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# Academic Stakeholders' Level Of Perceived Barriers To Accessing Mental Healthcare

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**Abstract**

*This study examines the perceived barriers to accessing mental healthcare among academic stakeholders—students, faculty, and support service personnel—at a university in Davao City, Philippines. Utilizing a descriptive-comparative quantitative design, the research assessed instrumental, attitudinal, stigma, and discrimination barriers through two validated instruments: the Mental Health Continuum-Short Form (MHC-SF) and the Barriers to Access to Care Evaluation (BACE V3). Data from 540 respondents were analyzed using frequency, mean, standard deviation, One-way ANOVA, and t-tests.*

*Key findings revealed that most respondents (53.1%) reported moderate mental health, while 41.3% were flourishing and 5.6% were languishing. Individuals with languishing mental health faced significantly higher barriers across all categories ($p < .001$). Faculty members perceived the highest barriers, particularly attitudinal barriers (mean = 1.71) and stigma-related concerns, such as family judgment (mean = 1.62). Instrumental barriers, notably financial constraints (mean = 1.50), were prominent. Significant differences emerged across respondent categories, with faculty experiencing greater barriers than students ($p < .001$), but no significant variations were observed by sex or socioeconomic status.*

*The study underscores the critical need for targeted interventions addressing attitudinal resistance and stigma, particularly among faculty. An intervention plan, Mind Matters: A Holistic Mental Health and Wellness Program, was proposed, featuring monthly thematic workshops (e.g., mindfulness, burnout prevention) tailored to faculty and students. Anchored in the Biopsychosocial Model, this program aims to reduce barriers through peer support, skill-building, and institutional advocacy.*

*These findings contribute to the global academic and mental health discourse by highlighting context-specific barriers in a Philippine setting. They advocate for systemic reforms to enhance mental healthcare accessibility, emphasizing the role of institutional support in fostering resilience and equitable well-being.*

***Keywords:*** *mental healthcare access, academic stakeholders, perceived barriers, mental health intervention, Philippines.*

## INTRODUCTION

Mental health concerns are prevalent among college students and academic personnel, often exacerbated by stressful personal and professional challenges. The transition to college can be overwhelming for students, while faculty and staff face workload pressures, work-life balance issues, and reluctance to disclose mental health difficulties due to stigma (Montesi, 2018; Halat et al., 2023; Price et al., 2017). Despite the high prevalence of mental health issues, many individuals do not seek professional help due to various barriers (Borenstein, 2020).

Key barriers to mental healthcare access include instrumental barriers—practical constraints like scheduling difficulties, financial limitations, and unfamiliarity with support structures (Abo-Rass et al., 2023; Czyz et al., 2013; Que et al., 2014; Halat et al., 2023; Gearheart, 2022). Attitudinal barriers, such as self-reliance and fear of being perceived as weak, further hinder help-seeking behaviors among both students and faculty (Clement et al., 2012; Salaheddin & Mason, 2016; Arnado & Bayod, 2020; Smith et al., 2022). Additionally, stigma and discrimination discourage individuals from seeking support, as mental health issues are often misunderstood and associated with weakness or incompetence (Vidourek & Burbage, 2019; Subu et al., 2021; Halat, 2023; Donachie, 2017).

While various interventions, such as the UK's Mentally Healthy Universities Program (Wray & Kinman, 2021) and the Philippine Mental Health Act of 2017 (Elemia, 2017), have been implemented, gaps remain in addressing mental health concerns within higher education. Limited research on perceived barriers among academic stakeholders, particularly in Davao City, necessitates further investigation to inform targeted interventions. This study aims to explore these barriers and contribute to improving mental healthcare accessibility in higher education institutions.

Findings from this study can guide the development of institutional policies, enhance support services, and inform university programs such as the UIC Guidance Office and Psychology Program in creating targeted mental health interventions. Ultimately, the study seeks to foster a more inclusive and supportive academic environment.

## STATEMENT OF THE PROBLEM

This study aims to assess the perceived barriers to accessing mental healthcare among academic stakeholders and examine differences based on demographic profiles and mental health status. Specifically, it seeks to answer the following questions:

1. What is the demographic profile and mental health status of academic stakeholders in terms of: 1.1 Sex; 1.2 Socioeconomic Status; 1.3 Respondent's Category; and 1.4 Mental Health Status (Languishing, Moderate Mental Health, Flourishing)?
2. What is the level of perceived barriers to accessing mental healthcare among academic stakeholders in terms of: 2.1 Instrumental Barriers; 2.2 Attitudinal Barriers; and 2.3 Stigma and Discrimination?
3. Is there a significant difference in the level of perceived barriers based on demographic profile and mental health status?
4. Based on the results, what mental health intervention can be developed?

## REVIEW OF RELATED LITERATURE

Academic literature reveals that academic stakeholders—both students and faculty—face a myriad of barriers that impede access to mental healthcare. Instrumental barriers are among the most frequently cited, encompassing practical challenges such as the high cost of services, limited availability of on-campus counseling, complex and time-consuming intake procedures, and scheduling conflicts arising from busy academic and work schedules (Clement et al., 2012, 2014; Weissinger, 2022; Wray & Kinman, 2021; Gearhart et al., 2022). In addition to these tangible obstacles, attitudinal barriers significantly hinder help-seeking behaviors. Many individuals strongly prefer self-reliance, often choosing to manage their emotional difficulties independently rather than seeking professional support (Ebert et al., 2019; Andrade et al., 2015). Moreover, the persistence of stigma and discrimination—both perceived and internalized—creates an environment where mental health issues are associated with weakness or failure, further deterring students and faculty from accessing needed services (Vidourek & Burbage, 2019; Subu et al., 2021). These barriers are

not isolated; they interact to create a compounded effect that significantly reduces the likelihood of individuals receiving timely and effective mental healthcare.

The literature also emphasizes that perceived barriers to mental healthcare are influenced by demographic factors such as gender, socioeconomic status, and academic role. Research indicates that traditional masculine norms and societal expectations can discourage men from seeking help, as help-seeking behaviors are often perceived as a threat to their masculinity (Yousaf et al., 2015; Panaligan, 2021). Conversely, women may experience additional challenges related to financial constraints and the dual pressures of academic and familial responsibilities, which further complicate their ability to access mental health services (Gasparini, 2024; Sorkhou et al., 2023). Socioeconomic status plays a critical role as well; individuals from lower-income backgrounds often face heightened barriers due to the combined effects of financial strain, limited access to quality services, and the additional stressors associated with poverty (Hodgkinson et al., 2017; Villamor & Dy, 2022). These demographic disparities underscore the need for tailored interventions that address the unique obstacles faced by different groups within the academic community, ensuring that mental healthcare resources are both accessible and equitable.

In addition to external barriers, the mental health status of academic stakeholders is a critical area of concern, with research highlighting widespread issues of stress, anxiety, and depression across various academic settings. Studies have shown that a significant proportion of college students experience moderate to low mental well-being, with many reporting symptoms consistent with languishing mental health (Lipson et al., 2023; Meeks et al., 2023; Bryant & Welding, 2024; Vidourek et al., 2014). In highly demanding fields such as medicine and engineering, the culture of normalized stress further exacerbates these issues; medical students, for instance, report elevated levels of anxiety and burnout that impact their academic performance and overall well-being (Hill et al., 2018; Jensen et al., 2023; Asghar et al., 2023). Faculty and support staff are not immune to these challenges, as high workloads, job insecurity, and limited institutional support contribute to increased stress levels, burnout, and overall psychological distress (Halat et al., 2023; Flannery, 2024). These findings indicate that the mental health challenges within academic environments are multifaceted and interrelated, necessitating comprehensive, targeted interventions that address both the structural and individual factors contributing to mental health disparities in higher education.

## THEORETICAL FRAMEWORK

This study is anchored in the Theory of Planned Behavior (Ajzen, 1991) and the Health Belief Model (Hochbaum, Rosenstock, & Kegeles, 1950). According to the Theory of Planned Behavior, an individual's intention to engage in mental healthcare is shaped by three core beliefs. First, behavioral beliefs influence attitudes toward care by weighing the perceived positive outcomes (e.g., improved well-being) against potential negative consequences (e.g., being judged). Second, normative beliefs reflect the perceived social pressure from peers, family, and influential figures, which can encourage or deter help-seeking. Third, control beliefs pertain to one's perceived ability to access care, considering availability, affordability, and logistical constraints. Together, these beliefs help explain why individuals decide to seek or avoid mental healthcare, highlighting the importance of reducing stigma and enhancing access.

Complementing this framework, the Health Belief Model posits that health-related behaviors are driven by an individual's perceptions of susceptibility, severity, benefits, and barriers. In the context of mental healthcare, if individuals perceive a high susceptibility to mental health issues and recognize severe consequences, they are more likely to take action, provided that the perceived benefits of treatment outweigh the barriers (e.g., cost, accessibility, and stigma). Both theories underscore the interplay between personal

beliefs and social influences in determining mental healthcare utilization, offering a basis for interventions aimed at improving attitudes toward treatment and reducing systemic obstacles.

## CONCEPTUAL FRAMEWORK

The conceptual framework of this study examines the relationship between academic stakeholders' demographic profiles and their perceived barriers to accessing mental healthcare, ultimately informing a tailored Mental Health Intervention Program. The independent variable encompasses demographic factors—such as sex, socioeconomic status, and academic role—which are hypothesized to influence the extent of perceived barriers. These barriers are categorized into three dimensions: instrumental (e.g., service cost, transportation, availability), attitudinal (e.g., self-reliance, beliefs about mental health), and stigma/discrimination (e.g., social rejection, negative stereotypes). The dependent variable is the perceived barriers to accessing mental healthcare, directly affecting stakeholders' ability to obtain the necessary support.

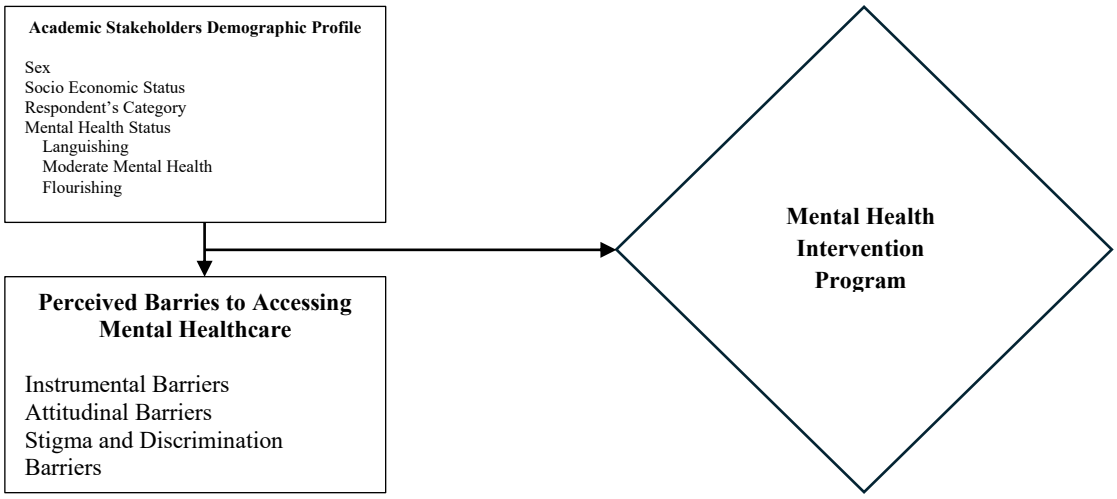


**Figure 1.** Conceptual Framework of the Study

The framework posits that understanding the interplay between demographic characteristics and perceived barriers can guide the design of effective interventions. The Mental Health Intervention Program is developed as an outcome variable to reduce these barriers by addressing systemic issues and individual attitudes. By leveraging insights from the Theory of Planned Behavior and the Health Belief Model, the program intends to enhance mental healthcare accessibility and promote a supportive environment for all academic stakeholders.

## 1. METHODOLOGY

This study employed a descriptive-comparative quantitative design to systematically examine the demographic profiles and perceived barriers to mental healthcare among academic stakeholders at a university in Davao City, Philippines, during the academic year 2024–2025. Stratified sampling was used to ensure that the sample accurately reflected the diversity of the population across various academic programs and institutional roles. Specifically, 350 students and 191 faculty and support service personnel were selected based on their respective proportions within the university. Data was collected through self-administered, standardized questionnaires, following a detailed briefing on the study's purpose and procedures. Institutional permissions

were secured from university authorities after obtaining ethical clearance, ensuring that all steps adhered to rigorous research protocols.

## INSTRUMENTATION

Two primary standardized instruments were utilized in this study to capture a comprehensive picture of mental health and the barriers to accessing mental healthcare. First, the Mental Health Continuum–Short Form (MHC-SF; Keyes, 2009) assessed respondents' overall mental well-being. This instrument comprises 14 items distributed across three dimensions: emotional, social, and psychological well-being. Participants responded using a 6-point Likert scale ranging from 0 (never) to 5 (every day), with the scores subsequently aggregated to classify individuals as languishing, moderate mental health, or flourishing. The MHC-SF has demonstrated robust internal consistency and satisfactory test-retest reliability across diverse populations, thereby ensuring its appropriateness for capturing subtle differences in mental health status among academic stakeholders.

| Criteria | Descriptive Rating | Interpretation |
|---|---|---|
| Minimum 1 EWB item and 6 of 11 PWB & SWB items | Never to once or Twice | Languishing (Low Mental Health) |
| Responses not fitting Languishing or Flourishing Profiles | About once a week to about 2 or 3 times a week | Moderate Mental Health |
| Minimum 1 EWB item and 6 of 11 PWB & SWB items | Almost everyday to Everyday | Flourishing (High Mental Health) |

Second, the Barriers to Access to Care Evaluation (BACE) Scale Version 3 (Clement et al., 2014) was employed to measure the extent and nature of obstacles encountered when seeking mental healthcare. This 30-item tool covers three domains: instrumental barriers (e.g., service cost, transportation issues, and scheduling conflicts), attitudinal barriers (e.g., self-reliance and skepticism about professional help), and stigma/discrimination-related barriers (e.g., fear of social judgment). Respondents rated each item on a scale from 0 (not at all) to 3 (a lot), with higher scores indicating more significant perceived barriers. The reliability and validity of the BACE have been well established in previous research, making it an ideal instrument for this study's objectives.

| Range Interval | Description | Interpretation |
|---|---|---|
| 0.00 – 0.79 | Very Low | Barriers are perceived as not evident |
| 0.80 – 1.59 | Low | Barriers are perceived as somewhat evident |
| 1.60 – 2.39 | High | Barriers are perceived as moderately evident |
| 2.40 – 3.00 | Very High | Barriers are perceived as highly evident |

## DATA ANALYSIS

After data collection, responses were carefully coded, anonymized, and entered into a secure database for analysis. Descriptive statistics were calculated to summarize the demographic characteristics, mental health status, and levels of perceived barriers among the respondents. The frequency distribution and means for each item on the MHC-SF and BACE were computed to provide an overall picture of the data. Inferential statistical techniques were employed to examine differences among various groups (e.g., by gender, academic role, and mental health status). One-way Analysis of Variance (ANOVA) was used to compare mean scores of perceived barriers across multiple demographic groups. At the same time, independent samples t-tests facilitated the comparison between the two groups where appropriate. Standard deviation was calculated for each measure to assess the variability and dispersion of responses. These statistical methods allowed the researchers to identify significant differences and trends, pinpointing specific areas where targeted interventions might be most effective. All analyses were conducted using standard statistical software, with significance levels at $p < .05$.

### ETHICAL CONSIDERATIONS

Ethical integrity was paramount throughout the research process. Prior to data collection, the study protocol was submitted for review and received approval from the University of the Immaculate Conception Review Ethics Committee (UIC-REC), ensuring that the research adhered to the highest ethical standards. Informed consent was obtained from all participants following a comprehensive briefing that explained the study's objectives, procedures, potential risks, and benefits. The consent form clearly stated that participation was voluntary and that participants could withdraw without repercussions. To safeguard privacy, all responses were anonymized and stored securely following the Data Privacy Act of 2012 (Republic Act 10173), with access restricted only to authorized personnel. Data were coded, and identifying information was removed before analysis to ensure confidentiality. Moreover, participants were provided contact information for support services should they experience any distress during or after the survey. These measures collectively ensured that the study met ethical research standards and respected all academic stakeholders' autonomy, dignity, and privacy.

## 2. RESULTS AND DISCUSSION

### DEMOGRAPHIC PROFILE

The sample consists predominantly of females (65.4%), while males constitute 34.6% of the respondents. In terms of roles within the academic institution, students represent the largest group (64.8%), followed by faculty members (21.1%) and support service personnel (14.1%). Socioeconomic status was diverse: the majority of respondents were classified as middle-income (30.2%), followed by those in the lower middle-income (28.3%) and low-income (25.6%) categories, with smaller percentages in the upper middle-income, high-income, and rich categories. These findings are consistent with the national income classifications reported by the Philippine Institute for Development Studies (2018) and establish a foundational context for examining how variations in socioeconomic background and role within the institution may affect access to and perceptions of mental health services.

### MENTAL HEALTH STATUS

Table 1.2 categorizes the respondents' mental health status into three groups: flourishing, moderate, and languishing. The data indicate that 41.3% of respondents are classified as flourishing, 53.1% as having moderate mental health, and 5.6% as languishing. A closer look at gender differences shows that more female respondents are flourishing than males. However, moderate mental health is the most common status among both groups. These results are in line with findings from the National Institute of Mental Health (2017) and the American Psychiatric Association (2021), which suggest that academic environments tend to be associated

with moderate levels of mental health challenges due to stressors such as academic pressure and financial burdens. The high prevalence of moderate mental health, particularly among students, underscores the ongoing impact of academic and socioeconomic stressors on overall well-being (Guan et al., 2022).

**Table 1.2** Mental Health Status

| **Levels** | **Frequency** | **Percentage** |
|---|---|---|
| Flourishing | 223 | 41.3 |
| Moderate | 287 | 53.1 |
| Languishing | 30 | 5.6 |
| **Total** | **540** | **100.00** |

**LEVEL OF PERCEIVED BARRIERS TO ACCESSING MENTAL HEALTHCARE**

Table 2 details the perceived barriers to accessing mental healthcare, providing a comprehensive breakdown across three domains: instrumental, attitudinal, and stigma/discrimination. Overall, respondents reported a low level of barriers with a mean score of 0.96 (SD = 0.48), suggesting that while obstacles exist, they are generally not perceived as insurmountable. Within the instrumental domain, which covers practical challenges such as uncertainty about where to seek care and transportation issues, the overall mean score was 0.84 (SD = 0.49). Notably, the item assessing the financial cost of care yielded a higher mean of 1.50 (SD = 1.01), indicating that affordability remains a more significant concern relative to other instrumental factors. In the attitudinal domain, respondents demonstrated a mean score of 1.11 (SD = 0.53). Here, the desire to solve problems independently emerged as the most pronounced barrier (mean = 1.71, SD = 1.02), reflecting a tendency among many to rely on self-management rather than seeking professional assistance—a finding that echoes the observations of Andrade et al. (2015).

Meanwhile, the overall mean of stigma and discrimination was 0.92 (SD = 0.56). Despite the relatively low average, specific concerns related to family judgment (mean = 1.62, SD = 1.10) indicate that social perceptions and fear of adverse reactions are noteworthy in deterring help-seeking behavior. These detailed results prove that practical and psychosocial factors influence academic stakeholders' ease of access to mental healthcare (Clement et al., 2014).

**Table 2** Level of Perceived Barriers to Accessing Mental Healthcare

| **Instrumental Barriers** | **Mean** | **SD** | **Description** |
|---|---|---|---|
| Being unsure where to go to get professional care | 1.04 | 0.84 | Low |
| Having problems with transport or traveling to appointments | 0.86 | 0.90 | Low |
| Not being able to afford the financial costs involved | 1.50 | 1.01 | Low |
| Professionals from my own ethnic or cultural group not being available | 0.58 | 0.77 | Very Low |
| Being too unwell to ask for help | 1.02 | 0.92 | Low |
| Difficulty taking time to work | 0.47 | 0.83 | Very Low |
| Having problems with childcare while I receive professional care | 0.22 | 0.57 | Very Low |
| Having no one who could help me get professional care | 1.00 | 0.96 | Low |
| **Category Mean** | 0.84 | 0.49 | Low |
| **Attitudinal Barriers** | **Mean** | **SD** | **Description** |
| Wanting to solve the problem on my own | 1.71 | 1.02 | High |

| | | | |
|---|---|---|---|
| Fear of being put in hospital against my will | 1.07 | 1.07 | Low |
| Thinking the problem would get better by itself | 1.37 | 0.97 | Low |
| Preferring to get alternative forms of care (e.g. traditional/ religious healing or alternative / complementary therapies) | 0.95 | 0.93 | Low |
| Thinking that professional care probably would not help | 0.70 | 0.87 | Very Low |
| Dislike of talking about my feelings, emotions or thoughts | 1.49 | 1.08 | Low |
| Concerns about the effects of the treatments available | 1.07 | 0.96 | Low |
| Having had previous bad experiences with professional care for mental health | 0.46 | 0.77 | Very Low |
| Preferring to get help from family or friends | 1.14 | 0.98 | Low |
| Thinking I did not have a problem | 1.14 | 0.94 | Low |
| **Category Mean** | **1.11** | **0.53** | **Low** |
| **Stigma and Discrimination Barriers** | **Mean** | **SD** | **Description** |
| Concern that I might be seen as weak for having a mental health problem | 1.22 | 1.04 | Low |
| Concern that it might harm my chances when applying for jobs | 0.68 | 0.89 | Very Low |
| Concern about what my family might think, say, do, or feel | 1.62 | 1.10 | High |
| Feeling embarrassed or ashamed | 1.35 | 1.02 | Low |
| Concern that I might be seen as 'crazy' | 0.94 | 1.05 | Low |
| Concern that I might be seen as a bad parent | 0.29 | 0.67 | Very Low |
| Concern that people I know might find out | 1.09 | 1.00 | Low |
| Concern that people might not take me seriously if they found out I was having professional care | 0.98 | 1.00 | Low |
| Not wanting a mental health problem to be on my medical records | 1.00 | 1.03 | Low |
| Concern that my children may be taken into care or that I may lose access or custody without my agreement | 0.23 | 0.62 | Very Low |
| Concern about what my friends might think, say or do | 1.10 | 1.00 | Low |
| Concern about what people at work might think, say or do | 0.48 | 0.77 | Very Low |
| **Category Mean** | **0.92** | **0.56** | **Low** |
| **Overall Mean** | **0.96** | **0.48** | **Low** |

## SIGNIFICANT DIFFERENCES BETWEEN PERCEIVED BARRIERS AND DEMOGRAPHIC/MENTAL HEALTH STATUS

Table 3 presents the inferential statistical analyses that explore the relationship between demographic factors, mental health status, and the perceived barriers to accessing mental healthcare. The analysis reveals that neither sex nor socioeconomic status significantly influences perceived barriers. However, when comparing respondent categories, significant differences emerge in the attitudinal ($F = 8.54$, $p < .001$) and stigma/discrimination domains ($F = 9.13$, $p < .001$). Specifically, faculty and support service personnel report significantly higher levels of these barriers compared to students, suggesting that professional responsibilities and concerns regarding reputation and career progression may amplify these perceptions (Jayman et al., 2022; Wray & Kinman, 2021). Moreover, mental health status plays a crucial role; individuals classified as languishing report significantly higher barriers across all domains ($p < .001$) compared to those with moderate or flourishing mental health. This indicates that poorer mental health status is closely associated with an increased perception of obstacles to care, highlighting the need for interventions that address both individual mental health challenges and systemic barriers. These findings suggest that targeted, multifaceted

interventions are essential to reduce these obstacles and improve access to mental healthcare among diverse groups within academic settings.

**Table 3** Significant Differences between Level of Perceived Barriers to Accessing Mental Healthcare and Demographic Profile and Mental Health Status

| | F | df1 | df2 | P | Remark |
|---|---|---|---|---|---|
| Sex | | | | | |
| Instrumental Barriers Average | 0.92 | 1 | 368 | 0.33 | Not Significant |
| Attitudinal Barriers Average | 0.04 | 1 | 375 | 0.82 | Not Significant |
| Stigma and Discrimination Average | 0.31 | 1 | 364 | 0.57 | Not Significant |
| Barrier to Access to Care Evaluation Average | 0.00 | 1 | 358 | 0.92 | Not Significant |
| Socioeconomic Status | | | | | |
| Instrumental Barriers Average | 1.53 | 6 | 46.8 | 0.17 | Not Significant |
| Attitudinal Barriers Average | 0.58 | 6 | 47.5 | 0.74 | Not Significant |
| Stigma and Discrimination Average | 0.35 | 6 | 47.6 | 0.90 | Not Significant |
| Barriers to Access to Care Evaluation Average | 0.32 | 6 | 47.2 | 0.91 | Not Significant |
| Respondent's Category | | | | | |
| Instrumental Barriers Average | 1.77 | 5 | 159 | 0.12 | Not Significant |
| Attitudinal Barriers Average | 8.54 | 5 | 157 | <.001 | Significant |
| Stigma and Discrimination Average | 9.13 | 5 | 159 | <.001 | Significant |
| Barriers to Access to Care Evaluation Average | 7.39 | 5 | 158 | <.001 | Significant |
| Mental Health Status | | | | | |
| Instrumental Barriers Average | 22.8 | 2 | 78.8 | <.001 | Significant |
| Attitudinal Barriers Average | 17.5 | 2 | 82.6 | <.001 | Significant |
| Stigma and Discrimination Average | 25.7 | 2 | 82.0 | <.001 | Significant |
| Barriers to Access to Care Evaluation Average | 28.1 | 2 | 82.0 | <.001 | Significant |

**MIND MATTERS: A HOLISTIC MENTAL HEALTH AND WELLNESS PROGRAM**

This intervention program addresses academic stakeholders' multifaceted mental health challenges by fostering a proactive, integrative, and sustainable approach to wellness. Recognizing that mental health is a critical component of overall well-being—particularly in academic settings where students, faculty, and support personnel routinely experience high levels of stress from academic and professional responsibilities—the program advocates for a Monthly Mental Health Day. This recurring initiative is intended to provide regular opportunities for stress reduction, prevention of burnout, and normalization of mental health care, thereby reducing the stigma associated with seeking help (Andrade et al., 2015).

The program is grounded in the Biopsychosocial Model (Engel, 1997) and addresses mental well-being through interconnected biological, psychological, and social dimensions. Biologically, activities such as yoga, guided meditation, and relaxation exercises are incorporated to alleviate physical stress and promote physiological recovery. Psychologically, interactive workshops focus on stress management, emotional intelligence, and self-compassion, equipping participants with practical tools to build resilience and effectively manage personal and professional challenges. Socially structured peer support sessions and group discussions are integral, as they foster a sense of community and mutual support within the academic environment.

Although the intervention primarily targets faculty—who, as noted by Blakeley (2024) and O'Farrell et al. (2022), face unique stressors and higher risks of burnout—the program is also tailored to include students and support service personnel during designated sessions, ensuring a comprehensive approach to mental health across the institution.

Implementation of the program is organized around monthly themes catering to each stakeholder group's distinct needs. For instance, in July, the theme "Building Resilience and Managing Work Stress" is directed at faculty and support staff through mindfulness meditation, resilience-building workshops, and peer support circles. In August, the focus shifts to students with the theme "Mindfulness and Stress Management for Academic Success," where similar activities are adapted to address academic pressures. Other months feature themes such as "Preventing Burnout and Fostering Mental Wellness" for faculty and "Embracing Self-Compassion and Healthy Academic Habits" for students, ensuring that both groups receive targeted support throughout the academic year. Each session follows a structured schedule—from guided meditation to interactive workshops, creative breaks, and movement-based relaxation—culminating in group reflection sessions that consolidate learning and foster collective well-being. This flexible, evidence-based program design is intended to evolve in response to participant feedback and emerging needs, ensuring its continued relevance and impact in promoting a healthier, more supportive academic community (Engel, 1997).

## 3. CONCLUSION

**Findings** Based on the results, the summary of the findings was the following:
The demographic profile of the respondents reveals that out of 540 participants, 353 were female, and 187 were male. Regarding socioeconomic status, the majority belonged to the middle-income class, with 163 respondents, followed by the lower middle-income class, with 153 respondents, and the low-income class, with 138 respondents. Smaller groups included 35 respondents each from the upper middle-income class and the poor category and 16 respondents each from the high-income class and the rich category. Concerning the respondents' category, students formed the largest group with 350 individuals, followed by 114 faculty members and 76 support service personnel.

Most respondents were classified as having moderate mental health, followed by those who were flourishing, with a smaller group identified as languishing. Among females, 148 were flourishing, 184 were moderate, and 21 were languishing; among males, 75 were flourishing, 103 were moderate, and nine were languishing. Regarding socioeconomic status, there were no languishing cases in the wealthy and high-income groups, while the upper-middle-income group had two languishing respondents. The middle-income class had five flourishings, 101 moderate, and nine languishings, and the lower middle-income group had 68 flourishings, 79 moderate, and six languishings. The low-income class had 65 flourishings, 63 moderate, and 10 languishings, and the poor group had 16 flourishings, 16 moderate, and six languishings.

Respondents' perceived barriers to accessing mental healthcare had an overall mean of 0.96 with a standard deviation of 0.48. The overall mean for instrumental barriers was 0.84 with a standard deviation of 0.49, with the most significant barrier being not being able to afford the financial costs involved, which had a mean of 1.50 with a standard deviation of 1.01. The overall mean for attitudinal barriers was 1.11 with a standard deviation of 0.53, with the most prominent barrier, wanting to solve the problem on my own, with a mean of 1.71 with a standard deviation of 1.02. The overall mean for stigma and discrimination barriers was 0.92 with a standard deviation of 0.56, with the most significant barrier being concern about what my family thinks, says, or feels, with a mean of 1.62 with a standard deviation of 1.10.

There were no significant differences in perceived barriers to accessing mental healthcare among academic stakeholders based on sex or socioeconomic status. Significant differences were found for specific categories. Instrumental barriers showed no significant differences between respondents' categories. However, attitudinal barriers were higher among faculty compared to students. Stigma and discrimination barriers were also perceived as more significant among faculty than students. Additionally, significant differences were found across mental health status groups for all categories of barriers. Respondents from languishing had significantly higher barriers in terms of instrumental, attitudinal, and stigma and discrimination.

## CONCLUSION

Based on the findings of this study, several conclusions were drawn:
The survey sample of 540 respondents revealed that moderate mental health was the most common status across genders, socioeconomic groups, and academic categories, with 287 respondents reporting moderate mental health. Middle and lower-middle-income groups showed similar results, with moderate mental health being most prevalent. However, a slightly higher percentage of flourishing individuals was observed in the lower-middle-income group. Among respondent categories, students in health-related programs predominantly reported moderate mental health, while faculty members were more likely to experience flourishing mental health. Overall, most respondents experienced moderate to flourishing mental health, with languishing being the least common. The results imply a need for focused mental health support, particularly for those with moderate mental health status, to prevent further decline into more severe conditions.

The findings suggest that most respondents, regardless of gender or socioeconomic status, experience moderate mental health, with a smaller proportion of individuals in the flourishing or languishing categories. Females reported higher levels of flourishing mental health compared to males, while both genders had a significant proportion in the moderate category. Socioeconomic status appears to influence mental health outcomes, with individuals in higher-income groups having fewer languishing cases and those in middle and lower-income groups experiencing a more noticeable presence of moderate and languishing mental health. Interestingly, the lower-income and poor groups still reported a considerable number of flourishing individuals, highlighting that while financial challenges can contribute to mental health struggles, a portion of people in these groups still maintain good mental health. Findings imply that moderate mental health is the most common experience across demographics, and socioeconomic factors may influence shaping mental health outcomes.

Findings indicate that the respondents face various barriers to accessing mental healthcare, with preferred self-reliance being the most significant challenge. The high mean for instrumental barriers and, particularly, for the financial cost of mental healthcare indicates that affordability is a major barrier for many respondents. Additionally, attitudinal barriers, such as the tendency to handle issues independently, reveal that personal beliefs and self-reliance contribute to hesitance in seeking professional help. Stigma and discrimination also contribute, with concerns about family judgment being the most significant barrier in this category. Overall, it shows that just as practical issues like self-reliance and fear of judgment can interfere with access to mental health services, so can psychological factors. This hints that what is required is the need for structural as well as cultural changes in how mental health care is perceived and provided. These imply improving access to mental healthcare, which means that not only external barriers, such as financial costs but also internal barriers, such as self-reliance and fear of stigma, need to be addressed. This may include the reduction of the financial burden of mental healthcare, promoting mental health awareness, and creating supportive environments where individuals feel comfortable seeking help without fear of judgment.

Results show that the perceived barriers to accessing mental health care from the respondents varied significantly based on the category and mental health state of the respondents, but sex and socioeconomic status had no significant impact on respondents' perceptions of these barriers. Compared with students, faculty reported higher levels of stigma-related and attitudinal barriers, indicating that faculty members may face more barriers in their personal and professional lives when seeking assistance. In addition, those with deteriorating mental health reported the highest level of all barriers-instrumental, attitudinal, and stigma and discrimination. This indicates that those with poorer mental health conditions might be challenged more by internal and external barriers to care. While there certainly exist some differences between groups, the findings imply that one's respondent category and current or observed mental health status have more of an impact on perceived barriers to mental healthcare than sex or socioeconomic status. Overall, the findings highlight the importance of eliminating the stigma around mental health and treating those who are struggling, especially among faculty members, regarding more serious mental health concerns.

**RECOMMENDATIONS**

The need for mental health will be addressed by recommending one program called "Mind Matters: A Holistic Mental Health and Wellness Program," an intervention program. This program is available to faculty, students, and all campus personnel supporting those services. Monthly Mental Health Day covers stress, burnout, and categories of mental health issues through mindfulness exercises, workshops, peer support, and artistic activities directed toward targeted groups. Because faculty are the targeted group, it helps create interventions for their problems (e.g., work-related stress and burnout prevention). During certain months, the program also invites students and staff to participate, as it strives to equip individuals with the skills to bolster resilience and overcome adversity. This program is founded on the Biopsychosocial Model, which provides a 360-degree perspective, correlating biology and psychology relevant to the clients and social determinants of mental health. It raises awareness, diminishes stigma, and strives for better mental well-being in a healthier academic environment. The events vary each month to leave room for flexibility and adaptability in response to each participant's changing needs. The program values mental health in the university community because it recognizes how performance can be affected by stress and mental health issues. It promotes a culture where the faculty, students, and staff can discuss wellness, making resilience thrive, shrinking stigma, and balancing work and life endeavors. Equipping our participants with the skills they learn through this program to manage stress and nurture their well-being will ensure a more inclusive and productive academic environment for all institution members.

Through the qualitative research design, the perceived barriers to accessing mental healthcare among the respondents would allow future researchers to explore tangible barriers to accessing mental healthcare that the respondents identified. Qualitative interviews or focus group discussions will be conducted among the academic stakeholders to gain an in-depth understanding of their narratives of specific barriers that may provide rich insights into the possible reasons behind such quantitative findings.

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