

Intimate Partner Violence Among College Students: Service Utilization and Quality of College
Campus Mental Health Services

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Abstract

Objective: About one in four women and almost one in ten men will experience some form of intimate partner violence (IPV) during their lifetime (Centers for Disease Control and Prevention, 2020). Individuals aged 18-24, which is the age range of many college students, are considered a high-risk population for experiencing IPV and its subsequent mental and physical health consequences (Truman et al., 2014). These consequences may be in addition to the increased mental, physical, and emotional risks that attending college already imposes, further emphasizing the need for mental health support on college campuses (Pedrelli et al., 2015). There is also a gap in previous research examining college campus mental health services. Therefore, the current study is unique in examining the quality and accessibility of the college campus mental health services at Union College for students who have experienced IPV.

Method: 96 student participants from Union College completed a Qualtrics survey assessing their experience with IPV, attitudes toward help-seeking, and service utilization experiences. Expert clinician interviews were conducted with three clinicians at Union College's counseling center over Zoom in a semi-structured format.

Results: A regression analysis ran on the student survey data showed that IPV and attitudes toward help-seeking were not predictors of service utilization. Consistent with the hypothesis, a correlation statistical analysis showed that the relationship between IPV and service utilization was not statistically significant, while the relationship between attitudes toward help-seeking and service utilization was statistically significant. The thematic analysis of the expert clinician interviews showed that the clinicians provide quality services, but do not have the resources to reach everyone on campus in need of these services.

Discussion: The findings from this study suggest future research directions looking at other college campuses and including explanatory variables in future similar research. The findings also suggest an increase in staffing and expanded continuity of services to improve services on college campuses.

Keywords: IPV, college students, services, service utilization, mental health

Intimate Partner Violence Among College Students: Service Utilization and Quality of College Campus Mental Health Services

Background / Aim and Purpose of the Study

Intimate partner violence (IPV) is a national and global crisis. According to the World Health Organization (2021) nearly 1 in 3, or 30%, of women globally have been subjected to a form of IPV at some point in their lives. Men can also be victims of IPV, though women are considered higher risk, causing more research to exist on violence directed towards women than men. According to the Centers for Disease Control and Prevention, about one in four women and almost one in ten men will experience some form of IPV during their lifetime, showing that the national victimization rate is similar to the international reports (Centers for Disease Control and Prevention, 2020). Similarly, increased vulnerability is also noted for transgender individuals. According to the U.S. Department of Justice (2022), the rate of violent victimization against transgender individuals was about two and a half times the rate among cisgender individuals between 2017 and 2020 (Truman et al., 2022). Increased vulnerability and victimization have also been identified for members of the LGBTQ+ community. For example, according to Truman et al. (2022) individuals who identified as bisexual were eight times more likely to experience IPV, and those who identified as gay or lesbian were more than twice as likely to experience IPV in comparison to individuals who identified as straight. Even with these shocking statistics, previous research suggests that the prevalence of lifetime experiences with IPV is actually likely higher than we have recorded due to the challenges of getting accurate self-report data on this sensitive, and possibly triggering subject (Abramsky et al., 2022).

IPV also can have severe and long-lasting consequences on the victim including physical injuries, genitourinary problems, mental health disorders including depression and post-traumatic

stress disorder, and a higher risk of drug or alcohol abuse (Campbell, 2002; Warshaw, et al., 2009). These consequences can impact individuals' quality of life and their ability to function daily (Campbell, 2002). Individuals between the ages of 18-24 are included in a vulnerable age population that is at high risk for experiencing IPV (Truman et al., 2014). This is a common age for Americans to be attending college, therefore college students may be experiencing decreased mental and physical health as a result of IPV exposure, in addition to the increased mental, physical, and emotional risks (i.e. substance abuse, anxiety disorders, depression, or eating disorders) that attending college already provides (Pedrelli et al., 2015).

Due to the high prevalence of IPV and its harmful consequences, there is a myriad of previous research on violence prevention, services, and treatments for survivors in the general population. Additionally, the utilization of mental health services on college campuses with specific populations such as the LGBTQ+ community and students with mental or behavioral disabilities has been previously researched (Bourdon et al., 2021; Nichola et al., 2018). Despite previous research studying specific populations, there is a lack of previous research about student victims of IPV, although this is a vulnerable population. Furthermore, there are studies about the barriers to service utilization for survivors of IPV, but many of the studies do not assess if the barriers generalize across age groups or if there are some barriers specific to certain populations (Fugate et al., 2004). Hyunkag et al. (2020) attempted to address these gaps by studying service utilization of mental health services on a college campus by survivors of IPV in a South Korean population. Although this study does examine IPV and college campus service utilization, the findings cannot be generalized to an American college student population due to varying stigmas, cultural influences, and barriers (Hyunkag et al., 2020). There are also surveys that exist that are meant to be implemented on college campuses, but their purpose is to quantify the

amount of IPV on the college campus, not to study it beyond frequency. A Campus Climate Survey was launched in 2019 by the American Association of Universities, an independent research institute, that had 33 schools in America surveyed and ultimately reached a total of 18,752 students from a total student sample size of 830,936 (American Association of Universities, 2019). The goal of this survey was to provide estimates of how much sexual assault, IPV, stalking, and sexual harassment occur on these college campuses (American Association of Universities, 2019). Similar to the AAU survey, Union College is part of the Higher Education Consortium that allows members to take a survey called the Higher Education Data Sharing Consortium (HEDS) Sexual Assault Campus Climate Survey (HEDS, 2023). This survey also collects mostly quantitative data assessing the frequency of sexual assault and perceptions of their campus climate and support for those who experience sexual assault (HEDS, 2023). Both surveys have shortcomings in terms of how many students take it and how representative the population that takes the survey truly is, but the existence and implementation of these surveys show the need for more knowledge about the prevalence of IPV. IPV for college students and mental health service utilization in general are both topics that have been previously and are currently studied individually. The current study intends to fill gaps in previous research to study an American sample where clinical providers and student recipients of the campus mental health services are all analyzed together.

In this study, we are exploring whether students on college campuses who have experienced IPV use the mental health services provided by their college. We are also examining what barriers to this IPV service utilization may encourage or discourage students from accessing these services. A previous study found that 21% of college students report having experienced dating violence by a current partner, and 32% of college students report

experiencing dating violence by a previous partner (Libertin, 2017). Although there are reports and statistics on IPV, they are usually under-representative of the realistic IPV rates due to widespread underreporting (Follingstad & Rogers, 2013). The aspect of IPV with the most robust and available concrete data is on sexual violence data that is collected through Title IX reports from college campuses. Even with these campus reports, underreporting still has to be taken into account due to the consequences that may occur after reporting. According to Nesbitt and Carson's 2021 report titled "The Cost of Reporting," "39 percent of survivors who reported sexual violence to their schools experienced a substantial disruption in their education. Broken down, this means that 27 percent of survivors who reported took a leave of absence, 20 percent transferred schools, and nearly 10 percent dropped out of school entirely" (Nesbitt et al., 2021). Additionally, 70 percent of survivors who reported experiences of sexual violence to their schools experience adverse effects on their safety (Nesbitt et al., 2021). Further, the perpetrator of this sexual violence is likely someone that the victim knows, which may also discourage them from reporting due to fear of social backlash (Nesbitt et al., 2021; RAINN, n.d.). One study showed that about one-third (31.1%) of the IPV perpetrators were someone the victim recognized, 25% were a friend, and 32.9% were previous partners (Cantor et al., 2020). Because sexual violence is likely to occur from a partner, this type of violence can be considered in the context of IPV (RAINN, n.d.). Beyond these statistics, some students do not even know they are experiencing abuse, adding to the underreporting of IPV (Follingstad & Rogers, 2013). Due to these unreported IPV experiences, we know that IPV is even more rampant than any statistics can accurately present.

The purpose of this study is to assess how well college campus mental health services can actually reach their population, given that college students are at high risk for experiencing IPV

and the subsequent physical, emotional, and mental consequences. The subjects of service utilization and the barriers to receiving these services have been widely studied nationally and globally in other types of samples through broad studies. Additionally, previous research shows that college-aged individuals are at high risk to experience IPV (Nesbitt et al., 2021). There is very little research examining college campus mental health services in particular and how those services are able (or unable) to effectively reach the at-risk population of college students. This study's population, college-specific population, and analysis of both student and clinician experiences fill a gap that previous research has not fully explored.

Literature review

Intimate partner violence in America / college student prevalence

According to the previously stated statistic from the Centers for Disease Control, IPV is a widespread issue amongst many different populations, but the risk of experiencing certain types of IPV (i.e. physical violence) is specifically high amongst college-aged students (Nabors et al., 2009). Additionally, college students, especially first years, are at high risk to already be experiencing social and emotional adjustment issues to being away from home and in a college environment, therefore the consequences of experiencing IPV during this time may elevate already heightened mental health struggles (Lapsley et al., 1989, Nesbitt et al., 2021). Previous research identifies college students as a high-risk population to experience IPV, further emphasizing the importance of college campuses having the necessary and available mental health services to help support this population in the unfortunately quite likely case that a survivor of this violence needs support and healing. Previous studies have examined different aspects of intimate violence on college campuses, including students' perceptions towards IPV,

but not as many have studied how student survivors handle this abuse and recover from it (Sylaska et al., 2014).

Services

There are many different types of treatments and interventions for individuals committing IPV behaviors and for those who are survivors of a relationship with IPV. Previous research shows that these treatments and interventions may differ based on many unique factors to the individual including their gender or ability to foresee the consequences of their actions (Avnaim et al., 2022). According to past research, some effective treatments and programs for IPV survivors include and are not limited to a crisis hotline, counseling, advocacy, and shelter services because they prioritize victim safety and comfort (Bennett et al., 2004). The literature on IPV has a strong focus on prevention through methods such as relationship education programs, specialized kinds of couples or family therapy, cognitive behavioral interventions, or parent education programs (Stith et al., 2022). However, in the case where prevention fails, it is necessary to have treatments and interventions prepared to support the victims of IPV. Some treatment interventions and programs have been examined in previous studies and found to help specific populations. For example, the findings from a recent study concluded that veteran women prefer patient-centered therapy, supporting previous research showing that women typically prefer flexibility and empowerment regarding the content, type, and length of their IPV treatment (Shayani et al., 2022). This study's results cannot be generalized to a college student population because it specifically studied the veteran women population and the current study is aiming to identify what a college student population finds accessible and helpful in terms of service utilization in this study.

Barriers to services

Although experiencing IPV has a variety of serious consequences including psychiatric disorders like post-traumatic stress disorder, not all individuals seek treatment or mental health services after leaving IPV relationships. This may be due to a variety of internal and external influences including healthcare, personal, legal, and accessibility barriers toward service utilization by IPV victims (Johnson et al., 2022; Kulkarni et al., 2010; Próspero et al., 2008). Internal barriers include the internalization of societal stigmas or traumatic bonds that may keep IPV survivors from seeking help. Traumatic bonding is an emotional attachment between an abused person and their abuser and is often developed within and as a result of a repeated cycle of abuse that creates powerful emotional bonds as a result of intermittent positive and negative treatment (Effiong et al., 2022). Traumatic bonds explain the attachment that victims may have with their abusers which may prevent them from leaving their abusive relationships, including feelings of love, sympathy, and confusion (Kippert, 2021). There is a societal stigma associated with help-seeking, especially with asking for assistance or support with mental health which individuals may internalize, possibly preventing them from accessing mental health services (Próspero et al., 2008). Other internal barriers toward service utilization are shame and embarrassment which are often related to this social stigma with mental health and help-seeking (Próspero et al., 2008). Some individuals also may feel like they cannot leave their partners, despite them being abusive and partaking in IPV behaviors. This internal barrier or lack of desire to leave can be explained by the traumatic bonding theory previously discussed and Stockholm Syndrome which is a psychological bond developed from a power imbalance, such as an abusive relationship (Dutton et al., 1993; Effiong et al., 2022). Traumatic bonds and Stockholm Syndrome highlight how IPV victims may feel deeply connected to their partner and may still think that they love them, regardless of the violence they may be experiencing. IPV victims may

also be experiencing gaslighting from their partners, possibly convincing them that this abusive treatment is normal or that this negative treatment is their own fault (Sweet, 2019).

Oftentimes, IPV victims may also feel as though mental health services would not be effective for them. While this may be sometimes true, previous research has examined how quality service delivery can be effectively tailored to fit the unique, individual needs of survivors of IPV (i.e. using trauma-informed, culturally specific, and patient-centered interventions to look at the individual holistically; Kulkarni, 2019). One of the ways to narrow the gap between effective and ineffective services and to alleviate this barrier is to have interventions focus on what the survivors feel comfortable with and what they feel fits their personal situation. It is critical to focus on supporting the most marginalized communities that are at the highest risk of experiencing multiple forms of violence, emphasizing the importance of this personalized care. Understanding each individual's unique personal history can help the clinician figure out how to best support them based on their lived experiences and identity (Kulkarni, 2019).

In addition to the internal barriers to service utilization, there are also many external barriers to service utilization including the expense of services and perceived or actual ineffectiveness or low quality of available services (Próspero et al., 2008). Previous research revealed that another barrier to service utilization is that individuals are not able to find the services they need or do not have enough support from professionals who can connect them to the proper services to fit their unique needs (Kulkarni et al., 2010). An integral part of a successful connection to services is the help of informal support including friends, family, or even strangers. These interpersonal relationships are important because, without these connections, IPV victims may not be encouraged by outside sources to seek out services due to their isolation in an abusive relationship. Research shows that perceptions of the severity of IPV

situations can vary due to the identity of the individual viewing the situation and the abuser or victim's gender (Sylaska et al., 2014). This means that support for the victim and level of encouragement toward help-seeking from outside sources can vary depending on the victim's gender or the gender of those in their life who could be observing the abuse, therefore leaving the victim with a weakened support system and without the outside encouragement to receive services (Sylaska et al., 2014). Previous research has also shown that treatment or service compliance for abusers can be impacted by factors such as fatherhood status (Poole et al., 2009). This means that another barrier to seeking services could be personal or home life and lived experiences in one's unique environment (Poole et al., 2009).

Unfortunately, getting access to services may also be a massive safety risk for individuals experiencing IPV, presenting a very challenging barrier to service utilization. Experiencing IPV makes individuals more at risk to be killed by their partners or experience intentional injuries (Nesca, et al., 2021). About half of the female deaths in America are related to IPV, with many of these victims being physically abused before their deaths (Carmichael et al., 2018). Previous research also has shown a significant relationship between IPV relationships and stalking behaviors, emphasizing this additional risk to help-seeking in a relationship with IPV because they may feel that seeking help will increase or worsen their partner's dangerous behaviors (Norris et al., 2011; Stalking Prevention Awareness and Resource Center, 2017). According to the Stalking Prevention Awareness and Resource Center (2017), the majority of stalking victims are stalked by someone they know and many are stalked by a current or former intimate partner. 81% of women who are stalked by a current or former intimate partner were also physically assaulted by that partner, and 31% of the women stalked by an intimate partner were previously sexually assaulted (Stalking Prevention Awareness and Resource Center, 2017). The presence of

these internal stigmas and external risks provide barriers toward service utilization for IPV victims, explaining why IPV survivors may not seek help despite the damaging, and possibly long-term consequences of experiencing IPV.

Service utilization / on college campuses

Mental health services on college campuses can present many of the same barriers as those found in the general population, explaining why students may or may not use services even in times of need (Nichola et al., 2018). However, because college students are at high risk to experience trauma and abuse as a result of IPV experiences, it is crucial that college campuses provide readily available and quality support services for their students. Past research has shown that not only are there varying levels of quality of services across college campuses, but the services may not be readily available to students (Sabina et al., 2017). For example, many colleges do not differentiate services for domestic violence and sexual assault, showing a lack of specificity and generalization of services (Sabina et al., 2017). Generalizing these services is harmful because not all sexual assault and intimate partner violence situations overlap. If situations are mutually exclusive, then they deserve specialized attention, which some broader services may not be fully equipt to properly address. Many college campuses across America have Title IX offices which are intended to support students with cases of sexual assault and violence, however, this type of service is not specialized in training to support the mental health needs of the students like the wellness or counseling centers are (Wiersma-Mosley et al., 2018). These services should serve different purposes, yet work together to protect and support students. However, these services are often combined, possibly causing the prevalent issue of IPV to be overlooked at universities. Additionally, the amount of mental health clinicians on college campuses varies depending on the institution's resources, size, and prioritization of mental

health. It is difficult to define what a typical college counseling center looks like, but the Association for University and College Counseling Center Directors' (AUCCCD) 2021 annual report determined that colleges typically have about eight counselors on staff (Gorman et al., 2021). This report also acknowledged that this staffing amount ranges dramatically. Colleges with less than 1,500 students usually have about three clinicians, while colleges with more than 45,000 students have about 29 clinicians (Gorman et al., 2021; Leonhardt, 2022). This shows there is clear variability in what services on-campus mental health centers have the resources to provide depending on the amount of staff present to meet the needs of the student population.

The current study

The purpose of this current study is to examine mental health service utilization on college campuses by students who have experienced IPV. This study is aimed to fill the gaps in previous research due to its specific focus on college-aged students and college-campus mental health services. The analysis of both student and clinician perspectives on college campus mental health services also makes the current study unique. In the current study, college students will answer questionnaires assessing their history of IPV, their attitudes toward seeking mental health support, and reports of service utilization of their college campus's services. Clinician interviews with college campus mental health providers are conducted in this study as well to further understand the availability and quality of mental health services on college campuses from the perspectives of providers. Consistent with previous research on IPV and service utilization, we hypothesize that the mental health services on college campuses will be present, however relatively difficult to implement for all of the students in need, and the center will not be very well supported by the college according to student survivors of IPV and clinicians on the college campus. We also hypothesize that IPV experiences will not be predictive of mental health service

utilization due to internal and external barriers that can prevent survivors from seeking out services. Additionally, we hypothesize that clinicians on college campuses will have certain services for college students that may cover IPV treatments, but not focus on these survivors specifically. We also predict that many clinicians will feel that there is room for improvement in their services in terms of quality, accessibility, and the ability to specifically address IPV amongst the college population. Lastly, we predict that attitudes toward help-seeking behaviors will impact service utilization, building on the internal and external barriers that individuals may experience when considering using services.

Method

Participants

Student participants in this study were recruited through Union College's SONA systems and by word of mouth for \$2.50 cash compensation or course credit. From 123 responses, 27 responses were removed for incorrect attention check responses leaving 96 participant responses. The participants included 69 women (72%), 26 men (27%), and one gender nonbinary individual (1%). Out of the total 96 participants, 77 identified as White, four participants identified as Black or African American, eight identified as Asian, eight participants identified as "Other," and one participant did not disclose their race. Within the "Other" category, one participant identified as Caribbean, three as Jewish, one as African, Native, and White, one as Hispanic, and two participants as Asian and White. Regarding ethnicity, nine participants are of Hispanic origin, 89 participants are of non-Hispanic origin, and one did not disclose. The mean ($SD = 1.408$) age of the participants was 19.73 years old, ranging from 18 - 24 years old. Data on participants' romantic relationship experience, therapy experiences, and utilization of and connection with their on-campus mental health services are included in Appendix A, Table 1.

Clinicians were recruited through a scripted email sent out to Union College's counseling center. Clinician participants were not compensated. There were a total of three clinician participants. The clinicians interviewed included two women and one man who were all counselors in the counseling center. The clinicians work at the same undergraduate institution, Union College.

Measures

Hurt, Insult, Threaten, and Scream

The first measure presented to participants in the Qualtrics survey is the Hurt, Insult, Threaten, and Scream (HITS; Sherin et al., 1998) questionnaire. This is a self-report scale to determine the frequency of intimate partner violence (Centers for Disease Control and Prevention, 2007). This questionnaire has four items (i.e. *How often does your partner insult or talk down to you?*) measured on a five-point Likert scale (1=*never*, 5=*frequently*). The scores for this questionnaire range from 4-20. A HITS score of 10 or more for female participants indicates that they are being victimized and a score of 11 or more can be used to classify male participants as victimized. The Cronbach's alpha for the HITS scale was $a = .80$ and was $a = .88$ for this dataset (Sherin et al., 1998).

Women Screening Abuse Tool

The second survey that participants completed was the Women Screening Abuse Tool (WAST; Brown et al., 1996) as another measure to determine the extent of IPV that individuals have experienced (Centers for Disease Control and Prevention, 2007). This assessment is used to screen participants for abusive experiences and has eight items (i.e. *Do arguments ever result in you feeling down or bad about yourself?*). The first two questions had three options to choose from (i.e. 1=*a lot of tension*, 0=*some tension*, 0=*no tension*), with the most extreme positive

response score being 1 and the score of 0 for the other response options. For the other six questions, participants chose from three options (i.e. 2=*often*, 1=*sometimes*, 0=*never*). This survey is coded by summing the WAST scores for each individual and if the sum is higher, there is a higher reported frequency of abusive experiences. The Cronbach's alpha for the WAST was $\alpha = .95$ and was $\alpha = .87$ for this dataset (Brown et al., 1996). The WAST and HITS measures were combined into one IPV measure with possible scores ranging from 1-15.

Attitudes Toward Seeking Professional Psychological Help

The participants then completed The Attitudes Toward Seeking Professional Psychological Help (ATSPPH-SF) questionnaire which is used to determine which barriers to services individuals identify with and their openness to seeking professional help for mental health problems (Chen et al., 2020; Fischer & Farina, 1995). Identifying these barriers can explain their likelihood to use services or not. There are 10 items on this scale and the participant will indicate their level of agreement with each item using a four-point Likert scale (0=*disagree*, 1=*partially disagree*, 2=*partially agree*, 3=*agree*). This scale is coded by adding up the ratings to get a sum after reverse scoring half of the items. Once calculated, higher scores indicate more positive attitudes toward seeking professional help (Fischer & Farina, 1995). The total scores can range from zero to 30 with the total cut-off score being greater than 20 points with each dimension being greater than 10 points, otherwise, the help-seeking attitude is classified as negative (Chen et al., 2020). The Cronbach's alpha for the original survey was $\alpha = .87$ and was $\alpha = .76$ for this dataset (Fischer & Farina, 1995).

College campus mental health service utilization questions

To assess service utilization, we developed a questionnaire for the purposes of the current study. This was necessary because past research on service utilization either uses data from

national surveys or qualitative interview questions. None of those past measures asked questions relevant to determine college campus mental health service utilization. Therefore, we developed our own measure to determine if students use the services and to assess students' opinions on the quality of those services. This measure included six questions (i.e. *I have found the mental health services at my college to be helpful*) measured on a seven-point Likert scale (1=*strongly disagree*, 7=*strongly agree*). The full questionnaire used is in Appendix B. Exploratory Factor Analysis using principal components analysis extraction method and Varimax rotation found that five items grouped together explained most (54.41%) of the variance in the service utilization measure. The sixth item (the third question on the questionnaire) was deleted for both conceptual and statistical reasons. The measure was coded and the answers for each section will be averaged to show the student's overall service utilization of their college's mental health services. Higher scores reflect greater college campus mental health service utilization related to IPV experiences. The Cronbach's alpha of this dataset after the removal of the third question was $a = .85$.

There was also an open-ended response at the end of the Qualtrics survey asking student participants to elaborate on their experiences or lack of experiences with their college's mental health services (*Please elaborate on your personal experiences using your college's mental health services or why you may not be using the services*). These responses were thematically analyzed and will help give further insights into the exact barriers that students who have experienced intimate partner violence may be encountering.

Expert Clinician Interviews

Expert interviews were conducted with clinicians who work in mental health clinics on college campuses, therefore for this study the expert interviews will be called clinician interviews. We chose to conduct qualitative, semi-structured interviews so we could ask

clinicians exactly what we wanted while allowing clinicians to share what they felt comfortable with regarding their individual experiences and opinions. According to previous research, this expert interview format has been effective at collecting qualitative data (Scheck McAlearney, 2006). Clinician participants were asked six scripted questions (i.e. *In your experience, what seems to be the most impactful barrier that students face when thinking about utilizing services?*) in a semi-structured interview format over Zoom. After each question, there are one to two scripted follow-up questions that may be asked for clarification as needed (i.e. *What made you choose ___(the certain barrier)___ as the strongest barrier to students experiencing intimate partner violence?*). The full script is included in Appendix C. The interviews were recorded for reporting accuracy. The clinician responses were thematically analyzed and organized into a table with themes and subthemes.

Procedure

After providing informed consent, student participants were presented with demographic questions and four additional questionnaires to assess their experiences with IPV, feelings towards service utilization, and their feelings towards their college campus services. They were also given the option to elaborate on their usage of their college campus mental health services to explain their experiences using an open-ended question. After they completed the survey, participants were debriefed, thanked for their participation, and provided with a list of counseling and hotline resources.

Clinicians who volunteered to participate and scheduled an interview time joined a 45-minute semi-structured interview conducted over Zoom. Participants were read the informed consent before the interview began and the interviews were recorded. During the interview, clinicians were asked a list of six scripted, open-ended questions. There were optional scripted

follow-up questions that the interviewer chose to ask on a case-by-case basis for clarity, as needed. After the interview, clinicians were allowed to ask questions, then were thanked for their time and reminded about the purpose of the study. Clinician interviews were conducted with three college-counseling clinicians on Union College's campus who gave consent to participate. All interviews were conducted over Zoom Video Conferencing and were recorded and transcribed by the principal investigator. After the transcription of the interviews, all of the interviews were read by the principal investigator in one session. After reading them over, each interview was examined individually and coded using thematic analysis. The codes were developed into general themes found throughout the interviews.

Data Analysis

Data for the Qualtrics results were recorded. Summary scores for the questions about IPV and the questions about service utilization were calculated using SPSS software. After that, we ran a moderation analysis. Regression and correlation statistical analyses were run using the IPV summary scores, attitudes toward help-seeking scores, and the service utilization scores. The dependent variable for the regression was the service utilization measure and the independent variables were the IPV measure, the attitudes toward help-seeking measure, and a combined measure of the IPV and attitudes toward help-seeking measures. The open-ended question in the service utilization measure was thematically analyzed.

Responses from the expert interviews were recorded, transcribed, coded, and reorganized into a table using thematic analysis, instead of statistical analysis. The steps to identify codes, categories, and researcher-produced themes typical to a thematic analysis were taken to create the theme chart presenting the findings (Lochmiller, 2021).

Results

Student Survey

For the HITS survey response, the mean was 1.31 ($SD = 0.63$). For the WAST survey response scores, the mean was 0.22 ($SD = 0.33$). The mean was 5.05 ($SD = 3.40$) for the combined IPV variable of HITS and WAST scales. The ATSPPH-SF survey response scores had a mean of 1.99 ($SD = 0.48$) and the service utilization survey response scores had a mean of 1.99 ($SD = 0.48$).

The attitudes toward help-seeking variable, the IPV variable, and their interaction did not predict service utilization, $R^2 = .085$, $F(3, 92) = 2.85$, $p = .042$. The only variable that was a significant predictor of service utilization was the constant ($p < .001$). Regression results are included in Table 1, see Appendix D.

The relationship between the IPV measure and the help-seeking measure was not statistically significant and showed a quite small correlation between the two variables, $r(96) = -.089$, $p = .387$. The analysis also did not show a statistically significant relationship between the IPV measure and the service utilization measure, also with a small correlation between the variables, $r(96) = -.034$, $p = .739$. Unlike the other two correlations, the relationship between the help-seeking measure and the service utilization measure was significant, $r(96) = .248$, $p = .015$. The analysis partially supported the hypothesis because it did not show a significant relationship between IPV and service utilization, but did show a significant relationship between attitudes toward help-seeking and service utilization.

The themes found from the open-ended question were made into a table with the main themes, sub-themes, and relevant quotes identified as shown in Appendix E. According to the themes, the majority of students who do not use services reported knowing how to access them if needed, with only a few reporting not knowing how to access services. Many students reported

internal barriers toward service seeking, with very few reporting experiences with stigma or external barriers toward service seeking. Additionally, the majority of students who reported using services had positive experiences with only a few reporting negative experiences mostly due to difficulties with clinician fit.

Thematic Analysis

A total of five themes were identified: mission, support for individuals who have experienced IPV, internal barriers to service utilization, external barriers to service utilization, and staffing. The nine following sub-themes were detected: student mental health safety and well-being, student academic success, outreach to the wider campus community, student feels like a burden and may be experiencing internalized negative self-talk, stigma, family or support system, perceived financial barrier, diversity of the providers, and the waitlist can be attributed and connected to a lack of providers. The themes, sub-themes, and quotes were organized into a chart. Please see Appendix F for the full chart. The principal investigator consulted with the faculty advisor Professor Patterson about the themes identified before proceeding with the analysis.

Analytic Themes

Mission

Student mental health safety and well-being. It was hypothesized that the college counseling services would focus on student mental health. The clinicians all reported that the role of Union College's counseling center is to serve as a mental health treatment and support service for the students (P3:1).

P1:2: Not only to be successful at school, like yeah, that's great that they're graduating but also, more importantly, they are able to be safe and survive and be healthy

The clinicians also reported being judgment-free and doing their best to be informed about different topics, trends, issues, and identities to help all students meet their goals (P1:3). The clinicians also emphasized wanting to be a safe, comfortable setting for students to receive services (P1:3). The clinicians also reported offering a variety of services:

P3:1: Our general role within the Union College community is to serve as a mental health treatment and support service for our students. We are the primary source of support for our students. We offer free and confidential counseling services to our students. That includes individual group and couples services and there's no limit to our services. Students can be seen here on average on a once-a-week to once-every-other-week basis we also serve as the crisis on-call response for any mental health emergencies after hours or on the weekends for our students.

Student academic success. Clinicians also recognized that the college's goal is student education and while that is not the direct goal of the counseling center, they have found that students who are connected to the counseling center show higher retention rates (P1:4; P2:3).

P1:4: research does show that when students are connected to the counseling center, their retention rates are much higher [...] of staying in school, graduating, and being successful.

Outreach. It was hypothesized that it would be difficult for counseling centers to reach students who are experiencing IPV. In the interviews, clinicians all mentioned some degree of outreach that the counseling center does to get on campus to reach the students and make themselves and their services readily available (P1:5). There are many different ways to reach out to the campus, and the clinicians mentioned: thesis support groups or working in partnerships with many different offices with student involvement. A clinician mentioned working on bystander intervention programming and educating the students on IPV, physical health, and time or stress management topics (P3:3). Clinicians also mentioned that the counseling center works collaboratively with the Title IX office (P3:4).

P2:5: We do a lot of other outreach around you know relationships and you know thesis support groups like we do all of these other outreach programs because not everyone's

going to walk to the office, we want to make sure they can find a way to get the help they need if they choose to walk through the door.

P3:2: We work very collaboratively with offices such as Res Life, Greek Life, Minerva Programs, Athletics, and so on and so forth really there's not an office within the division that we don't work with and collaborate with.

Support for individuals who have experienced IPV

It was hypothesized that although college counseling centers may be equipped to work with students who have experienced sexual assault, IPV may not be the exact same as sexual assault and there may be a blend of services provided that are not specialized for IPV survivors.

Unlike the hypothesis, all clinicians mentioned working with students who have experienced IPV and how they actively try to be aware of IPV amongst the college student population.

P1:8: from the first meeting I am asking about any issues as far as history of abuse, history of violence [...] and any concerns about relationships, about friendships. So I am trying to ask the questions to see if that is an area they want to explore in individual counseling.

P2:8: we're dealing with mostly 18-22-year-olds, they're, many of them do not have significant experience, no one's talked to them about consent, no one's talked to them about what dating looks like. Everything we see is online or on television or in a movie and that's drama

The clinicians also reported understanding nuanced differences between individual experiences with IPV. They mentioned how different students may need different types of support or connections unique to their situation.

P3:5: Not only can we be that source of clinical counseling support for someone who has experienced intimate partner violence, but we can also be that for what we would call secondary or tertiary survivors as well. So for the student that was directly impacted, so for the student who experienced the violence firsthand, we can be that immediate crisis response right after it happened or they can come to us at any point in time after that so sometimes we might see students who experience this as a child we might see someone who experienced it in middle school or high school maybe on a term abroad perhaps during the summer or a trip away. The intimate partner violence does not have to have happened on or affiliated with Union's campus or community members for us to offer services. So we would be doing both the triage and crisis support if someone came to us immediately after, or we would work with them from a clinical sense, counseling-wise as far as treating the symptoms they presented with. So whether that be perhaps symptoms of something like post-traumatic stress disorder or difficulty sleeping things like that

difficulty entering into new partner relationships perhaps really it runs the gamut but we will just provide individualized clinical and counseling services based on the needs of the student.

P3:9: probably the most important thing that I can say to someone is that you are unique in this process how you process it and how you move forward is yours and yours alone there's no right or wrong and we're not there to say what is or is not so we really try to just meet the individual where they're at.

Clinicians also reflected having a deep understanding of wanting to support survivors in whatever way best suits their needs, without having a vested interest in their decision of how to move forward (P3:7; P3:8). The counseling center can also connect students to other services if they would like, but it was emphasized that this is an option to make student's lives easier and not to provide pressure but rather guidance through this time (P3:6; P3:10). In general, all of the clinicians provided awareness that Union's counseling center is a place for students who have experienced IPV to talk through their lived experience and be acknowledged and validated that this should have never happened to them and that they did not do anything wrong. The clinicians showed knowledge about working with students who have experienced IPV and recognized that students on college campuses are a high-risk population, therefore understanding the importance of connecting this population with services that they are comfortable with utilizing.

P3:11: just having a place where someone can talk through their experience, share their lived experience, and be acknowledged and validated and told that this never should have happened to them they did nothing wrong in this situation and that they our role is really to help them see ways that they can reclaim that power and control in their life and that's incredibly powerful for someone to be granted that opportunity and hopefully feel supported in that.

Internal barriers to service utilization

Student feels like a burden and may be experiencing internalized negative self-talk.

It was hypothesized that internal barriers such as feeling unworthy to receive services can result from traumatic bonds, Stockholm Syndrome, and gaslighting from IPV relationships. The clinicians reflected that a significant barrier to receiving services or opening up during sessions

was due to these individuals being made to feel like a burden and the internalized negative self-talk that can occur as a result of IPV relationships.

P1:9: the biggest barrier is someone's thought process and the negative beliefs, which has occurred because over an extended period of time, the abuser tends to influence how the person feels about themselves, so that can cause a person to really feel like they don't deserve treatment or can't trust anybody else outside of just that abusive relationship.

Another internal barrier is self-blame for this treatment and feeling like the IPV relationship is their fault (P3:12). Clinicians also acknowledged how difficult it can be to take the step to receive services and acknowledge that they need help (P2:9). Overall, the clinicians felt like one of the most significant barriers to service seeking were the internal factors.

External barriers to service utilization

Stigma. It was hypothesized that the stigma associated with receiving or seeking out mental healthcare would strongly impact mental health service utilization for individuals who have experienced IPV. According to clinicians, stigma from friends or family due to culture, gender, social groups, or perceived expectations can impact individuals' comfort using services (P1:11; P3:13). Additionally, clinicians recognized that students are often worried that they will need to report their experiences with IPV to the Title IX office and open a case or that their friends will find out about their experiences, which would increase fear and serve as a barrier to service utilization.

P3:14: [The] social [barrier] is probably one of the harder ones that we see on our campus and that's because we are such a small campus community. The notion that if someone comes forward towards anything, even if they report it to a confidential entity like us, oftentimes we'll hear from students that it's a fear that it is then going to initiate a process.

One clinician reflected that they think society has done a decent job of reducing the stigma surrounding mental healthcare.

P2:11: one of the things I have loved to see in my time here is how much more people are

talking about therapy and that they, that they get it.

Although the clinicians mentioned that people are becoming more open about utilizing mental healthcare services, they also recognized that there is still work to do. Sometimes students still do not want to identify with needing help (P3:15). Additionally, a clinician reflected that many students still think that counseling is only for very extreme situations.

P1:12: I still think many students still feel that counseling is only for really extreme situations. That if you go to the counseling center and talk about some of your negative thoughts that you will be sent to the hospital right away, something really extreme. So I think that is an area that I would like to see improved. To normalize all help-seeking behaviors. That it doesn't need to be a major issue where someone is on the verge of hospitalization, it could be more short-term issues.

Overall, despite the stigma against seeking out mental healthcare services has possibly decreased, it is still quite prevalent and is typically based on external social pressures.

Family or support system. Many college-aged students are still somewhat dependent on their parents or guardians, therefore it was hypothesized that parental involvement could be a barrier to service utilization. Clinicians reflected that many individuals who experienced IPV and participated in services often feared their parents' or friends' reactions to finding out about their personal situation (P1:13). Additionally, the clinicians reported that students were hesitant about receiving services that involved insurance because their parents would be informed.

P3:16: if they need to use their insurance especially if that is affiliated with a parent or a guardian that they may not wish to have notified about what happened.

Perceived Financial Barrier. It was hypothesized that finances would be a significant barrier to service utilization especially because college students may be dependent on others for financial reasons, making it more complicated and expensive to seek out services where their financial supporter would not be informed or aware. Thankfully, the clinicians reported that the services at the counseling center are free for all students (P1:14; P2:12). Regarding connecting

students with other services, the counseling center reported being able to have fees waived in the health center for certain testing, but that can only occur through the Union wellness center.

P3:18: if a student were to be coming in having experiences with intimate partner violence for instance and they wanted to receive HIV prophylaxis information, Plan B, other STI testing, or any other treatment or prophylaxis treatment, we can coordinate services with health services where we can get all of the fees waived for that for a student as well. They don't need to come through us for that, health services will do that on their own, but especially if they're working with us we can just help grease the wheels so that they don't really have to you know jump through those extra hoops to get that. Additionally, we can help them out in the community access those services at free cost or very low cost as well by getting them connected.

Conducting referrals to outside sources seemed to be more difficult financially. Clinicians reported the most significant perceived financial barrier occurs with copays from places they were referring students to outside of the campus counseling center (P1:15; P2:13). Overall, the financial barrier on Union's campus was reported to be as minimal as possible and the largest perceived financial barrier is when students need referrals outside of the campus services.

Staffing

Diversity of the providers. Clinicians reported being well-trained in areas of diversity and inclusion, however, many clinicians voiced the desire for a more diverse staff to better connect with all of the students from different backgrounds (P2:16).

1:16: I would like to be able to see more staff, especially a more diverse staff. I know that that's something we have been trying to do and that we have not yet been able to fill that position to have a more diverse group of counselors here.

P2:17: I would want to make sure that we could meet the set needs of certain students. So I would love to have a BIPOC-identified clinician and I would also love to have even a halftime someone that speaks Mandarin and somebody that speaks Spanish because to be able to talk in potentially what is your native language about some of these issues would make it a lot easier because some languages do not have words to describe what you might be feeling.

Despite the lack of diverse staffing, the clinicians spoke with cross-cultural awareness and expressed that the clinicians in the counseling center are motivated and want to learn about

diversity and how it impacts students' lived experiences. Although clinicians reported a lack of diversity among the providers, they also reported that efforts are being made to change that and to increase awareness of this topic.

P2:16: all of us are ally-trained, all of us are working with the intercultural affairs office, and on our staff meeting agenda each week, there actually is a bullet point for intercultural competence, so we're making sure we are talking about what we could be doing better for the cultural aspect and types of things on our campus.

The waitlist can be attributed and connected to a lack of providers. IPV survivors can often be overshadowed, especially if their experiences are not immediately disclosed as discussed in the literature review. Unfortunately, the clinicians reported that there is a waiting list for students who call asking to receive services because there are not enough clinicians to meet the student's needs (P1:17; P3:21). Clinicians explained that this waiting list is organized by need and that if the student is at high risk or need, they can squeeze them in for an appointment. The clinicians also mentioned that students who experience IPV would not be put on the waitlist and would receive services immediately.

P1:19: The people on this waiting list are prioritized according to safety, risk, needs. Certainly, if someone has an immediate safety issue, we find a way to squeeze them in somehow. We're not going to let someone really be in danger. But for the people we feel that might have some other support, we try to give them some other options. If they have a therapist at home, we encourage them to reach out to that person for a couple more times until they are able to start their appointments with us here.

P3:20: While we will absolutely always prioritize individuals who have experienced intimate partner violence and get them connected quickly it would be all the better if we had expanded resources to do that even more efficiently.

Overall, clinicians reported needing more staff, despite already being quite well-staffed compared to other similar institutions, to meet the needs of the students (Gorman et al., 2021). They also mentioned a telehealth service that the counseling center partnered with to help support students in the meantime while they wait to be paired with a clinician, but recognized that this is not meant to be a permanent solution (P1:20). The sentiment shared was that more

staff would decrease the waiting list and also allow staff to reach out to the broader community doing advocacy work to educate and connect students on and to services who may not reach out by themselves or be aware of what is offered (P3:21).

P3:19: If we had more staff and more resources we would be an unstoppable force right. I think at times we end up in situations where there is such a high demand for our services that students are sometimes waiting to get partnered with an ongoing clinician we have walk-in services available every day those can be to get established and also for crisis-related issues and from there we will assess the needs of the students so if someone who would experienced intimate partner violence who needed services immediately came through our walk-in system, they're going to get partnered with someone right away.

Discussion

This study's purpose was to examine the relationship between experiences with IPV, attitudes toward help-seeking, and the utilization of college campus mental health services by students. There is previous research on IPV, service utilization, and barriers toward service usage, however, there is a lack of research specifically assessing the utilization of mental health services on college campuses by students who have experienced IPV (Hyunkag et al., 2020; Sylaska et al., 2014; Truman et al., 2014). There are also gaps in research assessing the quality of services and the efforts to reach out to the community of individuals who experience IPV through anything beyond surveys similar to the HEDS survey. This study did not measure the exact external and internal barriers to service utilization for IPV or explanatory variables which would include possible independent variables such as a stigma experience measurement that researchers would be able to examine in relation to the IPV and service utilization relationship. The current study was the first, to the authors' knowledge, to examine the relationship between IPV and service utilization among college students, who are at particularly high risk for IPV (Truman et al., 2014). The novelty of the current research question is a strength of this study. Regression analyses showed that both IPV and attitudes toward help-seeking did not predict

service utilization. Correlation statistical analyses showed that IPV was not correlated with service utilization, while attitudes toward help-seeking was found to be correlated with service utilization and showed a statistically significant relationship between the variables. In addition, thematic analysis findings indicated that clinicians do provide services for students who experience IPV and do attempt to reach out to the wider campus community. However, clinicians reported struggling with staffing barriers that have contributed to a waitlist creating delays in care.

A strength of this study is the creation of the service utilization measure. Currently, there are no service utilization measures that examine college campus mental health services specifically. This measure can be used again in other studies to examine the quality and experiences with mental health centers on college campuses for any students, regardless of IPV experiences. The service utilization measure may be useful to assess other questions related to college students' mental health needs. Future research should provide additional evidence of validity and reliability in more diverse undergraduate and graduate student samples. There are no existing self-report measures of mental health service utilization on college campuses which emphasizes gaps in previous research regarding studies on college campus mental health centers and services. This measure showed initial validity from its significant positive correlation with attitudes toward help-seeking. There is also evidence of reliability because the exploratory factor analysis supported the unidimensional structure of the measure following the removal of the third question in the original survey. There is evidence that this measure assesses what it was intended to and where no prior measure existed, making it a strength of the current study.

The study must be considered alongside certain limitations. First, the sample size was relatively small and homogeneous. There were only 96 participants in this study out of a total

student population at Union College of 2,050 students (Union College, 2022), meaning that only about 3% of the college's population is represented in the survey. Additionally, the majority of the students who completed the survey were in the psychology department due to the distribution of the survey on SONA systems. This may have created a sampling bias because these participants may be more likely to seek out psychological services than students associated with other academic departments at Union. Future research should be conducted in more diverse colleges and universities and with students from a range of academic departments and programs. Furthermore, the current study's statistical analyses showed means of the HITS and WAST scores were inconsistent with norms from previous studies with larger sample sizes utilizing these scales. For example, a previous study using the HITS scale with 160 participants found a mean score of 6.13, while the current study's HITS mean score was 1.31 (Sherin et al., 1998). A previous study using the WAST scale with 202 participants showed a mean score of 10.3, while the current study's mean for the WAST scale was 0.22 (Chen et al., 2005). This comparison of the current and previous studies further emphasizes the importance of future research conducting a similar study with a larger sample size.

Second, the current study did not include other variables that may partially explain the relationship between IPV and service utilization. Previous research has shown that certain internal and external factors, such as negative self-talk, traumatic bonds, gaslighting, stigma, and normalizing problematic behavior, can serve as barriers to service utilization (Dutton et al., 1993; Effiong et al., 2022; Próspero et al., 2008; Sweet, 2019). Therefore, it would be beneficial for future studies to assess typically cited barriers to help-seeking to explore how they impact the relationship between IPV and service utilization.

Third, the results may not be generalizable to other institutions beyond Union College.

Union College has a mostly White population, which was reflected in the participants who took this survey who were mostly White women (Union College, 2022). The demographics of the student population at Union including gender, race, ethnicity, geographic origin, and socioeconomic status may limit the generalizability of the results to other campuses which may have different student demographics. Additionally, Union College has access to the HEDS survey due to being a part of the Higher Education Consortium, which not all other institutions have access to, giving Union College more insight into the campus climate regarding sexual assault (Union College, 2023). This insight may allow Union to respond differently and recognize the importance of connecting students who have experienced IPV to mental health services than institutions that do not have this type of student survey. Due to Union's unique student population and experience with IPV measures and awareness of IPV, the results of this study may not be able to be generalizable to other colleges and universities. The current research question could be examined and replicated on other college campuses to build on data found in HEDS or AAU surveys to give more details on lived experiences of IPV survivors beyond the quantitative measures of IPV.

This study showed that attitudes toward help-seeking correlated with service utilization. Therefore, future research exploring ways to improve attitudes toward help-seeking may have implications for improving service utilization. For example, future research can examine outreach programs or training modules and their effectiveness in changing attitudes toward help-seeking, which may have implications for how to improve service utilization. Another example of future research could be examining what kinds of interventions can actually improve individuals' attitudes toward help-seeking, which could provide suggestions for strategies to improve service utilization as well.

The current study also highlighted that Union College's mental health counseling center could benefit from more staff to ameliorate or decrease the waitlist and to increase provider diversity to allow students to feel comfortable and well-connected with their clinicians. The waitlist may be particularly harmful to students who have experienced IPV. As a result of possible traumatic bonding, during which IPV victims are made to feel worthless and confused about how they are being treated, students who experience IPV may be less likely to advocate for themselves to be at the top of the waitlist, despite their need for services (Johnson et al., 2022; Kippert, 2021; Kulkarni et al., 2010; Próspero et al., 2008). Regardless of an increase in the staffing of clinicians, it would be helpful to implement a pre-screening or intake survey where students seeking out services can fill out a survey including questions about IPV experiences to assess need through an actual measure. It is standard protocol for IPV or domestic violence to be screened for in physical health settings, but it would also be beneficial for that screening to occur in mental health settings (Hamberger et al., 2015; Ramaswamy et al., 2019). Incorporating the HITS or WAST scales into a broader mental health screening for all students seeking services, to identify where students should be placed on the waitlist, would be a simple way to increase IPV identification. This way, IPV survivors who may not even be aware they are in an abusive relationship can be identified and either moved higher up the waitlist or be provided with emergency services.

The continuity of services can also be improved upon during college breaks and post-graduation transitions. Additionally, some students leave Union College temporarily for mental health reasons, but may not be able to continue services during this time because they are no longer active students on campus. Previous research supports the importance of the continuity of services, therefore it would be beneficial to improve the continuity of services through

expanded referral options, teletherapy services, and coordinated care plans (Haggerty, et al., 2003; Sweeney et al., 2016). This improvement in services would be beneficial for students during school breaks and for those making post-graduation transitions. Changes in an individual's environment can increase feelings of a lack of control or support, which would put students who experience IPV in an increased state of vulnerability, therefore emphasizing the need for continuity of care and support through these transitions (Ravi et al., 2021). Additionally, since the COVID-19 pandemic, there is a shortage of physical and mental health providers in America (Stringer, 2023). The lower availability of clinicians may also be problematic for students on the waitlist who may not be able to be connected with a provider in the community. This would lead to greater delays in care, further supporting the importance of expanding the continuity of care services that on-campus counseling centers provide.

Conclusion

This study's examination of both student experiences and clinician perspectives has shown that Union College's mental health services can be a very helpful resource for students if the individual and their needs fit well with the clinician and if they are able to access services regardless of the waitlist. The clinicians could benefit from more institutional support in the form of additional staff and administrative support to allow them to increase services, service options, preventative services, and outreach and to decrease the waitlist in order to reach the wider student population, especially those who have experienced IPV. Additionally, this research shows that it is crucial to move past quantifying the issue of IPV on college campuses and to start examining connections to mental health services to create action to help affected students. Overall, the current study's novel research question has implications for Union College specifically and for future research seeking to examine IPV, college campus mental health

service utilization, and attitudes toward help-seeking.

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Appendix A

Table 1

Number of students	Romantic relationship experience
9	Never been in a romantic relationship
24	Romantic relationship prior to starting college
15	Romantic relationship since starting college
50	Romantic relationships prior to and since starting college
Number of students	Therapy experiences
38	Never received therapy for mental health concerns
17	Received therapy for mental health concerns prior to college
20	Receives therapy for mental health concerns since starting college
20	Receives therapy for mental health concerns prior to and since starting college
3	Chose to not disclose
Number of students	On-campus mental health service utilization
63	Never used their college's mental health services
21	Sometimes used their college's mental health services
14	Frequently use their college's mental health services
Number of students	Student connection with mental health center outreach
53	Never attended events that their college's mental health wellness center partnered with or led
40	Sometimes attends events that their college's mental health wellness center partnered with or led
5	Frequently attends events that their college's mental health wellness center partnered with or led

Appendix B

Service Utilization Measure Questionnaire

Please indicate your response to the following prompt on the scale:

(1 = *strongly disagree*, 2 = *disagree*, 3 = *somewhat disagree*, 4 = *neutral* 5 = *somewhat agree*, 6 = *agree*, 7 = *strongly agree*)

1. I have found the mental health services at my college to be helpful.
2. I know where I can go to find mental health support on my college campus.
3. I only have received mental health services at my college because my friends or family convinced me to.
4. I feel supported by my college's mental health resources and services.
5. My college's mental health services are easy to access.
6. My college prioritizes mental health.

Please elaborate on your personal experiences using your college's mental health services or why you may not be using the services:

Appendix C

Clinician Interview Script

1. Please describe your understanding of Eppler Wolff Counseling Center's role within the Union community?
 - a. *What is their purpose within the community?*
 - b. *What is their mission?*
2. To build on our discussion of the Eppler Wolff Counseling Center's role at Union, I would like to focus on what kinds of services are provided. Specifically, what services or outreach programs are offered for students who experience intimate partner or dating violence?
 - a. *In addition to participating in student-run outreach programs, are there any of these programs that your wellness center leads and invites students to?*
3. Please describe your perception of the social, emotional, personal, or financial barriers that students may experience when trying to access services.
 - a. *Do you perceive any other domains being barriers to service utilization?*
 - b. *What makes these barriers difficult for students to navigate?*
4. In your experience, what seems to be the most impactful barrier that students face when thinking about utilizing services?
 - a. *What made you choose ____ (the certain barrier) ____ as the strongest barrier to students experiencing intimate partner violence?*
5. When reflecting on these service options, describe your perception of the efficacy of these services in terms of impacting students successfully.
 - a. *Do you think that the students who are impacted by the services provided find this help to be beneficial?*
 - b. *How do you evaluate the efficacy? Does your campus center carry out any kind of campus-wide evaluation or initiatives to assess the efficacy of services or interventions?*
6. As a provider of services, what is one thing you would like to see change with the mental health services provided on your college campus?
 - a. *What do you think that the wellness center is doing well?*
 - b. *What do you think the wellness center can improve on?*

Appendix D

Table 2

Independent Variable	Unstandardized B (slope)	Coefficients standard error	Standardized Coefficients Beta (effect size)	t	Significance
Constant	4.849	1.003		4.836	<.001
Combined IPV measure	-.286	.187	-.847	-1.531	.129
Attitudes toward help-seeking	-.041	.474	-.017	-.087	.931
IPV measure x attitudes toward help-seeking measure	.138	.090	.866	1.534	.129

Dependent variable: service utilization

Appendix E

Table 3: Student Survey Service Utilization Thematic Analysis Chart

Themes	Quotes
<p>Does not use services</p> <p>Does not feel the need for it</p>	<p><i>“I do not feel as though I have needed the service.”</i></p> <p><i>“I have had no reason to attend mental health counseling at Union College.”</i></p> <p><i>“I have never used the mental health service.”</i></p> <p><i>“I have not had any problem that need to be solved with professional opinion.”</i></p> <p><i>“I have never used the school's mental health services outside of one meeting with my teams sports psychologist because i never felt i needed to talk to anyone.”</i></p> <p><i>“I dont currently use them. I dont have really time for them and don't think I necessarily need it.”</i></p> <p><i>“I haven't had mental health issues during my time in Union College so I haven't used the health services.”</i></p> <p><i>“I am not using these services because I don't think I need it.”</i></p> <p><i>“Unnecessary for me”</i></p> <p><i>“I am not using the services becauss my mental health is good and strong currently. I do not feel like I need that extra support at the moment in my life, but I know many other people who are.”</i></p> <p><i>“My mental health challenges are not something I believe the college health services can help with.”</i></p>

<p>Would consider it and knows how to access it if needed</p>	<p><i>“I have not used Unions mental health services so far”</i></p> <p><i>“I am not using the services here because I receive help outside of college”</i></p> <p><i>“I have not used them”</i></p> <p><i>“The only reason I didn't use the college's mental health services because I believed that I didn't need any guidance or anyone in the professional field to talk to.”</i></p> <p><i>“I am aware of the services offered by the college but I have not though about going to them. Though things are promised to be kept confidential, when it comes to seeking professional help, I would seek services outside of campus because it does not involve with being on campus during the sessions.”</i></p> <p><i>“I haven't used them”</i></p> <p><i>“I don't have the time and I don't believe it is that bad enough that I need to visit them.”</i></p> <p><i>“I have never had any mental problems here”</i></p> <p><i>“It feels useless”</i></p> <p><i>“I have not had many mental health issues”</i></p> <p><i>“I have not used the mental health services because I have not had the need to yet”</i></p> <p><i>“I have recieved help from a therapist before attending Union, so I use the strategies they taught me when I am undergoing stress. This is why I typically do not need to make use of the mental health services.”</i></p> <p><i>“I have not used the services but have considered it.”</i></p>
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Does not know how to access services if needed	<p><i>“I’m not using the services mostly because I’ve felt no need to use them and if I was in a position where I needed to I’d be fine to do so.”</i></p> <p><i>“I have not needed to use the services in my time at union college. If I did I would have no issue or difficulty accessing them”</i></p> <p><i>“I have not used the resource yet, but I am aware of the type of resources we have here at Union College and know where help can be found.”</i></p> <p><i>“Haven’t used the services yet, when needed, I’ll ask and find out.”</i></p> <p><i>“I have not accessed the mental health services yet but I know they are available”</i></p> <p><i>“I have not used my college’s mental health services yet but I definitely know that they are available and will use them if I ever need.”</i></p> <p><i>“I don’t use the services because I don’t currently need them but I’m perfectly comfortable seeking them out should I ever need their services.”</i></p> <p><i>“I have not needed to use the college’s mental health services, though, if I did, I would be hesitant to use them as I do not know them.”</i></p> <p><i>“I have not used the mental health services, and I only have a vague idea of how to access them (go to wicker and ask around); but I would be very open to seeking out help if a strong need ever arose.”</i></p> <p><i>“our counseling services are not advertised well at all, only when an event occurs but mental health should be a priority 24/7”</i></p>
Barriers to services	<i>“I know that therapy is helpful but the thought of talking</i>

<p>Internal barriers</p> <p>Stigma</p>	<p><i>about my inner thoughts, conflicts, and emotions out loud is intimidating.”</i></p> <p><i>“I personally dislike talking about my feelings which is why I resort to other coping with my mental health rather than looking to my college for help.”</i></p> <p><i>“I haven't used the services because I feel as though my problems are small compared to others and that I can figure things out myself. I'm also scared to talk to someone.”</i></p> <p><i>“I have not used them because I tend to seek out friends for advice and mental health support.”</i></p> <p><i>“I have trust issues when it comes to therapists from previous experiences in my life.”</i></p> <p><i>“I'm not using them because my current way of coping, even if unhealthy, is alone time for me to catch up on things that I like to watch or laying down doing absolutely nothing. I'm also too busy to have time to go and schedule a meeting with a professional.”</i></p> <p><i>“I would feel nervous to admit I need help and I would have a hard time opening up to anyone.”</i></p> <p><i>“There's also a cultural stigma against mental health issues in my culture, and while I have grown up in the US in an environment where mental health is more embraced, it is still something that sticks with me.”</i></p>
<p>Positive experiences</p>	<p><i>“I use these services as my mentor is also a therapist as the wicker wellness center so I talk to her about my everyday life.”</i></p> <p><i>“I have used the sports psychologist a number of times for struggles I have experienced on and off the field.”</i></p> <p><i>“I use the nurse practitioner for medication and anxiety relief, a therapist, the therapy animals, and the relaxation room. Wicker is a fantastic resource.”</i></p> <p><i>“i loved doing zoom therapy and i felt like it was very accessible and i could email my therapist whenever i wanted”</i></p> <p><i>“I use the college’s mental health services once a week, and</i></p>

	<p><i>find it very helpful to deal with mental health issues and stress. I started going after being encouraged by friends on campus, and find that I have a lot more coping skills to deal with issues than when I had started”</i></p> <p><i>“The psychiatrist can be cold and difficult to talk to, but the therapist, Michele, is absolutely wonderful.”</i></p> <p><i>“The psychiatrist there can be rather cold, but I do appreciate the therapists at Wicker, especially Michele.”</i></p> <p><i>“I do like going to the events that are put on by the counseling center at this school.”</i></p> <p><i>“I used the mental health services because I was sexually harassed on campus last year and it was the only way the school responded to the issue. I actually still go to these services because I had a connection with my provider and he is the only provider that has actually been useful to me at Wicker.”</i></p> <p><i>“I started using my college's mental health services because I realized I could not keep dealing with my things by myself. It was easy to access and I have seen great improvement since I started going to it. I 100% would recommend it.”</i></p> <p><i>“I just started therapy again on campus also for anxiety symptoms and it has been a much more pleasant experience. The counselor I talk to is extremely understanding and does not make me feel like I am taking away services from other students.”</i></p>
<p>Negative experiences</p> <p>Not the right provider fit</p>	<p><i>“They seem limited, and are not as talked about on campus as they should be. I went to one therapy session and I felt like I was being questioned for a survey rather than given ways to help cope with my situation.”</i></p> <p><i>“I saw a therapist on campus for a time but I felt that it was a negative experience. We were talking more like friends and just talking about week to week events rather than focusing on the issues I was having and my goals for solving them”</i></p> <p><i>“I have heard bad things about it in the past from friends who have tried them, like the therapists not being helpful or</i></p>

	<p><i>dismissing their issues.”</i></p> <p><i>“I was forced to see a school therapist through wicker and did not like talking to someone who had a relationship to my coach who made me go.”</i></p> <p><i>“I had met with a psychologist who prescribed a weird plethora of medications to me along with a therapist that just happened to not be a good fit”</i></p> <p><i>“It was ok, not super personable and didn't seem to engage much with my specific situation, but decent advice”</i></p> <p><i>“Last year I tried the on-campus counseling but found it difficult to connect with the therapist.”</i></p> <p><i>“I have used my college wellness center but the therapist kept pushing medication instead of other forms of coping with my depression”</i></p> <p><i>“During my freshman year I attended therapy on campus to address issues with anxiety that I had been previously diagnosed with at home. When I did not have enough to talk about for the entire one hour session the therapist told me that I "should not be coming if I can't use the full hour because I am taking sessions away from people who actually need help". ”</i></p> <p><i>“I used the UWill Telehealth once and did not get any satisfaction or help from it.”</i></p>
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Appendix F

Table 4: Clinician Interview Thematic Analysis Chart

Themes	Quotes
<p>Mission</p> <p>Student mental health safety and well-being</p>	<p><i>P1:1: our mission statement really is to assist students in being able to make healthy decisions for themselves [...] We're not giving advice or telling people what to do. We're guiding people and assisting them so they can ultimately make those healthy decisions and be able to become independent in their own lives.</i></p> <p><i>P1:2: Not only to be successful at school, like yeah, that's great that they're graduating but also, more importantly, they are able to be safe and survive and be healthy</i></p> <p><i>P1:3: The counseling center is a safe place, we try to make this a really comfortable, safe setting for people where there's not judgment. We try to be really informed about different topics, different trends, different issues, different identities. We really try to help all types of people and help them to meet their goals.</i></p> <p><i>P2:1: to provide the therapy, mental healthcare for the student body.</i></p> <p><i>P3:1: Our general role within the Union College community is to serve as a mental health treatment and support service for our students. We are the primary source of support for our students. We offer free and confidential counseling services to our students. That includes individual group and couples services and there's no limit to our services. Students can be seen here on average on a once-a-week to once-every-other-week basis we also serve as the crisis on-call response for any mental health emergencies after hours or on the weekends for our students.</i></p>
<p>Student academic success</p>	<p><i>P1:4: research does show that when students are connected to the counseling center, their retention rates are much higher [...] of staying in school, graduating, and being successful.</i></p> <p><i>P2:2: the mission of the college is an educational one [...] to educate students in the liberal arts and sciences, but I'm a big believer that education is, that you're going to learn more from your friends and your interactions than you're going to learn through a major.</i></p>

<p>Outreach to the wider campus community</p>	<p><i>P2:3: We have seen over the past ten years, we are at least one percentage point higher when it comes retention. When students who utilize the counseling center are retained at a higher rate than the general campus and given that we are working with the more vulnerable students, as well as the fact that, my job isn't to make sure a student stays on campus, my job is to make sure that they're making good healthy decisions. But then they also graduate at a higher percentage then again it goes up each year. So it is like 2 or 3ish percentage points for four years and then if you look at five and six, it goes up to like 6 and 7 percent higher rates, which is great.</i></p> <p><i>P1:5: We do partner up with community resources [...] so that we can have resources and do tabling and fun events, educational events. So we do try to go out onto the campus where the students are. Where there is a lot of foot traffic so that they can get the information they need.</i></p> <p><i>P1:6: We do have someone specific to outreach, [...] it's great that they have carved out that specific position so that that person can devote their time to reach out to the students and really reach out to the students.</i></p> <p><i>P2:4: We took over the education for first-year students when they came in to talk to them about sexual health and consent and what it looked like and how to make sure you have it and then we would do a lot of programming with the Greeks and athletes around what was called conversations on consent. Now, thankfully, we have a whole office dedicated to that, so it doesn't fall solely to us. Now a lot of our work is centered around bystander intervention.</i></p> <p><i>P2:5: We do a lot of other outreach around you know relationships and you know thesis support groups like we do all of these other outreach programs because not everyone's going to walk to the office, we want to make sure they can find a way to get the help they need if they choose to walk through the door.</i></p> <p><i>P3:2: We work very collaboratively with offices such as Res life, Greek Life, Minerva Programs, Athletics, and so on and so forth really there's not an office within the division that we don't work with and collaborate with.</i></p> <p><i>P3:3: I'm the assistant director for health promotion and student Outreach so in that role I provide a lot of our education and outward facing awareness raising events for a variety of Health and Wellness topics from mental health and well-being to intimate</i></p>
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	<p><i>partner violence to physical health, stress management, time management.</i></p> <p><i>P3:4: By being granted these funds we were able to hire a grant administrator [...] to expand our bystander intervention program, expand our peer education program around these, these topical areas. She works very collaboratively with our office, with the office of community standards, and with Title IX as well.</i></p>
<p>Support for individuals who have experienced IPV</p>	<p><i>P1:7: I try to have information around my office about dating violence, about other types of domestic violence.</i></p> <p><i>P1:8: from the first meeting I am asking about any issues as far as history of abuse, history of violence [...] and any concerns about relationships, about friendships. So I am trying to ask the questions to see if that is an area they want to explore in individual counseling.</i></p> <p><i>P2:6: 67% of the students that were involved in a Title IX process the previous year had utilized our services at least once.</i></p> <p><i>P2:7: [The Title IX office will] actually reach out to me and say “can you reach out to this student, they’re going through a process” or on the flipside like they’re about to get a notification that they are going to go through a process, they are being accused of something or there is going to be a no-contact order, can I give them your email address to have them email you.</i></p> <p><i>P2:8: we’re dealing with mostly 18-22 year olds, they’re, many of them do not have significant experience, no one’s talked to them about consent, no ones talked to them about what dating looks like. Everything we see is online or on television or in a movie and that’s drama</i></p> <p><i>P3:5: Not only can we be that source of clinical counseling support for someone who has experienced intimate partner violence, but we can also be that for what we would call secondary or tertiary survivors as well. So for the student that was directly impacted, so for the student who experienced the violence firsthand, we can be that immediate crisis response right after it happened or they can come to us at any point in time after that so sometimes we might see students who experience this as a child we might see someone who experienced it in middle school or high school maybe on a term abroad perhaps during the summer or a trip away. The intimate partner violence does not have to have happened on or affiliated with Union’s campus or community members for us to offer</i></p>

services. So we would be doing both the triage and crisis support if someone came to us immediately after, or we would work with them from a clinical sense, counseling-wise as far as treating the symptoms they presented with. So whether that be perhaps symptoms of something like post-traumatic stress disorder or difficulty sleeping things like that difficulty entering into new partner relationships perhaps really it runs the gamut but we will just provide individualized clinical and counseling services based on the needs of the student.

P3:6: We can also act as an arm of the college in an advocacy sense. So what we can do is, so perhaps if a student is in need of things such as a room change or a class change or a no-contact order, we can support that student in either working through the dean of students office, the office of community standards and/or Title IX whatever the student wishes to pursue to access and arrange for those accommodations to be made. Since we are one of the only confidential sources of support when a student comes to us first we will lay out all of the options for support and services that are available on campus as well as off-campus so if they instead wish to work with an off-campus agency for advocacy and counseling support or access the legal system or the criminal justice system we can connect them with those services as well.

P3:7: We do not have a vested interest in what they do as long as they are you know safe and prioritizing you know that their health and wellness needs and the immediacy whatever they choose to do when you wholeheartedly support them in it.

P3:8: Personally and emotionally the other ways that we see this is they have just experienced a great trauma right. I don't quantify or put on a scale of magnitude how much or how little they've been traumatized. They've been traumatized period by what's happened to them. And so it is our job to support whatever their personal and/or emotional response is.

P3:9: probably the most important thing that I can say to someone is that you are unique in this process how you process it and how you move forward is yours and yours alone there's no right or wrong and we're not there to say what is or is not so we really try to just meet the individual where they're at.

P3:10: Students who come in early and who come in often after experiencing trauma tend to respond well to the services that we provide. We not only, as I said before, can provide the talk therapy and the advocacy, but if appropriate we can also refer students to

	<p><i>our medical director who's a psychiatric nurse practitioner who can prescribe medications for psychological reasons it might be something like an SSRI or an NRI if they're experiencing anxiety or depression it might just be something that they take temporarily to help them get to sleep at night. It might be something that they take for panic or anxiety. those things can be incredibly effective at getting someone through the initial response phase of things</i></p> <p><i>P3:11: just having a place where someone can talk through their experience, share their lived experience and be acknowledged and validated and told that this never should have happened to them they did nothing wrong in this situation and that they our role is really to help them see ways that they can reclaim that power and control in their life and that's incredibly powerful for someone to be granted that opportunity and hopefully feel supported in that.</i></p>
<p>Internal Barriers to Service Utilization</p> <p>Student feels like a burden and may be experiencing internalized negative self-talk</p>	<p><i>P1:9: the biggest barrier is someone's thought process and the negative beliefs, which has occurred because over an extended period of time, the abuser tends to influence how the person feels about themselves, so that can cause a person to really feel like they don't deserve treatment or can't trust anybody else outside of just that abusive relationship.</i></p> <p><i>P1:10: students that are not facing violence issues there can also be some of those bit of beliefs that 'I don't want to burden anyone' [...] so there's even that perception when, you know, in the absence of violence, for some reason the person is not deserving of any support.</i></p> <p><i>P2:9: I think that the first step is definitely the hardest, and acknowledging that you can't do it on your own, that you might not be able to do it on your own.</i></p> <p><i>P3:12: It is a common sentiment among survivors of intimate personal violence for them to somehow find or place blame on themselves for some way that they believe that maybe they should have or could have known or done something differently in that situation. Typically when we see individuals who have experienced trauma they're going to respond in one of three ways [...] fight, flight, or freeze. And so especially if someone did not for some reason have the capabilities or the wherewithal to fight back, I think oftentimes they might get caught up in a loop of saying "well I could have done this, or I should have done that, or why did I go to that event? or I might have been drinking or using other substances" and our role is really to help them see that no matter what they did or where they were or who they were with they never</i></p>

	<p><i>should have been victimized period. so I think sometimes those personal barriers can really get in the way of students accessing services.</i></p>
<p>External barriers to service utilization</p> <p>Stigma</p>	<p><i>P1:11: There is stigma about mental health issues, especially in certain cultures, especially in different genders it gets reinforced, [...] so oftentimes that is often reinforced, not only in their friend group here on campus but from back home, growing up, their family, their parents.</i></p> <p><i>P1:12: I still think many students still feel that counseling is only for really extreme situations. That if you go to the counseling center and talk about some of your negative thoughts that you will be sent to the hospital right away, something really extreme. So I think that is an area that I would like to see improved. To normalize all help-seeking behaviors. That it doesn't need to be a major issue where someone is on the verge of hospitalization, it could be more short-term issues.</i></p> <p><i>P2:10: not everyone feels comfortable coming for mental healthcare. Not everyone, not every culture is okay with receiving mental healthcare, so we try to go out and normalize it as much as we can and talk about you know how many students utilize us during an academic year which is about 25%, we talk about, the course of four years between 67% and 71% utilize us in their time here.</i></p> <p><i>P2:11: one of the things I have loved to see in my time here is how much more people are talking about therapy and that they, that they get it.</i></p> <p><i>P3:13: Oftentimes a barrier is a student wondering how their friends will perceive what they've experienced. Being concerned perhaps if it was another student that they were experiencing the violence from that they might not be believed or that people would side with that individual instead. Or even the notion that students would back away from them and not want to get involved can feel very unsupportive right. That can be very invalidating to their lived experience.</i></p> <p><i>P3:14: Social is probably one of the harder ones that we see on our campus and that's because we are such a small campus community. The notion that if someone comes forward towards anything, even if they report it to a confidential entity like us, oftentimes we'll hear from students that it's a fear that it is then going to initiate a process.</i></p>

<p>Family or support system</p>	<p><i>P3:15: While we've done a really good job at reducing stigma around mental health, there's still that stigma right that sometimes students don't want to identify with or with needing help or needing support.</i></p> <p><i>P1:13: We get a lot of students that are coming to see us and their family doesn't know and they don't want their family to know and oftentimes that's okay but it becomes an issue when things are more serious and we then have to involve the family for safety reasons. And that is a big barrier because there is a lot of hesitance about including the family because the student is afraid of how the family will react.</i></p> <p><i>P3:16: if they need to use their insurance especially if that is affiliated with a parent or a guardian that they may not wish to have notified about what happened.</i></p>
<p>Perceived financial barrier</p>	<p><i>P1:14: When a student is on campus, they can go to counseling for free here at the counseling center.</i></p> <p><i>P1:15: If they have to be home for some reason we can't continue to meet with them. So trying to give them a resource in their community locally, that can be difficult. There might not be health insurance or they may have difficulty paying the copay. I run into this sometimes, even here. Students can get their medications sent here from the pharmacy, but payment is an issue.</i></p> <p><i>P2:12: Thankfully the financial aspect we don't charge so if you want to, and we don't deal with insurance at all, so we have tried to remove the financial barriers around receiving care as best we can.</i></p> <p><i>P2:13: We can work with their insurance and we can work with referrals, but they're still paying some money for a copay, so that's something that we have struggled with.</i></p> <p><i>P2:14: If a student takes a medical leave for mental health or a physical health reason, up until, basically they'll tell you they'll take it up until week 5, they're not going to get any money back for their tuition, but they do get a tuition credit so that credit, or for tuition, they wouldn't have to pay the next term. We don't want students hanging on and trying to finish a term because they feel "I don't want to waste the money", but meanwhile they're better off getting help.</i></p> <p><i>P3:17: a common fear that we hear is that they fear how they're</i></p>

	<p><i>going to pay for services or if they need to use their insurance especially if that is affiliated with a parent or a guardian that they may not wish to have notified about what happened. So the great thing about our services here is that we take that completely off the table. Because we don't need to deal with their insurance at all, all of our services being free and confidential, we don't bill insurance, we don't care if you have insurance or not.</i></p> <p><i>P3:18: if a student were to be coming in having experiences with intimate partner violence for instance and they wanted to receive HIV prophylaxis information, Plan B, other STI testing, or any other treatment or prophylaxis treatment, we can coordinate services with health services where we can get all of the fees waived for that for a student as well. They don't need to come through us for that, health services will do that on their own, but especially if they're working with us we can just help grease the wheels so that they don't really have to you know jump through those extra hoops to get that. Additionally, we can help them out in the community access those services at free cost or very low cost as well by getting them connected.</i></p>
<p>Staffing</p> <p>Diversity of the providers</p>	<p><i>P1:16: I would like to be able to see more staff, especially a more diverse staff. I know that that's something we have been trying to do and that we have not yet been able to fill that position to have a more diverse group of counselors here.</i></p> <p><i>P2:15: We have six staff members, only two of them are diverse and you know we can't match everyone's identity on campus. [...] We don't have one that identifies as an African American, uh clinician or a Latinx clinician, so I really want that.</i></p> <p><i>P2:16: all of us are ally-trained, all of us are working with the intercultural affairs office, and on our staff meeting agenda each week, there actually is a bullet point for intercultural competence, so we're making sure we are talking about what we could be doing better for the cultural aspect and types of things on our campus.</i></p> <p><i>P2:17: I would want to make sure that we could meet the set needs of certain students. So I would love to have a BIPOC-identified clinician and I would also love to have even a halftime someone that speaks Mandarin and somebody that speaks Spanish because to be able to talk in potentially what is your native language about some of these issues would make it a lot easier because some languages do not have words to describe what you might be feeling.</i></p> <p><i>P2:18: Only 4% of the mental health workforce identifies as African</i></p>

<p>The waitlist can be attributed and connected to a lack of providers.</p>	<p><i>American or Black, that makes trying to hire somebody at Union College more, very difficult but, I think that's the thing I would love to see change, would again, be more opportunity for our students to get help from somebody who looks like them, speaks like them, who they may be able to identify with beyond just you know the training that they're being offered.</i></p> <p><i>P1:17: I do think we could use more support because we do run into having a waiting list.</i></p> <p><i>P1:18: the waiting list usually ends up happening, you know, about midway through the term and then through the rest of that term, so we can never guess how long a student will need our services, sometimes it's every week for the entire term. So as more and more students keep coming in we still have those students from earlier in the term that still need support.</i></p> <p><i>P1:19: The people on this waiting list are prioritized according to safety, risk, needs. Certainly, if someone has an immediate safety issue, we find a way to squeeze them in somehow. We're not going to let someone really be in danger. But for the people we feel that might have some other support, we try to give them some other options. If they have a therapist at home, we encourage them to reach out to that person for a couple more times until they are able to start their appointments with us here.</i></p> <p><i>P1:20: We also have partnered up with the telehealth resource which is not perfect, I'll say. It's good in theory and I think for some students it has possibly been helpful, but it's a resource we offer where someone can have telehealth resources through UWill, a side partnership, and that can hold them over until they are able to schedule their appointments here at the counseling center.</i></p> <p><i>P1:21: There's one psychiatric nurse practitioner through the health services [...] and she does part-time psychiatric appointments for students to prescribe medication, so if I had my wish, that would be increased. I really think that just a half-time position for that is not really enough. Again, we are fortunate. Many campuses do not offer on-site, on-campus psychiatric, so we're very fortunate, I am grateful, however, I'd love to be able to see more. Especially because of the financial barrier we talked about earlier right. Not every student can just get their own psychiatrist somewhere else. Those copays are expensive.</i></p> <p><i>P3:19: If we had more staff and more resources we would be an unstoppable force right. I think at times we end up in situations</i></p>
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	<p><i>where there is such a high demand for our services that students are sometimes waiting to get partnered with an ongoing clinician we have walk-in services available every day those can be to get established and also for crisis-related issues and from there we will assess the needs of the students so if someone who would experienced intimate partner violence who needed services immediately came through our walk-in system, they're going to get partnered with someone right away.</i></p> <p><i>P3:20: While we will absolutely always prioritize individuals who have experienced intimate partner violence and get them connected quickly it would be all the better if we had expanded resources to do that even more efficiently.</i></p> <p><i>P3:21: Additionally, I think then if we had you know greater resources, greater services, greater volume of staff on hand we could be doing even more of the things that I mentioned before that I'm doing more of the advocacy work more of the education more of the primary prevention work. Getting out and being a part of helping change the conversation around being an informed bystander, being someone who is informed on how to gain consent, being someone who knows the resources that are available so that our students don't sit for any length of time not knowing where to go for support. So I would love it eventually to see our services expand in that way so that we can do even more of that work.</i></p>
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