes to scheduling and like, having additional like, crisis support, counseling would be extremely beneficial*. Similarly, another administrator said *Or, so um, how do I say this? Um, you know, we don't have a lot of money. We're understaffed and we're just trying to do our best.* Other administrators mentioned, *It's an issue of uh, a lack of resources for us* and *the counseling services department is just really under, its underfunded*. Lastly, one administrator reflected on the dynamic relationship between funding, personnel, and services, *I mean, the number one [problem] that I see is um, well twofold, one is lack of funding and the other is lack of staff, and obviously that goes back and forth*.

Contextual Issues

This theme/essence has been identified as, *equitable access to mental health services and supports is context dependent and impacts student outcomes in higher education*. It was clear throughout the interviews that not all campuses were able to provide the same amount or type of services to meet the needs of the student body. Both students and administrators identified that services specifically located on campus should be available to facilitate optimal success in higher education. One student stated, *we definitely need just a specific um, place to go on campus*. An administrator made a comparable statement, *that's the huge part I've been talking about is the lack of access to mental health um, counseling centers on college campuses*. Some larger campuses, while still struggling, were able to provide a variety of supports (e.g., substance abuse treatment or counseling, groups for minority students). Smaller and rural campuses had additional challenges related to implementing mental health supports and services including smaller staff numbers and lack of expertise. These difficulties ultimately necessitated referring students to outside service providers to meet specialized needs. In addition to the calls for on campus services, contextual issues related to stigma and discrimination related to mental health also emerged. Specifically, one student stated, *there's still a lot of stigma around mental health* and another stated, *we have as a society such, you know, misguided perceptions of people with psychosis*. Administrators echoed these concerns about stigma and discrimination by stating, *… and the first and most significant barrier, which is true not only for students but for the general population, is the stigma associated with seeking help.*

Last, a code related to need for additional supports for special populations at higher risk of mental health challenges emerged. Populations mentioned ranged widely but included, LGBTQIA+, individuals of color, first generation students, single parents, and individuals with substance use disorders. One student stated, *I would say get more staff of color in those support services because as far as I'm aware we only have one, like, person of color who is working in the counseling services.* Another stated, *I was a first-gen college student and um, an only child, single mom, and so being at college and not knowing how to navigate was really really challenging*. Administrators also echoed these needs with statements such as, *what we're thinking about focusing on is a single parent support group um, because we have a pretty significant population of single parents.* Another administrator stated, *When we think about underrepresented groups on campus, we don't really think about students in recovery much. There really aren't a lot of spaces that recognize the challenges they have.*

Research Question 2: What are the key *differences* in the lived experiences of accessing supports and services for mental health in higher education settings including an examination of the essence of these differences in lived experienced?

Although students and administrators communicated a variety of shared needs and barriers there were a number of comments

that demonstrated different perspectives between these two groups. A specific need or barrier was considered *different* between groups if a particular theme was only identified by one group (i.e., students or administrators).

Student Specific Barriers

The five student specific codes within this category include: (a) the need for relationships/having an individual on campus they could trust and relate to, (b) the need for family and/or peer support, (c) difficulty finding or knowing about mental health services, (d) fear of getting "kicked out" of school due to mental health related challenges, and (e) temporality—need for access to services throughout the school year (OHECC, 2018). The analytic process examining these unique codes revealed a theme/essence of, *it's all about relationships*. Specifically, findings suggest that student specific barriers centered largely around the need for consistent relationships and personal supports with family, peers, and trusted faculty. See Figure 2 for the essences, categories, codes, and exemplar meaning units related to unique experiences for students.

Many students identified a need to have an individual on campus they could identify with and trust. *I feel like there's a lot of students who don't necessarily feel like there's someone there that they can really identify with and someone that would like understand their problems and stuff.* Another student described a desire for more positive interactions from faculty with one student stating, *I think that they need to be more in tuned with not just running into lectures and making sure that they are creating some sort of atmosphere*. Another student stated the following in reference to faculty, *they should just care, which I know is kind of harsh to say but I really don't think they care.*

Students also commonly identified the need for community and peer supports with statements identifying the need to find a support group on campus. This was particularly critical for a student experiencing issues related to substance use because the only community support in their area for alcohol use was a local Alcoholics Anonymous group that was made up of individuals twice the student's age; *there weren't like any sort of like support groups on campus*. This was echoed by statements from another student that described similar difficulties, *So you know, if you have any serious mental health issues, you know, beyond the routine ones that I've just talked about um, you kind of have to have your own support system before going to school*. This student's reflection of their own serious mental illness represents not only a need for comprehensive supports for varying degrees of mental illness on campuses, but also the need to reduce stigma to ensure these students may find the support necessary to be successful throughout their enrollment. In addition to the overall lack of services, students also described difficulty knowing where to turn even when they knew supports were available. *If I was having like, uh, an anxiety attack or panic attack or mental health breakdown or something like that I would not know where to go at school."* Another student stated

Figure 2

Codes, Meaning Units, Categories, and Themes/Essence Unique to Students

Theme/ Essence [Category]	It's all about relationships!  [R = Relationships]	
Codes and Meaning Units	Need someone can trust/ relate to [R]	*"I feel like there's a lot of students who don't necessarily feel like there's someone there that they can really identify with and someone that would like understand their problems and stuff"* *"They should just care, which I know is kind of harsh to say but I really don't think they care."*
	Family/peer support [R]	*"I think it would be really great if there were more support groups on college campuses for people with mental illness"* *"If you have serious mental health issues…you kind of have to have your own support system before going to school"*
	Difficulty finding/knowning about services [R]	*"If I was having like, uh, an anxiety attack or panic attack or mental health breakdown or something like that I would not know where to go at school"* *"There doesn't exist any um, signs or posters or anything. That wasn't something discussed in orientation…put some signs up please."*
	Fear of getting "kicked out" [R]	*"By kicked out I mean put on kind of a leave, you know, forces to drop classes [sic], it's something that's happened to me at other schools. It's something I'm very mindful about…which is why I don't disclose to anyone"* *"If you tell them you're hearing voices that other people can't hear uh, they see that as a reason in and of itself to kick you off campus or to find reasons to get you out of campus.*"
	Temporality – needing services throughout the year [R]	*"Sometimes the resources aren't there because it's summertime"* *"But then it get later in the year and it's harder to get an appointment"*

similar comments related to lack of messaging and outreach for connecting students supports on their campus, *There doesn't exist any um, signs or posters or anything. That wasn't something discussed in orientation . . . put some signs up please.*

In addition to these elements of "what" the students experienced as needs, elements of "where" and "how" they desired to have these supports were also identified. Students were interested in ensuring that the campus they attended was able to provide services when (i.e., throughout the year) and where (i.e., on campus) they needed. For example, one student mentioned changes in service availability throughout the year and reduced services during episodes of low student enrollment and identified concerns related to getting services during the summer stating, *depression manifests in different ways and I think that it's really hard um, staying here for the summer*. Similarly, another student stated, *But then it gets later in the year and it's harder to get an appointment*. This student was reflecting on the increase of students accessing services when stress is high as the term/semester progresses, particularly during midterms and final examinations and how that impacts the ability to see a provider. These discrepancies in relationships and availability may contribute to the noted feelings of "getting kicked out," as communicated by several students. For example, one student stated, *so basically I create this wall of separation between my personal life at the school and I have to be very, very careful about what I disclose*. In addition, another student stated, *if you tell them you're hearing voices that other people can't hear uh, they see that as a reason in and of itself to kick you off campus or to find reasons to get you out of campus.*

Administrator Specific Barriers and Needs

In addition to unique student needs, three additional codes for administrators were identified. Specifically, codes emerged concerning (a) provider stress, (b) providers covering multiple roles/stretched thin on college campuses, and (c) a need for new or innovative approaches for mental health services (OHECC, 2018). The analytic process examining these unique codes revealed a theme/essence of, *caring for caregivers—supports for mitigating stress and burnout in mental health providers on college campuses*. See Figure 3 for the essences, categories, codes, and exemplar meaning units related to unique experiences of administrators.

As described in the commonly identified themes, there is considerable need for service providers on campus. The demand for services has been outpaced by the current service provision practices for many institutions. Administrator interviews revealed why there is a need: Provider burnout and stress. One administrator stated, *now so many universities are having a hard time filling their positions and because therapists are just getting so burnt out and you know, now we're hiring case managers*. This was also echoed by other administrators,

> The burn out rate for folks in university counseling center now I know is really, really high and people are just, the psychologists are leaving to go into private practice. Um, and so it's, I mean, there's so many openings right now in the different, you know, universities and they're not able to fill them.

This stress followed by subsequent attrition, has led to providers feeling stretched thin and needing to cover multiple roles. Specifically, one administrator stated, *I feel like we have an approach of overload, every employee with multiple responsibilities, multiple initiatives, and projects that you know, you're not working hard enough if you're not drowning in work.* In addition, another stated, *It's a lot for just one person to take care of.* This is compounded by the lack of supports for stress mitigation. Specifically, supports typically available to mental health providers, such as reflective supervision, were reported by some participants as lacking in higher education institutions. One administrator referred to reflective supervision and the lack thereof stating, *here I don't have supervision, like supervision in terms of clinical supervision where you can basically kind of destress and staff cases.*

Figure 3

Codes, Meaning Units, Categories, and Themes/Essence Unique to Administrators

Theme/ Essence [Category]	Caring for the caregivers: Mitigating stress and burnout in mental health providers on college campuses  [B = Burnout and stress]	
Codes and Meaning Units	Provider stress [B]	"N*ow so many universities are having a hard time filling their positions and because therapists are just getting so burnt out and you know, now we're hiring case managers*." *"The burnout rate for folks in the university counseling center now, I know, is really, really high"*
	Multiple roles/ stretched thin [B]	*"I feel like we have an approach of overload, every employee with multiple responsibilities, multiple initiatives, and projects that you know, you're not working hard enough if you're not drowning in work."* *"It's a lot for just one person to take care of."*
	Need for new/ innovative approaches to services [B]	*"We need to be focusing on prevention; the skills, the education, changing the conversation on campus."* *"Here I don't have supervision, like supervision in terms of clinical supervision where you can basically kind of destress and staff cases"*

Last, administrators identified a need for improved and innovative approaches for identifying, supporting, and intervening on mental health challenges in higher education in order to improve outcomes for students. Specifically, one administrator stated, *we need to be focusing on prevention; the skills, the education, changing the conversation on campus*. Other administrators discussed ideas for using technology, ongoing messaging, and providing innovative training for faculty and coaches to improve collaboration, outreach, and supports in higher education. *We need to be breaking down the barriers to being able to access resources that they need in their ability to stay in school.*

Discussion

Overall, many shared and different perspectives were expressed from students and administrators related to mental health supports and services in the higher education settings. In a field with little research, it is important to understand key stakeholder perspectives to drive theory and next steps in research, practice, and policy. Additional interpretation of key findings in the areas of shared needs and barriers as well as specific needs and barriers to students and administrators is provided below.

Common Barriers

The identification of needs and barriers at the systems level by both students and administrators aligns with other research identifying the importance of systems level supports when it comes to embedding services at scale. In fact, systems level supports have been identified as key predictors of uptake of evidence-based practices (Saldana et al., 2012) and are hypothesized to be one of the biggest factors impacting quality of practices in educationally related systems (Tseng et al., 2011).

Similarly, students and administrator's identification of needs and barriers related to funding aligns with recent research stating that in 2017, states spent 16% less on higher education in general than in 2008 (Mitchell et al., 2017). When there are ongoing shortages in funds within public higher education it is critical to ensure that priorities identified in this research (i.e., supporting mental health and safety of students), align with and are supported by available funds. It is particularly salient since reported access to services for mental health is linked to improved outcomes and graduation rates (Leviness et al., 2018). Previous research paired with our findings indicate the need for two priorities related to funding. First, there is an overall need to advocate for more state and federal allocation of funding in higher education systems. This includes ensuring that these funds are then linked directly to identified priorities, such as those discussed herein for mental health in higher education, in order to ensure funds support prioritized initiatives for mental health in higher education and do not get allocated over time to other initiatives. After all, research has shown that priorities linked to funding demonstrate improved actionability and sustainability (van Kerkhoff & Szlezák, 2016).

Finally, both students and administrators described a link between campus context (e.g., urban vs. rural) and equitable access to services, or lack thereof, which aligns with current findings on higher education access in general. Specifically, rural communities have historically struggled with regular access to higher education opportunities (Myers, 2018). The findings of this study echo these concerns through participant descriptions of inadequate or missing supports for mental health at higher education institutions, particularly in rural areas. This was exemplified by descriptions of limited on-site services, often only available through contracted outside agencies. In addition, participants were noted to describe a dearth of mental health services in general throughout some rural communities (i.e., both on and off campus), whereby neither on-site or contracted services were readily available. In addition, participants noted that some communities did not feel as welcoming to all groups of individuals. Specifically, participants described concerns related to biases against underserved populations, including persistent stigma and discrimination related to mental health challenges. These findings, combined with prior research findings by Brown et al. (2016) regarding biases and lack of supports and access with special populations, identify a pressing need for improved attention to supports for special populations.

Student Specific Barriers

Research demonstrates that consistent positive personal relationships make a difference in a variety of outcomes for individuals with mental health needs including reduced re-hospitalization, lowered overall cost of services, and increased quality of life outcomes (Mental Health America, 2018). Hence, it is not surprising that personal relationships emerged as a theme related to supports for mental health as well. Having consistent, meaningful relationships with teachers and faculty and having places that feel safe and welcoming are reiterated in the literature, not just in higher education but throughout all of our educational systems (e.g., Decker et al., 2007; Roorda et al., 2011). Yet, to provide equitable access to services and trusted providers will take a shift in thinking about staffing contracts and services on campus. Specifically, it will require decreasing the gaps in services and student support groups during scheduled breaks and also require increased access during stressful times in the school year (e.g., midterms and finals). This need for temporally equitable access to services during breaks and high times of need has also been emphasized by other experts in the field (e.g., Brown, 2020; Pedrelli et al., 2015).

Administrator Specific Barriers

The mental health profession has long identified the need for interventions targeted to mental health providers to mitigate stress and burnout (e.g., Gibbs, 2001). However, none of the administrators participating in this study discussed having access to supports, such as reflective supervision, which typically are known to help mitigate stress and burnout of providers (Wallbank & Hatton, 2011). This becomes especially concerning because supports for mental health providers, such as reflective supervision, are associated with improved patient outcomes and effectiveness of care (Snowdon et al., 2017). In addition, the high caseloads and concurrent lack of support for occupational stressors create an ongoing risk of employee turnover due to burnout; which then holds potential to increase financial strain on institutions due to costs of hiring and training new employees (O'Connell & Kung, 2007). These findings also align with a recent report in the Chronical of Higher Education focused on the mental health crisis in higher education which discusses in detail the critical shortages and lack of supports for mental health providers in higher education (Brown, 2020). Even

more concerning is that turnover of key staff supporting students with mental health concerns ameliorates opportunities for building consistent relationships and an infrastructure of supports for students, a need clearly identified by participating students. Overall, these findings provide valuable information relevant to future research, practice, and policy. However, prior to discussing these implications it is important to address limitations of the study.

Limitations

Three main limitations warrant discussion due to potential impacts on future research and recommendations. First, there were time constraints to collect data due to the Senate Bill mandates. Specifically, the research team had only 3 months to collect data from college students and administrators thereby representing only a cross sectional analysis of lived experience for the interviewees. Although this is a common constraint in policy-driven work and a balance point for timeliness versus depth, it is important to mention for understanding of direction and recommendations for future research. Second, due to the time constraints, member checks (also known as participant checks) with interviewees on the transcripts and findings were not possible. Rather, validation checks of findings with the Task Force members/mental health experts and research team non-coding members were conducted for credibility along with other recommended validation methods such as dual coding and triangulation. Third, although this study did purposefully recruit and obtain experiences from across the state and specifically from different types of communities (e.g., rural versus urban) and college settings (e.g., community college versus 4-year university), the lived perspectives may have limitations with generalization due to the selected focus on public institutions within only one state. That being said, limitations to generalization are part of qualitative research, but are balanced with the value of findings that improve theory and understanding of critical issues and phenomena, such as in this study. As Vasileiou et al. (2018) state, "generalizability does not nullify the ability of qualitative research to still be relevant beyond the sample studied" (p. 14). One example that explicates the need to examine these issues across states and settings in future studies is the student who describes no longer qualifying for mental health services once they receive a scholarship due to the change in income. Although this particular example is state specific because every state has different funding structures, it does exemplify how funding structures can be impacted in unique or unexpected ways. Hence, it will be important for other agencies and states to examine impacts of funding mechanisms and supports relative to the particular communities and rules.

Future Research Directions

In spite of the aforementioned limitations, the findings hold significant potential to inform theory, future research, practice, and policy in the area of mental health on college campuses. College counseling centers promote the practice of evidence-informed practices when they are providing services to students, yet there is limited information on the effects (e.g., improved outcomes) of implementing those practices. Therefore, not only replicating this work in other states but also engaging in larger scale randomized controlled trials examining interventions in higher education would be beneficial to the field to begin understanding what works, for whom, and under what conditions. Another area of future research should investigate the infrastructure for dissemination of information about services and access to services for students, faculty, and administrators which is a complex and dynamic challenge for campuses. Part of this research could include improving understanding about a student's self-determination to overcome perceived barriers to understanding about and accessing services.

Last, we feel it is important to discuss the concerns and needs identified uniquely by students and not by administrators. Specifically, we feel it is concerning that students identified a need for trust with faculty as well as fears of being "kicked out" of the college or university; yet these were not identified within the administrator themes. This disconnect, if unaddressed, could lead to ongoing difficulties and poorer outcomes for students with mental health challenges in higher education. After all, it is the administrators, faculty, and high-level personnel who often make the final policy and systems change decisions and if administrators are unaware of key needs, they likely will go unaddressed. Hence, we feel further research on these potential needs across states and settings is needed to find out if these are universal concerns of students with mental health challenges in higher education. In addition, ensuring student voice is represented on college committees and in other decision-making processes is imperative to overcoming these differences in understanding. In addition, it would be critical to understand if the concerns of trust and fear of "getting kicked out" may stem from impacts of implicit or explicit biases and discrimination. After all, the negative link between bias and poorer outcomes in individuals with mental illness is well known in health disparities research and subsequently has been identified as a priority research need (Merino et al., 2018). Yet, in spite of increasing research on the negative impacts of bias and discrimination across a range of systems in education and health (e.g., Sukhera & Watling, 2018; Westerberg, 2016), there remains a dearth of research on the impacts of bias and discrimination in higher education related to mental health. Lastly, future research should evaluate campus policies across higher education institutions and a variety of states, including the examination of funding policies and priorities, and their relation to service implementation and student outcomes. Focusing on identification of the most effective and efficient ways to promote and deliver services and impacts of linking funding to specific mental health priorities and services may help college counseling centers across the United States understand and optimally plan for a broader range of supports and services.

Conclusion

This study identified similarities and differences in student and administrator experiences surrounding access to critical supports and services for mental health challenges in higher education institutions. Although this study was focused in scope on one state, the findings hold potential to initiate scholarly discourse on research needs, interventions, policies, supports, and systems of services and care related to mental health challenges in higher education. In addition, this work provides a foundation for researchers who may be considering partnerships with policymakers and state systems leaders. After all, research practice partnerships, such as the one described herein, are needed to begin solving some of the toughest questions in education and health (Coburn & Penuel, 2016). Through advancing understanding of determinants to supports

and services in higher education student populations, we hope this work provides the impetus for innovation and next steps in research related to mental health supports and interventions in higher education institutions.

Keywords: mental health, stigma, higher education, policy

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