Mental Health Needs for Students Enrolled in Inclusive Postsecondary Education Programs

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Abstract

As students with intellectual disabilities (SWID) are increasingly attending inclusive postsecondary education (IPSE) programs, their specific needs and barriers to success must be assessed and addressed. Additionally, mental health (MH) conditions are common in college age students; this remains true for SWID enrolled in IPSE programs. This study surveyed 33 IPSE program directors nationwide regarding the MH needs of SWID enrolled in their programs. Survey results concluded that the majority of IPSE program directors reported having experienced students having MH concerns while enrolled in an IPSE program. The most frequently observed MH concerns were noted to be anxiety and depression. Barriers to MH services for SWID in IPSE programs included lack of competent MH professionals on campus, long wait times, and IPSE students not being eligible for campus-based MH services.

Keywords: mental health; intellectual disabilities; inclusive postsecondary education

Plain Language Summary

- There are more students with intellectual disabilities (ID) attending inclusive college programs than ever before. Because these programs are new, little is known about the mental health needs of college students with ID.
- 33 program directors took a survey asking about the mental health traits they see in their students. The survey also asked about mental health services on hand.
- Anxiety and depression were the most common student issues. Students with ID face problems getting mental health treatment on campuses such as counselors who are not ready to work with students with ID. Students also face long waitlists for services.

- Students with ID must have access to all campus resources to be fully included in college life. Access to mental health services must be a top priority.

Following graduation from high school, attending some type of postsecondary education (PSE) is the societal norm for many students and is often celebrated as a developmental rite of passage. However, for students with disabilities, this "next step" is not always a given. The National Longitudinal Transition Study-2 (Newman et al., 2011) noted that 93% of students without a disability expected to continue on to some type of PSE, whereas a mere 50% of students with disabilities had the same expectation (Lipscomb et al., 2017). While 50% of students with intellectual disabilities (SWID) consider attending PSE, only 23% enroll in a two- or four-year college or university. However, with the recent passage of legislation, increases in federal funding, focus on the transition process out of secondary education for students with disabilities, and the resulting increase of inclusive postsecondary education (IPSE) programs, these statistics are changing.

College and Intellectual Disability

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination against persons with disabilities in federally funded programs, including PSE. Despite this, SWID are often considered unqualified and unable to meet minimum requirements for admission into PSE. With the passage of the Higher Education Opportunity Act (HEOA; 2008), provisions were included to specifically support SWID to access Inclusive Postsecondary Education (IPSE) programs. In addition, the HEOA provided a pathway to federal financial aid for SWID through the Transition and Postsecondary Programs for Students with Intellectual Disabilities (TPSID). Due to the increase in legislative actions and federal funding sources, IPSE programs grew from 148 in 2008 (Grigal et al., 2012) to 298 programs as of October 2020 (Think College, 2020), a 101% increase in a dozen years. Currently, it is estimated that 6,440 SWID are enrolled in an IPSE program (Grigal et al., 2020).

Typically, IPSE programs are housed within traditional universities or community colleges. IPSEs provide supports and resources to assist SWID in both their academic experience and their social inclusion on campus. Each IPSE is unique in the way the program is designed, the supports and resources offered, if campus housing is part of the program, and the type of degrees or certificates available for students. While each IPSE program is unique, they all have shared goals and objectives. Programs work with SWID to improve social and career goals in order to improve employment and independent living outcomes for adults with ID. While there is a dearth of research regarding the outcomes of IPSE programs, the limited evidence is promising. Research demonstrates that compared to individuals with ID who had not completed an IPSE program, individuals with ID who have completed some type of IPSE program have higher rates of employment (Ryan et al., 2019), significant increases in their earnings (Miller et al., 2019), and greater independent living outcomes (Petroff et al., 2019; Ryan et al., 2019).

College and Mental Health

The intersection of college and mental health (MH) conditions in general is a growing concern for many college administrators and MH staff at college campuses across the United States. Many studies demonstrate an escalating crisis, with college students' MH problems increasing in both intensity and frequency (Auerbach et al., 2018; Mitchell et al., 2013), and colleges and universities appearing unable to keep up (Mistler et al., 2013; Xiao et al., 2017). Most MH conditions are diagnosed between the ages of 14 and 25, which corresponds with the typical age range of students experiencing the transition from high school to postsecondary education settings (de Girolamo et al., 2012; Kessler et al., 2005). For traditional college students, postsecondary education may be their first experience having to balance demands and expectations from school, work, and social life (e.g., roommates with different cultures and values), and thus they are learning to cope with demands above and beyond academic requirements (Pedrelli et al., 2015). Beiter et al. (2015) found that students experiencing MH conditions in PSE had three main concerns: (1) academic performance, (2) pressure to succeed, and (3) post-graduation plans.

Prevalence of MH concerns in college students has been estimated in several studies to be between 28 and 45% (Auerbach et al., 2018; Eisenberg et al., 2013; Lipson et al., 2016). The most common MH conditions occurring in college students are mood disorders (i.e., depression), anxiety, and substance use disorders (Auerbach et al., 2018; de Girolamo et al., 2012; Pedrelli et al., 2015). MH conditions experienced by college students can adversely impact physical health and well-being, academic success, and overall quality of life (Brieler et al., 2015; Oswalt et al., 2020; Yozwiak et al., 2012). One survey noted that MH issues were the most frequent reason students did not complete higher education (Gruttadaro & Crudo, 2012). It has been estimated that 50 to 80% of college students with MH concerns do not seek out treatment or assistance, with a common reason being a perceived lack of need (Oswalt et al., 2020). Additional reasons for university students not seeking MH treatment can be stigma, accessibility, fear, culture, and gender (Brunner et al., 2014; Marsh & Wilcoxon, 2015).

Due to the high frequency of faculty and student interaction, it has been recommended that all faculty should be aware of and recognize early warning signs of mental illness (Mowbray et al., 2006). This can be difficult, as faculty members' areas of expertise may not readily align with recognizing MH conditions. Additionally, faculty should be familiar with the MH resources and services available to students through disability resource centers campus counseling services, and other campus-based MH resources for students (Mowbray et al., 2006). However, faculty attitudes towards students with MH conditions and their overall impression of academic success for students with MH conditions have been shown to be less favorable when compared with their impressions of students with learning and physical disabilities (Sniatecki et al., 2015).

Mental Health and ID

Persons with ID have high rates of MH problems relative to the general population (Buckles et al., 2013), but low rates of service utilization (Slayter, 2010; Whittle et al., 2018a). Symptoms mistakenly associated with ID can cause problems with the accurate assessment, diagnosis, and subsequent treatment of MH in individuals with ID (Fletcher et al., 2018). Among those who have sought services, few have received MH treatment from practitioners who have experience treating comorbid ID and MH disorders (e.g., depression, anxiety, trauma; Whittle et al., 2018a). Persons with ID have expressed feeling further discriminated against and stigmatized when they have comorbid MH needs (Robinson et al., 2016). Individuals with ID stated that they feel as if "nobody understands" their MH symptoms, and this attitude from others makes them feel as if it is "all in their head" (Mattock et al., 2020, p. 95). Additionally, people with ID often do not feel like they have autonomy in their own lives (Donner et al., 2010) and might do not understand why taking medication for their MH needs is important (Mattock et al., 2020). Although there is a general dearth of research specific to SWID experiences around MH in IPSE programs, research on the health and wellness of SWID in IPSE programs indicates that stress and anxiety are a major concern for participants (Oakes et al., 2020).

Barriers

The most widely cited reason for the disparity between prevalence of MH problems and service utilization among persons with ID involves barriers to access (Whittle et al., 2018b). Historically, several common barriers have been noted among researchers, such as lack of specialized training for practitioners, lack of specialized services for persons with ID and MH problems, and ineffective service collaboration among service agencies (Whittle et al., 2018b). Individuals with ID and comorbid MH conditions experience significant barriers to accessing the MH services they need (Hassiotis & Turk, 2012; Lamar, 2020; Whittle et al., 2018a). It has been well-documented that MH providers often feel unprepared to meet the needs of clients with comorbid MH disorders and ID (Dagnan et al., 2015; Lunsky et al., 2007; Weise et al., 2017, 2018; Whittle et al., 2018b). Several countries, including the UK and Australia, have reformed their MH service systems to provide more inclusive and specialized MH services to those with ID, but policy frameworks do not provide for the kind of inter-agency collaboration and training that effective MH treatment for this population requires (Dew et al, 2018; Lunsky et al., 2007).

Whittle et al. (2018b) found that barriers to MH access for persons with ID could be separated into four categories: (a) availability, (b) utilization, (c) relevance, and (d) equity. Due to a lack of service providers with training and expertise in treating comorbid ID and MH issues, research has demonstrated a general lack of services specifically targeted towards the MH needs of persons with ID (Lamar, 2020). Additionally, since such services are scarce, persons with ID may be restricted in their access by distance and transportation (Lamar, 2020; Lunsky et al., 2007).

Persons with ID experience organizational as well as intrapersonal barriers in accessing MH services. Organizationally, MH and ID services are often "siloed" and offered by differing entities. As a result, research has demonstrated that persons with ID experience barriers at transition points in their care (Mandarino, 2014), where lack of coordination between agencies and lack of follow-up with persons as they transition from adolescence to adulthood significantly restricts access to MH services for persons with ID. Persons with ID tend to be referred for services by others, rather than self-referred, so a lack of help-seeking behaviors, as well as relying on gatekeepers for MH services (e.g. caregivers) who may not readily understand the MH needs of persons with ID, also serve as a barrier to access (Costello & Bouras, 2006; Sullivan et al., 2013). Further, communication difficulties may serve as a barrier for persons with ID in accessing traditional talk therapy service.

Persons with ID often experience misidentification of their MH problems due to "diagnostic overshadowing" (Whittle et al., 2018b). Diagnostic overshadowing occurs when MH practitioners and other professionals attribute MH symptoms to a person's intellectual disability, rather than considering them to be evidence of a comorbid MH disorder (Donner et al., 2010; Whittle et al., 2018b). As a result, persons with ID often do not experience their emotions being taken into consideration and are referred more frequently to ID services, which may not focus on their MH. A lack of an appropriate diagnostic system for individuals with ID also exists, as practitioners typically rely on self-report when diagnosing MH disorders in the general population (Fletcher et al., 2018). Additionally, many professionals demonstrate deficiencies in their knowledge and confidence relative to treating the MH needs of persons with ID (Hinde & Mason, 2020; Hronis et al., 2018; Lamar, 2020). As a result, practitioners may be willing to treat persons with ID, but lack the proper specialized training to do so. Lastly, persons with ID may experience inequity in their access to MH services, as providers may be more experienced with and willing to provide MH services to persons with less severe manifestations of ID (Lamar, 2020).

Given the barriers SWID experience relative to MH, the growing rates of MH needs on college campuses, and the general dearth of research examining MH supports in IPSE programs, the purpose of this study was to explore the following research question: How do IPSE program directors describe the mental health needs of postsecondary students with intellectual disabilities in their programs?

Research Design

Method

This study employed a cross-sectional, exploratory mixed-methods design that was largely descriptive in nature. This was done to ascertain current practices across IPSE programs in relation to students' MH and the needs, resources, and concerns of the program. Survey questions were developed based on existing research about SWID and MH in IPSE programs and the experiences of one IPSE program director. The survey was

piloted with an individual meeting the inclusion criteria for the study to best estimate the time that survey completion would take, to check the readability and language used on the survey, and to evaluate if survey questions elicited the type of information the researchers were seeking (Kim, 2010). Following institutional IRB approval, the research team sent an email to the IPSE directors' listserv and also emailed recruitment information to each program listed on the Think College website. This invitation email explained the scope and design of the project and invited them to participate in the study; the link to an anonymous internet-based survey via Qualtrics (2020) was also included in this invitation email. The Qualtrics survey asked 10 demographic questions and up to 23 content related questions. Participants spent an average of 5 minutes completing the survey. The number of questions each participant was presented depended upon participant responses to prior dichotomous questions (e.g., subsequent questions were adjusted based on an initial Yes/No response to certain questions regarding services). Following the collection of participant response via Qualtrics (2020), descriptive statistics were analyzed using SPSS version 25 for Macintosh (IBM Corp, 2017). Data collection took place during the month of February, 2020. The data collection process was impacted by the COVID-19 pandemic, in that follow-up reminders and repeated email invitations were not sent to potential participants due to the strain caused on universities and staff across the nation.

Participants

Thirty-three IPSE program directors started and completed the Qualtrics survey. The participant group largely identified as female (81%, n = 27), with 17% of respondents reporting as male (n = 5) and one participant selecting that they preferred not to answer. The majority of participants reported that they were White/Caucasian, (n = 28, 84.4%), two participants identified as Indigenous Peoples/Native Hawaiian (6%), one participant identified as Black/African American (3%), one participant identified as Hispanic/Latino (3%), and one participant preferred not to answer the Race/Ethnicity question (3%). The level of education reported by the sample group predominantly reflected graduate-level training: 94% of the participants reported having a masters (57%) or doctoral (37%) degree. Only two participants (6%) reported being employed in an IPSE program with a bachelor's degree. When considering the length of time study participants had been working in an inclusive postsecondary education program, 76% of study participants (n = 25) had worked in IPSE for 5 years or less. Approximately half of the participant sample (n = 16) had less than two years of experience working in an IPSE setting. The majority of participants reported that Special Education was their field of expertise (n = 14, 42%), 18% reported Counseling/Social Work as their field of expertise (n = 6), 18% selected Education, and 21% of participants either reported a unique field or chose not to respond (n = 7).

Data Analysis

Due to the overall design and flow of the survey, the quantitative data analysis was done through descriptive statistics via the SPSS platform (IBM Corp, 2017). Given that some questions were open-ended and allowed for individual participant responses, some qualitative analysis was required. Significant statements in each qualitative response were analyzed into meaningful categories and “an essence description” was generated

(Creswell & Creswell, 2018, p. 198). Each response potentially contained multiple statements reflecting MH concerns that did not necessarily fit into a single category; therefore, the number of categories created does not match the number of responses given (i.e., a single response could contain references to suicidal ideation, depression, and anxiety). Researchers independently analyzed the open-ended responses provided by the participants and then met to review their findings to ensure that accurate interpretation had occurred. This form of data analysis through multiple reviewers, or analyst triangulation, helped to minimize the potential for biased interpretation of qualitative responses (Patton, 2015).

Results

The primary research question for this cross-sectional research project was: How do IPSE program directors describe the MH needs of postsecondary students with intellectual disabilities in their programs? Results largely indicated a pattern across three areas: (a) program specific data, (b) mental health supports, and (c) mental health concerns.

Program Specific Data

Participants were asked descriptive questions regarding housing options, number of students served in their program, and length of time providing campus-based housing options. Sixteen (48.5%) of the programs represented had campus housing options, with six (18.2%) having a mandatory campus-housing requirement. Only five programs indicated that they provided specialized training to resident advisors on how to approach/interact with students with intellectual disabilities. Questions regarding length of time providing housing options and the number of students housed on campus did not provide usable results (i.e., insufficient responses, missing data).

Mental Health Supports

Participants were asked to consider five questions designed to better understand the type of MH supports and resources offered through the IPSE program, the university, and/or the community. These five questions focused on MH evaluation, training of staff relative to MH needs, and the provision of and access to MH services. Although 17 participants (51.5%) indicated that their program provided MH supports of some kind, four participants responded that individual counseling is available within the IPSE program, two participants indicated group counseling is part of their program, and three respondents indicated that program curriculum includes MH content.

Inversely, a majority of participants indicated that they do not conduct MH evaluations within their program (n = 23, 69.7%), nor do they provide training on MH first aid, such as the Question Persuade Refer (QPR) program (n = 21, 63.6%). Only eight participants (24.2%) indicated having a policy relative to students and MH needs; two of these policies were program-specific, while the other six were largely reflective of the general university statement/policy on student MH.

Many participants reported that they refer students to campus-based MH service providers (n = 20, 60.6%). The frequency with which these referrals were made in a given

semester is reported in Table 3. Eight participants (24.2%) indicated that they did not refer students to campus-based MH providers; a follow-up open-ended question asked participants to identify reasons for not referring students to campus-based MH services. Results (also seen in Table 3) indicated that the primary reason for not referring students to campus-based MH providers was tied to university constraints. Examples of this include: program students did not pay traditional student fees and so were not able to access campus-based MH services; lack of a campus-based counseling center; long waiting lists for services with campus-based providers; campus-based services indicating that they are not adequately trained to provide MH services to SWID; and accessibility issues.

Mental Health Concerns Experienced by Students

To evaluate the student MH concerns encountered by IPSE program directors, the following open-ended question was asked: What are some examples of past students' MH concerns that have been encountered, and what was the resolution? As noted in the data analysis section, these responses generated several statements that were organized into categories. Twenty-two participants (66.7%) provided responses with specific examples of MH concerns, and three participants indicated that they had not experienced student-related MH concerns to date. The categories with the highest frequency were anxiety (n = 14, 63.3%) and depression (n = 13, 59.1%). Suicidal ideation was the next most commonly reported concern with nine (40.9%) of the IPSE program directors identifying this concern as experienced by former students. Experiences of bereavement/grief (n = 4, 12.1%) and psychosis (n = 3, 9.1%) were reported by IPSE program directors. Significant events such as abuse and trauma (n = 2, 6.1%) and suicide attempts (n = 2, 6.1%) were also reported. Eight other student MH concerns were reported as happening with less consistency across programs; these are detailed in Table 4.

Program Responses

Of the 22 responses submitted, 17 (77.3%) provided information regarding the resolution of student MH needs. These needs were categorized the same way as the student MH needs. When a response indicated more than one resolution, multiple categories were assigned to that response. Resolutions were categorized into four types: (a) campus-based resources (e.g., campus counseling center, wellness center), (b) community-based resources (e.g., private counseling, group therapy, off-campus psychiatrist for medication management), (c) behavior support plans, and (d) program specific supports (i.e., program employees trained to provide MH services, curriculum specific to MH). For example, one IPSE director reported using on-campus counseling services, community-based counseling services, and program specific supports (mentors). The most common resolutions were a referral to campus-based supports (n = 9, 40.9%) and referral to community-based supports (n = 8, 36.4%). Program specific supports were used by five (22.7%) of the IPSE programs. Only one (4.5%) of the IPSE program directors reported using behavior support plans to resolve student MH needs. Five (22.7%) of the IPSE program directors reported using more than one type of resolution support or resource.

Discussion

While the MH experiences and needs of traditional college students have been well established in the literature, there remains a paucity of literature regarding the MH needs and experiences of postsecondary SWID enrolled in IPSE programs. With only four program directors reporting that they have yet to experience a student MH concern, it becomes clear that the majority of program directors for the 33 IPSE programs surveyed have experienced a student MH issue. This majority aligns with the existing research showing that individuals with ID have MH concerns similar to those in their neurotypical peers (Whittle et al., 2018a).

The IPSE program director participants in this survey described some of the barriers SWID having comorbid MH conditions encountered when trying to access college/university MH services. Ten participants noted that they do not refer IPSE students to on-campus MH services. For some, it was simply a matter of availability, that the college/university does not have MH counseling services, or that because the IPSE program students did not pay university fees, they were not eligible for MH services on campus. More concerning are the responses from participants where their college/university does have MH services available to IPSE students. Such reasoning includes long wait lists, and MH professionals who are unskilled at working with SWID. While concerns about individuals with ID reporting difficulty finding a competent MH professional to work with is not unique to academia (Dagnan et al., 2015; Lunsky et al., 2007), this lack of MH professionals familiar with ID on campuses having IPSE programing is particularly disquieting. One must take into consideration the fact that many SWID in IPSE programs live on campus, may not have transportation to off-campus providers, and may not have the financial resources to seek outside MH treatment. It is an understatement to say that participant responses indicating campus-based counseling centers are not equipped to provide services to SWID is merely unfortunate; campus-based providers need to be familiar with the needs and characteristics of all students. Regrettably, a lack of access to MH treatment on campus implies that SWID are not fully included in the college environment. Full inclusion for SWID within postsecondary educational settings mandates access to and provision of equitable health care, including MH care, as compared to their neurotypical peers.

Anxiety and depression were noted by program directors as the most common MH conditions that SWID experienced. This aligns with the existing literature relating to the MH conditions experienced by college students in general (Oakes et al., 2020; Pedrelli et al., 2015). It is important that IPSE program directors, college MH professionals, and college administrators understand that the MH needs of SWID enrolled in IPSE programs are not different from neurotypical students. Diagnostic overshadowing is an important concept that must be understood in the PSE system: that SWID can have unique MH needs that are completely unrelated to their ID (Whittle, 2018b).

In response to HEOA and other legislation and TPSID funding sources, the number of SWID within higher-education institutions continues to increase each year (Grigal et al., 2020). In order to provide inclusive education opportunities for students with disabilities, higher-education institutions need to address the many barriers SWID face. There is,

however, little research concerning barriers to accessing MH services among SWID enrolled in IPSE programs. However, one can surmise that similar barriers exist for SWID engaged in higher education as they do for persons with ID attempting to access services within the community. For instance, it is unlikely that all universities with an IPSE program also have specialty MH clinics on campus. Additionally, as noted by participants in the current study, SWID in IPSE programs may not be enrolled as traditional students and therefore may not be permitted to access campus MH services. Thus, the MH needs of SWID involved in IPSE programs remains an important and timely topic to explore..

Recommendations

As this study notes, SWID enrolled in IPSE programs do experience MH symptoms similar to neurotypical college students. While recognizing the need for appropriately-trained MH professionals to be part of the overall solution, IPSE program directors must take a step back to evaluate their own familiarity with the MH services available to SWID on campus. IPSE programs must consider their own programmatic resources to evaluate SWID MH concerns and supports to address them. Mental health symptoms for SWID may manifest differently (Fletcher et al., 2018). Program directors and staff should be familiar with common mental health features and how these features may manifest differently in SWID.

Given the commonly reported deficiencies in practitioner knowledge and confidence relative to treating the MH needs of persons with ID (Hinde & Mason, 2020; Hronis et al., 2018; Lamar, 2020) and the prevalence of diagnostic overshadowing (Whittle et al., 2018b), outreach and education should be provided to campus-based counseling services. Advocacy and outreach within the larger campus community may be needed to draw attention to the MH needs of SWID participating in IPSE programs. This can help offset the potential for professionals to mistake MH symptoms for intellectual disability, rather than a comorbid MH disorder (Donner et al., 2010; Whittle et al., 2018b). For those situations where campus-based counseling services are not an option, program directors and staff should be familiar with community-based providers and supports to provide appropriate referrals.

If the IPSE program is without a formal policy on how to identify, support, and accommodate mental health needs of SWID, it is recommended that programs formalize such a policy. This policy should systemically address student MH issues that may arise. Additionally, IPSE programs using peer mentors should consider requiring that peer mentors take a mental health/first aid course to identify and address MH issues that may occur. IPSE program personnel may need to take a suicide prevention training course, such as QPR, in order to be prepared to engage with a SWID in a MH crisis. If nothing else, this study should demonstrate to program directors that a SWID experiencing a MH concern is not an “if” but a “when” situation.

Limitations

The findings from this study must be considered within the context of its limitations. Due to the lack of previous research on this topic, this study asked exploratory questions to better understand the current state of affairs for SWID experiencing MH concerns while

enrolled in IPSE programs. Since most program directors are not credentialed MH professionals, their analysis of student MH concerns could be diagnostically incorrect. For example, when we mention the number of participants who reported students with anxiety and depression, we did not ask if these were clinical diagnoses provided by a MH professional, or if it was simply their observation. Additionally, due to the COVID-19 pandemic, researchers did not continue with follow-up reminders in the data-collection process. Thus, the results could differ with a larger sample size of IPSE program directors.

Future Research

With the increase of SWID on college and university campuses, it is imperative that there are appropriate campus MH resources available to meet their needs. This study was carried out as an explorative study to understand the experiences of IPSE program directors specific to MH; as such, clear directions for future research are evident. For starters, 17 participants stated that their program provides MH supports; however, this survey did not ask for specification about what those MH supports entail. Future research is needed to examine college counseling center availability and competence to serve SWID as well as explore campus policies that exclude IPSE students from obtaining MH services on campus. Additional participatory research is needed to address the specific MH needs of SWID in PSE, as this is an area of continued growth. Ideally, future research would include the direct perspectives of SWID experiencing MH concerns while enrolled in an IPSE program.

Conclusion

The purpose of this study was to examine the experiences of IPSE program directors as they relate to SWID's MH needs. Findings reported here confirm that SWID experience MH concerns while enrolled in IPSE programs, just as their peers without ID enrolled in PSE do. Although IPSE program directors and staff should not be expected to be mental health experts, training on MH health and the needs of SWID could better prepare directors and staff to provide support and access to resources in times of crisis. Coordination between IPSE program directors and campus MH providers is necessary to ensure that appropriate services are available to SWID when needed. Considering and planning for the MH needs of IPSE students must be on the forefront of all IPSE program directors' minds moving forward.

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Table 1

Mental Health Supports Identified by Program Directors

Item		*n*	%
Do staff evaluate the MH of students?	Yes	7	21.2
	No	23	69.7
	Missing	3	9.15
Do program staff receive formal MH first aid training (e.g., QPR)?	Yes	6	18.2
	No	21	63.6
	Missing	3	9.1
Why are MH services not provided by the program?	Program accesses providers outside of the university	12	36.4
	Do not have the capacity/expertise to provide MH counseling services	9	27.3
	Students referred to campus-based MH services	8	24.2
	Program has not experienced MH related concerns	4	12.1
	University constraints	2	6.1
	Working to improve campus-based MH services	1	3
	Providers lack understanding on how to serve students with ID and MH concerns	1	3
	Lack of a campus counseling center	1	3
Refer students to a campus-based MH provider	Yes, 4x or more per semester	2	6.1
	Yes, 2-3 times per semester	10	30.3
	Yes, but rarely	8	24.2
	No	10	30.3
	Missing	3	9.1
Reasons for not referring students to campus-based supports	University constraints	5	15.2
	Community provider is the primary source of support.	1	3
	Not needed.	1	3
	Students have a prior provider.	1	3
	Refer students to community providers.	1	3
	Staff have clinical training and expertise.	1	3

Note. N=33

Table 2

Mental Health Concerns Experienced by Students

Mental Health Concern	*n*	%
Anxiety	14	63.6
Depression	13	59.1
Suicidal Ideation	9	40.9
Bereavement/Grief due to Loss	4	12.1
Psychosis	3	9.1
Abuse/ Trauma	2	6.1
Suicide Attempts	2	6.1
Stress	2	6.1
Paranoia	1	3
Non-compliance with psychotropic medication	1	3
Addiction to Pornography	1	3
Inappropriate Sexual Behavior	1	3
Anger Management	1	3
Problem Solving	1	3
Social Skills	1	3

Note. *N=22*. 22 of the 33 total participants provided examples of the Mental Health Concerns
% calculated based on the 22 provided responses.