

“It’s an important thing and can change someone without you realising”: New Zealand Students’ Views of University Mental Health Services

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Students face significantly more psychological distress than the general public, yet the view of New Zealand students about their university mental health services is overlooked in research. Consequently, nine individual semi-structured interviews were conducted with students from different universities in New Zealand and analysed to explore views and experiences on service quality. Participants mostly described being satisfied with their university MHS, but many highlighted aspects that could be improved. Therapists’ qualities and skills played a leading role in views on service quality. However, long waiting times for appointments and the lack of information provided about therapists and services were barriers to use. Advertisements were identified as a route to increase service awareness and reduce mental health service-use stigma.

Keywords: Consumer Perspectives, Students, University Mental Health Services, Service Quality.

Introduction

The problems university students present with at their university counselling centres are no longer predominantly about adjustment or career support but are multi-faceted (Benton, Robertson, Tseng, Newton & Benton, 2003). This reflects the co-existing nature of some disorders and the varying range of difficulties faced by students, including sexual trauma, identity difficulties and suicidality (Kitzrow, 2009; Pledge, Lapan, Heppner, Kivlighan & Roehlke, 1998; Sarmiento, 2015). University mental health services (MHS) in New Zealand have students presenting with similar concerns as those overseas. They work with a range of difficulties including, but not limited to developmental and transitional issues, grief, learning difficulties, anxiety/stress, depression and traumatic incidents (Auckland University of Technology, 2017; Canterbury University, 2017; Massey University, 2017; Otago University, 2017; University of Auckland, 2017; Waikato University, 2017).

The psychological distress and symptoms presented by students before attending university worsen across their degree study (Bewick, Koutsopoulou, Miles, Slaa & Barkham, 2010; Cooke et al., 2006). University students have significantly higher levels of psychological distress when compared to the general public in most Anglo-American countries (Cvetkovski, Reavley & Jorm, 2012; Cooke, Bewick, Barkham, Bradley & Audin, 2006; Stallman, 2010; Storrie, Ahern & Tuckett, 2010). Although there is a lack of published prevalence rates for New Zealand, it has been reported that around 45% of students from one New Zealand University have described struggling with their emotional wellbeing (Hoffman, 2017).

The implications of untreated mental health difficulties for students are significant and can affect

academic achievement, drop-out rates, concentration and output, as well as interpersonal relationships (Brackney & Karabenick, 1995; Hunt & Einsberg, 2010; Kitzrow, 2003; Svanum & Zody, 2001). The utilisation of campus MHS results in better student retention rates and stress reduction (Lee, Olson, Locke, Micheloson & Odes, 2009). This makes it important to consider the support that university students are receiving.

Barriers and attitudes to help-seeking

The attitudes of students towards help-seeking, as well as the barriers to the utilisation of MHS, have been explored in clinical, non-clinical and specific populations (such as those with disabilities or medical students) (Coduti, Hayes, Locke & Youn, 2016; Givens & Tjia, 2002; Russell, Thomson & Rosenthal, 2008). When engaging in help-seeking, consistent with trends in the general population, students often approach general practitioners rather than counsellors (Andrews, Henderson & Hall, 2001; Stallman, 2010). Students can be unwilling to seek support from a counselling centre due to their difficulties being deemed not serious enough to require such support (Megivern, Pellerito & Mowbray, 2003). Further, there is concern that they will be stigmatized for being in a state of emotional distress (Stanley & Manthorpe, 2001; Warwick, Maxwell, Statham, Aggleton, Simon, 2008).

Generally, factors identified as barriers to the use of campus MHS include the therapy models used (predominantly western models of therapy), cost, accessibility, a lack of knowledge around the services provided, a lack of perceived level of supportiveness by staff, and perceived stigma by family or friends regarding mental health disorders (Benton, Robertson, Tseng, Newton & Benton, 2003; Collins & Mowbray, 2005;

D'Amico, Mechling, Kemppainen, Ahern & Lee, 2016; Eisenberg, Hunt & Speer, 2012; Leong & Lau, 2001; Sontag-Padilla et al., 2016; Vivekananda, Telley & Trethowan, 2011; Yorgason, Linville & Zitzman, 2008).

Mental health services and effectiveness

There is a rising demand for MHS in universities (Ketchen Lipson, Gaddis, Heinze, Beck & Eisenberg, 2015). However, limited data from several unidentified universities in New Zealand suggests that only 5.2% of enrolled students receive counselling (Stallman, 2012). This is similar to findings in other Anglo-American countries, where students do not utilize on-campus MHS (Eisenberg, Golberstein & Gollust, 2007). There is a lack of available information on how university counselling centres in New Zealand are coping. In terms of funding support, most New Zealand universities allocate money to their counselling centres from student levy fees, which each student pays upon enrolment (Auckland University of Technology, 2019; Canterbury University, 2019; Massey University, 2019; Otago University, 2019; University of Auckland, 2019; Waikato University, 2019). Although some universities provide student levy allocation information publicly online, the percentage allocated towards MHS specifically is not always clear. In example, in 2016 Massey University allocated 39% of student levy fees to health and counselling centres (Massey University, 2016). Whereas, Victoria University of Wellington specified that, in 2017, counselling services were allocated 11.3%, and health services 16.8% of student levy fees (Victoria University of Wellington, 2017).

Definitions of quality in health services are influenced by different policies worldwide (Ferlie & Shortell, 2001; Choudhry, Fletcher & Soumerai, 2005). The term 'quality' concerning MHS is made up of two factors: A focus on the client and obtaining a positive result from using the services and a practitioner-orientated aspect, which emphasises the importance of evidence-based knowledge (World Health Organization, 2003). Focus is often placed on 'indicators' of quality as a framework for service quality. This includes ease of access (including appointment times), the service process (including appropriate mental health disorder-specific care), and explicit changes found from service outcome measures administrated (Shield et al., 2003; Valenstein et al., 2004).

The research on university MHS effectiveness has tended to consider effectiveness through the use of various outcome measures. For example, Connell et al. (2008) studied counselling service effectiveness with United Kingdom university students using the Clinical Outcomes in Routine Evaluation and Assessment measures (CORE). Counsellors and clients completed the measure at the start and end of therapy. Overall, there was an improvement seen in more than half of the students who accessed the counselling services. This improvement was influenced positively by whether there was an agreed therapy termination plan (a set number of sessions). Similarly, in another study (Murray et al., 2016), the CORE-OM was used to assess engagement with student counselling services and the effectiveness of such services. More than half of the students who initially presented with severe distress showed clinically

significant improvement, although around 2% of students got worse.

In the Connell et al. (2008) study, the timing of when the therapist versus client completed the measures is not clear. When students dropped out of therapy, a final measure was not completed. Consequently, regarding those who dropped out, it is not clear whether counselling was effective, and they stopped attending as they no longer needed support or dropped out because they were not getting the support needed (Connell et al., 2008; Murray et al., 2016). The results, therefore, risk response bias in favour of successful instances of therapy being reported, as they are essentially based on MHS staff responses. A lack of exploration around what students found useful from university counselling services is a common limitation in research evaluating university MHS effectiveness.

When assessing the effectiveness of some studies, which consider university student populations, focus predominantly on the effectiveness of the psychological treatment rather than the counselling centre (Monti, Tonetti & Bitti, 2013). The number of sessions offered in such studies is also much higher than the range of sessions offered at university counselling centres in New Zealand, which is generally set at six (Destefano, Mellott, & Petersen, 2001). When considering effectiveness, attention has also been placed on the working alliance between clients and counsellors. More specifically, the positive and/or negative influences the working alliance can have on therapy outcomes and effectiveness (Ackerman & Hilsenroth, 2003; Martin, Garske & Davis, 2000).

Studies exploring health service user perceptions regarding quality or effectiveness are often in primary health settings with specific populations (for example, those who are terminally ill) (Al-Momani, 2016; Khamis & Njau, 2014; Mohebifar, Hasani, Barikani & Rafiei, 2016; Papanikolaou & Zygiaris, 2014). Research specifically considering psychological distress and quality of care from patient perceptions, are often based in medical practice settings (Gask, Rogers, Oliver, May & Roland, 2003; Johnston et al., 2007; Nolan & Badger, 2005; Pollock, Mechanic & Grime, 2002; Rogers, May, Oliver, 2001).

Studies around university MHS quality has focused on: What services are provided, accessibility, the services that have been found to work, funding, the skill level of practitioners, as well as the ratio of practitioners. However, to date, most research in this area has only been conducted with university staff members (such as lecturers or counsellors) and directors, rather than with tertiary students (Guiene & Ness, 2000; Hunt, Watkins & Eisenberg, 2012; Jaworska, De Somma, Fonseka, Heck & MacQueen 2016; Stallman, 2012; Stone, Vespia & Kanz, 2000). The view of campus counselling service users is really important to learn about, as a client's view can differ from that of a clinician's view or understanding (Sofaer & Firminger, 2005).

Research of the experiences of students attending an educational based counselling service has focused on those who have accessed secondary school-based counselling (Shi, Liu & Leuwerke, 2014). Generally, secondary school students see the services as helpful in

different areas of their lives (including behavioural, emotional and interpersonal outcomes) (Lynass, Pykhtina and Cooper, 2012). However, research is needed for the specific experiences of tertiary students, as the needs and concerns of students at a university level are arguably different from those at secondary schooling (including differing adjustment concerns and differing levels of support systems). Furthermore, age difference results in different developmental concerns (Parker, Summerfeldt, Hogan & Majeski, 2004).

The limited studies that have focused on the experiences of tertiary students have mostly considered students' experiences with general university services (including, but not strictly limited to counselling services) in Anglo-American countries. Findings are not explorative and only briefly note that students are generally aware of such services, are satisfied with them and, at times, do engage with them (Russell et al., 2008). To date, there has been no research on the views of domestic students around university MHS engagement.

Current study

The purpose of this study is to explore the views of New Zealand based students around service quality of campus MHS. Therefore, the main research question is: What are the views and experiences of students who have accessed a New Zealand University MHS? Some supporting key questions include: What are their thoughts around local campus MHS after attendance? Also, in what ways may their experiences have increased or decreased the likelihood of them accessing other mental health/general health services in the future?

This study seeks to address the gap in research around the views of New Zealand tertiary students' MHS use. This will allow for the identification of areas specific to the needs of a New Zealand student population. Most studies considering the quality of care perceptions have focussed on views of clinicians or used closed-ended questions (survey formats or psychological measures). A qualitative method will allow for a more detailed exploration of what service users find important.

METHODS

Participants and Recruitment

Recruitment was through posts on public New Zealand wide Facebook groups, mass email lists (for example, university graduate email lists) and posters around two university campuses. Interested participants contacted the researcher through email and were then provided with an information sheet and consent form. Participants who agreed to continue on to the interview set up an interview time and date with the researcher through email. There were nine participants aged 18 and over (Table 1). All were current or past domestic students of two New Zealand universities (last year of attendance being within the last three years) and had previously attended a university MHS for at least one session.

Procedure

Interviews were one-to-one and semi-structured, ranging from 20 minutes to an hour and a half. These were held in a private room at a library or via Skype. Before beginning the interview, the main sections of the

information

Table 1. Participant Demographical Information

Characteristics	Count (N)
Gender	Female 9
Age	18-24 5
	25-34 1
	35-44 3
Ethnicity*	New Zealand/European 7
	Maori 3
	Chinese 2
	Niuen 1
	Burmese 1
	Scottish 1
	Irish 1
Qualification level	Bachelor degree 6
	Postgraduate diploma 1
	Doctorate 2

*Note. Some participants identified with more than one ethnic group.

sheet were once again discussed with participants. Participants all signed a consent form and completed demographic information. All interviews were audio-recorded with permission. As the focus was on the students' experience, interview questions were not theoretically grounded but open-ended and general. This was to encourage the participants to direct the conversation to the areas they wanted to speak about. The initial question set given to the first three participants was found to be unclear. The wording of some initial interview questions was changed, producing a new adapted set. This was clearer and allowed for more personal interpretations by the rest of the participants.

This project was reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 17/14 (Appendix A). Participants were provided with a list of helpline contact details (e.g., Lifeline, Depression Helpline, Health and Disability Commissioner) at the beginning of the interview. This acted as additional support should the participants wish to discuss their experiences in a therapeutic context. The data was anonymised with pseudonyms being used when reporting participants' experiences in this study. Identifying information about the universities or where participants sought and received MHS was removed.

Data Analysis

Thematic analysis was chosen as the method for data analysis as it allowed for the exploration of the specific research question and the views of participants (Braun & Clarke, 2006). Braun and Clarke (2006) provide a six-step guideline so that the process of thematic analysis is clear and thorough. In line with their guidelines, all nine of the recorded semi-structured interviews were first personally transcribed. Participants were sent the transcripts for their review and approval. Step one involved creating notes on what stood out with transcripts each re-read several times. In step two, initial coding was inductive-based, whereby codes were kept as close as possible to the participants' experiences and focussed on their answers (rather than the questions asked) (Clarke & Braun, 2013). In step three, themes that emerged from the codes were placed together in groups. During step four, each theme was reviewed,

edited and refined. This process was repeated several times resulting in eight over-arching themes being merged into five. In step five, the themes were defined and, in the final step, analysed with the results and discussion section written. Sub-themes often vary in their distinctiveness, although the overall themes identified are distinct (Maguire & Delahunt, 2017).

There were various considerations made in order to aid with the credibility of this study (Golafshani, 2003; Shenton, 2004). One form of triangulation is the comparison of participants' experiences with each other so to verify the experiences (Shenton, 2004). That is, although each participant's experience is unique, it was found that by the ninth interview, there was a significant degree of overlap in what participants were describing. The credibility of this study was also addressed through encouraging honesty; in each interview, participants were encouraged to be as up-front as they wished (Shenton, 2004). The researcher also being a student aided this by not being affiliated with any mental health services at universities. Further, participants had the chance to go through their transcripts afterward, although no amendments were requested (Patton, 1999). The dependability of this study is supported through the detailed methodology provided (Shenton, 2004).

ANALYSIS

Three over-arching themes were identified in relation to the accounts provided about university MHS by students who were service users (Table 2).

Accessibility of university MHS, an over-arching theme, was the most discussed area by participants from the two universities. In the first theme, barriers, many felt service access was difficult and intimidating. Therapy misconceptions, a sub-theme, pulled together participants' acknowledgments that stereotypes or common misconceptions about therapy had initially shaped expectations. The influence of stereotypes on what therapy might be like was present for participants regardless of their educational background.

...Even with study, I still thought it would be someone behind a clipboard going, 'ok, well tell me what's going on'... [Ashley].

Participants identified areas of apprehension before session attendance, which generally reflected a lack of information around university MHS. There was concern about what disclosures might be required in counselling session discussions.

...I thought it would be invasive... I didn't want to talk about my childhood or all those other things... [Isabelle].

Similarly, a fear concerning what remained confidential when engaging with their university MHS was common. Participants wanted confidentiality to be respected because of apprehension around the consequences of others knowing what was spoken about.

...it was really important that confidentiality was maintained, cause she likely knew a lot of the people I was talking about [Paige].

Some participants had high positive expectations regarding attendance outcomes. A face-to-face session meant that concerns would be alleviated instantly and that they could then go on with their lives.

...To put it very black and white, I felt bad and I wanted them to make me feel good.... I thought I would be in a stronger place and I would be able to just do the all-nighters that you were supposed to do [Isabelle].

Although participants were hopeful that they would gain instantaneous relief; there was the eventual insight that an instant fix might not be the case, regardless were not put off therapy.

...I just need to make it to that two-week mark and then I will be ok. Um, obviously, that's not how it works and that's not how it happened [Kate].

Participants felt there was a lack of information provided by their university MHS, as identified in the sub-theme: low publicity. Some were unaware of the free counselling service at both universities or the number of sessions provided, which was also a pattern observed

Table 2. Summary of over-arching themes, themes and sub-themes.

Over-arching Themes	Themes	Sub-themes
Accessibility of the university mental health service	• Barriers	<ul style="list-style-type: none"> i. <i>Therapy misconceptions and expectations</i> ii. <i>Low publicity</i> iii. <i>Stigma</i> iv. <i>The appointment</i>
	• Advertising	<ul style="list-style-type: none"> i. <i>Multiple faces of access</i> ii. <i>Efficiency</i>
Perceptions of service quality	The role of the counsellor	<ul style="list-style-type: none"> i. <i>The ideal therapist</i> ii. <i>Therapist: The experience</i>
The influence of university mental health service	Attendance and new knowledge	

within their peer groups. This was an area that participants wanted more information around.

I didn't know a lot... I didn't know it was free until I went. I just know it was there because it was called health and counselling [Kiana].

Participants reported that some universities did not provide information about the therapists at their mental health centres anywhere. The result was a distinct sense of vulnerability about disclosing personal information to a stranger.

...Had I known who I was having the appointment with, I would have been like, 'oh ok, I'm talking to blah, blah' and like, become comfortable with the fact that I'm going to be speaking with this person [Ashley].

A few participants stressed needing something serious or severe to trigger the use of the university MHS. This 'required extremity' was an obstacle to service access as those who feel they do not meet the prerequisite might not approach the service, even when support is needed.

...My feeling is that, I think that, that people would think that you need to have a massive serious problem to go and see a counsellor [Emily].

Stigma was a key sub-theme raised and seen as a barrier. Concerns about the attitudes individuals have towards mental health meant trepidations about using the MHS at their university.

...I thought that my lecturer would make opinions based on me asking for help [Isabelle].

The service met this desire some participants had to blend in, allowing for more comfortable MHS use. Participants from one university highlighted the location of the service, specifically the waiting rooms as positive in reducing fears of stigma.

...The receptionist was kind of like going to GP appointment... it felt pretty normal... if someone was sitting in the reception and waiting, they wouldn't have even known I was going in for a counselling session, which was quite nice [Hannah].

However, with the merging of health and mental health centres, only one reception desk is available. Participants felt that reception staff should acknowledge that students coming in for different services have different needs. Treatment of students by receptionists can influence ease of accessibility and comfort for service users (Mowbray et al., 2006).

The sub-theme, the appointment, comprised the many ways participants attempted to access MHS at their universities and their struggles with this. Participants often had to play an active role in learning about the service and finding out about access pathways. For most, the first point of access was through the Internet.

...I googled it. I found it on the [name of university] website [Kate].

Opinions around the use of online platforms to learn more about university MHS varied depending on what university the participant attended. Participants from one university found access to be more difficult with limited

availability of information online. However, participants from another university found the experience positive to reasonably neutral.

I think the websites probably ok, I mean in terms of their- people look for it [Paige].

...Finding phone numbers, um, finding a website which had that questionnaire, like all of those things were easy to access [Emily].

Both the universities that participants attended required completion of a questionnaire online before offering their MHS. There were varied reactions to and feelings about the perceived purpose of this questionnaire. By some, it was seen as an attempt to identify students who might need immediate support. A few found the questionnaire to be frustrating and as a 'task' required to get support from the service. For others, it had a negative personal impact.

...Made me feel a bit stink, because I was like, well obviously I'm not resorting to alcohol, I haven't been abused, I'm not suicidal and I thought... it was kind of like they were asking, 'well if you got these specific things, go talk to someone' and I was like, well I'm not really feeling any of that, so maybe I don't need the counselling service? [Hannah].

Participants were frustrated about trying to make an appointment with MHS. Setting appointments was not always a clear or easy process.

...It's also very confusing, cause sometimes you make an appointment with your counsellor for your sessions and then other times they book you at the front desk; and then other times the front desk will book you in without talking to the counsellor and the counsellors already booked you in, so you end up with two different appointments or that will happen, but you end up with no appointments ...I feel like, that I got so mucked around with [Kate].

The tussle in trying to secure regular appointments with no success was indicated as a pressure that staff was also aware of.

...when I reach out to make [an] appointment, um, the receptionist will also make a joke about it. They'll say like, 'oh no, there won't be any appointments available.' So, it's this... understanding within the service that the counsellors have a lot of clients and it's pretty rare to ring up, say on a Monday and expect to see someone that week [Emily].

Many students grappled with the limited number of counselling sessions available. Through a yearly session number limit, many faced the struggle of having to decide when their distress required support or if they were able to go on without MHS input for the time being. Some felt like the need for additional sessions outside of the set limit must mean that there is something wrong with them.

I was told you've got...like nine free sessions, but it was like, 'oh ok, am I meant to have only nine breakdowns?' [Ashley].

Others felt it became risky to open up and speak about what is going on clearly, as they would not receive long-term support.

I found it pretty hard that they would number the amount of sessions that you would typically attend for...so being aware that I only had like three or four more sessions, was quite, um, hard for me to relax and be forthcoming [Isabelle].

In the second theme, Advertising, advertisements were portrayed as invisible, although useful in different ways. Often it was commented that university MHS advertisements were restricted to the health centres at universities and therefore not visible to the general public. Many wanted their university MHS to move away from this. Adverts were seen to be in specific places due to associated stigma.

It wasn't something that was widely shown around university, oh you know 'you could go see somebody if you're feeling down'... [Ashley].

Adverts were also seen as a potential action against stigma by allowing a conversation point and reducing the views around the 'types' of people or problems MHS are for.

I think the more it's talked about the less the stigma becomes... I think one of the biggest steps we can take is making sure people are talking about and know about these services, and that it's available for all types of problems not just specific ones [Hannah].

Similarly, clear and openly placed advertisements about university MHS were seen as an advantageous way to help vulnerable persons recognise available support.

...People with severe mental health problems might be too overwhelmed to like seek help, maybe it would not make it seem as overwhelming to seek help if it was more just made really clear [Kiana].

This study explored what participants thought about the quality of the service provided at their university MHS. The overarching theme, Perceptions of Service Quality, comprises what participants felt reflected service quality. Participants indicated areas not related to the therapist that they felt made a service effective. This included accessibility and the approachability of service. Participants felt that a good quality university MHS would be accessible and affordable, especially when considering whether they would re-engage with the MHS.

...I think from the front of house, there needs to be a start there for that person to feel safe [Ashley].

Embedded within the 'role of counsellor' theme, participants described various preferred counsellor qualities and skills as a vital aspect of what makes up good service. This description of what was sought in a therapist encompassed the sub-theme, the ideal therapist. Emphasis was on the counsellor's various skills, values and characteristics. It was primarily desired for therapists to be open-minded and non-judgmental. Further, participants highlighted a need for genuineness and sincerity from a therapist. The ability for a therapist to be able to distinguish between empathy and sympathy and be present with the client in an empathetic manner was identified as necessary for an effective therapist.

I don't appreciate that [sympathy], I don't want somebody that was there to cuddle me. I wanted the

emotional support, but yeah, not feel like they felt sorry for me [Isabelle].

Some participants with a background in Psychology indicated that at times they could predict where the therapist was going in the session and that they would then attempt to interrupt this process. They indicated that they desired their therapist to confront them about such attempts gently.. The importance of a therapist's theoretical knowledge and training was also stressed. However, one participant strongly emphasised the therapist having lived knowledge in addition to having had more direct experiences of mental health difficulties.

...I think they need to have lived with mental health themselves, that's regardless of whether that's them having gone through it personally themselves or their partner or something [Kate].

The sub-theme, Therapist: The experience, brings together participants' descriptions of their experiences during their sessions. Participants felt that their therapists were non-judgmental.

...Treats you unbiased, that they speak with an open-mind and that from this side of the couch, I don't feel like I'm being judged [Ashley].

Participants also found their therapists to be empathetic, sincere and understanding and found it useful when their therapists would listen and give them the space needed to vent at their own pace. However, there were different experiences of how 'heard' participants felt. One participant spoke about how the therapist would not really listen to the feedback provided. This meant she ended up being pushed into agreeing with what was done.

... 'Tell me if this isn't working' ...anytime I did, he got really defensive. So I ended up sitting there going, 'oh no, this was great, I'm getting exactly what I want and what I need' even though it wasn't [Kate].

There were also comments about collaborative work in looking for a solution to certain difficulties by therapists with participants. Participants indicated that the therapists guided them rather than told them what to do. Many participants described the importance of rapport or a sense of connection with their therapist.

[Referring to first counsellor] was really nice, I just don't feel like I connected with her and so that kind of made the counselling a bit unsuccessful...I felt like she didn't understand... what's it's like at this age growing up in New Zealand [Kiana].

Participants' descriptions and examples of the verbal support received from their therapist reflect the use of normalisation, affirmation and validation (Bedi et al., 2005; McLeod, 2013; Slatery & Park, 2011).

...The counsellor reassured me that what I was feeling was normal, and that was a big thing for me, cause I was like 'oh maybe it's just me, maybe I'm just being a little weird...She reassures me...she's always kind of like, congratulates me in a way, she's like, 'you know, you're actually doing a good job' and for me that makes me feel good [Hannah; an example of normalisation and affirmation].

...When I was really hesitant to ask for an extension, they would say, 'you have no idea how many students ask for an extension, this is one of the forms I used the most at this service, so I'm telling you, you're not an anomaly and they aren't gonna think you're getting favouritism or anything like that...' [Isabelle, an example of normalisation and validation].

...My sort of right to be able to spend that hour talking about my life [laughs] and just sort of actually really assuring me that I'm fully kind of entitled to that [Paige, an example of validation].

Many participants felt that their therapist provided them with various tools that they could use outside of therapy when needed, including breathing techniques, practical resources and reading materials. This was described positively and found to help participants cope outside of sessions and reduce distress.

...Coping mechanisms: sleeping well, breathing out, that sort of stuff and I remember that was met. I walked out knowing what I can do, not completely healed, but knowing that [there] was other ways of going about trying to get myself of where I was [Ashley].

Within the overarching theme, The influence of the University MHS, participants described how attending the counselling sessions resulted in various conclusions drawn about the university MHS. In the theme, Attendance and new knowledge, attention is drawn to how influential the service was on views and future recommendations to others. There were varying views on the overall experience with participants' university MHS. Through attendance at their university MHS many learnt about what counselling offered students and what was specifically available at local university MHS. One participant, who had attended independent counselling before, highlighted the welcome cultural support available at one university.

...They met my needs really well. Especially in terms of being Māori. I initially met with somebody that I... wasn't comfortable with...and I said that and they moved onto a Māori counsellor and I feel that was just so much a benefit [Isabelle].

Another participant who had attended two university MHS found that a holistic approach to MHS, expected with more culturally aware services, was not provided.

...The idea of your health, your mental health in a wider context...I don't think they hold that view [Kate].

It was highlighted repeatedly by all participants that they were generally happy to access MHS in the future.

...Wherever I move to, I'm definitely going to look for someone that I can, would be able to talk to... [Hannah].

...Thanks to the help I've got... I'd definitely be more willing to look for help [Brianna].

For those who were not completely happy, future engagement with that specific university MHS was unlikely:

...Pushed off, that's how I felt. So, I wouldn't want to engage with them again. I wouldn't want to go back. I just had such a horrible experience ...I would

recommend it to other students because there is pretty much nowhere else to go and pretty much no other option [Kate].

Others would be encouraged to use the service due to external mental health services being regarded as expensive and thus unaffordable for students.

DISCUSSION AND CONCLUSION

University MHS are generally seen as plausible and attractive support networks for students, with external services often regarded as unaffordable (Macdonald, 2018, July 19). However, there were many barriers to the service. Many participants were wary of university MHS use due to a lack of knowledge around services, which is access obstacle for tertiary students more generally (Flisher et al., 2002). As reflected by participants in this study, a concern around what remains confidential also hinders tertiary populations MHS attendance (Chew-Graham, Rogers & Yassin, 2003).

The lack of advertisements, although not explicitly stated as a barrier, can be interpreted as such since adverts were seen as the gateway towards initially learning about university MHS. Clear and openly placed advertisements about university MHS were seen as an advantageous way to help vulnerable persons recognize such available support by participants. One study has previously found that sometimes individuals can struggle in identifying their concerns (as related to mental illness) and clear adverts can aid in identification (Flisher et al., 2002)

Stigma, a commonly identified barrier for tertiary-level students (Corrigan, Druss & Perlick, 2014; Yorgason, Linville & Zitzman, 2008), was mentioned in this study by participants about several aspects: It was predominantly seen as a barrier with concerns expressed about what others might think of mental health service use. Participants found that their misconceptions served to work as a hurdle in accessing university mental health services. The influences of the media on how therapy is seen by society, primarily through inaccurate or dramatized representations in film, are well known (Bischoff & Reiter, 1999; Gabbard, 2001). Participants' comments in this study often reflected distorted images of therapy from wider contexts, such as movies, which fostered them feeling intimidated prior to attendance of their first counselling session.

Interpretations of counselling based on stereotypes and misconceptions were not always a barrier to accessing university MHS. Some students expressed the belief that attending therapy would lead to an 'instant cure,' which increased the desire to attend, making it beneficial to service access. Therapy as an 'instant cure' has been highlighted previously by services as being a common occurrence, while counsellors have recognised it as misconception or stereotype that many clients entertain (Much, Wagener & Hellenbrand, 2009). Although participants in this study realised that there would be no instant cure, this did not seem to hinder further service use specifically. Stigma was also raised in conversations for change, where reduced stigma was considered an outcome of increased services advertisements around the campus. The use of various media is a tactic often used to combat

stigma by encouraging conversation around a stigmatised topic (Clement et al., 2013).

A frequent requirement for access to university MHS in NZ is the completion of an online questionnaire on the respective university's website. Despite views that the questionnaire allowed for an indication of risk or was a screen for better support, it served as a barrier to access. For some participants it created anxiety that their concerns were not 'severe' enough for support, as students had to choose from a list of significant concerns such as alcohol abuse or suicidal ideation. Remarks also indicated a sense of vulnerability amongst participants when disclosing recent personal concerns through such an online questionnaire form.

Internet use to learn about mental health and the options available to seek MHS access is not uncommon (Powell & Clarke, 2006) and was found to be the key pathway to accessing university MHS identified by participants in this study. Accessing the university website to gain information about services was considered beneficial by some as it was easy to access and a discrete way to search for support. This is similar to overseas reports by young people finding that accessing information via the internet reduced the fear of facing stigma (Horgan & Sweeney, 2010).

One of the most agreed upon barriers were the long waiting times for appointments. Prior research has emphasized the struggle of university mental health centres worldwide in dealing with high demands for service use by students with complaints about long-waiting periods (Kitzrow, 2009; Macaskill, 2013). Such difficulties with waiting times suggest that university staff struggle to manage the high demand for service access by New Zealand students.

The term MHS 'quality' was seen to reflect the presence of various components within a service, including positive improvement using evidence-based knowledge (World Health Organization, 2003) and fast appointment times (Shield et al., 2003; Valenstein et al., 2004). Participants' comments on what they felt made a service 'good quality' also reflected the importance of evidence-based practice and good service, such as fast appointment times. However, predominantly, 'quality' for participants was perceived as the presence of certain qualities in a counsellor. Counsellors needed to be unbiased, open-minded, relatable, skilled and experienced. Although theoretical knowledge and training were important, so too was lived knowledge and understanding. The qualities desired by participants matched qualities fundamental to person-centred therapy; this included empathy, unconditional positive regard and congruence (Rogers, 1957; McMillan, 2004).

Participants also noted the importance of 'a connection' with the therapist for therapy. Research has found certain components to increase the relationship between a therapist and client, the therapeutic alliance, including collaboration, gentle challenging, empathy, warmth, friendliness and affirmation (Ackerman et al., 2003; Babatunde, MacDermid & MacIntyre, 2017; Bor & McCann, 1999; Bedi, Davis & Arvey, 2005; Manthei, 2007; Leach, 2005). In this study, a 'connection' consisted of therapists having shared knowledge with clients or communicating an understanding of where the participant

is coming from. Most participants interviewed indicated that they had had a good connection with their therapist. A good therapeutic alliance is important, as it is linked to clients judging the service to be of good quality and is linked to successful therapy outcomes (Noser & Bickman, 2000; Safran & Muran, 2000). Therapists in this study were described as providing other components linked to positive therapeutic alliance, including validation, affirmation and normalisation; skills and qualities also identified as promoting the therapeutic alliance (Leach, 2005).

Participants in this study all had differing views about what was most effective in their session (for example, the use of session plans). This divergent emphasis highlights the differing nature of the client's needs (Bohart & Tallman, 1996). For most participants, their experience with their therapist was predominantly positive and they would use such services again. Such commentary is similar to findings from previous studies, concluding that prior experience with a service influences the likelihood of attending MHS again (Kahn & Williams, 2003).

There were some limitations in this study. Unavoidably, the research process was influenced by the researcher's background knowledge. More specifically, a lack of experience in qualitative interviews meant being strongly focussed on remaining neutral and non-leading during the initial interviews, which was not always possible. This also meant certain comments by participants were not thoroughly explored. In later interviews, this was addressed and the focus was placed on the rapport with participants and more thoroughly exploring areas participants highlighted. Consequently, this might have impacted the data as some participant's experiences and views were explored more deeply than others.

Participants were also all female, which may reflect higher MHS use found amongst women (Cheung & Dewa, 2007). However, an all-female sample can have implications for the transferability of this study. There is the possibility of self-selection bias, with participants choosing whether or not they want to engage in this study (Nilsen et al., 2009). This might reflect the higher positive responses around university MHS.

Implications

This study provides an understanding of student views of their university mental health service. It also tentatively (considering limitations) offers an indication of what domestic New Zealand students find to be hindrances and supports and provides insight into what is important for students around service quality. We conclude with the following recommendations - key areas highlighted by participants as requiring addressing by university mental health services:

- Provide advertisements, which include students' views about the MHS, highlighting benefits and addressing common concerns.
- Increase advertisement visibility in different areas of university campuses.
- Provide MHS information at the beginning of the academic year.
- Clarify the process for setting up appointments and self-referring to the university MHS.

- Provide therapist profiles in order to decrease the views of therapists as 'complete strangers'.
- Clarify how many sessions are offered per year
- Describe the general purpose of the referral questionnaire to avoid student anxiety around whether their concerns are 'serious' enough for support.

References

- Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*(1), 1-33.
- Al-Momani, M. M. (2016). Gap analysis between perceptions and expectations of medical-surgical patients in a public hospital in Saudi Arabia. *Medical Principles and Practice, 25*(1), 79-84.
- Andrews, B., & Wilding, J. M. (2004). The relation of depression and anxiety to life-stress and achievement in students. *British Journal of Psychology, 95*(4), 509-521.
- Auckland University of Technology. (2019). *Compulsory Student Services Fee*. Retrieved from: <https://www.aut.ac.nz/study/fees-and-scholarships/fees-to-study-at-aut/compulsory-student-services-fee>
- Auckland University of Technology. (2019). *Counselling and Mental health support*. Retrieved from: <https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health>
- Babatunde, F. O., MacDermid, J. C., & MacIntyre, N. (2017). A therapist-focused knowledge translation intervention for improving patient adherence in musculoskeletal physiotherapy practice. *Archives of Physiotherapy, 7*(1), 1.
- Bedi, R. P., Davis, M. D., & Arvay, M. J. (2005). The client's perspective on forming a counselling alliance and implications for research on counsellor training. *Canadian Journal of Counselling, 39*(2), 71.
- Benton, S. A., Robertson, J. M., Tseng, W. C., Newton, F. B., & Benton, S. L. (2003). Changes in counseling center client problems across 13 years. *Professional Psychology: Research and Practice, 34*(1), 66.
- Bewick, B., Koutsopoulou, G., Miles, J., Slaa, E., & Barkham, M. (2010). Changes in undergraduate students' psychological well-being as they progress through university. *Studies in Higher Education, 35*(6), 633-645.
- Bischoff, R. J., & Reiter, A. D. (1999). The role of gender in the presentation of mental health clinicians in the movies: Implications for clinical practice. *Psychotherapy: Theory, Research, Practice, Training, 36*(2), 180.
- Bor, R., & McCann, D. (1999). *The Practice of Counselling in Primary Care*. London: Sage.
- Brackney, B. E., & Karabenick, S. A. (1995). Psychopathology and academic performance: The role of motivation and learning strategies. *Journal of Counseling Psychology, 42*(4), 456.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.
- Canterbury University. (2019). *Counselling*. Retrieved from: <https://www.canterbury.ac.nz/healthcentre/counselling/>
- Canterbury University. (2019). *Student Services Levy*. Retrieved from: <https://www.canterbury.ac.nz/get-started/fees/non-tuition-fees/student-services-levy/>
- Cheung, A. H., & Dewa, C. S. (2007). Mental health service use among adolescents and young adults with major depressive disorder and suicidality. *The Canadian Journal of Psychiatry, 52*(4), 228-232.
- Chew-Graham, C. A., Rogers, A., & Yassin, N. (2003). 'I wouldn't want it on my CV or their records': medical students' experiences of help-seeking for mental health problems. *Medical Education, 37*(10), 873-880.
- Choudhry, N. K., Fletcher, R. H., & Soumerai, S. B. (2005). Systematic review: the relationship between clinical experience and quality of health care. *Annals of Internal Medicine, 142*(4), 260-273
- Clement, S., Lassman, F., Barley, E., Evans-Lacko, S., Williams, P., Yamaguchi, S., & Thornicroft, G. (2013). Mass media interventions for reducing mental health-related stigma. *Cochrane Database of Systematic Reviews, 7* [CD009453].
- Collins, M. E., & Mowbray, C. T. (2005). Higher education and psychiatric disabilities: national survey of campus disability services. *American Journal of Orthopsychiatry, 75*(2), 304.
- Connell, J., Barkham, M., & Mellor-Clark, J. (2008). The effectiveness of UK student counselling services: an analysis using the CORE System. *British Journal of Guidance & Counselling, 36*(1), 1-18.
- Cooke, R., Bewick, B. M., Barkham, M., Bradley, M., & Audin, K. (2006). Measuring, monitoring and managing the psychological well-being of first year university students. *British Journal of Guidance & Counselling, 34*(4), 505-517.
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*(7), 614.
- Cvetkovski, S., Reavley, N. J., & Jorm, A. F. (2012). The prevalence and correlates of psychological distress in Australian tertiary students compared to their community peers. *Australian & New Zealand Journal of Psychiatry, 46*(5), 457-467.
- D'Amico, N., Mechling, B., Kemppainen, J., Ahern, N. R., & Lee, J. (2016). American college students' views of depression and utilization of on-campus counseling services. *Journal of the American Psychiatric Nurses Association, 22*(4), 302-311.
- DeStefano, T. J., Mellott, R. N., & Petersen, J. D. (2001). A preliminary assessment of the impact of counseling on student adjustment to college. *Journal of College Counseling, 4*(2), 113-121.
- Eisenberg, D., Downs, M. F., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. *Medical Care Research and Review, 66*(5), 522-541.
- Eisenberg, D., Gollust, S. E., Golberstein, E., & Hefner, J. L. (2007). Prevalence and correlates of depression, anxiety, and suicidality among university students. *American Journal of Orthopsychiatry, 77*(4), 534-542.
- Ferlie, E. B., & Shortell, S. M. (2001). Improving the quality of health care in the United Kingdom and the United States: a framework for change. *The Milbank Quarterly, 79*(2), 281-315.
- Flisher, A. J., Beer, J. P. D., & Bokhorst, F. (2002). Characteristics of students receiving counselling services at the University of Cape Town, South Africa. *British Journal of Guidance and Counselling, 30*(3), 299-310.
- Gabbard, G. (2001). Psychotherapy in Hollywood cinema. *Australasian Psychiatry, 9*(4), 365-369.
- Gask, L., Rogers, A., Oliver, D., May, C., & Roland, M. (2003). Qualitative study of patients' perceptions of the quality of care for depression in general practice. *British Journal of General Practice, 53*(489), 278-283.

- Givens, J. L., & Tjia, J. (2002). Depressed medical students' use of mental health services and barriers to use. *Academic Medicine, 77*(9), 918-921.
- Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report, 8*(4), 597-606.
- Guinee, J. P., & Ness, M. E. (2000). Counseling centers of the 1990s: Challenges and changes. *The Counseling Psychologist, 28*(2), 267-280.
- Hoffman, G. (2017, April 10). A Mental Health Crisis Among NZ University Students? Salient. Retrieved from <http://salient.org.nz/2017/04/a-mental-health-crisis-among-nz-university-students/>
- Horgan, A., & Sweeney, J. (2010). Young students' use of the Internet for mental health information and support. *Journal of Psychiatric and Mental Health Nursing, 17*(2), 117-123.
- Hunt, J. B., Watkins, D., & Eisenberg, D. (2012). How do college campuses make decisions about allocating resources for student mental health?: Findings from key participant interviews. *Journal of College Student Development, 53*(6), 850-856.
- Hunt, J., & Eisenberg, D. (2010). Mental health problems and help-seeking behavior among college students. *Journal of Adolescent Health, 46*(1), 3-10.
- Jaworska, N., De Somma, E., Fonseka, B., Heck, E., & MacQueen, G. M. (2016). Mental health services for students at postsecondary institutions: A national survey. *The Canadian Journal of Psychiatry, 61*(12), 766-775.
- Johnston, O., Kumar, S., Kendall, K., Peveler, R., Gabbay, J., & Kendrick, T. (2007). Qualitative study of depression management in primary care: GP and patient goals, and the value of listening. *British Journal of General Practice, 57*(544), e1-e14.
- Kahn, J. H., & Williams, M. N. (2003). The impact of prior counseling on predictors of college counseling center use. *Journal of College Counseling, 6*(2), 144-154.
- Ketchen Lipson, S., Gaddis, S. M., Heinze, J., Beck, K., & Eisenberg, D. (2015). Variations in student mental health and treatment utilization across US colleges and universities. *Journal of American College Health, 63*(6), 388-396.
- Khamis, K., & Njau, B. (2014). Patients' level of satisfaction on quality of health care at Mwananyamala hospital in Dar es Salaam, Tanzania. *BMC Health Services Research, 14*(1), 400.
- Kitzrow, M. A. (2003). The mental health needs of today's college students: Challenges and recommendations. *NASPA Journal, 41*(1), 167-181.
- Kitzrow, M. A. (2009). The mental health needs of today's college students: Challenges and recommendations. *NASPA Journal, 46*(4), 646-660.
- Leach, M. J. (2005). Rapport: A key to treatment success. *Complementary Therapies in Clinical Practice, 11*(4), 262-265.
- Lee, D., Olson, E. A., Locke, B., Michelson, S. T., & Odes, E. (2009). The effects of college counseling services on academic performance and retention. *Journal of College Student Development, 50*(3), 305-319.
- Leong, F. T., & Lau, A. S. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research, 3*(4), 201-214.
- Lynass, R., Pykhtina, O., & Cooper, M. (2012). A thematic analysis of young people's experience of counselling in five secondary schools in the UK. *Counselling and Psychotherapy Research, 12*(1), 53-62.
- Macaskill, A. (2013). The mental health of university students in the United Kingdom. *British Journal of Guidance & Counselling, 41*(4), 426-441.
- Macdonald, K. (2018, July 19). Why is mental health therapy in Auckland so expensive? *NZ Herald*. Retrieved from: https://www.nzherald.co.nz/lifestyle/news/article.cfm?c_id=6&objectid=12091138
- Maguire, M., & Delahunt, B. (2017). Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *AISHE-J: The All Ireland Journal of Teaching and Learning in Higher Education, 9*(3).
- Manthei, R. J. (2007). Clients talk about their experience of the process of counselling. *Counselling Psychology Quarterly, 20*(1), 1-26.
- Manthorpe, N. S. J. (2001). Responding to students' mental health needs: Impermeable systems and diverse users. *Journal of Mental Health, 10*(1), 41-52.
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review.
- Massey University (2019). *Frequently asked questions about fees*. Retrieved from: <http://www.massey.ac.nz/massey/admission/fees/frequently-asked-questions.cfm>
- Massey University. (2016). What is the Student Services Levy? Retrieved from: <https://www.massey.ac.nz/massey/fms/Student%20service%20student-questions/SSL%20Further%20Information%20Aug%202016.pdf?1C1581A15D34721B87B3DA1CB06E4F1D>
- Massey University. (2019). *Health and Counselling*. Retrieved from: http://www.massey.ac.nz/massey/student-life/services-and-resources/health-counselling-services/health-and-wellness_home.cfm
- McLeod, J. (2013). *An introduction to counselling*. McGraw-Hill Education (UK).
- McMillan, M. (2004). *The Person-Centred Approach to Therapeutic Change*. London: SAGE Publications.
- Megivern, D., Pellerito, S., & Mowbray, C. (2003). Barriers to higher education for individuals with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 26*(3), 217.
- Mohebifar, R., Hasani, H., Barikani, A., & Rafiei, S. (2016). Evaluating service quality from patients' perceptions: Application of importance-performance analysis method. *Osong Public Health and Research Perspectives, 7*(4), 233-238.
- Monti, F., Tonetti, L., & Bitti, P. E. R. (2013). Effectiveness of psychological treatments delivered at a counselling service for students. *Psychological Reports, 113*(3), 955-968.
- Mowbray, C. T., Mandiberg, J. M., Stein, C. H., Kopels, S., Curlin, C., Megivern, D., & Lett, R. (2006). Campus mental health services: Recommendations for change. *American Journal of Orthopsychiatry, 76*(2), 226-237.
- Much, K., Wagener, A. M., & Hellenbrand, M. (2009). Practicing in the 21st century college counseling center. *Journal of College Student Psychotherapy, 24*(1), 32-38.
- Murray, A. L., McKenzie, K., Murray, K. R., & Richelieu, M. (2016). An analysis of the effectiveness of university counselling services. *British Journal of Guidance & Counselling, 44*(1), 130-139.
- Nolan, P., & Badger, F. (2005). Aspects of the relationship between doctors and depressed patients that enhance satisfaction with primary care. *Journal of Psychiatric and Mental Health Nursing, 12*(2), 146-153.

- Noser, K., & Bickman, L. (2000). Quality indicators of children's mental health services: Do they predict improved client outcomes?. *Journal of Emotional and Behavioral Disorders*, 8(1), 9-18.
- Otago University. (2019). *Mental Health & Wellbeing*. Retrieved from: <https://www.otago.ac.nz/studenthealth/services/otago020535.html>
- Otago University. (2019). *Student Services Fees*. Retrieved from: <https://www.otago.ac.nz/studentservices/otago626140.html>
- Papanikolaou, V., & Zygiaris, S. (2014). Service quality perceptions in primary health care centres in Greece. *Health Expectations*, 17(2), 197-207.
- Parker, J. D., Summerfeldt, L. J., Hogan, M. J., & Majeski, S. A. (2004). Emotional intelligence and academic success: Examining the transition from high school to university. *Personality and Individual Differences*, 36(1), 163-172.
- Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research*, 34(5 Pt. 2), 1189.
- Pledge, D. S., Lapan, R. T., Heppner, P. P., Kivlighan, D., & Roehlke, H. J. (1998). Stability and severity of presenting problems at a university counseling center: A 6-year analysis. *Professional Psychology: Research and Practice*, 29(4), 386.
- Pollock, K., Mechanic, D., & Grime, J. (2002). Primary carePatients' perceptions of entitlement to time in general practice consultations for depression: qualitative studyCommentary: Managing time appropriately in primary care. *BMJ*, 325(7366), 687.
- Powell, J., & Clarke, A. (2006). Internet information-seeking in mental health. *The British Journal of Psychiatry*, 189(3), 273-277.
- Rogers, C., R. (1957) The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-103
- Rogers, Carl May, Dianne Oliver, A. (2001). Experiencing depression, experiencing the depressed: the separate worlds of patients and doctors. *Journal of Mental Health*, 10(3), 317-333.
- Russell, J., Thomson, G., & Rosenthal, D. (2008). International student use of university health and counselling services. *Higher Education*, 56(1), 59-75.
- Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York, NY, US: Guilford Press.
- Sarmiento, M. (2015). A "mental health profile" of higher education students. *Procedia-Social and Behavioral Sciences*, 191, 12-20.
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2), 63-75.
- Shi, Q., Liu, X., & Leuwerke, W. (2014). Students' Perceptions of School Counselors: An Investigation of Two High Schools in Beijing, China. *Professional Counselor*, 4(5), 519-530.
- Shield, B. M., & Dockrell, J. E. (2003). The effects of noise on children at school: A review. *Building Acoustics*, 10(2), 97-116.
- Shield, T., Campbell, S., Rogers, A., Worrall, A., Chew-Graham, C., & Gask, L. (2003). Quality indicators for primary care mental health services. *Quality and Safety in Health Care*, 12(2), 100-106.
- Slattery, J. M., & Park, C. L. (2011). Meaning making and spiritually oriented interventions. *Spiritually Oriented Interventions for Counseling and Psychotherapy*, 15-40.
- Sofaer, S., & Firminger, K. (2005). Patient perceptions of the quality of health services. *Annual Review of Public Health*, 26(1):513-591.
- Sontag-Padilla, L., Woodbridge, M. W., Mendelsohn, J., D'Amico, E. J., Osilla, K. C., Jaycox, L. H., ... & Stein, B. D. (2016). Factors affecting mental health service utilization among California public college and university students. *Psychiatric Services*, 67(8), 890-897.
- Stallman, H. M. (2010). Psychological distress in university students: A comparison with general population data. *Australian Psychologist*, 45(4), 249-257.
- Stallman, H. M. (2012). University counselling services in Australia and New Zealand: activities, changes, and challenges. *Australian Psychologist*, 47(4), 249-253.
- Stone, G. L., Vespia, K. M., & Kanz, J. E. (2000). How good is mental health care on college campuses?. *Journal of Counseling Psychology*, 47(4), 498.
- Storrie, K., Ahern, K., & Tuckett, A. (2010). A systematic review: students with mental health problems—a growing problem. *International Journal of Nursing Practice*, 16(1), 1-6.
- Svanum, S., & Zody, Z. B. (2001). Psychopathology and college grades. *Journal of Counseling Psychology*, 48(1), 72.
- The University of Auckland. (2019). *Compulsory Student Services Fee – 2019*. Retrieved from: <https://www.auckland.ac.nz/en/study/fees-and-money-matters/tuition-fees/cssf.html>
- The University of Auckland. (2019). *Counselling services*. Retrieved from: <https://www.auckland.ac.nz/en/on-campus/student-support/personal-support/student-health-counselling/counselling-services.html>
- Valenstein, M., Mitchinson, A., Ronis, D. L., Alexander, J. A., Duffy, S. A., Craig, T. J., & Barry, K. L. (2004). Quality indicators and monitoring of mental health services: What do frontline providers think?. *American Journal of Psychiatry*, 161(1), 146-153.
- Victoria University of Wellington. (2017). *Student Services Levy 2017 Year End Report*. Retrieved from: https://www.victoria.ac.nz/_data/assets/pdf_file/0019/231454/levy-report.pdf
- Victoria University of Wellington. (2019). *Student Counselling*. Retrieved from: <https://www.victoria.ac.nz/students/support/wellness/student-counselling>
- Victoria University of Wellington. (2019). *Student Services Levy FAQs*. Retrieved from: <https://www.victoria.ac.nz/students/money/fees/student-services-levy-faqs>
- Vivekananda, K., Telley, A., & Trethowan, S. (2011). A Five Year Study on Psychological Distress within a University Counselling Population. *Journal of the Australian & New Zealand Student Services Association*, 37, 39-57.
- Waikato University. (2019). *Non-tuition Costs*. Retrieved from: <https://www.waikato.ac.nz/study/costs/non-tuition-costs>
- Waikato University. (2019). *Student Counselling Services*. Retrieved from: <https://www.waikato.ac.nz/students/counselling/>
- Warwick, I., Maxwell, C., Statham, J., Aggleton, P., & Simon, A. (2008). Supporting mental health and emotional well-being among younger students in further education. *Journal of Further and Higher Education*, 32(1), 1-13.

World Health Organization. (2003). *Quality Improvement for Mental Health (Mental health policy and service guidance package)*. Geneva, Switzerland: World Health organization. Retrieved from: http://www.who.int/mental_health/resources/en/Quality.pdf

Yorgason, J. B., Linville, D., & Zitzman, B. (2008). Mental health among college students: do those who need services know about and use them? *Journal of American College Health, 57*(2), 173-182.

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