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Indian Students' Perceptions of Mental Health Initiatives in Higher Education

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ABSTRACT: Background: An increase in the prevalence of mental illness among Indian university students has led to educational policies that make mental health education and services compulsory in educational settings. However, students' perceptions of the effectiveness and role of these resources in meeting their mental health needs have not been sufficiently explored. The study used a qualitative exploratory design to understand participants' perceptions of services and mental health education offered by their institutions. **Methods:** Data was collected from 16 South Indian university students using semi-structured interviews. It was analyzed using thematic analysis. **Results:** Findings suggested that mental health education improved mental health literacy and personal attitudes towards help-seeking, mental health, and mental illness. However, mental health service utilization within the universities was more greatly influenced by prior experiences with these services, social mental health attitudes, and service protocols. Additionally, participants discussed academic and social experiences outside of structured institutional mental health initiatives as influencing their attitudes and literacy. These included exposure to diverse social groups, embedded and informal learning contexts, library and online resources, and informal help sources such as peers and faculty mentors. **Conclusions:** Based on participants' perceptions and experiences, the findings suggest that higher education institutions (HEIs) play a significant role in promoting mental health and addressing mental illness both through structured and informal means. It also suggests that exploring the social contexts within which educational institutions formulate and provide mental health education and services is important in ensuring their effectiveness.

KEYWORDS: Student mental health; mental health promotion; mental health literacy; mental health services

1 Introduction

It is estimated that there are approximately 254 million university students globally, with the number of students enrolled in higher education increasing twofold over the past decade [1]. Within India, emerging adulthood is often marked by enrolment into higher education, with 28.4% of the population between the ages of 18 and 24 years enrolled in undergraduate and postgraduate programs [2]. This rapid growth highlights the role of higher education in the enhancement and exchange of knowledge, as well as providing a platform for economic, social, and technological development [1].

The transition into higher education often includes the experience of various stressors, including appearance and health-related, romantic-related, financial, academic, and family stressors [3,4]. The transition to independent living and study, anxiety over future opportunities, and a perceived lack of preparedness further increase the stress experienced during this period [5]. Psychosocial challenges such as low self-esteem and loneliness also contribute to the stress experienced [6].

The economic, academic, social, and psychological stressors experienced by university students have contributed to the rise in mental health challenges and disorders among them both globally and in

India [6–8]. Within India, this included suicidal thoughts, depression, anxiety-related disorders, eating disorders, substance use disorders, and phone and gambling addictions [8,9]. Further, when addressing these challenges, they often encounter personal, cultural, and institutional barriers, including a lack of social support, isolation, financial constraints, policy-related barriers, lack of access to quality mental health care, and stigma associated with help-seeking for mental health concerns [10].

University responses to students' mental health needs often reflect social mental health attitudes and structural challenges to providing services [11]. In Western countries, initiatives tended to focus on digital self-guided applications, virtual peer networks, and lifestyle-focused counseling strategies aimed to manage the increased prevalence of anxiety and depression [11,12]. Institutional responses in sub-Saharan regions often provided decentralized onsite or remote counseling to accommodate infrastructural challenges and political instability [13,14]. Asian and South Asian countries appeared to focus on improving mental health literacy, psychological screening, and mental health services within HEIs to address cultural stigma, low community mental health literacy, and consequently reduced professional help seeking [11,15].

The focus on mental health literacy and service provision within HEIs is reflected in Indian policies relating to the provision of higher education for persons with pre-existing mental health conditions within the National Education Policy (NEP), 2020, and the Rights of Persons with Disabilities Act (RPDA) 2016 [16]. The NEP also emphasizes the need to promote the holistic development of the individual, with a focus on socio-emotional learning. It further recommends that the provision of counseling services be made compulsory in educational institutions to promote the psychological and emotional well-being of students [17]. Similarly, the University Grants Commission released a set of guidelines in 2023 detailing the responsibilities of higher education institutions (HEIs) in providing for the physical and emotional needs of students. This included building a Student Support Centre comprising mental health professionals, forming MOUs with national mental health institutions for psychiatric support, and providing mental health services that consider the linguistic, religious, economic, cultural, and social diversity of the Indian student population [18].

Several HEIs have utilized the guidelines and policies to formulate their own mental health policies [19]. Awareness and training programs are particularly focused on improving mental health literacy, which includes the knowledge of how to recognize challenges, risk factors, and causes, and self, interpersonal, and professional help-seeking strategies available [20]. Additionally, some institutions have integrated standardized psychological screening, resource allocation for counseling services, and psychoeducational module development as a part of their mental health service policies [21].

Presently available evaluations of the effectiveness of the policies implemented within HEIs in India focus on assessing institutional compliance with policy recommendations, broad symptom reduction, quantitatively assessed mental health literacy levels, and broad help-seeking metrics [21–24]. Explorations of students' perceptions often focus on their needs and suggestions for building mental health services rather than their experiences and perceptions of the initiatives that have already been implemented [25]. Further, while several studies focus on formally implemented programs and services, few studies discuss the perceived role of HEIs beyond these initiatives [26].

To address these gaps, the research conducted aimed to explore college students' perceptions and attitudes towards counseling services and mental health education already provided within their HEIs. Moving beyond quantitative indicators, it sought to understand their perceptions based on their engagement with presently available initiatives. Further, the study aimed to explore the perceived role that students attributed to HEIs rather than focusing exclusively on policy implementation. Based on this aim, the following research questions were formulated:

How did students perceive the role of HEIs in addressing their mental health challenges?

How did college students perceive and what were their attitudes towards the formal mental health initiatives provided by their HEIs, specifically counseling services and mental health initiatives?

What factors influenced the attitudes towards and perceptions of these mental health initiatives?

In answering these questions, the study aimed to provide insight that may be useful in understanding how students engage with mental health initiatives within their HEIs, and whether these initiatives are perceived as useful and effective by the intended service user. In focusing on perceptions and attitudes, it aimed to provide a nuanced understanding of the role of HEIs in addressing mental health challenges within the cultural and academic context of these South Indian students more holistically.

2 Methods

The study used a qualitative exploratory design to develop an integrated, holistic, and detailed understanding of college students' perceptions of the mental health initiatives provided to them by their universities, as well as the ways in which they perceived these initiatives influenced their approach towards mental health and illness. The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board of Christ University (protocol code RCEC/00423/03/23, Date of Approval: 18 March 2023).

All data collected was kept confidential and used solely for the purpose of this research. Identifying details of participants were removed to maintain their anonymity. Participants were provided information about the study and the costs and benefits of participating, following which informed consent was sought. Data was collected only if participants provided written informed consent.

2.1 Participant Selection

The study comprised participants from 5 colleges and 3 universities in South India. Of these, 2 were government colleges, 3 were private colleges, 1 was a State university, and 2 were private universities. Purposive sampling was used, and undergraduate college students were approached with the permission of the institution for the purpose of participating in the study. Students currently pursuing an undergraduate degree in a college or university in South India between the ages of 18 and 21 years were included in the study. Students who were pursuing medical degrees were not included in the study, as they were likely to have studied mental health disorders within Psychiatry courses. Students receiving psychiatric or psychological treatment outside of the services offered within the institution were excluded from the study as external treatment may substantially influence participants' perceptions towards counseling, mental health education and help-seeking, making it difficult to distinguish experiences specifically associated with the HEIs it helped to maintain greater contextual consistency when exploring students' perceptions of mental health initiatives within HEIs. All the participants had engaged with the two mental health initiatives being discussed, namely the counseling services and the mental health education courses and programs offered by the universities.

Considering the inclusion and exclusion criteria and availability of the participants, the initial sample size was 23 students. Data collection and analysis occurred concurrently, and after 12 interviews, it was found that no new codes or conceptual categories emerged from subsequent interviews. Two additional interviews were conducted, and data collected largely confirmed previously identified codes and categories. Two further interviews were conducted to reinforce the previously identified codes and themes. Data saturation was reached, and so additional interviews were not conducted. The final sample size was sixteen.

Of these 16 participants, 7 were male, and 9 were female. Six were enrolled in private colleges, 4 in State universities, 4 in private universities, and 2 in government colleges. Six participants were enrolled in Humanities and Social Sciences programs, 7 were enrolled in Commerce and Management programs, and 3 were enrolled in science programs. The number of participants in their first, second, and third years of study was 6, 4, and 6, respectively. Nine students were studying in institutions in their native state, while seven had migrated to pursue their education from other states. Those who were natives of the state resided at home, while migrant students resided in hostels (3), paying guest (2), and apartments (2) near the campus.

Participants were initially contacted through online and physical posters shared with student groups with the permission of the university. Interested students contacted the researchers and were provided with a brief description of the study and what participation entailed, including the costs and benefits of participating in the study.

2.2 Data Collection

Data was collected using semi-structured interviews with the help of an interview guide that was developed by the researchers and validated by two external experts. The comments provided by these experts were discussed and incorporated into the final guide by the researchers. This included simplifying questions to improve comprehensibility, reordering questions for better flow and adding probes to elicit a richer description of experiences from participants.

The guide consisted of five questions that aligned with the research questions posed by the study. These five questions explored students' perceptions and experiences of three domains, namely mental health education, counselling services and HEIs in general. The questions focused on their experiences, barriers and facilitators and perceived usefulness of these initiatives.

They focused on participants' perceptions and attitudes towards the counseling services and the mental health education courses or programs offered by their university or college, how these initiatives influenced the way they approach their mental health, and what role participants perceived HEIs played in addressing their mental health challenges. This included questions relating to their experiences of these initiatives, their perceptions of their usefulness, perceived barriers and facilitators and their overall perceptions of HEIs in shaping their mental health and addressing their challenges.

Each interview lasted for a duration of 45 to 90 min and was conducted offline. All interviews were conducted in English. Data was recorded with the consent of the participants and was transcribed by two coders to ensure the reliability of the transcribed data. Data was transcribed and coded manually. A member check was conducted with participants following initial transcription and subsequent analysis. Participants were asked to validate whether the transcriptions made of their data reflected their perceptions and experiences. Once the initial analysis was completed, interpretations were shared with participants for feedback and elaboration. These comments were incorporated in the final dataset and analysis to ensure that their perspectives were represented authentically.

2.3 Data Analysis

Data collected through the research interviews was analyzed using thematic analysis. Thematic analysis is often used to identify and analyze patterns of meaning within data. This was done manually. The process included familiarization with the data, generating codes, generating initial themes, and finally defining and naming them [27]. Both semantic and latent analyses were employed in order to ensure that both the explicit and the underlying meanings within the data were adequately explored. Initially, the researchers familiarized themselves with the data through repeated transcript reading and audio listening. Open coding

was conducted independently by the two researchers. Semantic coding focused on explicit statements and segments. Latent coding focused on underlying patterns and meanings across narratives. The codes derived independently were then compared, and the researchers engaged in iterative discussions to examine similarities and differences. Discrepancies were resolved through discussion and consensus with references made to the original transcripts and research objectives. Through these iterative discussions and refinement, agreement was reached on the final coding framework and thematic structure. Care was taken to remain close to participants' accounts. This included incorporating elaborations and comments derived from the member checking process. Related codes were grouped into categories from which preliminary themes and subthemes were developed. These themes were reviewed multiple times in relation to coded extracts and the dataset as a whole to ensure conceptual coherence and distinctiveness. Final themes were developed collaboratively following ongoing analytic discussions and refinement. Further, both researchers maintained reflexive journals and engaged in reflexive dialogue to ensure transparency and reduced chance of bias throughout the process of analysis.

Data collection and confidentiality and anonymity as well as non-maleficence and beneficence were maintained. This included offering provisions for support to participants who may have experienced distress when discussing their experiences.

3 Results

Analysis focused on students' perceptions of the counseling services and mental health education offered by their universities and colleges. Students focused on personal experiences with mental health professionals, the accessibility of the services, and social attitudes towards seeking professional help when discussing their perceptions and attitudes towards counseling services in their universities. Similarly, participants discussed the influence that the mental health education programs had on their mental health literacy and personal mental health attitudes. A thematic map is presented below (Fig. 1).

3.1 *Perceptions and Attitudes towards Mental Health Services*

Participants' perceptions and attitudes were primarily focused on accessibility of the services and their perceptions of the mental health professionals who provided these services. In discussing the accessibility of these services, they highlighted the cost-effectiveness of free therapeutic services for student populations. As one participant shared, "I understand how costly therapy is, and not everybody can afford it, and not everybody has the privilege of getting therapy for free, as I do in my college." (P5).

Factors that reduced the perceived accessibility included the protocols involved in seeking help: "It just seems like there are a lot of protocols. So, it seems a bit daunting to be honest" (P3). They stated that there was a lack of clarity on the types of services offered, how to schedule appointments, and, in some cases, the location of the counseling center. This lack of clarity reduced their ability and willingness to seek professional help, as it appeared to make the process more complicated when they were feeling especially vulnerable.

In relation to perceptions of mental health professionals, several participants expressed worry about being negatively evaluated and about breaches in confidentiality by them. P9 stated, "The first thing that comes to my mind when I think of sharing or seeking help is judgment or what the other person thinks about me when I open up to them, and I'm like, you know, fully honest and freely share with them. And then, what if they share this with someone else?" They also expressed apprehension about the professional's ability to provide emotional support, stating that "they give you solutions when really (they) just want someone to listen to what (they're) saying" (P16). Several other participants also discussed feeling unheard,

being provided “strict solutions” (P13) and their challenges being trivialized as a part of being young or a consequence of academic stress.

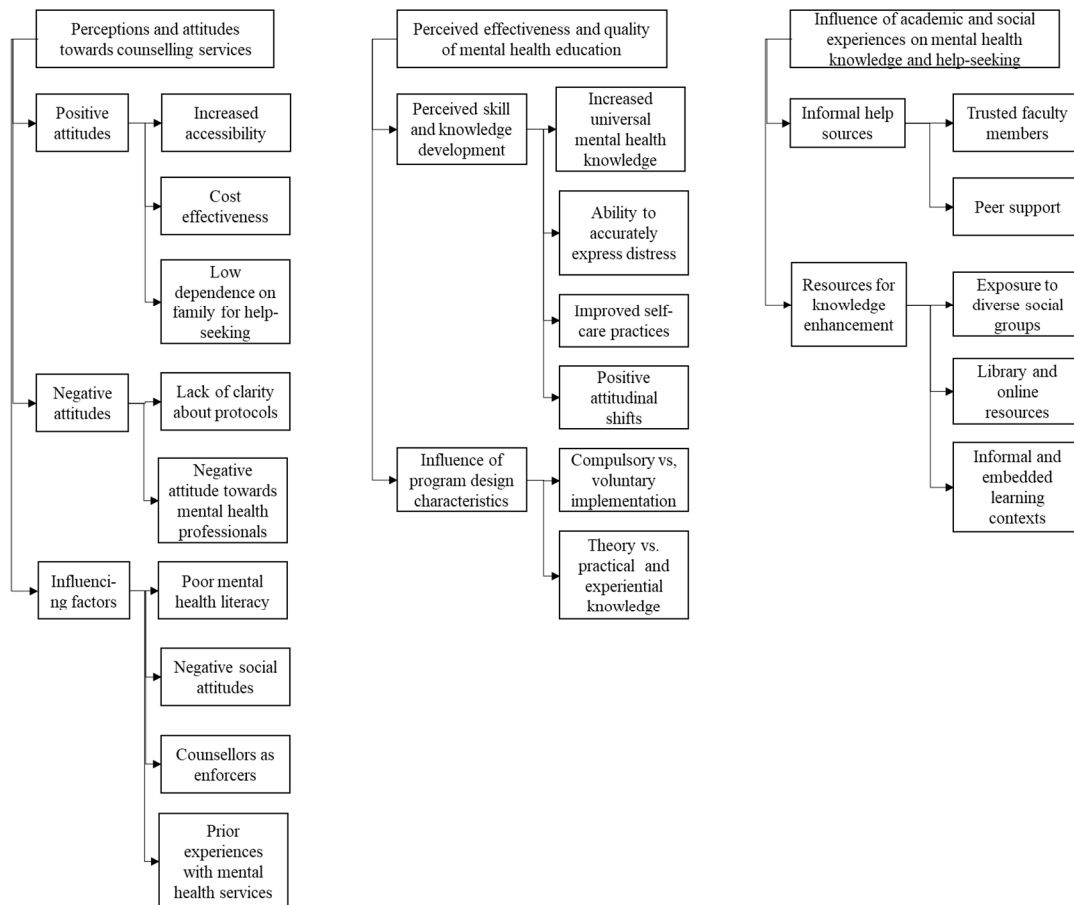


Figure 1: Themes derived from data analysis.

The characterisation of college counselors as enforcers of college regulations also negatively influenced participants from seeking help. As Participant 1 shared, “If there is a counsellor (in college), then we will only go to the counsellor if the teacher sends us. So mainly because we have low attendance, or low marks, or something has happened in the class. So that is the only time the counsellor will meet us. So we also will not want to tell them what the problem is. So when we are seeing it that way, then going to a counsellor means something is wrong with us, we are not doing well in the class. That is how we start to think about going to any counsellor”. This negative association of counselors with punishment and enforcement of college regulations further strengthened negative perceptions of the counseling services provided in HEIs.

Other participants had positive attitudes towards counseling services, believing that they provided support, helped in solving challenges, and provided emotional support. As Participant 7 stated, “I feel like having a counsellor in college is a pretty good thing because they can give you answers to your problems. I’ve seen a lot of students go there, and they do a pretty good job in helping them.” However, more participants (11 of the 16) discussed negative than positive perceptions of these services.

Prior experiences with counseling services, both at the school and college level, were particularly influential in shaping attitudes and perceptions of mental health professionals. Positive personal experiences and the experiences of other students led to a greater willingness to seek help. Participants were influenced

by specific negative or positive experiences with school and college counselors, as being influential in shaping these attitudes and perceptions. In contrast, participants who reported having negative experiences with school and college counselors reported feeling distrustful and dissatisfied with the services provided. In particular, they tended to focus on first experiences, experiences of extreme distress, and experiences relating to the breach of confidentiality. For example, Participant 4 recalled approaching a school counsellor when grieving the loss of a close friend: "I thought I was drowning. I went up to the counsellor, and I started opening up, trusting that person, but later it turned out to be really bad. They went behind my back to my mother and told her about it, and it was a really bad scene after that. So, I've always kept things to myself after that". Another participant reported that the school counselors were unable to provide the emotional support they required, while also breaking confidentiality. They recalled, "When I spoke to school counselors, various different schools, it didn't really help at all because the times that I spoke to someone, they said they would help me, but instead of being able to accept what I was feeling, they gave me very, very strict solutions, and I really just wanted support. And they also leaked some of what I had shared with others. So, I have never gone back after that". These negative experiences made them distrustful of professionals within the HEIs they now attend.

In discussing accessibility, negative social attitudes towards professional help-seeking both positively and negatively influenced perceptions towards counseling services in HEIs. Participants stated that seeking professional help was "something that was definitely frowned upon by most people, especially in India" (P6). Their awareness of the general societal impression of professional help-seeking made them apprehensive about seeking professional help outside their universities due to the discrimination they might face and the negative impact it might have on their own and their family's reputation. Participant 9 shared, "It's not easy to tell your family you are struggling and want to go to a counsellor. They will start to label you as 'mad'. And if they don't, then your extended family or family connections might. In the community, it is not just you; your whole family will get a bad name. I could never go for counseling, even in college". The ability to seek help without the knowledge of their family was perceived as a positive aspect of providing counseling services within HEIs: "It is easy for us to go between class hours, or we can say we are staying late or something. It's easier than telling our parents something is wrong, and we want to meet a counsellor. They may not support us, or they may make us feel bad about it. Here, it is easier to go to them without anyone knowing." Their ability to seek help for free while on campus allowed them greater agency in choosing to seek professional help.

Participants also discussed gender based social attitudes towards help-seeking, stating that within HEIs, it is easier for female students to seek counseling without stigma. Gender norms relating to the expression of distress and help-seeking appeared to reduce male students' willingness to seek help. One male participant stated, "One thing is, if one of my female classmates were to miss a class because they are going to the counsellor, no one would care. It would be like, yeah, okay, she is going through something, and she needs to meet the counsellor. I don't think any of my guy friends or male classmates would ever be comfortable doing that. I think the response would be so different. So even if we were open to getting help, it's not so easy to just go to a counsellor without thinking about how others would talk about you and how it affects your masculinity." (P3, male) Similarly, a female participant discussed the difference between her ability to seek help as compared to her brother, stating, "my brother and I both had a very difficult childhood. But then, for me, I talk about it to people, I talk about it, I went for therapy in my school and here in college, but my brother never does that. He always bottles up feelings, and he always comes off differently. I see that difference between him and me, a gender thing." (P1, female) Negative evaluation by peers and faculty, including being perceived as weak, unable to handle challenges on their own, and having poor strategies

to deal with academic and interpersonal stress, were discussed as negatively influencing willingness to use counselling services by all male participants. Most had sought help as a last resort or because it was made compulsory by the management or a faculty member due to poor academic performance, regular absenteeism, or failure to comply with institution policies and regulations.

3.2 Perceived Effectiveness and Quality of Mental Health Education

Mental health education programs in the participants' institutions included mental health awareness workshops and courses, as well as programs that focused on mental health promotion, such as mindfulness training programs, courses on building emotional intelligence, and gratitude workshops.

Participants perceived that the mental health education programs held by their HEIs helped enhance their universal mental health knowledge. In this context, universal knowledge refers to factual, scientific knowledge such as information about clinical disorders, symptoms, and evidence-based care. Enhanced knowledge of this type helped them express their mental health concerns more accurately. Participant 10 shared, "I was getting all these feelings, feeling jittery and unable to breathe sometimes. Only after sitting in the class did I understand that this is called anxiety. I was able to express my problem and say, 'This is what I am having. This is what is happening to me.'" They believed that being able to accurately verbalize their feelings made it easier to understand and navigate their mental health experiences: "When I know what is happening and I can use the words to say what is happening inside me, it makes it easier for me to figure out what I need to do. Sometimes I don't even need to tell others. Just knowing what I am going through makes it easier for me to think and say, 'okay, I need to address it in this way.'" (P16) They attributed their prior lack of knowledge to limited knowledge within their communities.

Similarly, participants described how mental health promotion classes helped improve their self-care practices as well as develop strategies for mental health enhancement. "When I feel my thoughts getting too overwhelming, I have started to write them down. I learnt this in the Gratitude classes. I write down what's bothering me and also what I am grateful for. It helps me see things in a balanced way rather than feeling everything is going wrong." (P12).

Participants also attributed the development of positive mental health attitudes to information received from these programs, stating, "I understood the science behind it. I was able to understand that this was just an illness like getting a fever or something. And you need treatment for this, just like that." (P6) It helped improve their willingness to seek help and to develop positive attitudes towards mental health and illness.

Participants focused on program design characteristics when discussing the effectiveness of these programs. In particular, they discussed the effectiveness of disseminating mental health information through compulsory programs: "The minute you make something compulsory, there is an immediate block. Half the class doesn't want to be there. The few people who want to listen feel awkward asking questions or engaging with the person giving the class because they know their classmates want to leave as soon as possible." Others discussed the content of the programs, favoring those that focused on practical information and lived experiences: "When someone is talking about what they went through and how they dealt with it, that gives us an idea of what we can do when we are in a similar situation. Just giving presentations or talking about what mental health is doesn't really help us much."

Another design characteristic was whether the information was practical or theoretical. Some participants found theoretical knowledge, such as the symptoms and names of specific disorders, useful in developing a language for communicating their distress. In contrast, others found such knowledge less useful than practical skills or the sharing of lived experiences as a way of learning how to navigate mental health challenges.

3.3 Influence of Academic and Social Experiences within HEIs on Mental Health Attitudes and Behaviors

Participants discussed indirect ways in which HEIs helped in shaping their mental health experiences. This included the development of informal sources for help-seeking. Participants discussed the role of trusted faculty members in providing academic and emotional support: “If anything happened to me, I used to share it with my teacher. Like if I could not understand something and I am not able to share it with my friends or anyone, then I used to tell my teacher, and they used to guide me on what to do.” They served as mentors and sources of social support.

Additionally, participants discussed the development of peer support networks. They believed that their peers served as an important source of support and guidance. In particular, they discussed how being in the same life stage and having similar life experiences enhanced their ability to provide support: “I know my friends and classmates are going through the same things I am. They know what I may be going through. They are less likely to jump to conclusions or judge me for how I am feeling. So I am able to rely on them. Sometimes they give me good suggestions of what has worked for them when they were going through something similar. Sometimes they just listen. Both are helpful in their own way.”

Higher educational institutions also provided opportunities for enhancement of their mental health knowledge outside of structured programs. An important influence was the exposure to diverse perspectives from being exposed to students and faculty from different cultures and social groups. As one participant stated, “When you go to college, and you start to meet all these different people, that’s when you start to get a different understanding, or a different way of seeing things than what you just grew up with. That really helps you to think for yourself about what is mental health, what is mental illness, how to feel about counseling, all these things.” The exposure to diverse perspectives allowed them to think beyond the community attitudes and insights they may have developed in childhood. Most believed that this helped them develop more positive attitudes towards mental health, persons with mental illness, and help-seeking.

Participants discussed additional resources for enhancing their mental health literacy, including library resources and internet services offered by their HEIs: “To me personally, I always had like a library in my school and now in college, so I just go there and read about things on my own.” Additionally, participants learnt about mental health and illness through embedded and informal learning contexts. This included classroom discussions and courses within the curriculum other than those covered in mental health education programs. For example, one participant discussed learning about mental health through discussions in their Biology class: “The first time I heard the word mental health was when my Biology teacher was talking about how it is important to eat and sleep well, to exercise for your mental wellbeing. So that is when I first understood that there is something called mental health and we should be aware of it.” (P11, Chemistry, Botany and Zoology major) Similarly, another participant discussed learning about disorders through their Sociology class: “In our Sociology of Aging class, we are learning about vulnerabilities to different mental illnesses at different ages in life. Like, from substance use to even dementia and all. It makes us more aware of what we are vulnerable to and how to prevent it.” (P7, Sociology and English major).

4 Discussion

Participants discussed two primary roles of HEIs in shaping mental health attitudes and perceptions, namely, an improvement in mental health literacy and the provision of formal and informal mental health support. They discussed how factual information about mental health and illness helped them develop positive mental health attitudes, as well as providing them with a language to express the challenges they experienced

and greater knowledge on how to address these challenges. Similar findings have been reported among primary and secondary school students, though not sufficiently explored within higher education [28,29].

In discussing the role of mental health education, participants highlighted the role that developing universal mental health knowledge played in providing them with a language to express and interpret their distress. This helped them move away from experiences of hermeneutical injustice caused by a lack of collective interpretive resources, often experienced when psychiatric illness is not discussed openly within a community or where mental health and illness are not widely discussed, something that is characteristic of social norms and attitudes within the Indian context [30–32]. As a consequence, they may have been positioned not to be able to fully express and access experiences and resources relating to mental health. Mental health education programs helped them better understand and express these needs. In other words, knowledge of psychiatric labels, symptoms, and terms helped bridge the gap in collective interpretive resources provided by the community, allowing them to express and process mental health challenges [33].

Apart from enhancing mental health knowledge, socio-emotional development programs such as mindfulness seminars, stress management classes, anger management courses, and courses relating to emotional intelligence enhancement were perceived as being useful in developing effective self-care practices. This may be perceived as meeting the objective of integrating socio-emotional learning within higher education to address challenges faced when transitioning into university life. It is likely to result in academic progress, improved responses to challenges, and a higher motivation to succeed [34]. Mindfulness programs and other forms of mental health promotion can be effective in improving the mental well-being of students [35]. It is likely to result in academic progress, improved responses to challenges, and a higher motivation to succeed [34].

When discussing the effectiveness of mental health education programs, participants focused on two characteristics, namely whether it was compulsory and whether it was theoretical or practical in content. They believed that making programs compulsory reduced their effectiveness. Experiential and integrative approaches to learning that focus on practical knowledge and skills have been found to be more effective for mental health education and training [36]. Further, while making programs mandatory is aimed at increasing their reach, it may reduce the effectiveness of soft skills programs such as emotional intelligence development, self-care, and mindfulness training. This is because it is likely to reduce feelings of autonomy and intrinsic motivation among participants [37].

Another indication that participants enjoyed the autonomy of seeking information for themselves is the use of library and online resources for enhancing their mental health knowledge. The use of digital resources such as mental health magazines and online forums may be more common among the present student population who are digital natives [38]. Enhancing these resources may be particularly useful in resource-limited spaces such as rural and semi-urban colleges and universities [39].

A more informal, unstructured way in which HEIs enhanced mental health promotion and socio-emotional learning was the opportunities they provided for the diversification of students' social networks. This enhanced participants' access to varied perspectives on mental health and illness that may differ from their own family and community attitudes. The role of diversity and inclusion as a formal and informal education practice has been found to be useful in developing a broader social understanding, critical thinking, and empathy, as well as providing the opportunity to learn from multiple viewpoints [40–42]. This study highlights how this may be extended to developing new perspectives on mental health and illness, just as it has been found useful in relation to other beliefs, viewpoints, and attitudes.

Enhancement of mental health literacy through mental health education, as well as academic and social experiences, had a positive influence on personal attitudes, help-seeking strategies, and mental

health management. Another key factor was prior experiences with mental health professionals. Negative experiences with mental health professionals often lead to discontinuation of treatment as well as an unwillingness to seek professional help in the future [43]. This included negative treatment effects, perceived misbehaviour from the therapist, and poor ethical considerations when practicing therapy [44].

Unique to this study, mental health professionals were often used to enforce college regulations, which further increased the likelihood of associating them with negative experiences or punitive consequences. The 'dual role dilemma' is often discussed in forensic mental health spaces, with a focus on the care-control conflict [45,46]. Similar to the characterisation by participants, care refers to providing emotional support while control focuses on the function of behavioral monitoring and rule enforcement [45]. This dual role often leads to reduced trust, perceived manipulation and invalidation and increased resistance within the therapeutic relationship [45–47]. Within the educational context, this conflict between roles is more widely reported at the school level, with students perceiving counsellors as being aides of teachers in enforcing school rules [48]. An exploration of this within HEIs may be useful to better address boundary crossing and role ambiguity among mental health professionals working in these spaces. An important factor was norms relating to gender and the expression of distress and need for help. Both male and female participants discussed the difficulties that male students faced in expressing distress and seeking help. They attributed this to the subscription to cultural scripts of masculinity. These aligned with typical scripts that promoted toughness and emotional control while stigmatizing vulnerability and expressions of distress [49–51]. Further, the tendency to use heteronormative masculine ways of coping, such as emotional suppression and exercise, aligned with following these cultural scripts [52]. It also reduced their willingness to seek professional help due to self-stigmatizing attitudes as well as anticipated discrimination due to subscription to these cultural scripts of masculinity by others [50,53].

Another important factor in determining perceptions towards counselling services was family attitudes towards mental illness and psychological help. Negative family attitudes including fear of stigma and adverse impact on family reputation often make it difficult to seek help for psychological challenges [54]. Unique to this study was that participants' perception of negative family attitudes had a positive influence on perceptions towards counselling services as the free services allowed them to seek help without having to disclose their needs to their parents. While focus on family reputation, stigma and negative family attitudes are common in the Indian context, in the context of this study it appeared to lead to favourable attitudes towards counselling services in HEIs.

Apart from mental health services, participants discussed the role that HEIs played in developing informal help sources. In particular, they focused on peer support and the support of teachers and mentors. Individual and group peer support has been identified as a protective factor in the prognosis of mental illnesses such as anxiety and depression. The shared lived experiences of peers are a pertinent factor in mental health promotion and the prevention of mental illness [55]. Similarly, teachers and mentors, particularly those belonging to disciplines related to health, can serve as important sources of mental health support outside of the professional services offered by the HEI [56]. Mentors with whom students experience closeness and connectedness may also serve as an important source of help and support [57].

4.1 Limitations of the Study

While the study's findings are relevant to mental health promotion within higher education, it must be noted that these findings are context-specific to HEIs in South India. As the study is qualitative, it is embedded within the cultural and social context in which it was conducted. Findings may not be generalizable to other populations. The sample size also reduces the capacity for generalizing the findings.

The purposive sampling technique and voluntary participation used in the study may have introduced self-selection bias, as participants may have been more involved in service utilization and engagement with mental health initiatives. Further, the inclusion and exclusion criteria limited the participants to those who had engaged with both initiatives as a way to better understand engagement and experiences of these two services. However, this meant that those who were disengaged, unaware of, unable to access, or dissatisfied with these initiatives were not represented in the study. Future studies may benefit from comparing their experiences with those who had actively engaged with these two initiatives to develop a more holistic evaluation of them. Further, as all interviews were conducted in English, it may have limited participants' ability to share their experiences more fully and comprehensively as they might have in their vernacular languages. However, it must be mentioned that all participants were studying in English medium colleges and had received education in English language since High School.

Finally, another significant limitation inherent in conducting qualitative studies is the subjective interpretation of data by the researchers. To address this, the researchers engaged in reflexive journaling and dialogue to enhance the reliability and transparency of the findings. However, qualitative analysis inevitably involves interpretive engagement with the data, which may result in researchers' assumptions and biases being reflected in the data despite efforts towards reflexivity and analytical transparency.

4.2 Implications of the Study

Although the study may not be generalizable beyond the context of its sample, the following implications are suggested. Through the analysis of data, it is apparent that strong influencing factors on how mental health services are perceived include prior experiences and social attitudes towards help-seeking. This finding emphasises the need to integrate stigma and mental health literacy interventions within service delivery as these factors shape service utilization and effectiveness. Further, the finding that allotting additional responsibilities relating to rule enforcement to counselors negatively influences students' perceptions suggests that clear role descriptions and delineation of administrative and counseling services must be undertaken. This is likely to make counselors appear more accessible and specialized in providing mental health services.

Apart from negative perceptions about mental health professionals, the complexity of protocols for access significantly reduced service use. Simplifying access protocols and communicating how to access services more widely and clearly may address these perceived structural barriers to access.

With relation to mental health education, it may be useful to integrate lived experiences and practical skill development within the curriculum for structured programs aimed at improving mental health promotion. Additionally, expanding access to mental health information through libraries and online resources increases students' autonomy to explore and build mental health awareness based on their needs. Further, embedding mental health education within the pedagogy and curriculum of allied and non-allied disciplines may be useful in increasing mental health literacy and improving mental health attitudes.

The influence of academic and social institutions within the HEI that are not structured to improve mental health or address mental illness indicates that institutions should take a more holistic approach to mental health promotion and illness prevention. Some of these factors may be made more structured, such as regular mentoring sessions or peer mentoring programs. Additionally, ensuring diversity within the student population and accessibility of faculty outside of classroom hours may further enhance support structures and mental health attitudes alongside formal services.

5 Conclusions

In understanding students' perceptions and attitudes towards the mental health services and educational programs offered by HEIs in India, it is evident that these resources help in improving mental health literacy and making mental healthcare accessible. It has the capacity to improve personal mental health attitudes and perceptions. Further, HEIs are spaces that offer diverse perspectives and informal support through teachers and other faculty members. However, while personal mental health attitudes and mental health literacy may improve, a greater influence on mental health service utilization may be experiences with these services and knowledge of social attitudes. These findings suggest that addressing the relational, structural, and educational contexts within which these services are embedded is as important as expanding services when aiming to improve students' mental health outcomes.

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Availability of Data and Materials: Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data is not available.

Ethics Approval: The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board of Christ University (protocol code RCEC/00423/03/23, Date of Approval: 18 March 2023). Written informed consent was obtained from each participant prior to data collection.

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