

CHAPTER TWENTY SIX

Mental Health on Canadian Post-Secondary Campuses: Reviewing the Status, the Impact, and a Proposal to Help

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ABSTRACT

Post-secondary students disclose struggling with mental health at far greater rates today than in earlier decades. Indeed, the prevalence and severity of mental health concerns have led many to declare the current state of affairs a “crisis.” Research has established a solid link between mental health and academic performance, with distressed students demonstrating an increased risk of academic suspension or attrition. Post-secondary institutions face the significant challenge of how best to foster student well-being, academic achievement, and overall life success while preserving their academic mandate. As the number of students accessing campus mental health services grows nationally and internationally, so too does research into the reasons behind this rising demand. Better understanding this shift has implications for campuses’ approach to treatment and prevention, with consideration of the stepped care model, student retention, and graduation rates. This chapter reviews the literature on student mental health and theories behind the apparent recent decline in mental wellbeing. Relations between mental health, academic performance, and cognitive functioning will be explored, as well as how some post-secondary institutions have addressed the calls for increased supports. Results of *From Intention to Action* (FITA), a mental health program for self-referred “at-risk” students, highlights a potential tripartite solution to the campus mental health crisis to (1) improve student mental health; (2) improve academic functioning; and (3) provide critical training to the next generation of mental health workers for the delivery of cost-effective services to at-risk students.

Keywords: Student mental health, post-secondary students, academic functioning, campus intervention, mental health service delivery

INTRODUCTION

Student Mental Health

Working in the mental health field, one of the most frequently asked questions we get is, “Is there *really* a mental health crisis across campuses?” followed by, “Why is that the case?” after the first is answered in the affirmative. Over the past ten years, the terms “mental health” and “crisis” have increasingly seemed to go together like “copy” and “paste.” Amidst dozens of reports of campuses facing a tsunami of mental illness and drowning in the concomitant demand for campus supports, some have concluded students are struggling with mental health issues now more than ever, while others argue that factors such as decreased stigma around mental health are contributing to this increase in demand and perception of a crisis; perhaps students are not floundering more than previous generations but, rather, are a more socially conscious, self-advocating, and support-seeking collective compared to their predecessors. Here, we bring the perspectives of various administrators, academics, and direct service providers in psychology to bear on some of the most salient topics in the discussion of Canadian post-secondary students’ mental health, and present an intervention model that can continue to respond to the thunderous call for a lifeline.

The Prevalence of Post-Secondary Student Mental Distress

Post-secondary student mental health has gained considerable attention from the media, and the surrounding discourse is one typically coloured by worry, with headlines such as “The Mental Health Crisis on Campus” (Lunau, 2012), “The Therapeutic Campus” (MacDonald, 2020), “The Way Universities Are Run is Making Us Ill” (Shakle, 2019), and “An Epidemic of Anguish” (Wilson, 2015). This public image places post-secondary institutions under immense pressure to

ensure that they are meeting the mental health needs of what seems to be an excess of mentally distressed students, while simultaneously meeting their other professional and intellectual responsibilities (Coniglio et al., 2005; Cornish et al., 2017). The primary role of post-secondary institutions is to provide education (Cooke & Huntley, 2015) and yet, they have taken on the responsibility to support student health and well-being; this has led to the generation of new resources and services focused on health and wellness, and the expansion of existing ones.

Internationally, approximately one third of the post-secondary student population live with at least one diagnosed mental disorder (Auerbach et al., 2018; Blanco et al., 2008). From 2007 to 2017, the prevalence of students in the U.S. with a lifetime mental health diagnosis increased from 22 percent to 36 percent, and treatment rates increased from 19 percent to 34 percent (Lipson et al., 2019). In Canada, national data show a steady increase from 2013 to 2019 in the diagnosis of mood, anxiety, and sleep disorders among post-secondary students, and a slower but significant increase in diagnoses of bipolar disorder, schizophrenia, and OCD (Linden et al., 2021). The concern for the mental health of post-secondary students has undoubtedly swept across campuses, many of which have observed an increase in students struggling with their mental health and seeking out support. Several surveys of student mental health have shown significant increases in the diagnosis and treatment of mood and anxiety disorders, personality disorders, sleep disorders, behaviour disorders, and substance use disorders (Auerbach et al., 2016, 2018; Oswald et al., 2020; Pedrelli et al., 2015; Twenge et al., 2010). Among these, mood and anxiety disorders are particularly prominent across university and college campuses.

Despite this concerning rise in rates of mental illness, there is little evidence it is unique to post-secondary contexts. In general, students and non-students of comparable ages, across high and low-income countries, exhibit similar rates of mental illness and service utilization (e.g.,

Auerbach et al., 2016; Blanco et al., 2008; Wiens et al., 2020). However, when compared to non-students and attriters (i.e., individuals that started but did not complete post-secondary education), post-secondary students have a *lower* prevalence for most mental disorders (see Auerbach et al., 2016). Whether growing rates of mental illness reflect a true increase in prevalence remains unclear and is subject to debate (Linden et al., 2021, p. 9). There are important limitations inherent in the study of student mental health trends, including: the utilization of cross-sectional data (this is especially apparent in the Canadian context), convenience sampling, and self-report data (often by students and counsellors) that are subject to biases.

How Did We Get Here?

It is likely that you consider mental health a core aspect of human functioning. There has been a proliferation of hypotheses describing various aspects of student mental health, most of which provide insights into the purported crisis. Here, we attempt to answer the question “how did we get here?” by providing a brief overview of some the key drivers of concern.

Accessibility

Over the last two decades, full-time enrollment in Canadian universities has increased by 78%, from approximately 600 thousand full-time university students enrolled in 2000-01, to just over one million in 2019-20 (Usher, 2020). With this rise in enrollment comes the consequent increased demand for care. As universities and colleges serve more students each year, the diversity of students expands, resulting in greater variety in motivations to learn and in overall academic and life preparedness (Côté, 2018). Moreover, the greater accessibility of post-secondary education provides students from different backgrounds an opportunity to gain access to care that may have previously been more difficult or impossible to access (MacKean, 2011). Additionally,

with the onset of mental disorders often occurring prior to school entry (Auerbach et al., 2016), more students now enter university with pre-existing conditions that require continuous care, ultimately adding to the strain on institutional resources.

Stigma

When we speak about mental health, we often speak of stigma in the same breath. Decreased stigma is often touted as one of the key factors for the surge in demand for care by students. In the current social climate, post-secondary students experience considerably less stigma around mental health and associated treatments (e.g., therapy, medication) than those of previous generations (Locke et al., 2016). A familiar example to many Canadians is *Bell Let's Talk*, an anti-stigma campaign aimed to normalize mental health challenges and encourage people to seek out support to care for their mental well-being. More recently, consider the global conversation surrounding the decision of Olympic gymnast Simone Biles and tennis star Naomi Osaka to step down from their respective competitions to prioritize and preserve their mental health and well-being. Might these conversations been had if not for a greater willingness to speak about mental health and well-being?

Despite the positive strides we have collectively made to combat stigma, the perception that mental health is a somewhat taboo topic remains, and this continues to have a negative impact on help-seeking behaviour. For instance, Eisenberg et al. (2009) surveyed post-secondary students across 13 U.S. institutions to examine the association between personal and public stigma on help-seeking behaviour. Personal stigma refers to one's personally endorsed beliefs about the negative stereotypes that characterise mental illness, whereas public stigma refers to one's perception of the public's treatment of people with mental illness. The findings revealed that personal stigma, but *not* perceived public stigma, was significantly associated with lower help-seeking behaviour.

Today, while self-reported rates of stigma are on the decline (Lipson & Eisenberg, 2018), the heterogenous impact of stigma among certain individuals and groups based on characteristics of biological sex, race, and socioeconomic status (to name a few; Eisenberg et al., 2009) are hard to ignore. Campus-wide anti-stigma campaigns are merely one way post-secondary institutions can contribute to diminishing stigma's impact.

Concurrent Transitions

The transition to university happens in tandem with numerous other concurrent changes in multiple domains. These include forming new social groups while leaving others behind, adjusting to the different academic demands and expectations of undergraduate classes, and for some people, living independently or semi-independently for the first time. For most students, the emerging adult years are a period of high risk for developing a mental illness (Kessler et al., 2005). One author routinely discusses emerging adulthood more colloquially with her clients, with the help of memes highlighting the woes of “adulthood.” A quintessential metaphor emerges recalling the character Kevin from *The Office* proudly carrying a pot of his famous chilli to share with his co-workers, only to fall to the floor with it, helplessly scooping it back up with nearby documents. “Adulthood” can sometimes feel like Kevin's chilli.

With exposure to many new potential stressors that accompany student life, it is unsurprising that many students soon experience the onset or exacerbation of psychopathology (Pedrelli et al., 2015). Others, however, argue that typical developmental experiences that are challenging are over-pathologized (e.g., Gallagher, 2012). Still, the opportunity for growth that comes with postsecondary transition can be quite overwhelming for some.

Generational Differences

So far, we have touched upon a few of the primary characteristics that might explain the upward trend in student mental health concerns and demand for care. These possible causes, however, could be similarly attributed to other generations, for which no comparable alarm was sounded (Côté, 2018, p. 255). Here, we consider why technology and lack of resilience are commonly raised as risk factors for poor mental health, and why these risks have been exaggerated and misapplied.

Technology. We exist in an era typified by rapid technological advancement, where “put the phone away” has become a common declaration at dinner tables. Technological dependence is unique to millennials and subsequent generations like Gen Z who, unlike previous generations, grew up with the internet and live much of their lives online. Students have reported significant pressures to keep up with a demand to present a perfectly curated version of themselves online (Linden & Stuart, 2020), so it is unsurprising to see blame leveled against social media for rising mental illness (e.g., Twenge et al., 2018). However, meta-analyses and comprehensive studies of large datasets show that social media and other digital technology use are only trivially related to young people’s well-being (e.g., Orben, 2020; Tang et al., 2021) and that the strength of these associations has not increased over time (Vuorre et al., 2021). Like all domains of work and recreation, students should strive to be intentional with their internet and social media use to ensure a healthy balance of daily activities, and to avoid further disruption in domains such as sleep patterns, self-esteem, and productivity (Kruisselbrink-Flatt, 2013).

Resilience. When older generations speak of their juniors, there is often an emphasis on a communal lack of resilience or grit, perceiving an inability of younger generations to bounce back from adversity. Although the requisite for “adulting” is ferocious responsibility, Levine and Dean (2012) remind us that 21st century youth typically received structured upbringings that emphasized

achievement, leading to a widespread belief that contemporary childrearing practices undermine the development of resilience, hampering their ability to learn from failure. A lack of resilience and poor coping strategies comprise additional risk factors for the onset or exacerbation of psychopathology (Pedrelli et al., 2015). Resilience is a notable protective factor, which might be why it is an often-targeted outcome in student interventions.

Messaging that attributes the rise in mental illness to lack of resilience is persuasive, but it also ignores important contextual differences for today's youth and shifts blame for systemic failures onto individual behaviour (Webster & Rivers, 2019). Differences are especially evident in the financial landscape students face today. Unlike previous generations, those born in the early 1980s and later are earning less than their parents at the same age, in a workforce where the share of part-time, contingent, and precarious work is much higher (Morissette, 2016). Many also face financial uncertainty while enrolled in university. In Canada, nearly 40% of undergraduates of all ages and years of study are food insecure (Silverthorn et al., 2016). And in first-year undergraduates under age 20, food insecurity has been associated with substantial mental health deficits relative to food-secure peers (Howard & Barker, 2021). Balancing post-secondary studies with family financial support obligations and other caregiving roles is also common among students whose parents are not university-educated (e.g., Corravubias et al., 2018).

Rather than reflecting generational differences, perceived deficits in students' resilience leading to mental health problems may be due to an illusory "kids these days" effect—the tendency for members of older generations to view the youth of subsequent generations as in a decline, and oneself as superior (see Protzko & Schooler, 2019), with a coherent identity devoid of similar developmental phases of immaturity and self-absorption (see Regehr, 2019). Identifying true

generational differences (i.e., “generational othering”) is a complex task with a multitude of confounding variables.

Student Mental Health and Academic Performance

In recent years, research on the impact of poor mental health on academic performance in college and university has confirmed what senior administrators and student service staff have suspected for over a decade (Bruffaerts et al., 2019; Eisenberg et al., 2007). In a randomized longitudinal study, Eisenberg et al. (2009) found that anxiety, depression, and eating disorders predicted lower GPA and significantly higher dropout rates. Another study showed that students with poor mental health experienced a decline in their performance of nearly half a grade point on average (Hysenbegasi et al., 2005). The effects of such a drop are insidious and can further demoralize students over time as the stakes get higher: Students with mediocre academic performance may eventually find themselves on academic warning, and initially strong students may find their options for professional and graduate school diminishing.

In one study, upper year students reported particularly high rates of academic difficulty related to mental health factors (Wyatt et al., 2017), suggesting that the first year of post-secondary is a “prime time” to intervene and promote strategies to combat the decline of mental health and academic performance. The first year of university is a particularly vulnerable time for students as they grapple with mastering an ongoing academic learning curve and developing adult life skills in a competitive and pressurized environment, wherein struggles can lead to greater anxiety, low moods, and substance use as a way of coping (Esmaeelzadeh et al., 2018).

Mental Health and Cognitive Function

Underlying academic performance, to a certain extent, are cognitive abilities that include working memory (simultaneous storage and manipulation of information), reasoning (the capacity to solve novel and complex problems), and executive function (cognitive and social-emotional processes that involve flexible thinking, self-control, and self-regulation; Peng & Kievit, 2020). It is important to explore the potential effects of poor mental health on cognitive functioning given the bidirectional link between cognition and academic achievement (see Stockard et al., 2018 for a review). Various levels of inquiry have demonstrated obvious connections between poor mental health and learning (Bruffaerts et al., 2018).

At the neuropsychological level, volumetric studies show that the hippocampus, amygdala, and anterior cingulate cortex are impacted by depression (MacQueen et al., 2003; Malykhin et al., 2010; Snyder, 2012). The hippocampus is the primary structure associated with a range of dimensions of memory that are essential for learning (McIntyre et al., 2013), and well-replicated studies have shown that with increasing periods of depression, it can decrease in size by up to 20% over time. This loss affects a significant component of higher educational development that is based on the ability to draw from a foundation of basic educational knowledge.

Systematic reviews show that cognitive deficits, thought to affect 25 to 50 percent of individuals with Major Depressive Disorder, are clinically significant and can result in impaired executive function, working memory, attention, and psychomotor processing speed (Gualteri, 2008; McIntyre et al., 2013; Porter, 2012; Snyder, 2012). These ‘cold cognition’ deficits can undermine motivation and trigger emotional responses that further compound anxiety and worry. Mediation studies show that cognitive deficits could be the largest contributors to psychosocial dysfunction among those with depressive disorders (McIntyre et al., 2013). Despite the significant effects disorders such as depression can have on cognitive functioning, traditional psychiatric

interventions have solely targeted mood, leaving cognition largely untreated (Ahern & Semkowska, 2016). This raises the question of how interventions might prevent the development of such deficits or help to reduce or remediate them.

Targeted interventions to improve or restore cognitive functioning can provide options to alleviate the many detrimental effects of poor mental health. Few studies have been done evaluating antidepressants with respect to remediating cognitive deficits, and while some show a positive impact (Herrera-Guzman et al., 2010), others report they are not sufficient and that more research is required to differentiate the effects of pharmacological interventions (McIntyre et al., 2013).

Along with medications, counselling and psychotherapy provide a mainstream intervention to treat the distress and poor mental health associated with anxiety, depression, and related disorders. Supplementing psychotherapeutic approaches for affective symptoms with some form of coaching that teaches new learning strategies, such as with cognitive remediation, could address the cognitive limitations that accompany disorders such as depression (see Thérond et al., 2020 for a review). Such coaching could involve plans around optimal places for study, pen and paper worksheets, mnemonics, and study skills. But while decades of research evidence supports a range of treatment approaches in a variety of populations, few studies have investigated the impact of traditional counselling and therapy on specific cognitive deficits (Makin et al., 2014).

In delivering therapy or coaching, the therapeutic alliance (the rapport built between client and clinician) can be paramount for improving psychological well-being in diverse populations (Horvath et al., 2011) and can be effective in promoting higher levels of academic performance. Bilodeau and colleagues (2021) examined the role played by early therapeutic alliance factors on mental health and academic performance using the Working Alliance Inventory (Horvath &

Greenberg, 1989), and found that an early alliance (in the first three sessions) significantly improved student grades. More specifically, grades were impacted by the degree to which the client and clinician agreed on the goals of therapy, the tasks to achieve the goals, and the bond between the two individuals.

Psychological Distress and Essential Academic Skills

Two of the six authors (JM and LM) are currently conducting a study investigating mental health, academic functioning, and functional limitations among students with documented disorders, the most common of which was a mental health diagnosis. Students were assessed using the WHODAS.20 (Üstün et al., 2010) for functional impairment, the OQ-45 (Lambert et al., 2004) for mental distress (higher scores denote higher distress), and the LASSI-3 (Weinstein et al., 2016) for learning and study strategies. Among the three domains assessed within the LASSI, *Skill* refers to recognizing and incorporating new ideas and procedures to generate meaning to demonstrate learning and understanding; *Will* reveals the degree to which students worry about their performance, their openness to new ideas and strategies, and their willingness to make the necessary efforts to complete work; and *Self-Regulation* shows the ability to maintain focus, to self-regulate in consideration of time, and to evaluate their own learning and make use of available tools and resources to do this. The OQ-45 is a tool commonly utilized in university counselling settings to measure clients' mental health and therapeutic progress. Total scores on the OQ range from 0 to 180, with a clinical cut-off of ≥ 64 denoting the normal range. Higher total scores reflect a greater number of symptoms (depression, anxiety), decreased life satisfaction, and interpersonal difficulty. Additionally, the total scores can be utilized to further distinguish students based on their level of distress: high (> 105), moderately high (83-105), moderate (64 and 82), and low (< 64).

Preliminary results show that functional impairments reflected on WHODAS scores correlated with OQ measures of mental distress ($r = .66, p < .001$), sharing a third of their total variance. Modest correlations also emerged between mental distress and learning and study skills that are necessary to compete at the university level, depicted in Table 1. The relatively higher correlations that emerged between the OQ and *concentration* and *time management* subscales are consistent with the reports that tie in executive function and working memory to poor mental health (McIntyre et al., 2013).

Table 1

Correlations for OQ 45.2 and LASSI-3 Subtests

LASSI-3 Subtest	Correlation with OQ Total Score
<u>Skill</u>	
1. Information Processing	-.052
2. Selecting Main Ideas	.265**
3. Test (Taking) Strategies	.337**
<u>Will</u>	
4. Attitude	.360**
5. Motivation	.308**
6. Anxiety	.490**
<u>Self-Regulation</u>	
7. Concentration	.456**
8. Time Management	.351**
9. Using Academic Resources	.352**
10. Self-Testing	-.078

Note. 1. OQ-45.2 Total Score

** $p < .01$

These and other findings demonstrating the links between mental health, cognitive functioning, and academic achievement underscore the need to focus on a treatment approach that

does not rely on traditional counselling approaches alone, but also addresses performance issues to more effectively moderate the impact of mental health on grades. A multifaceted approach that targets the links between psychological well-being and academic success could create a dynamic cycle where improvements in one area facilitate improvements in another.

Student Mental Health: Institutional Role

With growing acknowledgement of the prevalence of mental health concerns among post-secondary students, the increasing diversity of student populations, the expanding literature showing a relationship between mental health and academic functioning, and the frequency of suicides (e.g., Bruffaerts et al., 2018; De Luca et al., 2016; Hartley, 2010), post-secondary institutions are ever more conscious of their role in promoting and supporting student mental health (e.g., *Best Practices in Canadian Higher Education*, 2019; MacKean, 2011). Colleges and universities have acknowledged the need to extend the focus beyond treating individuals to the adoption of a health promotion approach at the population level (MacKean, 2011). “Healthy campus” initiatives aligned at the institutional and service delivery levels aim to create campus communities that promote mental health and learning, as well as adapt contemporary models of service delivery to improve access to mental health services (e.g., Canadian Association of College & University Student Services & Canadian Mental Health Association, 2013; Cornish et al., 2017; Education Advisory Board, 2018).

A Public Health Approach to Student Mental Health

In 2013, the Canadian Association of College and University Student Services (CACUSS) and the Canadian Mental Health Association (CMHA) released a systemic guide to post-secondary mental health as a national and collaborative effort to address the complexities of student mental

health (CACUSS & CMHA, 2013). This document was embraced across Canadian post-secondary campuses as a framework and systemic approach to promoting mental health at the population level, with the intention of creating campus communities to support mental health and learning. Two companion documents were later created to assist campuses in their assessment of existing student mental health resources and supports, as well as identifying promising practices and indicators (Daria Parsons Consulting Inc., 2015; Rashid & Di Genova, 2019).

Building on the Ottawa Charter for health promotion (1986), the Okanagan Charter was created in 2015 as a call to action, outlining key areas and principles for Canadian post-secondary institutions to unite in their commitment and actions to creating health promoting campuses (Okanagan Charter, 2015; see Canadian Health Promoting Campuses, <https://healthpromotingcampuses.squarespace.com/>). As of 2021, 29 Canadian universities and colleges have adopted the Charter. Alongside this work, several provinces created post-secondary healthy campus networks, including Healthy Minds | Healthy Campuses (<https://healthycampuses.ca/>), the Centre of Innovation and Campus Mental Health (<https://campusmentalhealth.ca/>), and more recently, Healthy Campus Alberta (<https://www.healthycampusalberta.ca/>) and Healthy Campus Saskatchewan (<https://hcsk.ca>). The mandate of these networks is to provide a community of practice to support institutions in their efforts to strengthen student mental health, to innovate, and to collaborate and create meaningful partnerships.

Embracing a public health approach, Canadian campuses began the work of creating institutional-level mental health strategies, with some focused solely on student mental health (e.g., Carleton University, 2021; University of Guelph, 2016; University of Windsor, 2018), and others focused on a whole-campus approach to support the mental health and well-being of students,

staff, faculty, and the campus community (e.g., University of Calgary, 2021; York University, 2015; see Best Practices in Higher Ed, 2018, for a timeline of Canadian mental health strategies). Mental health strategies spanned initiatives ranging from institutional structures and policies, creating supportive and inclusive campus and learning environments, enhancing mental health awareness and literacy, increasing capacity to respond to early indications of student concerns, enhancing student self-management and coping skills, improving access to mental health services, and crisis management (CACUSS & CMHA, 2013).

More recently, the Mental Health Commission of Canada, in collaboration with the Canadian Standards Association, released *The National Standard of Canada for Mental-Health and Well-Being for Post-Secondary Students* (Mental Health Commission of Canada, 2020), which outlines a set of flexible, voluntary guidelines for institutions to support the mental health and well-being of students. Grounded in continuous improvement principles, the guide allows campuses to continually prioritize their efforts in supporting mental health literacy, reduce stigma related to mental illness, promote healthier and safer learning environments, reinforce student success and flourishing, and enhance student resiliency and life skills across all domains of their lives.

At the institutional assessment level, Canadian colleges and universities have administered the National College Health Assessment Survey as a campus well-being surveillance tool to report on student health and well-being data at the local, provincial, and national level (<https://www.cacuss.ca/resources/health-data.html>). With support from the Canadian Association of Colleges and University Student Services, 34 post-secondary institutions initially administered the survey in 2013 and by 2019, participation rose to 54 campuses (American College Health Association, 2013, 2019). More recently, some campuses have also implemented the Canadian

Campus Wellbeing Survey, specifically designed for the Canadian context, to support student health and well-being (<https://www.ccws-becc.ca/>; Weatherson et al., 2019).

Campus Mental Health Service Delivery Models

At the service level, post-secondary mental health centres have re-evaluated their service delivery models not only to align with their campus mental health strategies, but to improve access and “meet students where they are at” by matching their levels of readiness with need. In general, campus mental health clinics have undergone several iterations, incorporating to varying degrees three different models of care: (1) integrated medical and mental health models (e.g., Turpin, 2018); (2) “walk-in” models (e.g., French, 2019; Walls, 2019); and (3) staged and progressive stepped care models (Cornish, 2020; CICMH stepped care toolkit, 2019).

Integrated Models. Inter-professional practice models have a long history within healthcare; however, in the post-secondary context, primary care and counselling services have historically been siloed, with medical and counselling clinics run separately, and varying degrees of collaboration between clinical teams (e.g., Bower et al., 2006; Mitchell et al., 2019). Integrated centres, on the other hand, provide opportunities for one-stop holistic care, integrating medical interventions with psychosocial interventions, and reducing administrative burdens (e.g., Mitchell et al., 2019; Turpin, 2018).

The Association for University and College Counseling Center Directors (AUCCCD) reported that between 2009 and 2019, campuses with integrated centres in the United States rose from 11.9% to 23.9% (AUCCD, 2009; AUCCCD, 2019). In a survey of post-secondary integrated centres, reported benefits include an improvement in students’ ability to meet academic demands, enhanced efficiency in utilization of services, a comprehensive and seamless approach to care, and enhanced cross-disciplinary consultation (American College Health Association, 2010).

Walk-In Models. With increasing demand for shorter wait times and increased access to services, campuses have also adopted “walk-in” models that provide same-day access to intake or triage appointments and/or single session counselling (e.g., French, 2019; Walls, 2019). These were likely modelled after youth mental health community hubs, for example the YouthCan IMPACT (<http://youthcanimpact.com/>), ACCESS Open Minds (<https://accessopenminds.ca/>), and Foundry (<https://foundrybc.ca/>). One institution reported that 77% of students accessing counselling supports were serviced using only one or two walk-in sessions, with 90% of survey respondents providing positive feedback about the walk-in service (York University, 2019). Using LEAN methodology (an approach geared toward optimizing services to better serve the client within an organization), one college reported that 77% of their students who walk-in or sought an urgent appointment were seen on the same day, and subsequently observed a 5% increase in total unique students seen, with a reduced wait time from over three weeks to same-day access (Stringer & Bridgstock, 2019). These results suggest enhanced care-seeking and satisfaction by students receiving same-day counselling supports.

Stepped Care. More recently, post-secondary mental health services have adopted staged, progressive, or flexible progressive stepped care models to enhance access to mental health supports (CICMH toolkit, 2019). Staged models are triage-based, matching clinical presentations with a low, medium, or high intensity mental health service, while progressive models further enhance flexibility by integrating client readiness and preference (Cornish, 2020). Recent published work reported an overall reduction in wait times of 68% using a contemporary stepped care model in the community (Mental Health Commission of Canada, 2021). In the post-secondary sector, increased provider caseload capacity and session attendance, reduced time spent with clients, and overall high client satisfaction rates have been reported benefits of progressive stepped

care models (Cornish, et al., 2017).

Program-Level Innovations

Many other program-level innovations have been utilized by campus mental health centers to increase capacity. As an example, use of “embedded” counselling models have proliferated across campuses (e.g., Adams, 2017; Beale et al., 1997; Beks et al., 2018). With this model, counsellors are co-located within academic or other student service departments to increase the footprint of the central clinic, and are thereby able to develop enhanced knowledge of the local culture and academic demands of their particular student population. Campuses have also partnered with student assistance programs, providing 24-7-365 immediate and brief counselling supports to students, with some offering services in multiple languages (e.g., Aspiria, www.aspiria.ca; MySSP, www.myssp.app). Peer support programming has also been popularized across campuses as a means of expanding services, but also so that students can get support from other students with shared or lived experience as active listeners, advocates, navigators, and educators (e.g., CICMH, 2021). Additionally, mental health clinics have a long tradition of providing clinical training opportunities for graduate students as a means to build counselling and psychotherapy capacity while also to provide experiential learning opportunities for future generations of mental health care providers. In this regard, campus mental health clinics are uniquely positioned to both provide training within a generalist clinical model and address the interplay between mental health and academic concerns by enhancing both psychological and academic resilience.

Importantly, with the integration of such programs, there has been increased interest in their evaluation and quality improvement processes to more clearly identify promising and best

practices to support student mental health (e.g., CICMH, 2019; University of Calgary, <https://www.ucalgary.ca/mentalhealth/education/program-evaluation-toolkit>; Best Practices in Canadian Higher Ed, 2018, www.bp-net.ca; Network for Improvement and Innovation, <https://collegehealthqi.nyu.edu/>). One such program, that is evidence-based, integrative of students' mental health and academic functioning needs, and ever-evolving based on continual feedback, will be reviewed in detail in the following section.

From Intention to Action: An Overview

From Intention to Action, or FITA, was borne over ten years ago out of the understanding that mental health and academic performance are intimately linked; that the transition to higher education can be challenging on multiple levels; and that post-secondary support services are being overtaxed amidst cries for help from overwhelmed students flooding the system. The program is based partly on the findings of a longitudinal study that showed students with registered disabilities (namely, AD/HD and learning disabilities) had higher graduation rates than their average peer with no registered disability after receiving ongoing disability support; remarkably, their graduation rate was 91% compared to the provincial average rate of 75% and Carleton University's own average of 70% (L. McCloskey, personal communication, September 7, 2021). Disability support typically comprises tailored accommodations (e.g., note-taking support, assistive technology), learning strategy appointments, and importantly, an ongoing relationship with an assigned disability coordinator. That students with learning disabilities could reach their academic potential with a relatively small investment raised the question of whether a similar model could be successful with students facing stress and potentially emerging disorders. Thus, FITA was co-developed at Carleton University by the founder of Carleton's disability services office and a clinical psychologist, specializing in cognition.

Initially, FITA was offered to students on Academic Warning at Carleton University who faced possible suspension if they failed to improve their grades. Such students were often encumbered by mental health issues, life circumstances that made learning especially difficult (e.g., financial hardship, recent trauma), and undiagnosed learning disabilities that became painfully apparent in university. In time, FITA branched out to serve students self-identifying as “overwhelmed,” regardless of academic performance. The evolution of the FITA program from a focus on students on academic warning to all “overwhelmed” students parallels other trends seen in post-secondary mental health. In the decade since its inception, FITA has adapted to the changing needs of the student population while maintaining the program’s core values (e.g., evidence-based treatment, cost-effectiveness) and demonstrating stable rates of improvement in well-being, student retention, and overall GPA (Antunes-Alves & Langmuir, 2021; Bilodeau & Meissner, 2016). The name *From Intention to Action* reflects both an institution’s actionable plan to respond to struggling students, as well as an invitation to students themselves to actively work toward self-improvement.

FITA Today: Structure of the Program

The FITA program is structured over 12 weeks, providing personal and academic counselling to university students to support their mental health. Within student services, FITA has a unique mandate and service delivery model, the latter of which features individualized, weekly counselling sessions intended to improve academic functioning by improving mental health. The program focuses on both personal and academic issues simultaneously, distinguishing itself from programs and services like academic advising that deal with these challenges separately (Antunes-Alves & Langmuir, 2021). It is offered at no charge to students and utilizes an integrative and holistic intervention model to support students who self-report difficulties with stress and

academics.

While students can self-refer, many are encouraged to join by staff of allied departments (e.g., academic advising, disability services office) who believe the student could benefit from intervention, in the spirit of the stepped care model. Fitting somewhere between a disability services office and a counselling centre, FITA falls on the higher end of the stepped care system. Students whose needs fall below the threshold of the 12-week counselling framework may be referred to less intensive or more self-directed campus services, such as mentorship programs, group wellness workshops, or a one-off counselling session. Likewise, those who would benefit from more escalated care such as psychiatric intervention are often referred to the campus' health and counselling service or beyond. Thus, the 12-week model typically serves those with moderate mental health concerns.

While students on Academic Warning are a particularly vulnerable population that are often ideal candidates for FITA's combined academic-mental health approach (see Trombley, 2001), the program is also available to students whose principal concerns are personal. Typical presenting problems parallel those of the average student seeking mental health support on campus (Pérez-Rojas et al., 2017), including symptoms of depression and anxiety, relationship difficulties, problems of motivation and procrastination, problems of adjustment and learning, grief, and sexual assault, to name a few. Along with personal counselling, students are provided with supplemental learning and coping strategies and healthy lifestyle habits (Bilodeau & Meissner, 2016).

Students in FITA undergo an extensive assessment process to determine program-fit. After students contact the program, they complete a semi-structured intake to assess their candidacy, review program expectations, and answer any outstanding questions. Once admitted, students are assigned a counsellor to meet with weekly and, concurrently, complete a battery of tests that

includes measures of achievement, personality, mental health, and career interests. The comprehensive testing component of FITA yields rich information that complements the student's therapy and can flag potential problems with reading comprehension or writing that warrant further assessment. Career interests and values that may conflict with the student's current educational trajectory may also be identified. Each student then meets with the program's psychologist for a feedback session to review the results, discuss any surprising findings, highlight their strengths and areas of improvement, and further discuss their mental health and academic concerns. Although feedback sessions are not intended to diagnose, they may lead to recommendations for psychoeducational assessment to rule out an undiagnosed learning disability or attention-deficit hyperactivity disorder. With this knowledge, FITA counsellors can work more effectively to gain a more complete understanding and allow for greater connection.

While students can withdraw from FITA at any time, their ability to commit to its conditions upfront is a requirement for admission. This is important given FITA's 12-week model, which is different than the typical postsecondary counselling services that tend to be less consistent or without a predetermined length (Jaworksa et al., 2016). The program therefore has a very high completion rate at approximately 85%, and the average number of sessions completed has been around 11 in recent years. Many have found a strong link between client engagement and therapeutic outcome (Mimic et al., 2019), and research on "at risk" post-secondary students demonstrates that a more directive, contractual intervention is particularly effective with this population (Abelman & Molina, 2002; Schewebel et al., 2008). While the vast majority of interested students are admitted into the program (typically around 90%), the rest are generally referred to more appropriate services, in keeping with the stepped care model. For a thorough review of the program's structure, please refer to the FITA manual (Meissner et al., 2017).

FITA Research

An important constituent of the FITA program is its basis in research and program evaluation. Consenting FITA clients participate in research examining the efficacy of the program each year, with important outcome variables such as academic performance (GPAs), self-reported academic functioning (e.g., study skills, motivation, goal setting), self-reported mental health, and general satisfaction questions about their experience with the program. Results of each year's program evaluation present crucial survey data on the status of students seeking support and can ultimately be used to inform more effective and efficient service delivery. For example, recent feedback from participants has resulted in efforts to improve the privacy of FITA offices, allow greater flexibility in the end point of counselling sessions, provide better training of staff and interns in addressing unique client needs, have longer feedback sessions for students who require it, enhance collaboration between allied mental health services on campus to optimize client care, and develop a supplemental group counselling workshop. These resulting responses collectively also address calls for university counselling centres to implement and collect a minimum pre- and post-counselling data set as a component of good practice, to honour initiatives aimed at improving access to therapy, and to show transparency about their individual effectiveness (Barkham et al., 2019).

Drawing on FITA data from 2013 to 2015, Bilodeau and Meissner (2016) evaluated the effects of FITA on student mental health and academic performance. Students were placed into three groups based on their scores for the Short Form Health Survey (SF-36, which measures quality of life and reflected mental health in this study) and student status (i.e., academic warning).

Accordingly, (a) students on academic warning were placed in the academically at-risk (AR) group, (b) students identified as both overwhelmed and academically at-risk were placed in the academic and overwhelmed (AO) group, and (c) students who were overwhelmed but not academically at-risk were placed in the overwhelmed (OW) group. Academic performance was measured by cumulative grade-point average (CGPA) and the Academic Functioning Questionnaire (AFQ). Overall, the authors reported that all participants (ungrouped) left the program with improved grades and improved mental health (i.e., higher quality of life scores), even when compared to a control group of non-FITA students. It was anticipated that mental health would improve for students in the AO and OW groups (but not the AR group), and that grades would improve for students in the AO and AR group, (but not the OW group), and that is exactly what was found (see Figure 1 and 2). Finally, academic functioning increased for all groups (see Figure 3).

Figure 1

Mean Pre-and Post SF-36 Scores from FITA Students From 2013-14 and 2014-15

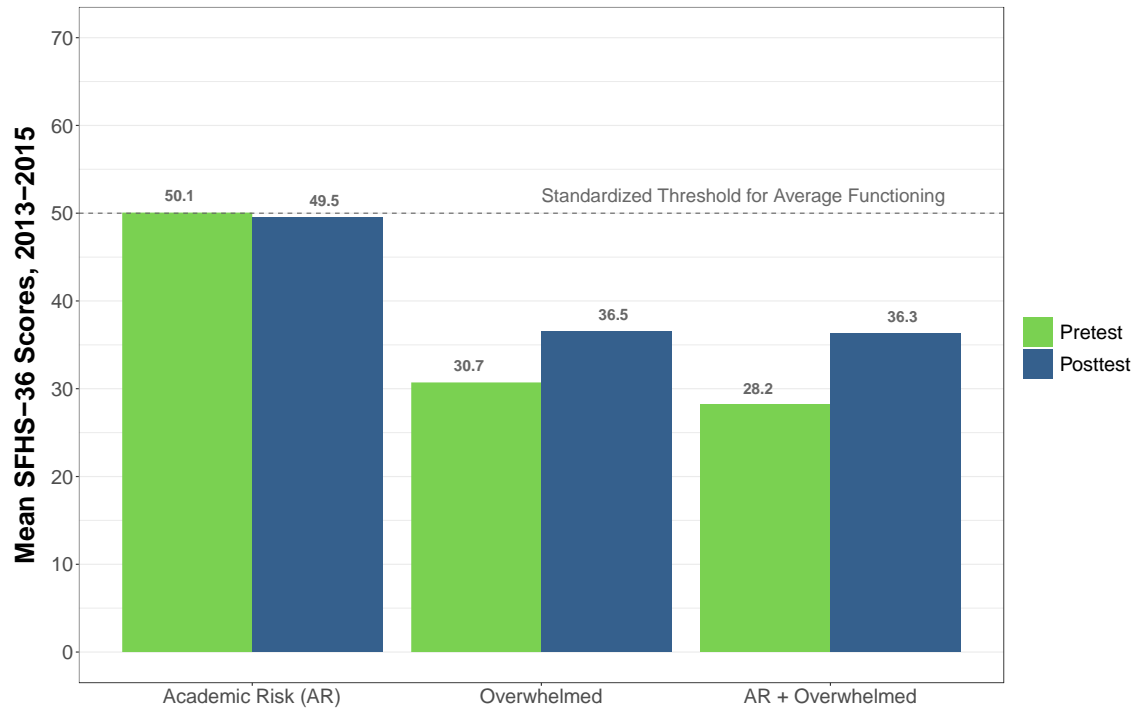


Figure 2

Mean Pre-and Post CGPA for FITA Students From 2013-14 and 2014-15

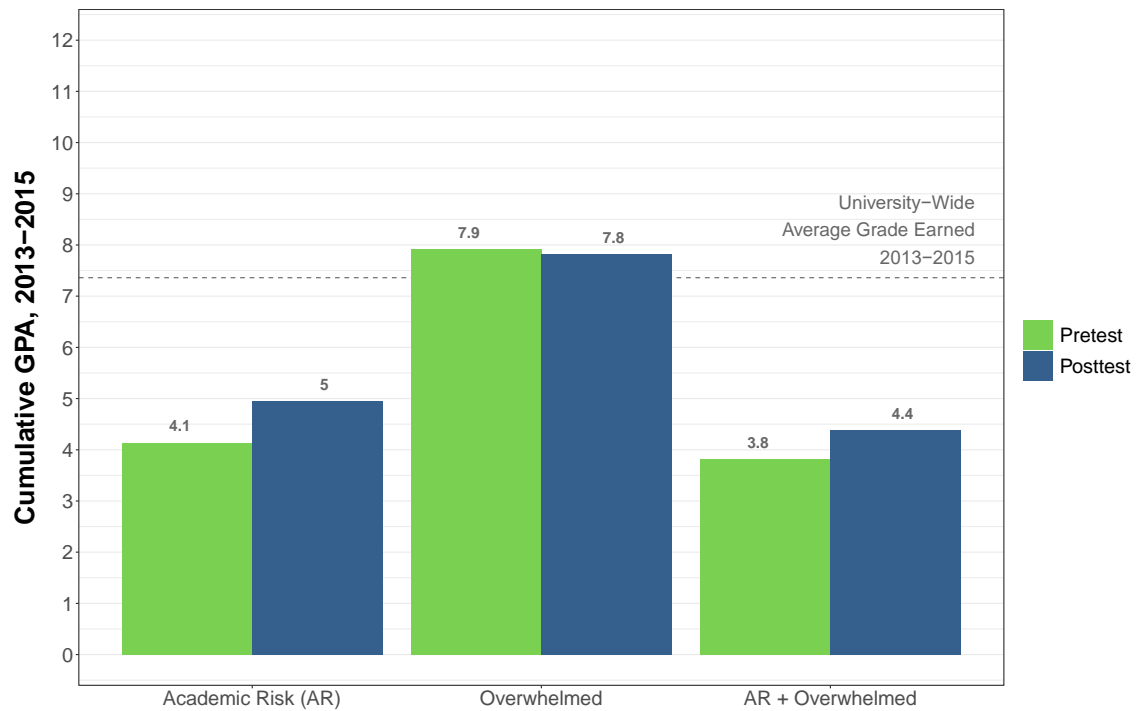
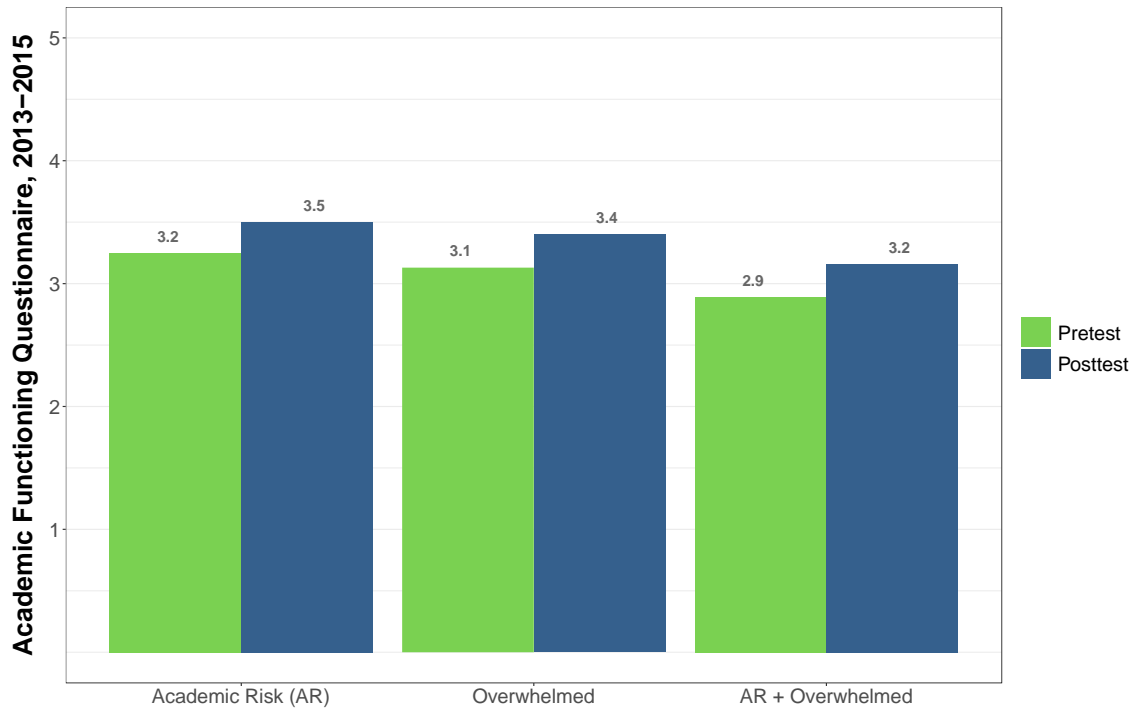


Figure 3

Mean Pre-and Post AFQ Scores for FITA Students From 2013-14 and 2014-15



A similar study using FITA data from 2018 to 2020 placed students in the same three groups, with the similar expectations that (1) the OW group would show significant improvement in mental health, (2) the AR group would show significant improvement in academic performance and academic functioning, and (3) the AO group would show significant improvements on all outcome variables: academic performance, academic functioning, and mental health (Antunes-Alves & Langmuir, 2021). In this study, mental health was again assessed with the Outcome Questionnaire (OQ-45.2), previously described.

In line with Bilodeau and Meissner's (2016) findings, all participants left the FITA program with better academic performance and improved mental health, and all students who entered the program on academic warning left it in good standing. The OW students demonstrated the greatest increase in mental health, followed by the AO group, while AR students' GPA

significantly improved. Results from both studies demonstrate the effectiveness of the FITA program on students' wellbeing and academic performance (see Figures 4, 5, and 6).

Figure 4

Mean Pre-and Post OQ-45.2 Scores for FITA Students From 2018-19 and 2019-20

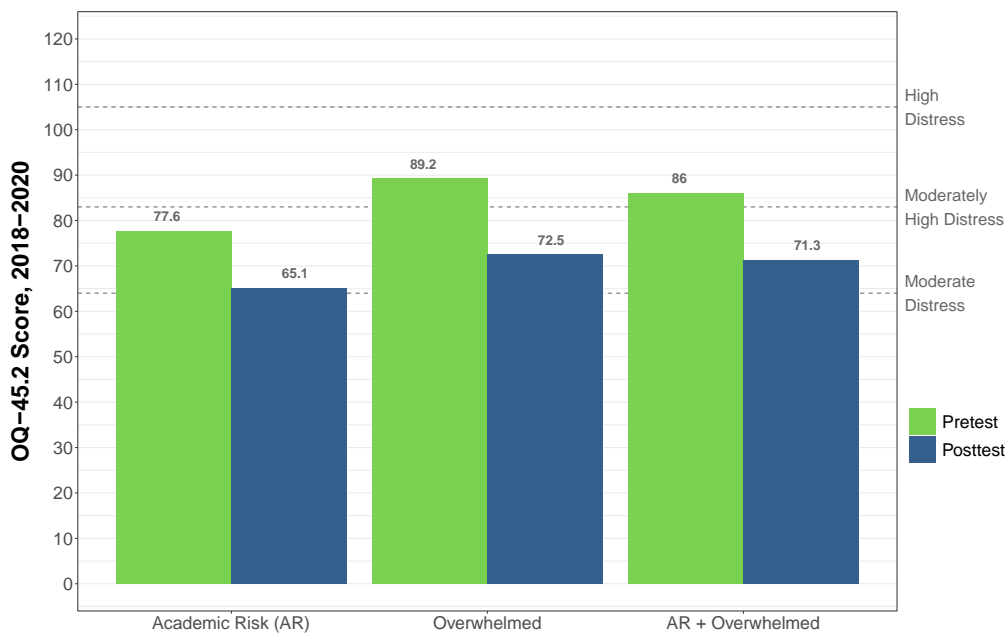


Figure 5

Mean Pre-and Post CGPA Scores for FITA Students From 2018-19 and 2019-20

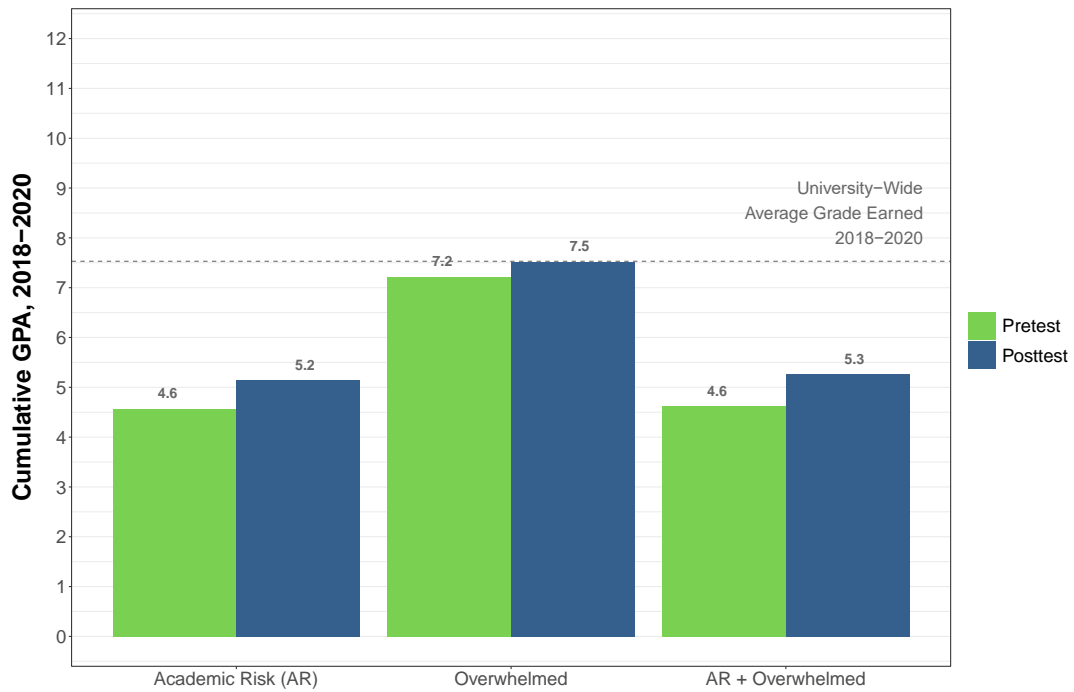
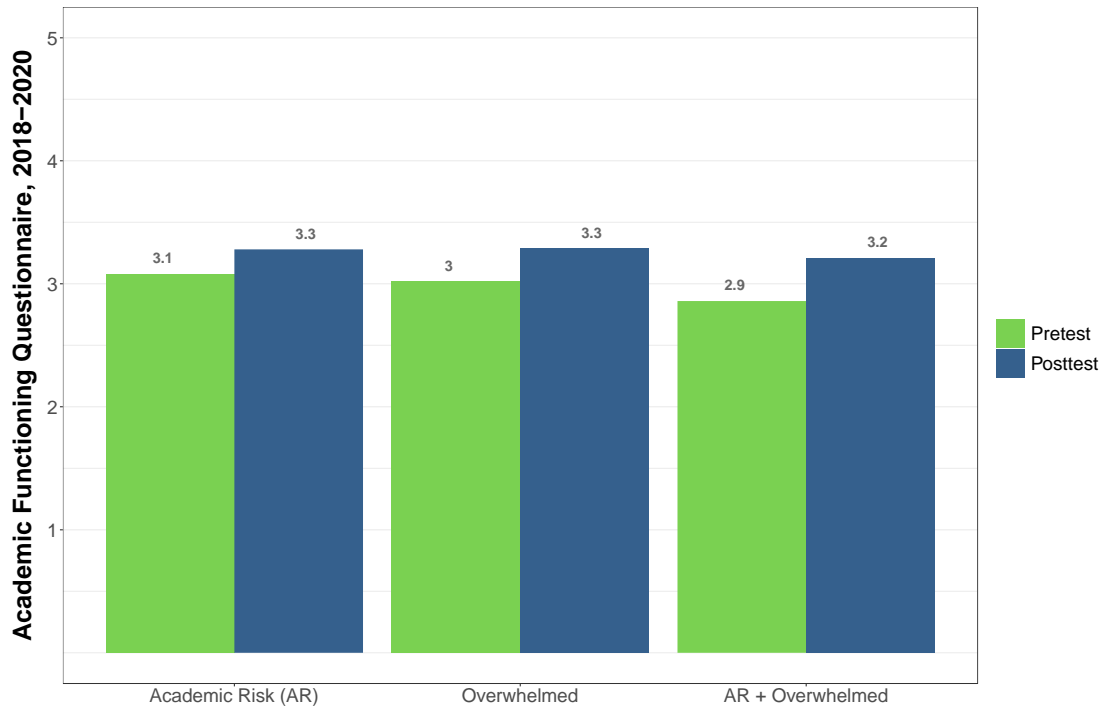


Figure 6

Mean Pre-and Post AFQ Scores for FITA Students From 2018-19 and 2019-20



FITA: A Training Model

The FITA program relies heavily on second-year graduate students of applied psychology to provide services, under the supervision of professional staff, as they complete their internships. Incoming FITA interns have completed most of their graduate coursework and have had some experience with providing counselling, as they look to develop further skills in a wide range of therapeutic approaches. Basic counselling microskills, goal setting, collaborating, and connecting with clients to develop a bond of trust is emphasized in FITA training. Interns are also taught how to administer and interpret tests and have the opportunity to observe feedback sessions, illustrating FITA’s “circle of care” approach to clients. The therapeutic alliance between counsellor and client provides a strong basis for success over time, as repeatedly demonstrated in counselling outcome studies (e.g., Glickman et al., 2018; Kazdin & McWhinney, 2018), and is frequently referenced favourably in FITA client satisfaction questionnaires. Clients report a greater sense of relief and

confidence after participation, and that they have a ‘go-to’ person on campus who ‘holds me accountable’ and ‘has my back.’

Interns at FITA receive weekly individual supervision by a clinical supervisor, and supervision is informed by direct experience with clients: FITA supervisors themselves meet every client who enters the program, either through intake assessment or feedback assessment, depending on their role. Importantly, supervision is a balance of further refining case conceptualization and supervisees’ professional development, focusing on countertransference, theoretical leanings, and the intersection of personal and professional identity. Group supervision also occurs on a weekly basis. The use of graduate interns, from both a training and service delivery perspective, is an exciting opportunity to train future generations of therapists, working in collaboration with educational institutions to apply ever-evolving clinical best practices and incorporate advanced theory that is informed by research and current client feedback. And given the scarcity of resources that often plagues postsecondary campuses, an additional administrative benefit of supplementing paid staff with the use of interns is that it helps to keep program costs lower.

Transferability to Other Campuses

The FITA program is a prototype developed in the spirit of collaboration, meant to be shared with other campuses who may then adapt it to the individual needs of their institution and student body. Four other Canadian post-secondary institutions have successfully adapted FITA, all of which showed significant improvements in students’ mental well-being upon completion of the program (see Transferability, p. 42 in Meissner et al., 2017). Most institutions who have adopted FITA have preserved the structure of the 12-week model, utilizing graduate interns for service delivery, with minor adjustments to specific assessment batteries, and scaling the program

back or out depending on availability of resources. And a fifth institution notably created a structured *group* counselling FITA model, based on principles of positive psychology (Thriving in Action, TiA, Ryerson University, 2021).

In its essence, FITA is a mental health counselling program, but it is also an amalgam of elements that set it apart from more traditional campus approaches to treatment. This promising concept-turned-reality addresses many of the calls to action considered in this chapter, combining (1), early intervention for at risk students, (2) comprehensive intake assessment, (3) a meeting with a supervising psychologist, (4) ongoing assessment, (5) outcome research, and (6) consistent, holistic, weekly sessions with a counselling professional or intern.

CONCLUSION

The transition to postsecondary education is oftentimes taxing for the average incoming student, both socially and academically, and with the onset for most mental illnesses occurring between age 16 to 24 (two thirds of whom filter through postsecondary campuses; Auerbach et al., 2018; De Girolamo et al., 2019), we have the makings of a challenging situation that cannot be ignored. Optimizing health and well-being during postsecondary education is important because it sets the stage for healthy individual, economic, and societal development (Duffy et al., 2020). Of particular importance to postsecondary campuses whose principal concerns are student retention and graduation rates, mental health has important implications for students' academic performance, with poor mental health predicting lower grades and higher dropout rates (Eisenberg et al., 2009). Regardless of the unanimity of the claim that campuses are in a mental health crisis, and whether or not it is the responsibility of campuses to solve this problem, the societal expectation that colleges and universities address this purported crisis prevails.

As public awareness campaigns help to destigmatize mental health issues and seeking treatment, so rises the demand for mental health services. Whereas in earlier decades it seemed that no one ever talked about their own mental health, it is now commonplace. Mental health awareness has expanded accordingly, but the unintended consequence of this is that the capacity for services to meet demand has not expanded by proportion. As institutions embrace the promotion of health and wellness on campus, they must continually search for innovative programs for students, without compromising on their intellectual promises (Linden et al., 2018). To an extent, postsecondary campuses have made varying efforts to respond to the demand for services, instituting stepped care models and programs of various intensities, with differing purveyors of services, as well as streamlining partnerships between medical and counselling services. Still, there is an obvious need for *more*: more immediate and longer-term supports, more adequate supports, more supports that address the interaction between academics and mental health and, most definitely, more research evaluating the efficacy of such efforts.

The *From Intention to Action* program has been reviewed in this chapter, as well as the results of its positive impacts on student mental health and academic performance. A program like FITA is one possible answer to these calls for more—developed specifically to address the dearth of combined intervention programs, rooted in research. Founded on principles of the importance of a targeted academic and mental health intervention, student commitment, the therapeutic alliance, clinical training and supervision, clinical assessment, progress tracking, and program evaluation, a FITA-like program can be a cost-effective, scalable, and transferable addition to postsecondary campuses seeking to bolster the academic and psychological resilience of students seeking a lifeline.

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