Sociology 1104: Higher Education: Institutions, Inequalities and Controversies
Final Paper

Students' Perceptions and Experiences of Campus Mental Health Services

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Abstract

Rates of mental illness are rising on college campuses nationwide, but many students in need of mental health care do not receive it. This concerning trend in mental health service usage indicates an urgent need to better understand the factors that influence whether students seek help for mental health issues. Additionally, Harvard's campus mental health services, CAMHS, has been the topic of much controversy over the past year, but it is unclear how the average Harvard student perceives CAMHS. In response to these questions, I used a qualitative, open-ended survey and supplemental interviews to explore Harvard students' thoughts on CAMHS. Five themes characterized students' perceptions and experiences of CAMHS: issues related to CAMHS' lack of resources, experiences with individual counselors, CAMHS' diversity problem, CAMHS' short-term approach to care, and the broader system unifying CAMHS with other parts of the College. Students' views of CAMHS were quite variable; overall, however, administrative and resource-related aspects of CAMHS emerged as highly salient barriers to help-seeking. Meanwhile, experiences with individual counselors and CAMHS' convenient location and affordability comprised its main perceived benefits. Individual factors, such as race, sexuality, urgency of mental health concerns, and experiences of close peers, may tip the balance between these costs and benefits to determine help-seeking behavior. Overall, this project's findings constitute a nuanced picture of students' experiences of campus mental health services and point to several areas of improvement for CAMHS and Harvard College.

I affirm my awareness of the standards of the Harvard College Honor Code.

Laura Kanji

Introduction

"CAMHS Pilot System a Good Start." "Despite Demands for Counselors of Color, CAMHS Chief Says Agency Unable to Hire More Staff." "You Cannot Help Us If You're Looking Past Us." As these Harvard Crimson headlines demonstrate, dialogue on Harvard's campus has focused intensely on the University's Counseling and Mental Health Services (CAMHS) over the past year. Conversations have been sparked by a tragic incident involving a black College student, University Health Services, and the Cambridge Police Department which called CAMHS' ability to serve a diverse student population into question; broader discussions of CAMHS' lack of diverse clinicians; and a pilot appointment-making model CAMHS implemented to reduce long wait times. While these headlines and discourse evoke a contentious picture of CAMHS, it is unclear how the average Harvard student perceives and chooses to use the professional mental health services available on campus.

More broadly, there is a concerning gap between the number of students experiencing mental health issues and those who access services nationwide. However, the literature lacks many comprehensive, qualitative examinations of factors that may contribute to this gap. Trends in student mental health and service usage indicate a critical need to better understand students' mental health help-seeking behaviors and students' beliefs about and experiences of mental health services, so that schools can improve the reach and efficacy of those services.

In light of these gaps and recent conversations on Harvard's campus, I used qualitative survey and interview methods to investigate Harvard students' perceptions and experiences of CAMHS, and how students' perceptions and backgrounds interact to influence their likelihood of seeking care. Overall, responses provide a rich picture of students' CAMHS experiences, touching upon CAMHS' resource-related issues, interactions with individual counselors, staff diversity, CAMHS' short-term model of care, and administrative interactions. Logistical and administrative aspects of CAMHS emerged as highly salient barriers to care, while experiences with individual counselors and CAMHS' convenient location and affordability represented its main perceived benefits. The extent to which a student perceives her concerns as urgent; her race and sexuality; and the experiences of her close peers can tip the balance between these costs and benefits to determine her help-seeking behavior. These results reveal important areas of improvement for CAMHS, and support arguments for more qualitative studies and greater investigation of the "supply side" of the student-mental health services relationship.

Literature review

The literature demonstrates that mental illness is common and persistent among college students and that rates of mental illness have risen dramatically in the past few decades (Hunt & Eisenberg, 2010; Watkins et al., 2012). Rising rates of mental illness and help-seeking have strained college mental health resources, which often have shortages of personnel and physical space (Watkins et al., 2012). However, studies also indicate that less than a quarter to less than half of students with mental distress actually receive services (Hunt & Eisenberg, 2010; Biddle et al., 2007). The low use and availability of campus mental health services are particularly problematic given that late adolescence is a crucial period for the maintenance of mental well-being and prevention of future problems (Eisenberg et al., 2009).

The literature indicates several potential barriers to students' help-seeking. Many authors mention stigmatizing attitudes, lack of time, privacy concerns, lack of emotional openness, lack of knowledge about services, and self-sufficiency orientation (Hunt & Eisenberg, 2010; Eisenberg et al., 2009; Yorgason et al., 2008). Some authors also mention students' low confidence in campus mental health resources (Yorgason et al., 2008). A small portion of the literature touches on factors that facilitate help-seeking, such as prior counseling experience, emotional openness, social support, and perceiving one's distress as serious (Gulliver et al., 2010).

Additionally, certain groups are less likely to access professional mental health services. Ethnic minorities seek help at lower rates than white students (Masuda et al., 2009; Barksdale & Molock, 2009; Turner & Llamas, 2017). Authors have offered several explanations for this disparity, including poor previous experiences with services, social norms, privacy concerns, and lower confidence in services. However, most of the studies examining this issue were quantitative and unable to fully explain help-seeking differences. The literature also points to other background characteristics that influence students' help-seeking, including socioeconomic status (Gulliver et al., 2010; Yorgason et al., 2008; Eisenberg et al., 2009; Eisenberg et al., 2007).

The few existing qualitative studies in this area reveal the need for a more complex, open-ended approach to studying barriers to mental health help-seeking. Stigma is commonly assumed to be a major barrier to help-seeking (e.g. Eisenberg et al., 2009). However, in two qualitative studies, students were more likely to report feeling that their distress was not great

enough to warrant psychological help, that seeking help would make their distress somehow more real or permanent, and a lack of time as barriers to help-seeking than stigma or fear (Czyz et al., 2013; Biddle et al., 2007).

Finally, the literature provides a few theoretical models of help-seeking health behavior to guide research. Multistage models of help-seeking incorporate individuals' experiences of their problems, perceived need for professional help, cost-benefit analysis of receiving treatment within the context of social norms, and actions taken to receive care. These models also acknowledge the influence of beliefs and attitudes about mental illness and treatment on individuals' perceived need for help and cost-benefit analyses (Eisenberg et al., 2009). The health belief model posits that health behavior is determined by an individual's assessment of the severity of health issues they are currently experiencing, individual cost-benefit analyses, and self-efficacy (Czyz et al., 2013).

Overall, the literature provides a rich list of possible barriers and facilitators to students' ability to seek mental health care on campus. However, several gaps remain. First, there is a dearth of qualitative research. Most studies are quantitative survey-based, asking students to check off a list of barriers or facilitators without the ability to expand on what each barrier means to them. A barrier that is salient to students but absent from the list of possibilities would go unnoticed in these studies. Secondly, studies have found partial but not full support for their hypothesized barriers. As a key example, stigma is often assumed to have a central role in blocking students from accessing mental health services, but cannot fully explain the absence help-seeking behavior for some students. These results support the use of a more nuanced, open-ended approach to studying mental health care-seeking barriers and facilitators.

Importantly, research tends to focus on the "cost" side of health behavior models, rather than students' perceptions of the benefits of seeking help at their campus mental health services. Additionally, as Hunt and Eisenberg (2010) state, future research must disentangle the effects of "demand side" versus "supply side" barriers on help seeking (p. 6), focusing on the ways in which specific campus services, interventions, and contexts affect treatment usage. Articles often mention but do not deeply examine low confidence in mental health services among students. However, it seems plausible that even if students do not hold stigmatized attitudes towards mental illness and treatment in general, they may hold negative attitudes towards their own campus's resources, meaning that the perceived benefits of seeking help on campus might be

lower than in a general population-based health behavior model. The discourse on Harvard's campus intuitively suggests that varying levels of confidence in CAMHS may strongly impact students' help-seeking behaviors.

Questions and Hypotheses

Informed by gaps in the literature discussed above, I used qualitative methods to examine the general picture of students' experiences and perceptions of CAMHS and to investigate the following questions.

Question 1: How do individual factors interact with perceptions of CAMHS to determine help-seeking behavior?

1. What are students' general attitudes towards CAMHS, and how do these attitudes differ across demographic groups?
    a. Hypothesis: Students will across the board hold ambivalent attitudes towards CAMHS, with students of color and from lower SES backgrounds holding more negative attitudes on average.
2. Do students perceive CAMHS as beneficial?
    a. Hypothesis: Students who have used CAMHS or who are close to someone who has used CAMHS will perceive it as more beneficial than students who have not.
3. What do students perceive as barriers to seeking help at CAMHS?
    a. Hypothesis: Students will point out a lack of diverse clinicians, a lack of time, a perception of problems as "normal," and a reluctance to seek help from strangers as major reasons why they would not access CAMHS.
4. Which groups of students are most and least likely to seek help at CAMHS?
    a. Hypothesis: Students of color and lower-SES students are less likely to seek help than their white, higher-SES peers.

Question 2: What factors facilitate student access to CAMHS?

Given the lack of research in this area, Question 2 is exploratory.

Methods

This project used an anonymous survey with qualitative, open-ended questions in order to shed light on the aspects of CAMHS that are most salient to students. (The sensitivity of this topic reduced the feasibility of interviews that would typically be conducted to answer these types of questions.)

I emailed the survey to all 12 upperclassmen Houses and public service and research listservs, gathering 68 responses (not all respondents answered every question). I asked survey respondents to email me if they were willing to be interviewed.

Within the survey, each participant answered a general question about their thoughts on CAMHS and indicated whether they had sought services at CAMHS. Those who had sought services rated their satisfaction with and described their experience, described why they chose to seek services through CAMHS, and rated and described the ease of accessing CAMHS services. Those who had not sought services described where they obtained their information about CAMHS, whether they thought CAMHS would be helpful if they were to have a mental health concern, how likely they would be to go to CAMHS with a mental health concern, and whether they had considered using CAMHS services in the past. All participants were also asked about the likelihood that they would recommend that a friend experiencing mental health concerns visit CAMHS. I also conducted 5 half-hour semi-structured interviews. I asked interviewees to elaborate upon their experiences with CAMHS and the campus mental health culture. A complete list of interview and survey questions can be found in the Appendix.[1]

Once I collected survey and interview responses, I used an inductive coding scheme to identify broad themes in students' perceptions and experiences of CAMHS and stated barriers and facilitators to mental health help-seeking. Additionally, I spoke with Dr. Barbara Lewis, the chief of CAMHS, to gain an expert, internal perspective.

This topic by nature required special attention to ethics, particularly confidentiality concerns. In response to these concerns, the survey was fully anonymous. Additionally, it is possible that discussing mental health services could cause distress to students. In the body of my recruitment email and at the end of the survey, I provided a list of mental health resources that students could utilize if they experienced distress.

Methodological limitations

This project is limited in several ways. First, I likely knew some survey respondents, which could reduce the completeness or honesty of their responses. However, since the survey was completely anonymous, this may not have been a major issue. Secondly, my sample was somewhat small and skewed. More respondents had gone to CAMHS than had not, likely

[1] Survey data is available on request.

because I advertised the survey as a way to share thoughts about CAMHS. The vast majority of respondents were female, making it impossible to analyze the effects of gender in this study. Thirdly, those who had stronger opinions about CAMHS may have been more likely to respond. Fourth, students did not indicate when they had used CAMHS, so some mentions of long wait times may date from before CAMHS implemented its wait-reduction pilot program. However, wait times were mentioned very frequently in survey responses, indicating that many students still believe long wait times and infrequent appointments characterize CAMHS, and that this belief influences their decisions about whether to use its services. Finally, because of the nature of my research questions, most survey items focused on students' thoughts on CAMHS specifically rather than their thoughts about seeking help for mental health concerns more generally. This framing may have reduced the likelihood of participants reporting concerns about stigma or personal discomfort. The following findings should be considered in light of these limitations.

Findings

Overall, 50 survey respondents had sought services at CAMHS during their time at Harvard, while 18 had not. Some participants chose not to report demographic information. Of participants who did, 40 identified as female, 8 as male, and 2 as non-binary or gender non-conforming; 10 participants were Asian, 6 Black, 2 Hispanic, 8 mixed-race, and 23 White; 26 identified as heterosexual, and 16 as LGBTQ+. 4 participants had an annual family household income of less than $45,000; 5 had an income between $45,000 and $65,000; 6 had an income between $65,000 and $85,000; and 22 had an income over $85,000. 12 participants were sophomores, 17 were juniors, 17 were seniors, and 3 were off-cycle (no freshmen participated, as the survey was mainly distributed over upperclassmen House lists).

Quantitative data

Students rated the four quantitative items in the survey on a 1-5 scale. Mean ratings by demographics are reported below. (Since survey respondents were so disproportionately female, I did not analyze gender differences across the study.)

	Likelihood of seeking services	Satisfaction with CAMHS	Ease of access	Likelihood of recommending a

	(non-CAMHS users only)	experience (users only)	(users only)	friend (all respondents)
Overall mean	2.36	2.45	2.69	3.35
White students	2.22	2.41	2.8	3.23
Students of color	3	2.47	2.72	3.57
Heterosexual	2.8	2.62	2.63	3.62
LGBTQ+	4 *only one student answered	2.13	2.5	3.47
<$65,000 household income	1.67	2.67	2.8	3.78
>$65,000 household income	2.71	2.81	2.86	3.5

These data reveal overall ambivalent attitudes towards CAMHS among students. Racial differences in students' likelihood to seek services support the hypothesis that students of color would be less likely to seek services at CAMHS. Additionally, LGBTQ+ students were less satisfied with their experiences at CAMHS. Given this study's relatively small sample size, strong conclusions cannot be drawn from these quantitative data. Instead, I have used these data to inform my qualitative inquiry and reinforce its conclusions.

Qualitative data

Participants' perceptions of CAMHS were overall very mixed. One respondent said, "I have had a very positive experience with the service and am very thankful for their continued support!," while another described CAMHS counselors bluntly as "Overwhelmingly White, overwhelmingly incompetent." Generally, responses fell somewhere between these two extremes; most students simultaneously discussed perceived benefits and drawbacks of CAMHS.

Students' discussions of CAMHS touched upon five major themes: issues related to CAMHS' resources or lack thereof, interactions with individual counselors, CAMHS' diversity problem, CAMHS' short-term approach to care, and interactions with non-CAMHS administrators and personnel. Perceptions and experiences in each of these areas encompass many of the perceived and actual benefits, cost, barriers, and facilitators to seeking care. Moreover, these areas help categorize students' nuanced CAMHS experiences. Thus, I will summarize findings regarding these five areas, discuss additional barriers and facilitators to seeking care, and finally explore how these findings relate to my original research questions and hypotheses. Overall, students had positive experiences with CAMHS counselors (with several notable exceptions) and CAMHS' location and affordability, but a lack of resources and diverse counselors, administrative difficulties, and confusion and disappointment around CAMHS' short-term approach posed barriers to students' help-seeking and ability to obtain quality care. Students' backgrounds, perceived urgency of concerns, and peers' experiences influenced the ultimate consequences of these barriers and benefits.

Perceived lack of resources

A substantial number of responses across all survey questions referenced issues related to CAMHS' insufficient resources. First, nearly one-third of participants mentioned long wait times for appointments when asked about general perceptions of CAMHS and their own experiences. For some, waiting days or weeks after requesting an appointment was a safety hazard. "In sophomore spring I experienced a major depressive episode… CAMHS said they couldn't find an appointment time for me until 3-4 weeks. In that time span I ended up being hospitalized for suicide ideation/attempt," one respondent said. "I really could not wait a month, as my mental health was also starting to deteriorate," another echoed. Wait times detracted from otherwise beneficial counseling, sometimes discouraging help-seeking altogether. "If you are struggling from serious mental health issues, the bureaucracy of seeing your doctor 30 days later is absolutely pointless," one CAMHS user said.

Three non-CAMHS users said wait times were the primary reason they would not use CAMHS if they were to have a mental health problem. "There is no immediate help/appointment dates. By that time, I probably would've solved the problem on my own," said a respondent who considered going to CAMHS but decided against it. According to Dr. Lewis, CAMHS' new appointment-making model successfully reduced wait times in the spring but has been less

effective this fall, indicating that wait times are a major concern both for students and CAMHS itself. Additionally, Dr. Lewis discussed the difficulty of getting appointments during the most stressful times of the semester, corroborating participants' observations that wait times are greatest when students need the most help. Finally, several students said they would warn a friend that getting an appointment can be difficult and that service can be slow and underresourced; some said they would therefore recommend CAMHS only for non-urgent concerns.

Relatedly, infrequent appointment availability emerged as a concern for CAMHS users. Participants said, "Meeting every 2-3 weeks meant that I couldn't always see my counselor when I wanted him, and sometimes met with him after I had already self-regulated," and "[My therapist and psychiatrist] weren't able to meet often… and that is when people need help frequently and immediately." One participant mentioned that they received helpful weekly appointments, but no others mentioned appointment frequency as a positive. This concern also led some respondents to choose not to seek care. "I tend to try to solve problems myself and would not want to wait to see a professional especially when I feel like they won't be able to schedule me regularly," one said; another thought services would not be "timely."

Finally, students noted that CAMHS seems understaffed, a few pointing directly to this issue as the main reason Harvard cannot meet student mental health needs. Respondents said, "I think that CAMHS (and students themselves) would greatly benefit if Harvard were to allocate more resources/funds to CAMHS as their staff may not be enough to accommodate the demand," and "The lack of counselors and the lack of diversity within limits the school's ability [to] meet the demand and need of students." Limited counselor numbers also detracted from individual students' treatment experiences. "My psychiatrist was very nice, but she was very quick… I got the sense that her schedule was very packed," one individual said.

Together, wait times, infrequent appointments, and the general lack of staff and resources at CAMHS comprised the majority of participants' sources of dissatisfaction with CAMHS. These issues can be conceptualized as part of a broader resource issue. Indeed, nine participants stated that they believe CAMHS is under-resourced; "I think they don't have the resources to support students in a sustainable way whatsoever," one said. According to Dr. Lewis, one of CAMHS' greatest challenges is balancing student needs with counselor workloads and stress levels, suggesting the accuracy of students' perceptions of insufficient resources at CAMHS.

CAMHS users, non-users, and students of all demographic groups were quite aware of these issues, suggesting that CAMHS' limited resources and long wait times widely characterize discourse about and experiences of its services.

Individual counselors

Meanwhile, students' greatest satisfaction with CAMHS was most often their experience with their therapists. Many participants cited therapists as "amazing," "compassionate, sensitive, and nonjudgmental," and "very kind and helpful and accommodating," saying they "loved" and "clicked well with" their counselors. Some non-users said their friends had had helpful experiences with counselors. Furthermore, several students said they would recommend CAMHS to a friend with mental health issues because of the availability of professional support there, suggesting a positive overall perception CAMHS' counselors. For example, students said, "Whatever stage they're at in their situation, it's always good to see someone and talk through," "It's important to talk to a professional outside of your friend group," and referenced their own experiences with helpful therapists as reasons their hypothetical friend should use CAMHS.

However, students also had negative experiences with individual counselors that, while less frequent than positive experiences, were quite intense. "[My therapist] just doesn't seem insightful or intelligent," and "The person I saw kept trying to give me simple solutions before even listening to what I had to say. They also kept invalidating some of my experiences on campus," students said. One interview centered on a student's experiences with a counselor who led her to stop seeking care for nearly an entire semester. The interviewee said of her therapist's response to her eating-related concerns, "Whatever she said was so immensely hurtful in that moment that I kind of shut myself off from that counselor in particular…. I ended up not making another appointment for about three months." Additionally, several non-users expressed mixed or negative perceptions of CAMHS counselors when asked whether they thought CAMHS would be helpful. Respondents also said CAMHS could be helpful for a hypothetical friend on the "off-chance" a friend got a good counselor, that the help provided at CAMHS is "slightly less than great," or that a negative counseling experience would be "kind of likely." Finally, as discussed in the next section, students had frustrating experiences with counselors they felt could not understand their experiences because of differences in identity.

Overall, then, students reported negative interactions with counselors that are cause for serious concern. These stories would also likely detract from non-CAMHS users' perceptions of

the service. Moreover, as the next section discusses, the relative lack of diversity among the CAMHS staff significantly detracted from students' perceptions and experiences of CAMHS. On balance, though, while students' negative experiences and perceptions of individual counselors are significant, students tended to cite their individual therapists more frequently as the main benefit of their CAMHS experience or a key positive component of their view of the services.

Diversity

Students mentioned the CAMHS' staff's lack of diversity frequently, echoing broader campus conversations. Some simply stated a belief that CAMHS lacks counselors holding a diversity of identities, particularly counselors of color; others discussed how this lack of diversity affected their own experience of treatment. Participants said their therapist invalidated their experiences, but "would have understood" if the therapist were a person of color or low socioeconomic status; that they left therapy altogether because they could not see a black counselor; that CAMHS is not equipped to support a diverse student body; and that CAMHS' lack of counselors of color exacerbates problems students of color already face on campus. Finally, one participant said that they would not recommend CAMHS to a friend because their friends are mainly black, and "none of them would go." Thus, the lack of diversity among CAMHS' staff emerged as a factor that detracts significantly from therapy's benefits, and as a major barrier to seeking and recommending CAMHS' care.

CAMHS' diversity problem was salient to both students of color and white students. However, only students of color mentioned diversity concerns when asked about their satisfaction with CAMHS. Additionally, LGBTQ+ students mentioned CAMHS' lack of diversity when writing or speaking about their perceptions of CAMHS more often than their heterosexual peers. While the sample size is too small to draw firm conclusions from these trends, they do support the intuition that, although many students are aware of and disappointed with the relative homogeneity of CAMHS' staff, it affects the cost-benefit balance of help-seeking only for students who hold marginalized identities themselves. Dr. Lewis stated that one of her missions at CAMHS' helm is to secure more diverse clinicians, including by posting available jobs more widely, but also noted that there are few counselors of color within the broader Cambridge community.

Short-term approach

When students seek help at CAMHS, they can be referred to short-term CAMHS treatment or to ongoing treatment with a community provider, based on their needs (CAMHS, n.d.).[2] Several CAMHS users mentioned this short-term model as a negative aspect of their experience. “They are putting pressure on me to stop going to CAMHS. It’s incredibly frustrating!,” one person said. An interviewee had heard that CAMHS “kicks you out” after a certain number of appointments, and said she stopped at three appointments because she “wanted to delay the rest of [her] appointments for when [she] really needed them.” Others said counselors told them there was not much they could do given CAMHS’ short term orientation, or looked only for problems that could be solved quickly. Overall, students felt that CAMHS; approach focused heavily on symptoms and solutions, which some found unhelpful: “My therapist mostly just wanted to medicate me, which helped with the short term symptoms but kind of left me high and dry in the long term,” one student said. These observations contradict CAMHS’ view that many students need only one to two appointments (B. Lewis). Additionally, CAMHS reports that many students hold the misconception that they can be cured in one appointment (B. Lewis). This project’s results directly contradict that view; one student who ultimately did not use services said, “[The intake form] asked...how many sessions do you think you'll need to be cured, which I found really offensive that they thought going...3 or 4 times would cure me.” CAMHS’ short-term orientation also reduced its appeal for some non-CAMHS users. One student who thought CAMHS would otherwise be helpful presented the possibility of being referred to community care as a drawback. Another thought CAMHS’ approach would not be suited to minor nor extreme mental health concerns, and said they would only seek services if they were experiencing a narrow range of issues.

Relatedly, several students (with one exception) had very negative experiences with CAMHS’ community referral process. Although CAMHS’ stated practice is to have referral coordinators promptly sit down with students, discuss their priorities, and then refer them (B. Lewis), students said it took CAMHS’ referral coordinator a month or more to get in touch, and that they subsequently provided vague suggestions or never followed up. Additionally, students said the idea that they would be referred to community care was disappointing and were discouraged by the thought of building a new therapeutic relationship.

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[2] https://camhs.huhs.harvard.edu/get-the-facts

CAMHS' short-term approach also contributed to students' perceptions of CAMHS' target population. "I believe CAMHS works for people who have one-time stressors that can be dealt with in a few sessions, but not those who need sustained and in-depth care," a student said. "It felt like the purpose of CAMHS is for people who are in crisis," another student said, leading them to feel that CAMHS was inaccessible "before things got really bad." Overall, CAMHS' short-term approach detracts from students' experiences of services and likelihood of help-seeking across demographic groups, and CAMHS seems to fall short of its goal of connecting students with ongoing therapy.

CAMHS and College administration

The final set of issues that students frequently discussed were related to the CAMHS administration and broader Harvard bureaucracy. One student said that CAMHS effectively advocated for them and connected them to other resources. Several students, though, had poor experiences navigating the CAMHS administration and CAMHS-College relationship. Some broadly criticized the CAMHS administration, saying that CAMHS is "horribly run" or "just another part of a difficult time navigating the healthcare system." One interviewee was hospitalized for longer than necessary and temporarily lost housing due to a rigidly-applied administrative policy. While he thought that the CAMHS therapists are "amazing," he said his experience with CAMHS and College administrators in this situation "killed any sense of belonging I had at Harvard." Another inflexibly-applied protocol led a student to feel "helpless." Two students stated that CAMHS had shared information with the College without their permission or under essentially forced consent. Dr. Lewis cited broken confidentiality as a common fear of CAMHS, and these students' experiences suggest it is a legitimate risk rather than an unfounded anxiety, which could justifiably reduce students' faith in CAMHS' services overall.

Additionally, some students discussed negative interactions with individuals associated with CAMHS that occurred before they were admitted to treatment. One interviewee was told falsely over the phone that her insurance would not cover CAMHS services; her intake appointment was later canceled because her concern was deemed too pressing, but the staff failed to notify her of the cancellation. Another was told within the first five minutes of a phone conversation that CAMHS could and would not support her. A third felt her interactions with the CAMHS front desk staff were insensitive, saying, "[They] don't make me feel welcome when I

walk into the space… I called them on the phone and it felt like they were annoyed with me." Finally, a student who sought services at Urgent Care after waiting a month for a CAMHS phone intake said that the practitioner there was "genuinely awful and said some really upsetting things." Overall, students' interactions with the CAMHS administration and larger Harvard healthcare system were negative and could pose barriers to future help seeking. As one interviewee noted, "I could definitely see myself giving up at any point in the process before getting there."

Additional barriers and facilitators

In addition to those encompassed by the themes above, responses from non-CAMHS users revealed three additional help-seeking barriers. A few participants mentioned personal discomfort with seeking help: one said, "I don't really like to talk about my feelings too much," another said "I tend to try to solve problems myself," and a third said that CAMHS seemed intimidating. Similarly, one CAMHS user said that seeking services was logistically easy but "personally difficult," and an interviewee noted that acknowledging one's issues can be extremely difficult. Secondly, a few students who had considered using CAMHS but ultimately did not reported feeling that their concerns were not "pressing" or "severe enough to force me to make time for it." Finally, two students said they felt that they did not have enough time to seek services. For students who did seek services, making appointments over the phone rather than online presented an additional barrier; many said having to call was inconvenient, intimidating, and anxiety-producing.

Meanwhile, students cited three major reasons for choosing to seek services at CAMHS. First, many experienced mental health issues they perceived as serious or urgent. For instance, participants said, "I had what I would describe as a minor mental breakdown at the end of a semester which prompted me to seek some kind of care as quickly and conveniently as possible"; "I was having pretty significant and troubling anxiety and depression"; and "[My] symptoms pass[ed] some kind of threshold that in my mind justified seeing a mental health care professional."

Second, some respondents mentioned the role of referrals from peers or advisers. Health services personnel, sports doctors, peers, parents, and friends had recommended CAMHS to students or taken them directly after a suicide attempt. Finally, many respondents mentioned CAMHS' convenience, discussing its affordability, location, and confidentiality. For one

participant, affordability was the primary reason they sought services: “I thought I would give it a try since it's free,” they said. For some respondents, these aspects outweighed potential drawbacks of CAMHS: “I have also sought out other services which provide more than what CAMHS can do - but I go to CAMHS because of proximity and convenience and affordability,” one wrote. In contrast, a few participants discussed these benefits in the context of the drawbacks they ultimately experienced. “It is covered by insurance, but now I have to move into the community anyway,” one said. Another noted “CAMHS was inexpensive, but I needed to see someone more often.” Overall, though, those students who chose to seek services at CAMHS perceived it as a convenient and usable resource that could suit their somewhat urgent needs. Additionally, students generally found the initial appointment-making process, besides having to place a phone call, easy. One student who had not sought services but said they would be likely to in the future echoed the perception that CAMHS is a convenient service, and the same interviewee who nearly gave up seeking services said she continued doing so because of her parents’ encouragement and the fact that CAMHS was free. There were no substantial demographic differences between students who did and did not report these facilitating factors.

Discussion

Question 1: How do individual factors interact with perceptions of CAMHS to determine help-seeking behavior?

Overall, survey responses and interviews revealed a number of factors relevant to students’ help-seeking decisions. My hypotheses regarding Question 1 were partially supported. As expected, most students held ambivalent attitudes towards CAMHS; many students stated, for instance, that CAMHS would be helpful but for difficulties making appointments, that they liked their therapist but could not see them frequently enough, or that they had an easy time accessing CAMHS only to have invalidating interactions with administrators. While satisfaction with CAMHS was similar across demographic groups, students of color reported being somewhat less likely to seek services if they were to have a mental health problem in the future, suggesting that these students held more negative attitudes towards CAMHS. Qualitative data indicated that CAMHS’ lack of counselor diversity is one source of this difference.

Secondly, students had mixed perceptions of CAMHS’ benefits. Many referenced CAMHS’ location and affordability as reasons why they chose to access care or would recommend it to a friend. Those who had been to CAMHS often had positive experiences with

individual counselors. However, negative experiences were sometimes egregious, making it difficult to determine the net average benefit of this aspect of CAMHS' services. Additionally, with some exceptions, many CAMHS visitors found its short-term, symptom-focused approach unhelpful. Most non-users thought CAMHS would be helpful if they were to go, a few noting that it had helped their peers or that its purpose is to help students. However, nearly all qualified this expectation with hesitations about wait times, individual counselors, and its short-term approach. Similarly, although some students would recommend CAMHS to a friend unequivocally, most described it as a beneficial but highly imperfect service - e.g., "Even hard to obtain or slightly less than great help is better than nothing at all" - both because of appointment-making barriers and a perception that it serves limited needs. My second hypothesis, that students who had been to CAMHS would perceive it as more beneficial than those who had not, was somewhat supported - those who had been to CAMHS tended to report better experiences with individual counselors than those who had not been expected, but differences between the two groups were relatively minor.

Thirdly, students who had not used CAMHS reported three main sets of help-seeking barriers: resource-related issues (e.g. an expectation of long wait times and low appointment availability), perceptions that counselors are less than optimally helpful, particularly because their identities are unlikely to match those of some students, and the conception that CAMHS can only provide short-term services. A few students also mentioned personal discomfort with help-seeking and lack of time, a handful said they would be unsure about where to go for help, and one mentioned stigma as a barrier a hypothetical friend might experience. As predicted, a lack of diverse counselors and, to a small extent, lack of time discouraged students from seeking care. However, many barriers students reported diverged from my hypotheses and from the barriers found in other studies. "Supply-side" administrative difficulties, such as wait times and CAMHS' short-term model, emerged as much more central than expected, whereas "demand-side" personal barriers like lack of time or a reluctance to seek help from strangers were less frequently reported. These findings contradict those of some studies on campus mental health services (e.g. Eisenberg et al., 2009), and corroborate Hunt and Eisenberg (2010)'s argument that researchers and practitioners must pay more attention to "supply-side" barriers, Czyz et al.'s argument about the importance of qualitative inquiry (2013), and Yorgason et al.'s finding (2008) that low confidence in campus mental health services presents a barrier to help-seeking.

Finally, as expected, students of color were less likely to seek care than white students. Of respondents who reported demographic information, 47% of CAMHS users were students of color, while 69% of non-users were students of color. Additionally, 25% of CAMHS users had household incomes of less than $65,000, while 33% of nonusers had incomes of less than $65,00, indicating that students of lower SES were also less likely to seek care. However, no qualitative data spoke to the SES disparity, potentially because the sample of low-income students was quite small.

The health belief model (Czyz et al., 2013) provides a useful framework for integrating these findings in order to answer this project's first overarching question. As this model and other qualitative literature (Biddle et al., 2007) suggest, perceiving mental health issues as severe is a crucial first step in many students' help-seeking decisions. Most service-seekers perceived their mental health issues as severe or urgent, while non-service-seekers tended to see their problems as minor or self-manageable, though they sometimes pushed the limit here. "I didn't consider [my mental health] worth taking care of or worth thinking about until I became so dysfunctional I couldn't complete the basic tasks of being a student," one individual said.

Secondly, the model calls attention to the costs and benefits of seeking treatment. In Harvard's context, the major costs of seeking services stemmed from logistical, resource-based difficulties (e.g. long wait times and infrequent appointments) and the sense that one cannot remain in care for long; these concerns were salient across all survey questions, demographic groups, and both CAMHS users and non-users. For some students, the difficulty of finding a counselor with whom they could identify was also a major barrier and cost. Meanwhile, those who did seek services often had positive experiences with individual therapists; interactions with CAMHS counselors as well as the service's convenient location and affordability emerged as the main benefits students perceived.

Three major individual factors seem to tip the balance between these significant costs and benefits to determine students' help-seeking behavior. First, race and sexuality affected students' views and likelihood of help-seeking. Students of color and LGBTQ+ students were especially likely to mention CAMHS' lack of diversity when speaking about the reasons they chose not to seek or remain in CAMHS' care, indicating that for students whose identities are underrepresented in the CAMHS counselor base, the benefits of seeking care are more likely to be outweighed by the costs. More research is needed to determine whether there are other

reasons why these groups had more negative experiences and perceptions of CAMHS. Secondly, severe perceived need led students to seek help even in the context of major barriers to care. For students with more minor concerns who perceive major inconvenience in CAMHS' wait times or model of care, though, help-seeking was unlikely. One student who had previously sought CAMHS care in an emergency summarized this trend: "Given how much trouble it was, I don't think I would go back for regular mental health care/under normal circumstances." Finally, about half of non-CAMHS users and a third of users reported that friends or peers were a main source of information about CAMHS (see Appendix for a list of the information sources students reported). Thus, many students may weigh the benefits and costs of help-seeking based on the experiences of those closest to them rather than an overarching campus narrative. Especially since experiences of CAMHS are so mixed, the experiences a student's closest friends happen to have could play a major role in determining whether she views the benefits of a fantastic therapist as worth the effort of waiting for an appointment, or stays far away from CAMHS after hearing a distressing story about the administration mishandling a sensitive case.

Question 2: What factors facilitate student access to CAMHS?

As discussed above, three major factors facilitate student access to CAMHS: its affordability- and location-related convenience, support from close others, and viewing one's mental health problems as urgent. Neither students' demographic characteristics nor past therapy experiences related to these factors. These factors are similar to those Gulliver et al. (2010) identified, including social support and serious perceived distress. Additionally, these results reveal that while administrative aspects of CAMHS can pose barriers to receiving help, they are also crucial motivators for help-seeking. Therefore, it is especially important that CAMHS services legitimate rather than undermine students' perceptions of convenience.

Other key findings

In addition to shedding light on students' help-seeking behavior, this project contributes to a picture of students' overall CAMHS experiences. At the broadest level, when students are able to enter the doors of CAMHS, they are likely to receive helpful support, but getting into the doors and leaving with a satisfactory long-term plan are much more difficult. However, students have quite varied experiences; factors representing benefits for some students, like interactions with individual counselors, represent drawbacks for others. Logistical and administrative aspects of CAMHS are highly salient to users and non-users, and many barriers to care and negative

aspects of students' experiences, such as wait times and infrequent appointments, can be traced to CAMHS' limited resources and short-term approach. These findings echo the literature's discussion of the current strain on campus mental health resources (Watkins, Hunt, & Eisenberg, 2012). Furthermore, students' responses corroborated campus discourse about the lack of diversity among CAMHS' staff. Unsurprisingly, the data suggests that while this problem is salient to many students, it detracts from treatment benefits mainly for students with marginalized identities, indicating one supply-side mechanism that contributes to ethnic minorities' lower help-seeking rates (Masuda et al., 2009). Finally, a number of students discussed egregious interactions with counselors, administrators, and staff members, indicating that while the baseline quality of CAMHS personnel is relatively high, serious issues still arise.

Interestingly, survey respondents spoke about stigma much less frequently than administrative or logistical concerns, a trend similar to that in other qualitative studies of campus services (e.g. Czyz et al., 2013). These results do not mean that Harvard's campus is free of mental health-related stigma. Several interviewees and one survey respondent said that students tend not to talk about mental health, or, conversely, talked about it in an exaggerated manner, trends which could be driven by implicit mental health-related stigma. Interviewees also mentioned a few stigma-related barriers to help-seeking, such as fear of judgment or perceived weakness. (See Appendix for a summary of interviewees' observations about Harvard's mental health culture.) Furthermore, the framing of this project's questions may have increased the likelihood that students discussed administrative aspects of CAMHS rather than their personal views on mental health. However, the bulk of survey data suggests that students are willing to consider the possibility of treatment. Moreover, several students said CAMHS did "important" work, that it has good intentions, and that they appreciate its presence on campus despite its challenges, indicating an affirmatively positive view of mental health services generally. Ultimately, this project indicates that students' levels of confidence in CAMHS and administrative aspects of accessing care, not personal characteristics or beliefs, are most crucial in determining help-seeking behavior.

Implications and conclusion

Given the key influence of administrative aspects of care on students' decisions and experiences, CAMHS must continue to focus on reducing appointment wait times and ensuring that the individuals with whom students interact as they seek care are informed and sensitive.

CAMHS' pilot intake program is a promising first step here. Additionally, switching from a phone to online appointment-making system could reduce both anxiety around scheduling appointments and the potential for negative interactions with staff members. Given that CAMHS cannot feasibly provide long-term care for every student, it must be more explicit about what its model entails in order to reduce students' disappointment, uncertainty, and tendency to self-limit their appointments based on hearsay. CAMHS' new website (B. Lewis) could provide an excellent opportunity for CAMHS to clearly communicate its model to students. Thirdly, some students' highly upsetting, inappropriate interactions with CAMHS staff and other administrators suggest a need for more careful mechanisms of quality assurance, such as frequent review of cases where students initiate but do not complete the intake process. (Interviewees made several additional suggestions for improvement; see Appendix for a full list.)

Most importantly, this project suggests that resources and logistics, not education or stigma, are the most pressing barriers to students' ability to access high-quality mental health care. CAMHS has already begun implementing changes that address many of these resource- and administrative-related issues, such as efforts to hire more diverse counselors, the implementation of the drop-in Let's Talk program as an alternative to one-on-one appointments, and an improved website. Support from the Harvard administration is crucial to hasten and cement these changes.

Ultimately, the picture this project reveals of students' views and experiences of CAMHS is sobering. However, many students' willingness to begin seeking care and positive experiences once inside CAMHS' doors are sources of hope. Although resource and administrative problems are certainly challenging, they are arguably more tractable than issues of stigma or mental health awareness. Overall, Harvard as a whole must focus on providing CAMHS with the monetary and infrastructural resources it needs to serve its students quickly and responsively; if it does, it may well see a tangible change in the well-being of its student body.

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Appendix

Contents:

Survey questions

1. What do you think about Harvard's Counseling and Mental Health Services (CAMHS)?
2. Have you sought counseling services at CAMHS during your time at Harvard?
    a. If yes:
        i. Please rate your satisfaction with your experience at CAMHS (1-5 scale)
        ii. What did you think about your experience at CAMHS? Please describe your experience, including what you found helpful and/or disliked
        iii. Please describe why you chose to seek counseling services through CAMHS (as opposed to another mental health service or not seeking services at all) and anything that factored into your decision to do so.
        iv. Please rate the ease of accessing services at CAMHS (1-5 scale)
        v. Please explain the above rating. How difficult or easy did you find the process of accessing services at CAMHS? Why?
    b. If no:
        i. What do you know about CAMHS? Where did you obtain your information about CAMHS?
        ii. If you were to have a mental health concern in the future, do you think going to CAMHS would help? Why or why not?
        iii. Please rate how likely you think you would be to seek services at CAMHS if you were to have a mental health concern in the future (1-5 scale)
        iv. If you were to have a mental health concern in the future, how likely do you think you would be to seek services at CAMHS? Why?
        v. Have you considered using CAMHS services in the past? Why or why not? If you have considered using CAMHS services, why did you ultimately decide not to use the services?
3. If you had a friend with a mental health concern, how likely would you be to recommend they seek services at CAMHS? (1-5 scale)
4. Please explain the rating you made above. If you had a friend with a mental health concern, how likely would you be to recommend to them that they seek services at CAMHS?

Interview questions (I did not ask all questions in every interview, but used them to guide the conversation)

1. Can you tell me a bit about yourself and your college experience? Concentration, what you do on campus, etc?
2. Where do you get your information about mental health resources on campus? Where do you think the average Harvard student gets their information?
3. If you are comfortable saying so, have you been to CAMHS?
    a. If so, could you speak a bit about your experience there (and in seeking treatment)?
        i. Did you find it helpful? Why or why not?
        ii. What else was significant about your experience at CAMHS?
        iii. Were there any factors that influenced your decision to seek services at CAMHS (as opposed to another mental health service, or not seeking services at all)?
    b. If not, have you ever considered going? Can you speak about why you did not decide to go? Are there any factors that were particularly important in your decision not to go?
    c. If you were to have a mental health concern in the future, do you think going to CAMHS would be beneficial? Why or why not?
4. Can tell me a bit about your thoughts or opinions about CAMHS more generally? Please feel free to share as much or as little as you'd like. If you'd like, expand upon what you wrote in the survey response, or talk about something entirely different.
    a. What sorts of information influence your opinions of CAMHS? Where did you get this information?
5. Shifting gears a bit, how do you think the average Harvard student thinks about CAMHS? What are some ways you have heard CAMHS talked about among your friends, or on campus as a whole?
6. Where do you think the average Harvard student's perceptions of CAMHS come from? Where and how does it get its reputation?
7. Are there aspects of CAMHS or other mental health resources here on campus that you think should change? How so?
    a. If you could change one thing about mental health here - whether it's CAMHS, the culture, something else entirely - what would it be?
8. Is there anything else that we didn't talk about that you think is relevant or you would like me to know?
9. Do you have any questions?

Additional findings

Observations around mental health culture at Harvard, from interviews

*These observations are not generalizable because of the small number of interviews conducted, but provide important insights into the broader environment at Harvard

- Each interviewee had quite different perceptions of the mental health culture at Harvard
- Two mentioned a culture of making light of mental health issues: "People will say I want to die, but not seriously. It's not uncommon for people to talk about their anxiety in very strong yet humorous ways that obscure the real problems… even though my roommate is not suicidal we were definitely going through a hard time just in terms of the stress of Harvard, and that's something we should talk about rather than obscuring it with hyperbole that was harmful to me," one said. Another said, "there's a big culture here of downplaying what you're feeling, brushing off things."
- One discussed the pressure to appear to be doing well: "I for one feel like I have to put up an appearance of being OK here, because we're here, and we're supposed to make the most of our time here."
- On the other hand, two interviewees also noted they were much more comfortable being open about mental health issues at Harvard than at home, and generally found their peers open, understanding, and willing to listen
- Most interviewees said that people do not talk much about mental health issues or talked only with their close friends. "It's definitely not talked about in a classroom environment" or with professors, one said.
- One interviewee spoke extensively about a culture of "burning out" and "working in sprints" - "a very stop and go kind of thing."
    - They noted that most people think about mental health as something they do not need to take care of until something "breaks." Then, they do something finite to recover, and then it's back to business as usual.
    - The same interviewee noted that students are often unwilling to acknowledge their problems or push themselves to change
- One interviewee spoke about the culture of perfection, especially among freshmen, and how they saw this culture contributing to suicidal ideation both in themselves and in their peers. This culture also contributes to an unwillingness to be open about the fact that one is seeing a therapist, which some see as a sign of weakness.

Suggested changes to CAMHS and mental health culture more broadly, from interviews

Structural suggestions

- Hire a social worker, ideally a person of color, who can advocate for patients when interacting with the Harvard administration
- Compile a comprehensive website of community clinicians to help with the referral process
- More clarity about the purpose of CAMHS and who qualifies for care there; disseminate this knowledge that students do not have to rely on word of mouth or rumors
- Add instructions or educational materials about how to "do therapy" and what to expect
- CAMHS should focus on providing short term, concrete solutions, and put significant effort and time into ensuring that every student who needs one finds a long term therapist
- Add workshops for students with chronic mental health concerns

- Split services into short-term and long-term care, or provide more options for students who need long-term care
- Institutionalize conversations with students - for example, have an anonymous online form or use the UC as a mediator
- Ensure that front desk and phone staff are trained on answering questions clearly and accurately
- Allow students to make appointments with specific clinicians

Cultural suggestions

- Have an exhibition about mental health on campus, or mental health "role models" who are willing to speak about their experiences
- Have a freshman-led program for increasing willingness to talk about vulnerability - for example, freshmen volunteer to speak about their own experiences with mental illness

Students' sources of information about CAMHS (includes survey respondents and interviewees)

Information source	**Number of CAMHS users endorsing**	**Number of non-CAMHS users endorsing**
Word of mouth/peers	11	6
Advisers/proctors	5	0
Healthcare professionals	2	0
Emails	1	3
SMHL	4	0
Website	11	2
Workshops	3	4
Opening days (freshman orientation)	7	0
General campus presence	2	1
House meetings	0	1
Flyers	0	1

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