CHAPTER TWENTY FIVE

What Are We Waiting for? Addressing Wait Times in Post-secondary Student Mental Health Care

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ABSTRACT

Wait times to access publicly funded mental health care continue to grow in many countries. Despite the realities of service limitations in health care systems, we are seeing escalating demand from multiple sources for immediate access to mental health care for students on our Canadian post-secondary campuses—along with growing discontent when institutions fall short of expectations. This poses considerable challenges for post-secondary service providers and administrators, who must determine how to respond to several complex and vexing questions. In this chapter, we provide context for the evolution of the wait time problem, identify factors contributing to its maintenance, and offer perspectives on how to understand and respond to wait times differently. The chapter includes a call to re-think our methods of post-secondary mental health service delivery to bring them in line with contemporary best practices in stepped care, along with advice on how to more effectively address common concerns related to the accessibility of mental health care for post-secondary students, including managing expectations, communicating effectively, and demonstrating accountability in service delivery.

Keywords*:* Counselling University Students, Student Mental Health, University Counselling Centres, Wait Times

INTRODUCTION

What are We Waiting for? Addressing Wait Times in Post-secondary Student Mental Health Care

Post-secondary institutions have been facing the difficult challenge of identifying how they can better meet students' growing and evolving mental health needs. Over the last few decades, the number of students accessing mental health services in North America has dramatically increased (Horwitz et al, 2020; Keyes et al., 2012) and service providers have been unable to meet this surge in demand. Since 1988, the number of post-secondary students reporting high levels of distress has been increasing exponentially year after year, with increasingly complex and severe presentations (Xiao et al., 2017; Marano, 2004). These factors have resulted in a range of challenges for post-secondary service providers and administrators, including how best to address the increasingly long wait times for mental health services at many institutions.

In the sections that follow we will provide additional context for the evolution of the wait time problem, identify factors contributing to its persistence, and offer perspectives on how to understand and respond to wait times differently. We will also issue a call to re-think our methods of post-secondary mental health service delivery to bring them in line with contemporary best practices in stepped care, and provide advice on how to more effectively address common concerns related to the question of access to mental health care for post-secondary students, including managing expectations, communicating effectively, and demonstrating accountability in service delivery.

Mental Illness is Stable—So Why is Demand Surging?

Today, 80% of post-secondary students report feeling exhausted and overwhelmed, with a concerning number having contemplated suicide (Horwitz et al., 2020). According to the Canadian Mental Health Association (2021), 10 to 20% of youth are impacted by a diagnosable mental health condition, and of those, only one in five receive appropriate care. Furthermore, mental health conditions account for the leading cause of disability worldwide (Canadian Mental Health Association [CMHA], 2021). Alarmingly, half of post-secondary students will engage in regular binge drinking or become depressed to the point of being unable to function, and one in ten will seriously contemplate ending their lives (Sussman & Arnett, 2014). Given that the epidemiology of mental illness has remained stable for the past 50 years (Baxter et al., 2014; McMartin et al., 2014), several explanations have been offered to account for the increased acuity of presentations, including expanded accessibility to post-secondary education as a result of legislative changes supporting mental health accommodations, the production and distribution of modern psychopharmaceuticals, and decreasing stigma associated with mental distress. As a result of these factors, there are simply more students with mental illness attending university (Michalski et al., 2017), and they are more likely to seek support.

Stress Pathologized

Reports on increasing student distress have often been misunderstood; the conflation of distress and mental illness is ubiquitous. For example, in his role as DSM-IV Task Force Chair, Allen Frances argued strenuously, albeit unsuccessfully, to mitigate the “medicalization” of everyday life by restricting the expansion of diagnostic categories (Frances, 2013). Frances feared

that increasing medicalization, spurred in part by the pharmacological industry, could lead to the overuse of medication to alleviate distress that is considered normal and natural (Rubin, 2018).

To avoid unnecessary medicalization of everyday life, it is important to recognize that measures of student distress may not be reliable indicators of acuity or mental illness. Instead, greater reporting of stress and distress could in some cases be attributed to increasing self-awareness and interest in or comfort with improving well-being (e.g., Wiens et al., 2020). In cases of relatively high functioning and motivated students, population level supports such as self-guided tools are warranted. Not all of the nearly 60% of students who report "overwhelming anxiety" (National College Health Association [NCHA], 2018) have a mental illness. What types of supports are needed for those who want help but are not mentally ill? It is neither feasible nor reasonable to treat 60% of the student population through traditional one-to-one counselling services. However, with decreasing stigma and greater encouragement in the kindergarten-to-grade 12 system for reporting and addressing mental health needs (Greenberg et al., 2017), students arriving on campuses are primed to expect ample supports, thereby increasing demand for mental health services.

Wait times on post-secondary campuses are therefore impacted by an intersection in demand both from students seeking support for normative stress and from those with diagnosable mental illnesses, making it difficult to determine and meet appropriate levels of care for the student population (Bridgemohan et al., 2018; Xiao et al., 2017). Students experiencing distress, whether due to mental illness or not, are typically directed to seek one-to-one counselling or psychiatric care, and this is neither appropriate nor sustainable. Increased student distress related to academics is an important driver of long wait times for one-to-one mental health services in post-secondary

institutions. Is this normal academics-related distress best dealt with through counselling or would efforts to adjust academic policies and learning objectives be more appropriate? Programs designed to increase population-level health promotion and prevention, including wellness-related policy reforms, are upstream measures that could reduce wait times downstream for those presenting with acute and complex needs.

Wait Times Depend on What is Counted

Wait times have dominated the political discourse on publicly funded healthcare for decades. More recently, this discourse has focused on the challenges of accessing mental health services, especially for youth attending post-secondary institutions (McGorry & Mei, 2018). Mental health is especially critical for postsecondary students, as they are experiencing a phase of developmental transition with multiple associated stressors (Conley et al., 2018). Within this context, where stress and distress are normal, the problem is not so much a question of wait time for mental health services, but what the help-seekers are waiting *for*. All too often, help-seekers wait for a very narrow range of options that are ill-suited to their needs. Currently, people interested in learning ways to better cope with stress must line up alongside those with mental illness to receive one-to-one care from highly paid specialists. Mental health care programs in general, including those offered by post-secondary institutions, have been restricted to mainly Eurocentric medical approaches and psychotherapy-based care (Joseph, 2015; Mills, 2014)—but most people looking for support do not need sophisticated psychological or psychiatric care (Mental Health Research Canada, 2020). Instead, many help-seekers want information on ways that they can improve their mental fitness on their own (Mental Health Research Canada, 2020). Given that most mental health issues are not disease-based, it is unfortunate that care has been limited to scarce,

expensive, biomedical, or deficit-oriented treatment modalities (Syme & Hagen, 2019). If we build a more broad-based continuum of care options, there will be something for everyone, and long wait times could become a thing of the past.

Wait Times Aren't Created Equal

Access and wait times for one-to-one counselling or psychiatric care remain problematic throughout North America (Malla et al., 2019). As reported by Barua and Moir (2020), the issue of wait times for one-to-one services (not specific to students) is widespread across the Canadian health care system; wait times between referral from a general practitioner and delivery of medically necessary elective treatment by a specialist in 2020 were at their highest ever recorded, having increased by 143% since 1993. Wait times to access publicly funded mental health care (i.e., psychiatry) continue to grow across Canada, ranging from 14.4 to 43.2 weeks across provinces, with an average wait of more than 22 weeks (Barua & Moir, 2020). While wait times are typically shorter than this for mental health care on post-secondary campuses (Association of University and College Counseling Center Directors [AUCCCD], 2020), research has shown that longer wait times for one-to-one mental health appointments may contribute to cancellations or no-shows; a delay of more than two weeks between an initial contact and a scheduled one-to-one appointment has been shown to contribute to a significant risk of an individual not following through with obtaining support for their mental health needs (Gallucci, 2005). Given that lengthy waits are often perceived as a barrier and are associated with poor outcomes and lower levels of treatment engagement, long wait times represent a serious public health concern (Westin et al., 2014).

Wait times to access one-to-one counselling services at post-secondary campuses continue to grow as well, despite various efforts to improve access (Brown, 2020). There are several challenges that can impact wait times for one-to-one mental health supports on campus, including variability of resources for supporting on-campus student mental health needs, counsellor-to-student population ratios, size of student service budgets, and limited resources in the surrounding community (Children's Mental Health Ontario, 2020; Xiao, et. al., 2017).

Campus models of care provision vary from traditional treatment models (assess to appropriate treatment with an available clinician) to models of absorption (assess and fit into caseload; Center for Collegiate Mental Health [CCMH], 2019), each of which entails a different wait time. In the context of the traditional model, the wait is for a course of one-to-one counselling, and it could be several weeks or even months before treatment begins (AUCCCD, 2020). In the context of an absorption model, the wait times might be shorter, but the clinical contact is often restricted to triage, case management, referral, or in some cases, a single session of individual counselling. Wait times are also impacted by the ebb and flow of university life with notable increases of counselling needed through peak times such as exam periods (Headspace National Youth Mental Health Foundation, 2019).

Wait times for service in the post-secondary sector are generally defined as the time a student waits to be first seen by a clinician, often for triage or assessment. However, due to the current mental health capacity challenges on campuses, there can then be a second wait between the first visit and the time at which appropriate treatment begins (e.g., AUCCCD, 2020). Wait lists are created to manage the queue of students waiting for either first contact or entry to treatment and act as a clinical management tool when providers' schedules are fully booked. Once

appointments become available, they are usually filled with those who are on the wait list on a first-come-first-serve basis, though prioritization is typically provided to students with higher acuity, severity, and/or complexity (Brown, 2020). In the current traditional model of care provision, this approach has been seen as the fairest way to manage increased demand with limited resources. Unfortunately, however, it can mean that students who are among the most motivated to make improvements to their well-being, but do not have high acuity, are left waiting for longer than necessary. In the context of the semester-based system of post-secondary institutions, access to mental health supports can have serious consequences for students' academic functioning and their ability to progress academically if care is not available in a timely manner.

While 45.7% of North American post-secondary counselling centres reported using a version of stepped care (AUCCCD, 2020) with a broader continuum of service options in 2020, little or no attention has been given to wait times for alternatives such as access to mental health literacy tools, peer support, guided self-help, educational workshops, or group counselling. In contrast to one-to-one care, these alternative programs are sometimes referred to as one-to-many, insofar as one service provider or one program can serve many people at once (Nundy et al, 2020; Wilbourne et al.,2018). For example, programs such as Foundry BC (www.foundrybc.ca) offer a range of options along a stepped care continuum (Mathias et al., 2021), while others such as "Doorways" in Newfoundland and Labrador support a walk-in rapid access model to the entire population (Cornish et al., 2020a). While rapid access to single session or one-at-a-time counselling is possible, it is unclear to what extent this will meet post-secondary student expectations, although it stands to reason that they would be less costly and help to shorten wait times if made widely available.

What Are Students Waiting For and is That What They Really Need?

With few exceptions, most contemporary North American post-secondary students have developed their values and expectations within a sociocultural context shaped by, among other things, consumerism, economic globalization, and rapid advances in technology including the ascendance of social media platforms (cf. Birnie, 2015). These contextual factors have influenced many aspects of student behaviour, including whether, when, and how they approach mental health help-seeking (Stewart et al., 2014), as well as their reactions when they encounter a wait list for service. It is therefore important for post-secondary student service providers to ensure they are presenting information about wait times and service accessibility in a manner that resonates productively with their clientele. By communicating proactively and positively, service providers will be able to manage student expectations about service accessibility more effectively, which will enhance service utilization and mitigate the potential negative outcomes associated with lengthy wait times.

In the absence of viable low-intensity mental health supports, students understandably expect to receive the only type of service that they know exists—one-to-one professional counselling and/or psychiatric care. Unfortunately, such specialized care will always be a scarce commodity. The World Health Organization's Mental Health Action plan clearly delineates that mental health services for youth should be focused on prevention and early intervention through evidence-based, non-pharmacological, psychosocial approaches that avoid medicalization (World Health Organization [WHO], 2013). Furthermore, the WHO has emphasized the need for self-management and skills development to increase resilience (WHO, 2017). However, mental health services for youth across post-secondary institutions and throughout health care systems have

traditionally been grounded within a medical model, with an over-reliance on one-to-one psychotherapeutic and psychopharmacological treatments and to a lesser extent on prevention, outreach, early intervention, or community-based approaches.

Today, best practice guidelines identify the client as the expert of their daily functioning and the clinician as a supporting guide or consultant (WHO, 2021). The 50-minute weekly session is based on a historical Eurocentric norm that until recently had not been challenged. Other healing modalities should be explored because approaching mental health from a broader cultural worldview is imperative to supporting student mental health. As described by Norcross and Wampold (2011), successful interventions are ones that are tailored to the individual. Although innovations have been reported in mental health literature, mental health systems' methods for delivering care have remained largely unchanged for a long time. Within the context of a quickly evolving technological landscape, we hypothesize that the ways in which service offerings are communicated to students play an important role in the wait time conundrum. Building a system requires some rethinking on what constitutes care; care must be marketed as holistic and extend along a continuum from low intensity supports aimed at the whole population to specialized clinical interventions. More resources are needed for supporting successful evidence-based implementation processes, including community co-design, a comprehensive communications strategy, and continuous quality assurance.

Managing Student Expectations

Most students do not seek out professional mental health services lightly (Stewart & Beatie, 2016; Stewart & Ritchot, 2010). Evidence suggests that students are most likely to reach out after exhausting their personal support networks (Stewart et al., 2014) and, beyond that, only when their

acute distress overcomes their self-stigma regarding help-seeking (Beatie et al., 2016). Research also shows that these individual factors are present even among students with positive attitudes toward mental health help-seeking (Stewart & Beatie, 2016), suggesting that students who hold negative attitudes toward mental health services may experience even more substantial hesitancy when contemplating care-seeking.

What does this mean for post-secondary mental health service providers? One key takeaway is that each student who seeks service has likely reached a point where they are feeling overwhelmed, exhausted, and out of options. They are also likely experiencing a high degree of acute distress and some degree of dysregulation. However, given that much of their experience is typical, institutions need to balance their responses to ensure that they are neither pathologizing student development issues nor failing to identify students who may be at risk of or presenting with mental illness.

Within this context, it is understandable that some students may have also developed very specific and narrow expectations about what form mental health services may take—perhaps as a way of reassuring themselves about their search, convincing themselves of its value, or simply due to a lack of awareness about the range of available services (cf. Stewart et al., 2014). While these expectations may have been instrumental in motivating help-seeking, they could become problematic in cases where they are associated with an idealized or fixed notion of what institutional mental health services involve, or when there is a perceived delay in accessing those services.

While most would agree that it is unreasonable to expect our post-secondary institutions to make up for a lack of mental health resources in the community at large, to offer unlimited services,

or to take on cases that go beyond the scope and competencies of what the service providers are able to ethically offer, we are seeing escalating demand from students for immediate access to mental health care on our post-secondary campuses—along with a growing willingness to turn to the media when institutions fall short of these expectations (e.g., Roumeliotis, 2019). Moreover, by persisting with traditional approaches to service delivery that are heavily weighted in favour of individual counselling sessions, institutions are likely to exacerbate problems related to wait times, service delivery, and public relations.

Given this state of affairs, there is nothing surprising about the reactions of students who express disappointment, frustration, or even anger when they are not able to immediately access the services they are seeking. In fact, it is undesirable from many perspectives to see students wait unnecessarily to access mental health services, which has prompted providers and institutions to ensure they have identified and addressed as many barriers to service as possible, including financial (e.g., Nunes et al., 2014), systemic (Woodgate et al., 2020), and individual factors (Beatie et al., 2016). Despite these efforts, however, there continues to be mismatches between student expectations and the perception of services offered by institutions.

So what should students reasonably expect when they seek help from their institution's counselling centre or mental health service, and how might such a system be organized? Given the fiscal realities of most institutions, it is not possible to simply add more counsellors as a sustainable response to ever-increasing student demands for service (Brown, 2020). Beyond this, such an approach anchors mental health services to a traditional one-to-one counselling model that may not truly reflect student needs or preferences, but merely what they expect based on stereotyped or naïve notions of counselling. Illustrating this point, a recent survey of clients accessing a mental

health service portal showed that over half the users chose self-guided tools, compared to less than one-third who chose to pursue counselling (Cornish et al., 2021). What this suggests, among other things, is that when fully informed and given a choice of service alternatives, students may demonstrate a much greater degree of flexibility than what many service providers imagine. It is therefore incumbent upon institutions to make efforts to ensure that student flexibility is matched by the service offerings available. In so doing, it is possible to simultaneously inform and respond to students' expectations for mental health services on campus.

With respect to how this may look in practice, based on a contemporary stepped care approach to mental health service delivery (Cornish et al., 2021), students should expect to encounter a system that is able to provide rapid accessibility to services and a diverse range of options to support them. It should also incorporate a flexible service-matching process that balances students' preferences with best-fit options based on availability and students' level of motivation for change. Service options would include a range of techniques, including self-guided tools, workshops, guided self-help, groups, and individual counselling, offered virtually and/or in-person, according to a best-fit assessment. The system should also provide information on how to access supports and resources in the event of a crisis or symptom escalation, and clearly describe its operations in advance to prevent misunderstandings when students present for service.

While it may sometimes seem like students are at odds with their institutions, this is not generally the case. Most of the time, students, post-secondary service providers, and senior administrators share the same overarching goal of promoting student health and well-being. For example, students continue to lobby provincial governments, senior administrators, and other stakeholders for increased mental health funding (e.g., Ontario Undergraduate Student Alliance,

2020), as do most student counselling centres and mental health services through their annual budget requests. While their methods and means may diverge at times, there is much to be gained by working in partnership with student unions and faculty associations, along with other stakeholders such as alumni and prospective donors, in efforts to secure resources—particularly when the resources are intended to directly address perennial issues with wait times and their attendant difficulties.

Facilitating a Paradigm Shift

Calls for bold action in transforming mental health care are emerging along with increased mass media attention on the toll that stress and mental illness exact on the population (Alegria et al, 2021; Cornish, 2020; Insel, forthcoming 2022; Vigo et al., 2019; WHO, 2021). Applications of implementation science and behavioural economics has been recommended to support innovation (Beidas et al., 2021). Such strategies are being applied in Canada to facilitate continuous improvement of the Wellness Together Canada mental health and addictions portal (Cornish et al., 2020b), wherein client-facing measurement-based care is in the hands of the user, with attention to continuous monitoring of symptoms, recovery, and functioning. Wait times for access to the 24/7 services available through the portal range from seconds for mental health literacy and self-guided tools to several minutes for peer support and single session professional counselling.

Applying More Meaningful Metrics

Little has been written on a common nomenclature or set of wait time metrics for post-secondary counselling centres, despite recommendations to do so (Centre for Innovation in Campus Mental Health (CICMH), 2015). The Association for University and College Counseling

Center Directors (AUCCCD) reports wait times for counselling services as the average and median wait in business days from (1) request for services to first appointment and from (2) triage to first appointment by school size (Gorman et al., 2020). In past reports, minimum and maximum wait times, as well as the minimum, maximum, and average number of students on a wait list have also been reported (LeViness et al., 2018; LeViness et al., 2019). While school size may allow for relative comparisons of wait times across campus counselling centres, conclusions are limited because different campuses have different clinician to student enrollment and student usage ratios, as well, reports appear to be limited to time waiting for the first appointment and for individual counselling services (e.g., Gorman et al., 2020).

The use of the Clinical Load Index (CLI), recently reported by the Center for Collegiate Mental Health (CCMH) and adopted by AUCCCD, may represent a promising practice for mental health centres to consider when reporting wait times (CCMH, 2021a). The CLI represents a "clients per standardized clinician" or "standardized caseload" (per year) metric used to report on student mental health and clinic outcomes (CCMH, 2021b). According to CCMH (2021a), centres with very low CLI scores operate more traditional models, including weekly one-to-one counselling visits with few limitations, while those with very high CLI scores provide predominantly crisis and referral services with minimal ongoing care. Centres with CLI scores in the middle range balance supply and demand with a variety of services. CCMH (2021b), notes that the CLI allows centres to shift decision-making from staffing models (number of staff needed) to service delivery models (types of services to provide students). CCMH has reported on CLI distributions by size of institutions and by the number of students utilizing counselling services, as well as CLI distributions by average number of individual appointments and average days

between individual appointments (CCMH, 2021a). However, CLI distributions have not yet been reported in the context of wait times. It would be particularly helpful to report on wait times for centres with mid-level CLI scores and a variety of services, or for each step for centres using a stepped care model (Cornish, 2020), rather than focusing solely on wait times to access counselling services.

In the healthcare sector, there are a variety of ways that wait times are reported, including retrospective and prospective indicators that reflect the time waiting for services or the number of users waiting for services (Naiker et al., 2018; Viberg et al., 2013). Common retrospective wait times are typically reported as a mean or median in days or weeks (e.g., Barua & Moir, 2020). In addition to reporting the number of users on a wait list, some organizations report the number or percentage of users seen within a specific time period, which can reflect a benchmark (e.g., 85% were seen within two weeks; Viberg et al., 2013). Retrospective indicators can include wait time segments, including time intervals between a user's first request for an appointment and the first appointment, and time between a referral and the first specialized care appointment and initiation of care appointment (e.g., Globerman, 2013). For a more comprehensive measure, cycle times are used to reflect the time taken from beginning to end of a treatment process (e.g., Robinson et al., 2020). When interventions are introduced to reduce wait times, organizations often report on the percentage reduction (e.g., Moldawsky, 2007). Prospective wait times include the minimum or average time for the first available appointment in the clinic schedule (e.g., Globerman, 2013).

Combining AUCCCD and general healthcare methodology, post-secondary wait times could be reported as mean and median business days (AUCCCD, 2020) for a range of mental health supports, allowing for cross campus comparisons and the determination of best-fit service

models. Reporting on a centre's CLI score could provide additional context of wait times and potential comparisons to other campuses with similar CLI scores. Each centre would need to determine the indicators to report for departmental or institutional purposes (e.g., annual reports, strategic planning, for resource allocation), indicators for quality improvement purposes (i.e., to reduce wait times), and indicators to report to students.

In order to reflect the broadening array of programming being made available to students, the following retrospective wait time indicators are suggested:

1. Number or percentage of students accessing same-day services (i.e., "zero" wait time);
2. Number or percentage of students accessing specific programs or services (e.g., mental health information, e-mental health tools, peer support, workshops, therapy groups, individual counselling, psychiatric care);
3. Mean and median wait times from a student first reaching out to their first care encounter (NOTE 1) (e.g., intake/triage appointment);
4. Number or percentage of students who received an initial care encounter within a centre's benchmark (e.g., 60% of students received their first care encounter within two weeks);
5. Mean and median wait times from intake/triage/referral to start of care;
6. Number or percentage of students who started care from intake/triage/referral within a benchmark period (e.g., 60% of students received their first care encounter within two weeks);
7. Mean and median wait times in between follow-up encounters when under care.

For prospective wait time, the following indicators are suggested:

1. Minimum, mean and median wait time for the first available care encounter from initial request, as available in a clinic's schedule.
2. Minimum, mean and median wait time for the first available care encounter following an intake/triage/referral, as available in a clinic's schedule.

Each indicator could be reported by:

a. Specific time periods, including by month, semester/term, and year;
b. Programs or services beyond individual counselling or psychotherapy services (e.g., different steps of a stepped care model; by workshops, individual counselling, group therapy); and/or
c. Clinical urgency.

While adoption of consistent measurement-based care practices has to date been limited (Krishna et al, 2020), campus health and wellness centres have had some success in implementing multi-level approaches to improve access to services and to reduce wait times, including institutional, departmental, provider, and student level initiatives (e.g., Coordinating Committee of Vice Presidents Students, 2015; Education Advisory Board, 2017).

At an institutional level, campuses have adopted proactive health promotion approaches to create healthy campus environments, partly as an attempt to reduce the need for reactive treatment-based approaches (cf. Best Practices in Canadian Higher Education, 2019; MacKean, 2011). Mental health centres have taken a multi-tiered approach by adopting a variety of service delivery models, including integrated medical and mental health centres (American College Health Association, 2010), walk-in or open access models (e.g., Access Open Minds, www.accessopenminds.ca; Foundry, www.foundrybc.ca; FRAYME, www.frayme.ca; YouthCan

IMPACT, www.youthcanimpact.com), absorption versus treatment models (CCMH, 2019), and stepped care models (Centre for Innovation in Campus Mental Health, n.d.; Cornish, 2021).

In terms of outcomes, open-access service models have demonstrated reduced wait times for specialty mental health services (e.g., Moldawsky, 2007; Williams et al, 2008). Absorption models are associated with increased access, fewer treatment sessions, increased time between appointments, and less improvement in post-secondary student self-reports of depression, anxiety, and distress levels (CCMH, 2019). Campuses have not yet reported on the impact of stepped care models on wait times, but a provincial demonstration project reported a reduction in wait times of 68%, with some communities not having wait lists at all (Mental Health Commission of Canada, 2019). The expansion of barrier-free or low barrier programming, such as same-day single session counselling, peer support programs, drop-in groups, and workshops have also been employed to increase access and/or to provide services while students wait for ongoing care (Canadian Association of College & University Student Services and Canadian Mental Health Association, 2013).

Campus centres have utilized quality improvement approaches both administratively and clinically by using triage models, seasonal staffing, session caps, evening and weekend appointments, team meetings to prioritize students waiting for care, reviews of clinician caseloads, and third-party providers (student assistance programs), to name a few (cf. Education Advisory Board, 2017). LEAN methodology has also been utilized to improve efficiency in campus centres (e.g., Boyko & Bradford , 2018; Stringer & Bridgstock, 2019). To augment these efforts, centres could consider the use of queueing models to make predictions about the length of a wait list and wait times for the purposes of resource allocation (e.g., Pagel et al., 2012).

Promoting Broader Care Offerings

While campus mental health centres have made efforts to improve service delivery and are aware of student dissatisfaction with wait times (e.g., Davidson et al., 2020), little has been written on the topic of communicating to students or improving their experiences with waiting. Queue psychology indicates that perceived waiting time is more problematic than the actual wait and that strategies can be used to enhance client experiences (e.g., Chu et al., 2019; Maister, 1985). Specifically, user experiences could be improved by distracting or occupying users during a wait, providing real-time information about the wait, reporting the user's progress during the wait, providing a rationale for the wait, communicating fairness, and reducing anxiety about the wait (Maister, 1985).

These are important considerations for campus mental health centres. For example, are there ways in which students can engage with other mental health supports instead of, or while waiting for, individual counselling or psychotherapy, and how can these be presented as a value add? Health literacy efforts and upstream programming may shift students' understanding that individual sessions with a clinician may not be the only option and that self-management or low-touch care with a clinician can be effective. What measures can be put into place, so students feel connected to care, even when waiting for services? Some centres utilize peer supports and clinical navigators who are readily available as points of connection between students and the clinic. Other centres might use a "you touch - you see" approach, whereby once seen by a clinician, an ongoing case management relationship exists, regardless of the intensity or frequency of care. Here, students are encouraged to contact the clinician whenever support is needed and/or the clinician or

other providers can reach out to the student for check-ins. Evaluation of these types of measures can assist in establishing best practices for follow-ups with students waiting for care.

Consideration also needs to be given to communication strategies for transparently informing students of wait times, the rationale for wait lists, the role of student choice on wait times (i.e., opting for individual counselling only), and additional or immediate services that could be utilized while waiting, or instead of waiting, for campus services (e.g., Government of Manitoba, n.d.). To minimize a sense of resource scarcity, messaging around types of care that uses wording such as "short-term" should be presented carefully through the lens of standard time-limited psychotherapy practice, rather than a clinic-driven policy. It is important to continue providing clients with information and messaging on more traditional approaches such as one-on-one psychotherapeutic care, and the option to choosing this pathway. We recommend using deliberate messaging to clients which effectively communicates all available options to allow for equal access to all service offerings. A multi-modal approach with other services that can be accessed while waiting for their appointment can be highly effective in contributing to positive outcomes (Cornish, 2020).

For example, some institutions have begun promoting various group modalities (e.g., Davidson, et. al., 2021) to supplement their one-on-one supports. Prioritizing one over the other may not be successful, and students are likely to benefit more from an unbiased choice of either option (Cornish, 2020). Failing to promote a fuller range of alternatives to traditional service reduces the visibility of such supports and misleads students into believing that these options are not available. Further to this, a "one size fits all" approach is reductionistic and should be eschewed

in favour of more holistic, client-and-family-centred practices that offer culturally appropriate interventions of varying intensities (Alegria et al., 2010).

Developing a Robust Communications Strategy

In addition to transforming post-secondary mental health service offerings into flexible, holistic models that consider clients' goals, strengths, and preferences, communication strategies can be used to promote new service offerings and to empower clients.

Firstly, communication strategies can be used to promote prevention and early intervention. Due to the history of mental health services often being grounded in overly medicalized models of care, and the stigma associated with mental health conditions, clients may often delay their access to care. Communication strategies should thereby focus on equipping the general population with tools and strategies to both prevent the onset of conditions and to identify when to seek help and what to expect from a service. Some examples of these include safe drinking campaigns and other harm reduction interventions implemented on post-secondary campuses (WHO, 2017).

Secondly, technology can be leveraged to disseminate accurate information on various topics in the form of psychoeducation, intervention options, and available resources to empower clients with the information they need to make appropriate choices for themselves. Over the last two decades, there has been more than a 200% increase in youth online activity regarding mental health, specifically with topics such as depression, anxiety, and suicide (Montague et al., 2015). Communication channels can be used to educate on a wide range of topics, as well as to debunk common myths that maintain stigma and delay help-seeking.

Thirdly, technology can be used as a tool to deliver care. In recent years, technology and social media have become omnipresent in our lives, and this is even more true for modern youth

that have been raised in a fully digitalized world. Although research is showing that social media can have negatively effects on youth mental health, studies are also beginning to show that the power of technology and social media can be harnessed for positive therapeutic ends (Nesi, 2020). Accordingly, several post-secondary institutions have turned to technological platforms to engage with youth accessing mental health services (e.g., Laureano et al., n.d.).

Finally, consideration needs to be given to communication strategies that transparently inform students of wait times. Such statements could provide the rationale for wait lists, the role of student choice on wait times (i.e., opting for individual counselling only), and additional or immediate services that could be utilized while waiting, or instead of waiting, for campus services (e.g., Government of Manitoba, n.d.). Some researchers have argued that communicating an institution's philosophy of care (also referred to as framework or theoretical model) that outline the scope, range, and modality of services can be beneficial in setting expectations and avoiding a mismatch between the services available in an institution and what a client may be looking for (Educational Advisory Board. (2018). Although there is no consensus on this topic, when promoted widely and presented to students in advance, clearly communicating service offerings—with or without an institution's theoretical framework—can help to increase accessibility by minimizing the mismatch between what students are expecting and what their institution can provide.

CONCLUSION

There is considerable evidence showing that the traditional medical model approach to mental health care service is not scalable to meet the needs of postsecondary students. From clinical, ethical, developmental, and economic perspectives, the evolving needs of our students

may be best addressed by a corresponding evolution in postsecondary mental health services that normalizes developmental and transitional stress, provides a range of rapid access options, and allows for more self-directed care. Along with this, a more concerted, evidence-informed effort is needed to develop resilience and empower students to take responsibility for their mental health. If we develop a much broader continuum of care options based on quality improvement practices through iterative evaluation of service offerings, organize them to be accessible, and proactively communicate their respective value, there will be enough to meet student needs. The current wait time challenges can be seen as a function of manufactured scarcity based on a traditional approach to service delivery. If we broaden our view of healing resources to include options that are formal and informal, medical and non-medical, upstream and downstream, into a cohesive system of supports, the opportunities to enhance the mental health of our students are boundless. So, what are we waiting for…?

NOTE 1: The term "care encounter" is used broadly in reference to care received by a provider as well as support received through mental health literacy resources, self-guided tools, workshops, support groups, and peer support.

REFERENCE

Alegria, M., Atkins, M., Farmer, E., Slaton, E., & Stelk, W. (2010). One size does not fit all: taking diversity, culture and context seriously. *Administration and Policy in Mental Health and Mental Health Services Research, 37(1),* 48-60.

Alegria, M., Frank, R. G., Hansen, H. B., Sharfstein, J. M., Shim, R. S., & Tierney, M. (2021). Transforming mental health and addictions services. *Behavioral Health Care, 40*(2), 226-234.

American College Health Association (2010). *Considerations for integration of counseling and health services on college and university campuses*. Silver Spring: American College Health Association.

Association of University and College Counseling Center Directors (2020). *AUCCCD Annual Survey.* Association of University and College Counseling Centers. https://www.aucccd.org/assets/documents/Survey/2019-2020%20Annual%20Report%20FINAL%204-2021.pdf

Barua, B. & Moir, M. (2020). *Waiting your turn: Wait times for health care in Canada, 2020 report*. Fraser Institute. https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2020.pdf

Baxter, A., Scott, K. M., Ferrari, A. J., Norman, R. E., Vos, T., & Whiteford, H. A. (2014). Challenging the myth of an "epidemic" of common mental disorders: Trends in the Global prevalence of anxiety and depression Between 1990 and 2010. *Depression and Anxiety*, 31, 506–516.

Beatie, B., Stewart, D., & Walker, J. (2016). A moderator analysis of the relationship between mental health help-seeking attitudes and behaviours among young adults. *Canadian Journal of Counselling and Psychotherapy*, *50* (3), 290-314.

Beidas, R. S., Buttenheim, A. M., Mandell, D. S. (2021). Transforming mental health care delivery through implementation science and behavioral economics. *JAMA Psychiatry, June 02, 2021.* https://doi.org/10.1001/jamapsychiatry.2021.1120

Best Practices in Canadian Higher Education. (2019). An environmental scan of Canadian campus mental health strategies. https://bp-net.ca/news-updates/an-environmental-scan-of-canadian-campus-mental-health-strategies/

Birnie, K.A. (2015). Avoiding a generational clash: Ethical considerations in supervising millennial psychology graduate students. *Psynopsis, 37*(3), 53-54.

Boyko, L., & Bradford, E. (2018, June 18). *Walk in counselling: Managing the volume*. CACUSS Annual Conference: Sea Change, Charlottetown.

Bridgemohan C., Bauer N. S., Nielsen B. A., DeBattista A., Ruch-Ross H. S., Paul L. B., Roizen, N. (2018). A workforce survey on developmental-behavioral pediatrics. *Pediatrics 141*(3): e20172164. https://doi.org/10.1542/peds.2017-2164

Brown, S. (2020). *Overwhelmed: The real campus mental health crisis and new models for well-being*. Chronicle of Higher Education. https://store.chronicle.com/products/overwhelmed

Canadian Association of College & University Student Services and Canadian Mental Health Association. (2013). *Post-secondary student mental health: Guide to a systemic approach.* Vancouver: Author.

Canadian Mental Health Association (2021). *Fast facts about mental illness.* Retrieved on July 20th, 2021 from https://cmha.ca/fast-facts-about-mental-illness

Center for Collegiate Mental Health. (2019, January). *2019 annual report* (Publication No. STA 20-244).

Center for Collegiate Mental Health. (2021a, January). *2020 annual report* (Publication No. STA 21-045).

Center for Collegiate Mental Health. (2021b). *Clinical load index guide.* Pennsylvania State University, Pennsylvania.

Centre for Innovation in Campus Mental Health (May, 2015). *Environmental scan of promising practices and indicators relevant to campus mental health.* https://campusmentalhealth.ca/wp-content/uploads/2018/03/Final-Environmental-Scan-Report-May-26-2015-PDF.pdf

Centre for Innovation in Campus Mental Health. (n.d.). *Stepped care for post-secondary campuses.* https://campusmentalhealth.ca/wp-content/uploads/2019/09/Stepped-Care-Guide-V13.pdf

Children's Mental Health Ontario. (2020). *KIDS CAN'T WAIT: 2020 report on wait lists and wait times for child and youth mental health care in Ontario* [White Paper]. https://cmho.org/wp-content/uploads/CMHO-Report-WaitTimes-2020.pdf

Chu, H., Westbrook, R. A., Njue-Marendes, S., Giordano, T. P., & Dang, B. N. (2019). The psychology of the wait time experience – what clinics can do to manage the waiting experience for patients: A longitudinal, qualitative study. *BMH Health Services Research*, 19, 459. https://doi.org/10.1186/s12913-019-4301-0

Conley, C. S., Shapiro, J. B., Huguenel, B. M., and Kirsch, A. C. (2018). Navigating the college years: Developmental trajectories and gender differences in psychological functioning, cognitive-affective strategies, and social well-being. *Emerging Adulthood, 8(2),* 103-117.

Coordinating Committee of Vice Presidents Students (2015). *White paper on post-secondary student mental health.* https://occccco.files.wordpress.com/2015/05/ccvps-white-paper-on-post-secondary-student-mental-health-april-2015.pdf

Cornish, P. (2020). *Stepped care 2.0: A paradigm shift in mental health*. Switzerland: Springer Nature.

Cornish, P. A., Churchill, A., & Hair, H. (2020a). Open-access single-session therapy in the context of Stepped Care 2.0. *Journal of Systemic Therapies, 39*(3), 21-33.

Cornish, P. A., Churchill, A., MacKay, T., & Jaouich, A. (2020b). Wellness Together Canada: Psychologists leading Canada's COVID-19 mental health response. *Psynopsis, 42(3),* 14-15.

Cornish, P. A., Jaouich, A., Mackay, T-L., Rash, J., Bobele, M., & Churchill, A. (2021). Stepped Care 2.0: An open-access flexible care system designed by psychologists. *Psynopsis, 43*(1), 8-9.

Davidson, M., Bourdeau, S., & Oprea, L., (2020, January 19). *Addressing mental health care wait-times for students. Strategy Corp.* https://strategycorp.com/2020/01/addressing-mental-health-care-wait-times-for-students/

Davidson, M., Witheridge, K., Yuen, S., & Palandra, A. (2021). Empirically supported group-based programming during the COVID-19 pandemic. Collaborations for Change Conference, 2021.

Education Advisory Board. (2017). *Meeting the escalating demands for mental health services: Targeted interventions for key student segments.* https://eab.com/research/student-affairs/study/meeting-the-escalating-demand-for-mental-health-services/

Educational Advisory Board. (2018). *Establishing a sustainable scope of service.* EAB Global Inc, Washington. https://attachment.eab.com/wp-content/uploads/2019/07/EAB-SAF-Scope-of-Service.pdf

Frances, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma, and the medicalization of everyday life.* New York: Harper Collins.

Gallucci, G., Swartz, W., & Hackerman, F. (2005). Impact of the wait for an initial appointment on the rate of kept appointments at a mental health center. *Psychiatric Services, 56*(3), 344-346.

Globerman, S. (2013). *Reducing wait times for health care: What Canada can learn from theory and international experience.* https://www.fraserinstitute.org/sites/default/files/reducing-wait-times-for-health-care.pdf

Gorman, K. S., Bruns, C., Chin, C., Fitzpatrick, N. Y., Koenig, L., LeViness, P., Sokolowski, K. (2020). *Annual Survey: 2020.* Association for University and College Counseling, Indianapolis.

Greenberg, M. T., Domitrovich, C. E., Weissberg, R. P., & Durlak, J. A. (2017). Social and emotional learning as a public health approach to education. *The Future of Children, 27(1),* 13-32.

Government of Manitoba. (n.d.) *Understanding wait times.* https://www.gov.mb.ca/health/waittime/why.html

Headspace National Youth Mental Health Foundation. (2019). *Increasing demand in youth mental health: A rising tide of need.* https://headspace.org.au/assets/Uploads/Increasing-demand-in-youth-mentalh-a-rising-tide-of-need.pdf

Horwitz, A. G., McGuire, T., Busby, D. R., Eisenberg, D., Zheng, K., Pistorello, J., Albucher, R., Coryell, W., & King, C. A. (2020). Sociodemographic differences in barriers to mental health care among college students at elevated suicide risk. *Journal of Affective Disorders,* 271, pp. 123-130.

Insel, T. (2022, forthcoming). *Healing our path from mental illness to mental health.* New York: Penguin.

Joseph, A. J. (2015). The necessity of an attention to Eurocentrism and colonial technologies: an addition to critical mental health literature. *Disability and Society, 30, 7,* 1021-1041.

Keyes, C., Eisenberg, D., Perry, G. S., Dube, S. R., Kroenke, K., & Dhingra, S. S. (2012). The relationship of level of positive mental health with current mental disorders in predicting suicidal behavior and academic impairment in college students. *Journal of American College Health 60*:2, 126-133. https://doi.org/10.1080/07448481.2011.608393

Krishna, R., Jeffery, J., & Patel, P. D. (2020). Implementing measurement-based care in various practice settings. *Child and Adolescent Psychiatric Clinics of North America, 29(4),* 573-586.

Leviness, P., Bershad, C., Gorman, K., Braun, L., & Murray, T. (2018). *The Association for University and College Counseling Directors annual survey 2018.* Association for University and College Counseling, Indianapolis.

Leviness, P., Gorman, K., Braun, L., Koenig, L., & Bershad, C. (2019). *The Association for University and College Counseling Directors annual survey 2019.* Association for University and College Counseling, Indianapolis.

Laureano, B., Togoh, L., & Tran, T. M. (2021). The use of technology to improve mental health services in universities. Grae Matta Foundation. https://www.graemattafoundation.org/wp-content/uploads/The-Use-of-Technology-to-Improve-Mental-Health-Services-in-Universities.pdf

MacKean, G. (2011). *Mental health and wellbeing in post-secondary education settings: A literature and environmental scan to support planning and action in Canada.* Canadian Association of College and University Services and Canadian Mental Health Association. https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.737.6978&rep=rep1&type=pdf

Maister, D. (1985). *The psychology of wait lines.* https://davidmaister.com/wp-content/themes/davidmaister/pdf/PsycholgyofWaitingLines751.pdf

Malla, A., Iyer, S., Shah, J., Joober, R., Boksa, P., Lal, S., ... & ACCESS Open Minds Youth Mental Health Network. (2019). Canadian response to need for transformation of youth mental health services: ACCESS Open Minds (Esprits ouverts). *Early Intervention in Psychiatry*, *13*(3), 697-706.

Marano, H. A. (2004). The mental health crisis on campus. *NASPA Leadership Exchange*, *2*, 5-9.

Mathias, S., Tee, K., Helfrich, W., Gerty, K., Chan, G., & Barbic, S. P. (2021). Foundry: Early learnings from the implementation of an integrated youth service network. *Early Intervention in Psychiatry,* Online ahead of print. https://doi.org/10.1111/eip.13181

McMartin, S. E., Kingsbury, M., Dykxhoorn, J, & Colman, I. (2014). Time trends in symptoms of mental illness in children and adolescents in Canada. *CMAJ, 186* (18), 672-678.

McGorry, P., & Mei, C. (2018). Early intervention in youth mental health: progress and future directions. *Evidence-Based Mental Health, 21,* 182-184.

Mental Health Research Canada (2020). *Mental health during COVID-19 outbreak: Poll #3.* https://static1.squarespace.com/static/5f31a311d93d0f2e28aaf04a/t/5fb547325fd88c0dffc87360/1605715765135/MHRC+Covid+Poll+3+Presentation+-+Public+Release+Final.pdf

Mental Health Commission of Canada. (September, 2019). Mental Health Commission of Canada e-mental health report provides roadmap for reducing wait times and improving care. https://www.mentalhealthcommission.ca/English/news-article/13811/mental-health-commission-canada-e-mental-health-report-provides-roadmap-reducing

Michalski, J. H., Cunningham, T., & Henry, J. (2017). The diversity challenge for higher education in Canada: The prospects and challenges of increased access and student success. *Humboldt Journal of Social Relations, 39,* 66-89.

Mills, C. (2014). *Decolonizing global mental health: The psychiatrization of the majority world.* London: Routledge.

Moldawsky, R.J. 2007. Applying an open-access model to a psychiatric practice. *The Permanente Journal, 11*(1): 33-36. doi: https://dx.doi.org/10.7812%2Ftpp%2F06-095

Montague, A. E., Varcin, K. J., Simmons, M. B., & Parker, A. G. (2015). Putting technology into youth mental health practice. *SAGE Open*, *5*(2), 2158244015581019-2158244015581019.

National College Health Assessment (2018). *American College Health Association-National College Health Assessment II: Reference group executive summary spring 2018*. Silver Spring: American College Health Association

Naiker, U., Fitzgerald, G., Dulhunty, J.M., & Rosenmann, M. (2018). Time to wait: A systematic review of strategies that affect outpatient wait times. *Australian Health Review*, *42*(3), 286-293. https://doi.org/10.1071/ah16275

Nesi, J. (2020). The impact of social media on youth mental health: challenges and opportunities. *North Carolina Medical Journal*, *81*(2), 116-121.

Norcross, J. C., & Wampold, B. E. (2011). What works for whom: Tailoring psychotherapy to the person. *Journal of Clinical Psychology*, *67*(2), 127-132.

Nundy, S., Kvedar, J. C., & Cella, G. M. (2020). From one-to-one to one-to-many: Rethinking health care relationships in the digital age. *Health Affairs Blog*. https://www.healthaffairs.org/do/10.1377/hblog20200320.600000/full

Nunes, M., Walker, J.R., Syed, T., De Jong, M., Stewart, D.W., Provencher, M.D., Swinson, R.P., Ferrari, J., Furer, P., & the Mobilizing Minds Research Group. (2014). A national survey of student extended health insurance programs in post-secondary institutions in Canada: Limited support for students with mental health problems. *Canadian Psychology*, *55* (2), 101-109.

Ontario Undergraduate Student Alliance (2020). *OUSA advocacy conference*. https://d3n8a8pro7vhmx.cloudfront.net/ousa/pages/2009/attachments/original/1606247140/SAC_2020_document.pdf?1606247140

Pagel, C., Richards, D.A., & Utley, M. (2012). A mathematical modelling approach for systems where the servers are almost always busy. *Computational and Mathematical Methods in Medicine*.https://doi.org/10.1155/2012/290360

Robinson, J., Porter, M., Montalvo, Y., & Peden, C. J. (2020). Losing the wait: improving patient cycle time in primary care. *BMJ Open Quality*, 1-6. http://dx.doi.org/10.1136/bmjoq-2019-000910

Roumeliotis, I. (2019, November 19). U of T students demand more mental health services after recent suicides on campus. *CBC News: The National*. https://www.youtube.com/watch?v=1KTKM9puJ_0

Stewart, D. W., & Beatie, B. (2016). Factors influencing student mental health help-seeking. *Communique*, *17* (2), 33-34.

Stewart, D. W., & Ritchot, K. (2010). What determines help-seeking at a university counselling centre? *Communique, 11* (1), 29.

Stewart, D. W., Walker, J., Beatie, B., Reynolds, K., Hahlweg, K., Leonhart, M., Tulloch, A., & the Mobilizing Minds Research Group. (2014). Post-secondary students' information needs and pathways for help with stress, anxiety, and depression. *Canadian Journal of Counselling and Psychotherapy*, *48* (3), 356-374.

Rubin, L. (2018). Allen Frances on the DSM-5, mental illness and humane treatment. *PsychotherapyNet.* https://www.psychotherapy.net/interview/allen-frances-interview

Stringer, D., & Bridgstock, B. (2019, October 15). *Using LEAN & stepped care process methodology to reduce wait times for counselling services.* Centre for Innovation in Campus Mental Health 2019 Conference, Whole Campus Healthy Communities. Toronto.

Sussman, S., & Arnett, J. J. (2014). Emerging adulthood: Developmental period facilitative of theaddictions. *Evaluation & the Health Professions*, *37*(2), 147–155. https://doi.org/10.1177/0163278714521812

Syme, K. L., & Hagen, E. H. (2019). Mental health is biological health: Why tackling "diseases of the mind" is an imperative for biological anthropology in the 21st century. *Yearbook of Physical Anthropology, 171(70),* 87-117.

Viberg, N., Forsberg, B. C., Borowitz, M., & Molin, R. (2013). International comparisons of waiting times in health care – Limitations and prospects. *Health Policy, 112*, 53-61.

Vigo, D. V., Patel, V., Becker, A., Bloom, D., Yip, W., Raviola, G., Saxena, S., & Kleinman, A. (2019). A partnership for transforming mental health globally. *The Lancet Psychiatry, 6(4),* 350-356.

Wiens K., Bhattarai A., Dores A., Pedram P., Williams J. V. A., Bulloch A. G. M., Patten S. B. (2020). Mental Health among Canadian Postsecondary Students: A Mental Health Crisis*? Canadian Journal of Psychiatry. 65(1),* 30-35.

Westin, A. M., Barksdale, C. L., & Stephan, S. H. (2014). The effect of waiting time on youth engagement to evidence based treatments. *Community Mental Health Journal,* 50: 221–8.

Wilbourne, P., Dexter, G., & Shoup, D. (2018). Research driven: Sibly and the transformation of mental Health and wellness. *PervasiveHealth*. Proceedings of the 12th EAI International Conference on Pervasive Computing Technologies for Healthcare. http://dx.doi.org/10.1145/3240925.3240932

Williams, M. E., Latta, J., & Conversano, P. (2008). Eliminating the wait for mental health services. *The Journal for Behavioral Health Services & Research, 35,* 107-114, doi: http://dx.doi.org/10.1007/s11414-007-9091-1

Woodgate, R.L., Gonzalez, M., Stewart, D.W., Tennent, P., & Wener, P. (2020). A socioecological perspective on anxiety among Canadian university students. *Canadian Journal of Counselling and Psychotherapy*, *54*(3), 486-519.

World Health Organization. (2013). *Mental Health Action Plan 2013-2020.*

World Health Organization. (2017). *Strengthening resilience: A priority shared by Health 2020 and the Sustainable Development Goals*. https://www.euro.who.int/__data/assets/pdf_file/0005/351284/resilience-report-

World Health Organization (2021). G*uidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization.* https://www.who.int/publications/i/item/9789240025707

Xiao, H., Carney, D. M., Youn, S. J., Janis, R. A., Castonguay, L. G., Hayes, J. A., & Locke, B. D. (2017). Are we in crisis? National mental health and treatment trends in college counseling centers. *Psychological services, 14*(4), 407.