

**President's Advisory Committee on Student Mental Health (PAC-SMH)**

**Mental Health Experts Panel**

FINAL REPORT

December 15, 2017

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## Executive Summary

The mandate of the mental health experts panel (MH Panel) was to investigate the current services on campus and determine if the current approaches are appropriate. The panel extended this mandate to examine concepts of mental health promotion on campus. Broadly speaking, the panel primarily focused on addressing two key questions: 1) What are the conditions needed to promote mental health on campus? 2) How far can/should an organization like the University go in providing treatment for mental illness?

Additional questions helped guide the responses to these questions, relating to issues of mental health promotions, barriers to service use, and approaches to service provision. To address these questions the panel met every 2 weeks to engage in detailed discussion of issues, developed working groups for mental health promotion and clinical services, and reviewed an extensive literature of research, practice-based, and University student mental health reports.

A large number of opportunities exist for student mental health promotion. One key condition for promoting mental health is *Organizing, planning, and policy at the institutional level*. Within this process, the importance of enhancing constructive organizational cultures and climates was emphasized across all departments and units of the campus. A second condition relates to having a *supportive, inclusive campus climate and environment*, recognizing the importance of built environment, resilience, social capital, as well as inclusivity and equity for student mental health.

Several areas for enhancing mental wellness were identified by the Panel. These include the development of a detailed health promotion framework that considers all aspects of wellness, using the Okanagan Charter for Health Promotion. A strategy related to substance use is also needed, both in terms of prevention of problematic use of alcohol and substances as well as further fostering connections with community partners for treatment. A large area of emphasis relates to enhancing mental health literacy on campus, including staff, faculty and students. Mental health literacy involves

knowing the signs and symptoms of mental health challenges, strategies for mitigating such challenges, and resources and supports available.

The Panel takes the position that the University should provide comprehensive mental health services for persons with serious mental health issues by providing stepped care and supports, comprehensive counselling and case management strategies, integrated mental health support in family physicians, and appropriate integration with community partners. This includes a review of the human resource capacity for counselling and health services, such as having appropriate skills and expertise, psychologists' roles, and mitigating stressors identified by counsellors and psychologists. Several additional models of service delivery are also reviewed, including collaborative complex care teams, stepped care, peers support from peers with lived experience, screening and assessment processes, walk-in and single sessions, and group counselling.

***Key Recommendations:***

1. Develop a framework for policy review that includes a special lens for mental health and well-being.
2. Develop guidelines for implementing supportive mental health practices within academic processes, such as senate/faculty/department policies and practices.
3. Integrate resilience and healthy lifestyle skills building opportunities into curriculum.
4. Ensure there are opportunities for engagement with faculty in healthy and supportive ways, and explicit mechanisms for dealing with conflicts or complaints that clearly communicate with students.
5. Review the policies, procedures, and practices related to health and counselling service provision with consideration for diversity, including race, ethnicity, faith, gender, sexual orientation, gender identity, and socioeconomic status.
6. Develop innovative, electronic, navigation systems to help students understand the various services available to them.
7. Review academic practices and scheduling to consider opportunities for increased actual and perceived time for engagement in skills building and support services, as well as health practices.
8. Implement a comprehensive education and training strategy to increase mental health literacy among students, staff, and faculty.

9. Increase funding available in the student health plan for accessing psychologists/counsellors in private practice, and education is provided to students about these funds and where they can be used in our community.
10. Review the parameters and feasibility of online services (monitoring and therapeutic) to University of Waterloo students.
11. Consider implementing the recommended ratio of 1 counsellor/psychologist FTE for every 1000 students, which would result in 36.67 FTE.
12. Ensure that any funding changes required to increase staffing or service provision do not result in an increase in student fees.
13. Develop a strategy to ensure a full complement of counsellors/psychologists are consistently available, particularly in instances of employee leaves.
14. The University develop a cultural competency strategy to meet diverse student needs.
15. Hire an external reviewer regarding the management structure and professional practice at Counselling Services, including the on-call system.
16. Health Services and Counselling Services to develop a complex care team to respond to students with more complex mental health issues.
17. Implement a stepped care approach within health and counselling services.
18. Peer support services at UW are enhanced to include support from persons with lived experience.
19. Implement strategies to prevent sexual violence.
20. Review opportunities for enhancing screening and assessment practices, including self-screening, person-centred suicide risk assessment, and assessment approaches available to first responders.

## **Panel Mandate**

The mandate of the mental health experts panel (MH Panel) was to investigate the current services on campus and determine if the current approaches are appropriate. The panel extended this mandate to examine concepts of mental health promotion on campus. The panel used the following questions to guide our process:

1. What are the conditions needed to promote mental health on campus?
2. What should the University<sup>1</sup> be doing or emphasizing proactively to enhance mental wellness?
3. Are the clinical approaches we are using the most appropriate?
4. How far can/should an organization like the University go in providing treatment for mental illness?
5. What are other institutions doing to deal with demands on front-line services? To address the need for wellness space and programming?
6. Why are students not reaching out to access mental health supports?

## **Methodology**

The MH panel met during the initial PAC SMH launch day in July 2017 then bi-weekly, for 2 hours, through August and during the Fall 2017 term until its final meeting on December 5, 2017. During the panel meetings, members discussed the panel's mandate and its related questions (listed above). These meetings included general discussions among the entire group, break out discussions where members discussed either mental health promotion or campus mental health services, within-meeting work sessions where members paired-off or worked individually to review key documents/literature, and guest presentations. The panel also discussed specific questions that raised at the campus-wide Mental

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<sup>1</sup> By stating "University" we are referring to all members, including students, staff, and faculty as well as academic and administrative bodies (e.g., academic units, student services, senior administration).

Health Awareness Day in October 2017, including cultural responsiveness, substance use, and sexual violence. The MH Panel also worked collaboratively with other panels whenever possible; for instance, in October 2017, Professor Chris Perlman, co-chair, met with a co-chair of the Student Experiences Panel to provide input/assistance for a questionnaire they developed for students to complete regarding their experiences of mental health services on campus. The Panel Co-Chairs also met in several formal meetings with the PAC-SMH to review progress and emerging themes.

Additionally, individual input was obtained from key informants who were not able to attend the panel meetings. For instance, in October 2017, Professor Perlman met with the Manager of Self-Help Peer Support at the Canadian Mental Health Association-Waterloo Wellington to understand better the nature of peer support services and the potential role of peer support at UW. In November 2017, Professor Perlman met with a graduate student at UW living with mental health and substance use conditions. The purpose of this consultation was to understand potential solutions to better support students with mental health needs. On November 21, 2017, Jennifer McCorriston, Associate Director of Health Promotion, University of Waterloo, spoke with the panel regarding her approach to her work in the area of health promotion.

Each panel member had at least one topic or document /article to review and to write a brief summary that included reference to the literature. In addition, panel members included review of various university and college mental health reports and the 2012 University of Waterloo mental health report. The Co-Chairs organized and integrated the summaries, including their own, into this report. Of note, many more topics from those documents and others could have been included in this report but were not due to time constraints. A limitation of this process is that the panel members had full-time commitments, i.e., some have full-time positions and others are full-time students, during this process and therefore did not have sufficient time to review all relevant documentation. Several panel members also had to step away from the panel due to various external commitments.

## **About This Report:**

The Canadian Association of College & University Student Services and Canadian Mental Health Association (2013) outlined a framework for supporting post-secondary mental health. We recommend that this framework is used as a guiding document in structuring and reviewing the campus mental health context at the University of Waterloo. As such, we have organized a number of sections in our report to coincide with the key sections outlined in this framework (sub-headings cited as CACUSS/CMHA, 2013), while also drawing upon other resources. Within each section, we introduce the key concepts at issue, provide an analysis of the issue within the campus context, and provide recommendations for the PAC-SMH.

## **What are the conditions needed to promote mental health on campus?**

*Institutional Structure: Organization, Planning and Policy (CACUSS/CMHA, 2013)*

### **Issue:**

Organizational Policies and procedures need to consider mental health in order to avoid adversely affecting overall health and well-being. This can be an implicit and explicit activity. Implicitly it is important to nurture a positive and supportive organizational culture and climate (Glisson & James, 2002). Organizational culture includes the norms and expectations regarding behavior and practices within an organization. Organizational climate refers to the perceptions of the work/educational environment and the impact of these perceptions on organizational members. Culture and climate are important as they have been found in mental health contexts to contribute to staff turnover morale, and job satisfaction, as well as to mental health problems among staff in mental health care settings (Aarons & Sawitzkey, 2006; Elovainio, Kivimaki, Steen, & Kalliomaki-Levanto, 2000; Morris & Bloom, 2002; Sørgaard, Ryan, Hill, & Dawson, 2007). Importantly, staff turnover affects clinical service delivery and can negatively influence attempts to implement new models of mental health service delivery (Aarons &

Sawitzky, 2006). The core concepts of trust, motivation, individualism, and self-actualization within positive organizational cultures are directly relevant to positive campus environments and student mental health. Positive, or constructive, cultures promote supportive interactions and can encourage goal attainment and achievement to result in increased satisfaction among mental health workers (Aarons & Sawitzky, 2006). Cultures that are defensive, requiring approval and consensus, and that are conforming and subservient are typically associated with lack of satisfaction and worse outcomes. Implications are that the mental health services with this type of culture will not be as efficient and streamlined, which can contribute to reduced accessibility to mental health services.

**Analysis:**

The overall culture and climate of the University of Waterloo is highly layered. Cultures can include academic units and faculties, the various student service organizations, student led organizations and clubs, athletics and recreation, human resources, maintenance and grounds crews, food services, and the entire campus through central administration. Similarly, cultures also include interactions within various academic units and campus services. For instance, fostering a supportive culture within mental health staff represents a foundational step in ensuring the optimal delivery of that mental health services on campus. The core constructs of culture and climate need to be considered at multiple levels, including within health, accessibility, and counselling services, within academic units, and across the University as a whole. These constructs may influence communication, trust, and workplace/educational satisfaction.

We recognize that there is a multitude of policy frameworks active at various levels at the University of Waterloo. Currently, the University of Waterloo has 77 active policies, some individual-focused and others more universal. These include, but are not limited to, policies about professional and ethical conduct (e.g., student mentorship), academic and research practices (e.g., course design), provision of health and social services, and human resources and job performance (e.g., health and

safety). The Secretariat at the University of Waterloo, in 2013, has undertaken a Policy Renewal Project, which aims to improve the ‘clarity, consistency and relevance of university policies’ (UW, 2017). In addition, it is important to recognize that additional policy and practices may exist within Faculties, academic units, and student service offices. It is important that all policies be reviewed with a mental health lens to protect against un-intended consequences on student, staff, and faculty mental health.

**Recommendations:**

1. Develop a framework for policy<sup>2</sup> review that includes a special lens for mental health and well-being. We recommend a systems-wide approach to promoting student well-being, which include assessing and influencing the broader institutional environment, such as organizational structure and policies. Organizational policies have the potential to promote or inhibit student well-being, through their influence on campus environment and culture (Olding and Yip, 2014). These policies could be individual-focused, as in supporting students directly, e.g. accessibility and accommodation policy; student housing policy etc. or more universal in a way of creating a broad health promoting organizational environment, e.g. diversity and equity policy; academic policies (Olding and Yip, 2014). With the current work underway, we recommend a mainstream approach in evaluation, whereby every policy is assessed through a wellness or health perspective lens (Olding and Yip, 2014; CDC, 2014). Toolkits are available to help guide such processes, such as the Disability and Inclusion Based Policy Analysis (Institute for Research and Development on Inclusion and Society, 2012). We propose a few questions for incorporating the wellness lens in policy evaluation (Olding and Yip, 2014):

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<sup>2</sup> For the purposes on this document, ‘policy’ is an institutional guiding principles or directive approved by the University of Waterloo Senate.

- “How does the policy enhance control through impacting a sense of agency, autonomy or self-efficacy at the individual or collective level?”
- “How does this policy impact individual resilience, as well as social relationships and engagement more broadly?”
- “How does this policy facilitate or inhibit students’ ability to connect with others and feel valued and useful?”
- “To what extent does this policy enable or inhibit social inclusion of individuals and groups within the campus? How does it impact social networks? The ability to access opportunities?”

We recommend that policies having the most influence on social determinants of student health are given priority for evaluation. Examples of these policies are human rights policies, diversity and equity policy, policy on student housing, religious accommodation policy, Sexual assault prevention/response policy; financial support policies.

2. Develop guidelines for implementing supportive mental health practices within academic processes, such as senate/faculty/department policies and practices. These could include, but are not limited to:

- a. A best-practice guide for supportive mental health practices in the classroom, including considerations for course design, processes for introducing to the class campus services available for supporting mental health, and procedures for supporting students who may be experiencing crisis. This should include practices for integrating discussion of mental health into all classes, perhaps in the first week, as a way to help normalize the emotions that might accompany the adjustment process to University (e.g., for first year students) and the fluctuations in stress throughout the academic process. Additional considerations should include:

1. Processes for how students can review their progress in courses for making informed decisions about dropping courses.
  2. Building opportunities for positive reinforcement and feedback
  3. Best practices in lecturing that support mental health. For instance, breaks should be regularly implemented within lectures to allow students a time to think or to process a question (for an overview see Gayle, Preiss, & Allen, 2006).
  4. Creating opportunities for open interactions, including open and flexible office hours.
- b. Streamlining processes for VIF/accommodation. Currently there is a differential fee structure between Health Services and Counselling Services, with Health Services charging students a fee for physicians to complete forms at Health Services because the Ontario Health Insurance Plan (OHIP) does not cover this service while Counselling Services does not charge a fee for completion of forms. For completion of forms for accommodations, the Ontario Human Rights Commission states that the institution that requires the forms to be completed is responsible for paying the fee for such forms. The University of Waterloo needs to make requisite changes in funding for this to occur so that physicians at Health Services can complete appropriate forms without students paying those fees if the forms are required for accommodations.
- c. Practices for the early identification of students experiencing challenges. Some faculties, such as Applied Health Sciences, have developed “red flag” practices whereby student advisors work with instructors to identify students who are exhibiting marked changes in classroom engagement and/or achievement (e.g., not submitting assignments, drop in performance). The advisor and instructors attempt to contact the student to discuss any academic issues and options for mitigation. This is also a way to direct students to support services if a need is identified. Anecdotally, several students have indicated to instructors that they appreciated this process, helping to instill the sentiment that “someone cares”.

- d. Best practices for communication following sentinel events, such as student deaths. These practices should include information about how the University will communicate these events in a way that respects the wishes of the student and the student's family.
- e. Policies and practices that support faculty and staff mental health, including positive and constructive work environments (e.g., processes for building trust, work-life balance). This should include practices for supporting leaves of absences. To support optimally student mental health, we need to ensure the health and well-being of staff and faculty.

### *Supportive, Inclusive Campus Climate and Environment (CACUSS/CMHA, 2013)*

The University of Guelph mental health report has a “call to action” in which it indicates that everyone has an important role to play regarding students’ mental health (University of Guelph, 2016). Queens University’s mental health report emphasized the importance of mental health support for students from the highest level of administration (Queen’s University, 2012). These messages are consistent with other post-secondary mental health reports reviewed by this panel. The mental health experts’ panel recommends that the University of Waterloo adopts a similar “call to action” with specific behavioural indicators for how university community members can fulfill it. The domains listed below are some areas that should be specifically addressed in such a call to action.

#### **Built Environment and Health**

##### *Issue:*

Understand the mechanisms through which the physical environment affects mental health for better implement changes that will improve mental health outcomes (Evans & Ferguson, 2011). “The built environment can promote or hinder mental health” (Dannenberg, Frumkin, & Jackson, 2011, p. 106). It can promote or reduce feelings of annoyance, distress, anxiety, and depression (Dannenberg, Frumkin, & Jackson, 2011). Crowded places cause stress, and low levels of daylight can lead to anxiety and

depression (Dannenberg, Frumkin, & Jackson, 2011). Housing quality is associated with mental health, as well as indoor air quality, light (Evans, 2003); and green settings reduce mental fatigue (Dannenberg, Frumkin, & Jackson, 2011).

*Analysis:*

On the UW campus, there are issues surrounding built environment that affect health, both mental and physical. These include the following:

- Food access: affordable healthy food on campus is badly needed
- The general conditions of some classrooms (including podiums) and bathrooms: the cleanness & lighting need to be improved
- Classrooms' table and chairs: some need readjustment or replacement
- Drinking water: some buildings have decades-old water-fountains that are moldy.
- Construction noise: may limit number of construction projects during the academic term.
- Limited green spaces with adequate seating on the main campus

*Recommendation:*

The University of Waterloo should develop a plan for improving the built environment of the campus, and develop a project planning process that considers the health and well-being impact of any capital or infrastructure development project.

**Fostering Resilience**

*Issue:*

The skill of resilience can make a stressful situation manageable, and provides positive coping mechanisms for the individual. Autonomy in the classroom can help develop a sense of self-confidence in a student, and can be enhanced with a learner-based approach (Morrison & Allen, 2007). We

recognize that resilience may not be normative, that certain students may have innate skills while others may struggle. Therefore, different levels of support for resiliency are needed.

Important components of resiliency include self-esteem and self-efficacy. Self-esteem is the perception one has of their own capabilities and abilities (Neff, 2011). A poorer self-esteem results in greater difficulty adjusting to university while higher self-esteem is associated with a greater capability to handle stress (Yıldırım et al., 2017). Related to this, self-efficacy refers to the belief an individual has in being able to accomplish tasks (Maddux & Kleiman, 2012). Students with higher levels of self-efficacy were found to view a greater academic workload as more of a challenge as opposed to a threat, resulting in lower levels of stress and better adjustment to university (Maddux & Kleiman, 2012). Supportive post-secondary environments should foster cultures and climates that help students build self-esteem and self-efficacy in both academic and non-academic contexts.

*Analysis:*

Some universities provide services and orientation for first-year students in the couple of months preceding the beginning of their first year, which can be offered online and may be more accessible to students in that format. One of the goals of this programming is to assist students in understanding more aspects of university life and beginning their transition to it earlier than the first-year orientation, which some students may find somewhat overwhelming and not as conducive an environment to process effectively all of the information that is provided. Post-secondary institutions have a role to play in assisting students with developing and shifting their expectations as they progress through their programs of study.

*Recommendations:*

1. Develop a resource to provide to parents about “How Parents Can Support their Students”. This includes tips for helping parents to prepare students for University (including academics, financial

planning and housing, and local services. The resource should also include information for ongoing support of students, including support through transitions.

2. Integrate resilience and healthy lifestyle skills building opportunities into curriculum. The University of Waterloo offers a multitude of skills training workshops and services but engagement tends to be low. Given that many of these resources lack an “immediate” reward for students (the skills take time and practice to have an effect) students may be less inclined to participate. We recommend integrating resilience skills training into orientation activities, including online skills workshops to be completed prior to arrival on campus. Whenever possible, students should be encouraged to take AHS 100 “Foundations of Healthy Lifestyle”. This course is available to all, non-AHS, students across campus (AHS students are mandated to complete a course equivalent).

## **Social Capital**

### *Issue:*

Social capital refers to the networks of relationships that an individual maintains to support one’s goals and well-being. These networks are important in helping students to adapt to the University environment and manage the myriad of stresses within and outside of the academic environment. Social relationships play a major role in both the prevention and support of mental health, including support of self-esteem and satisfaction with life (Ellison, Steinfield, & Lampe, 2007). We recognize that there may be instances where students’ ability to build or maintain social networks may be challenged, particularly within the context of off-campus housing and cooperative education. Opportunities for students to build *bonds* with each other can help mitigate some of the challenging scenarios such as transitions between cooperative education placements or living off campus. Bonds create circumstances where students can share information and supports, and provide emotional support that can help to mitigate the effects of stress (Turner & Brown, 2010). Social connectedness can also play a *bridge* role in providing mentorship or leadership through the provision of beneficial information or innovative perspectives about life and

career aspirations (Ellison, Steinfield, & Lampe, 2007). These could involve social contacts between academic faculty and students outside of the classroom, an area often viewed as lacking by students (Jensen & Jetten, 2015).

*Analysis:*

Brouwer et al. (2016) examined the impact of social capital on academic achievement among first-year university students; they examined three sources of social capital: a) Family Capital, b) Faculty Capital, c) Peer Capital. During this period, peer and faculty capital may become more prominent but family capital still remains prevalent, particularly for helping students cope (emotionally, socially, financially) with new circumstances and isolation. Peer capital can involve information and normative feedback and support about academic activities and adjustment to university life, as well as social relationships and support. Faculty may be source of capital by providing advice, information, motivation, and mentoring; however, the nature of the interactions may not contain the same emotional components of family or peer capital. Interestingly, Brouwer et al (2016) found that peer and faculty capital, but not family capital, were predictive of better school achievement among first year students.

*Recommendations:*

1. Ensure there are opportunities for engagement with faculty in healthy and supportive ways, and explicit mechanisms for dealing with conflicts or complaints that are clearly communicated with students.
2. Build and foster opportunities for mentorship. Implement a “buddy system” wherein second-, third-, and/or fourth-year undergraduate students are paired with first-year students. Some of the post-secondary institutions’ mental health reports referred to the importance of some type of “buddy system”. This may already exist in some Faculties; for instance, AHS has a program called weCONNECTu. The goal is for such a system to exist campus-wide to help with transitions and

mentoring for first-year students. The panel recommends that these programs should also be developed for graduate students.

## **Inclusivity and Equity**

### *Issue:*

Mental health awareness includes awareness of the intersectionality of dimensions of diversity, including but not limited to gender, racial background, ethnicity, cultural background, sexual orientation, socioeconomic status, physical ability, and how they affect students' mental health status. A significant component of mental health promotion is inclusion and addressing systemic factors and barriers that affect students' mental health.

Gender is a prominent factor to consider for mental health promotion and support. Some studies have suggested that rates of depression do not differ by the gender of post-secondary students and that post-secondary students may experience higher levels of distress than the general population (Ibrahim, Kelly, Adams, & Glazebrook, 2013). However, there is clear evidence that the patterns of other mental health conditions, the circumstances surrounding mental health conditions, help-seeking behaviours, and outcomes such as suicide do differ by gender. For instance, male students tend to have poorer awareness about mental disorders and report greater stigma about help seeking and professional support for mental health conditions (Furnham, Annis, & Cleridou, 2014; Furnham, Cook, & Batey, 2011; Vidourek, King, Nabors, Lynch, & Merianos, 2014). Coping strategies may also differ with some suggesting that males use more harmful coping strategies (Ellis, Collin, Hurley, Davenport, Burns, & Hickie, 2013). Alternately, a strong association has been found between the existence of major depression and periodic periods of heavy drinking, particularly among female students (Pedrelli, Borsari, Lipson, Heinze, & Eisenberg, 2016). This study found that students with major depression who engaged in heavy drinking were less likely to engage in mental health treatment, although female students were more likely to engage in treatment. In terms of suicide among students, depressive symptoms are

associated with greater risk among women while alcohol-related issues and lack of social support were associated with greater risk among men (Lamis & Lester, 2013). For both sexes, hopelessness, perceived burdensomeness, and reasons for living were associated with greater risk. These findings are consistent with the notion that men may be less likely to express overtly emotional distress than women, instead turning to harmful health behaviours when in distress. Studies about patterns of mental health by gender identities beyond cisgenderers are less common. Those that exist suggest a strong association between the presence of mental health concerns and non-cisgenderers. For instance, rates of eating disorders and eating disorder behaviours were highest among a sample of transgender students followed by cisgender sexual minority men and women (Diemer, Grant, Munn-Chernoff, Patterson, & Duncan, 2015).

*Analysis:*

It is essential to recognize the various unique experiences and needs of student across ethnic and racial backgrounds, genders and sexual orientations. We also want to recognize that the experiences of students related to mental health may not be the same across academic units. Large international studies have reported this finding. For instance, Lipson, Zhou, Wagner, Beck, & Eisenberg (2016) found that, among 81 campuses in the U.S., students in the Arts and Humanities reported the highest rates of mental health challenges; however, they found that among those with mental health conditions students in engineering and business were least likely to seek out treatment. Such findings suggest that different approaches to the prevention and support of mental health conditions are also needed based on academic disciplines.

Additionally, the panel discussed was the affordability of housing, issues in accessing housing off campus, and food. Some students commented that they were reluctant to access the food bank in the Student Life Centre due to the stigma related to how other students may perceive use of this resource.

*Recommendations:*

1. Review the policies, procedures, and practices related to health and counselling service provision with consideration for diversity, including race, ethnicity, faith, gender, sexual orientation, gender identity, and socioeconomic status. Such a review should examine the demographic of the University population, including international students, to ensure that the services available are responsive to the diversity representing in the student population.
2. Ensure there are appropriate financial and food security supports for students. In addition to affordable and health food options, it is recommended that an additional location be considered for the food bank, and renaming the food bank to reduce stigma (e.g., at McGill the food bank is called the “Midnight Kitchen”).

## **Why are students not reaching out to access mental health supports?**

*Issue:*

The CACUSS/CMHA strategy stresses that students need to be empowered to participate in maintaining their health and well-being. The University of Waterloo has a very rich inventory of services that are central to the maintenance of well-being, including athletic, recreational, and social activities, a food bank, academic peer supports such as MATES, the Glow Centre, the Women’s Centre, workshops and supports for academic achievement such as the Student Success Office, Accessibility Services, and the Writing Centre, and online and in-person workshops and supports through campus wellness. **However, empowerment embodies more than having supports available. Students need to be aware of these services, understand how to access them, and most importantly, have the time and opportunity to access such supports.** As such, a number of barriers may exist in accessing or fully utilizing these services, such practical and attitudinal barriers.

Practical barriers broadly consist of extraneously-driven perceptions. These include financial issues, lack of availability of treatment, lack of access to services, and lack of time to seek help (Vanheusden et al., 2008). Cultural competence and responsiveness can also act as a practical barrier, given the variations that exist in access that exist by race, ethnicity, and culture in accessing service (e.g., Zane, Bernal, & Leong, 2016; Zane, Kim, Bernal, & Gotuaco, 2016). Time perception is important to consider in terms of how much time one has and how one can make use of time (Wittman & Paulus, 2007). This choice relates to the reward systems that are perceived; a delay surrounding the reward once a choice has been made reduces the subjective value of that reward (Wittman & Paulus, 2007). In the student context, one might perceive less time to engage in skills building workshops in favor of studying or working on assignments because the “pay off” is not immediate. In addition, sleep deprivation has been found to exacerbate this reduction in the reward’s values (Wittman & Paulus, 2007). This research indicates the enormity of reframing mental health resources such as workshops, through tailoring them to have more short-term goals that present the attendees with a sense of accomplishment and reward.

Attitudinal barriers broadly consist of internally-generated or -evaluated perceptions that affect an individual’s decision to seek help. Some examples include perceived stigma (others’ or society’s negative attitudes towards mental health issues), personal stigma (one’s own negative attitudes towards mental health issues), negative beliefs about treatment, and the desire to treat issues on one’s own (Mojtabai et al., 2011). Notably, past work has found that only personal stigma is associated with help-seeking, and that reductions in perceived stigma have no impact on help-seeking behaviour (Golberstein, Eisenberg, & Gollust, 2008; Golberstein, Eisenberg, & Gollust, 2009; Eisenberg, Downs, Golberstein, & Zivin, 2009). This suggests that stigma interventions should focus on the individual’s own stereotypes about mental health issues. However, more recent work has found that 65% of student responders who had untreated issues also reported low stigma and positive beliefs about treatment

effectiveness (Eisenberg, Speer, & Hunt, 2012). If attitudes and knowledge about mental health are no longer main barriers to help-seeking, what is stopping students today?

In a large-scale study of around 9000 adults in the U.S., Mojtabai and colleagues (2011) found attitudinal barriers were significantly more common than practical barriers. However, the most pervasive barrier reported was low perceived need: the idea that the individual did not really need help or that the problem would go away on its own. Low perceived need was especially endorsed by individuals with low severity illnesses (Mojtabai et al., 2011; Andrade et al., 2014), suggesting that this belief that help-seeking is unnecessary allows early-stage mental health issues to progress to more severe stages. The finding that low perceived need is a pivotal barrier to help-seeking has been replicated in post-secondary students, showing that students consistently see mental health treatment as not urgent, or low priority (Eisenberg, Hunt, Speer, & Zivin, 2011) As such, the authors recommend 'nudging' treatments, such as mandatory annual mental health check-ups as an opt-out system. Further, it is recommended that institutions can intervene by encouraging primary care providers to recognize and treat mild to moderate disorders (McCrone & Knapp, 2007).

### *Analysis:*

Our analysis of student perspectives towards mental health services has identified procedural and attitudinal barriers to accessing and fully utilizing the variety of mental health services and supports on campus. In reviewing student petitions, analyses of student surveys, and our own discussions with undergraduate and graduate students barriers and challenges that have arisen include issues of student contexts (awareness, perceived time limits, stigma, lack of interest) as well as system contexts (timing of services, wait lists, ease of access). Actual and perceived wait-times are consistent issues in both help-seeking practices as well as barriers to accessing services. We also heard about concerns related to disclosure and confidentiality, particularly in relation to accessing peer-related services or group-based interventions. Culture and faith-based barriers were also identified, particularly the sentiment that

counselling services may not include practitioners representative of the breadth of cultural backgrounds existing on campus.

*Recommendations:*

1. Navigation systems are needed to help students understand the various services available to them. These systems should be electronic nature, perhaps leveraging existing platforms. The navigation component should include some sort of check-list or directory outlining the need/purpose the student is looking to fulfill, possibly saving them from going straight to counselling services for needs that could be met elsewhere.
2. Review academic practices and scheduling to consider opportunities for increased actual and perceived time for engagement in skills building and support services, as well as health practices. For instance, the nature of the academic calendar means that classes run continuously through the day with some passing through lunch (11:30 a.m. to 2:20 p.m.). Students are also often faced with back-to-back classes, in some instances leading to 6 or more hours of class-time.
3. Culturally informed student services are important to continue to develop for the University of Waterloo student population. While beyond the scope of this report to provide details about specifics for each service on campus, it is recommended that mental health services continue to develop in culturally informed ways and that students have ongoing opportunities to evaluate the services provided.
4. An internal audit of student barriers to treatment should be used, periodically, to help to continually adapt to student needs. The Barriers to Treatment Survey (BTTS) is an 18-item scale with strong internal consistency (Vanheusden et al., 2008; Hendricks, 2015) that is thought to measure perceived reasons for why treatment is not sought.

## **What should we be doing or emphasizing proactively to enhance mental wellness?**

### *Health Promotion Framework*

Health promotion is not only about providing information/education to stakeholders. Instead, health promotion is about empowering positive actions and behaviours while providing accessible support. Based on our consultation with Jennifer McCorrison, Associate Director, Health Promotion, and a review of various campus strategy documents, **the panel recommends adapting The Okanagan Charter: An International Charter for Health Promoting Universities and Colleges (2015) as the guiding framework for embedding health promotion into University practices.** This includes “(a) embedding health into all aspects of campus culture, across the administration, operations and academic mandates, and (b) lead health promotion action and collaboration locally and globally” (page 3).

### *Substance Use Strategy*

Substance use is an ongoing gap in many university strategies related to mental health. Few University mental health strategies, including Queens University, the University of Guelph, and the CACUSS/CMHA Framework, include substance use as a key focus of health promotion or service provision. This despite the strong relationship between substance use and other mental health issues. The University of Waterloo recognized this gap in the 2012 Student Mental Health Project Report. Since that report, the University of Waterloo has supported projects like *Leave the Pack Behind* and has developed a collaborative process with community partners for supporting students with substance use needs.

### **Recommendations:**

1. Review the need for expanded on campus services related to substance abuse, including support for abuse of alcohol and cannabis.
2. Join the Canadian Centre on Substance Use and Addiction Postsecondary Education Partnership – Alcohol Harms, a partnership that other Universities across Canada have joined

(<http://www.ccdus.ca/Eng/collaboration/Postsecondary-Education-Partnership-Alcohol-Harms/Pages/default.aspx> ). This partnership includes a framework for reducing harms associated with alcohol, and encourages institutions convene a team of students, staff and faculty to develop an institutional implementation and measurement plan based on the framework.

### *Community Capacity to Respond to Early Indications of Student Concern*

#### **Issue:**

A key dimension in building awareness and supporting mental health promotion is mental health literacy. Mental health literacy has been defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm, 2000). Critically, it has been noted that this knowledge must be directly linked to action that improves the mental health of the individual or those around them (Jorm, 2012). Health literacy has an impact on interactions with healthcare, including access and utilization, user-provider relationships, and self-care (Paasche-Orlow & Wolf, 2007).

Prior research has found that mental health literacy is low among post-secondary students. In the U.K., general knowledge about mental health conditions was low, with female students, those of higher emotional intelligence, and those studying clinical psychology having better awareness (Furnham, Cook, Martin, & Batey, 2011). Mental health literacy is also an important consideration for staff and faculty, both for their own mental health and for being able to promote and support mental health among students. A number of studies and campus mental health strategies recommend appropriate mental health literacy training that focuses on skills development for responding to students with mental health needs and connecting them to appropriate care (Gulliver, Amelia, et al., 2017).

Research about the effectiveness of mental health literacy training among students is somewhat mixed. Using vignettes, a randomized controlled trial of students found mental health literacy training improved student confidence in providing help and personal attitudes towards a person with mental

health issues (Jorm, Kitchener, Fischer, Cvetkovski, 2010). In a randomized trial of over 30 campuses in the U.S.A., Lipson, Speer, Brunwasser, Hahn, & Eisenberg (2014) found that mental health first aid training increased resident advisor knowledge, confidence, and ability to respond to students with mental health needs compared to status quo training. However, other studies have found no impact of training on mental health recognition or beliefs among students on wait-lists for counselling services (Kitchener & Jorm, 2004; Loreto, 2017). Recent research has suggested that mental health literacy specifically aids problem identification and help-seeking attitudes/intentions in individuals with untreated clinical-range mental health issues (Cawley-Fiset, 2016).

### **Analysis:**

There are several advantages to improving mental health literacy on campuses. First, the increased knowledge will help students, staff, and faculty to better distinguish the dimensions of mental well-being and the coping mechanisms and strategies available for supporting mental health. Second, increased literacy may improve awareness and use of the myriad of services available on campus for supporting mental health, beyond counselling services. The University of Waterloo already offers some of these types of programs to staff and faculty, such as Mental Health First Aid (Mental Health Commission of Canada), More Feet on the Ground (mental health awareness) and Question Persuade Refer (QPR Institute: suicide prevention). Sometimes the demand for these programs cannot be met soon after the requests are made due to staff resource/allocation issues. When they are offered, they often have a high level of attendance and participants indicate that they learned important and relevant information. It will be important to continue to offer these programs and for faculty and staff to have ongoing opportunities for “refreshers” of this material. There may be a need to consider the intensity of the types of training provided to match the level of risk exposure of the trainees. For instance, students *not in* advisory, peer support, or first response roles may not require mental health first aid. However, those who are more likely to interact with others in times of crisis should receive mental health first aid.

## **Recommendations:**

1. The University of Waterloo should implement a comprehensive education and training strategy to increase mental health literacy among students, staff, and faculty. For staff and faculty, such education and training should be mandated and tailored to the various levels of engagement with students, analogous to Workplace Hazardous Materials Information System (WHMIS) training. For instance, mental health first aid may be appropriate for student advisors while lower intensity training may be reasonable for other support staff.
  - Training should be ongoing, with annual refreshers.
  - Training should include information about the “upstream” contributors to mental health, potential inequities among vulnerable populations (e.g., race, gender), and strategies for supporting those with mental health needs.
  - To ensure the appropriate impact of training, scales to assess mental health literacy should be utilized periodically. For instance, the Mental Health Literacy Scale (MHLS) could be used to assess patterns and changes to literacy (O’Connor & Casey, 2015)
2. Campus Mental Health Wellness Day is important and should continue, with expansion to other times of the year. These days provide ongoing opportunities for education and engagement related to mental health promotion and support.

## **How far can/should an organization like the University go in providing treatment for mental illness?**

It is this Panel’s position that the University should provide comprehensive mental health services for persons with serious mental health issues by providing stepped care and supports, comprehensive counselling and case management strategies, integrated mental health support in family physicians, and appropriate integration with community partners. Services on campus should focus specifically on crisis

services and response to ensure that the person receives comprehensive care and ongoing support; given the burden already placed on community partners it would not be reasonable for community partners to support fully our high needs students. The provision of services may also extend beyond clinical contexts to include mental health and wellness training, coping skills workshops available in person and online, and the use of electronic resources for navigating available resources as well as self-help/monitoring.

The University of Waterloo is not able to provide mental health services for some issues due to the type of interventions required and these issues may not be amenable to online intervention. For some issues, the University of Waterloo refers to community resources, such as Trellis and St. Mary's Counselling. The Community Partners panel may have more information regarding some of the specific services available in the community. The University of Waterloo needs to consider what services to recommend when it currently does not offer services for particular issues and there are not accessible community services for these issues due to wait time and/or fees involved.

Outlined in the following sub-sections a number of domains are reviewed in relation to the accessibility of mental health services, human resources and management of counselling and health services, and enhancements to service provision.

### *Accessibility of Mental Health Services*

The CACUSS/CMHA (2013) reports calls for Accessible Mental Health Services on campuses. Formal mental health services are provided by the Centre for Mental Health Research, Counselling Services, and Health Services on campus. There are many other offices on campus that provide other forms of services that are focused on students' mental health, such as AccessAbility Services, Equity Office, FEDS, Health Promotion, and various forms of student peer support. The panel views the issue of accessibility from a number of perspectives, including issues of wait-list management, the under-utilization of certain available resources (e.g., coping skills seminars, peer supports), and factors related to the organization

and delivery of counselling and health services. In addition to areas discussed in previous sections, such as cultural competence and inclusive approaches to services, the following section provides some information about some potential solutions to increase the accessibility of mental health services.

**Recommendation:**

1. A significant increase for money available in the student health plan for accessing psychologists/counsellors in private practice is needed, and education is provided to students about these funds and where they can be used in our community. Currently, the plan is \$400/year for up to 80% of the services accessed. Usually, private practitioners can meet with clients relatively quickly because they often do not have a waiting list.

**Self-Management Competencies and Coping Skills.**

The MH Panel recognizes the developmental stages of students and supports their continued development of self-management and coping skills. The panel also recognizes that the complexity of students' mental health issues continues to increase; one recent study indicated that some students may not finish undergraduate studies due to onset of mental health concerns (Marsh & Wilcoxon, 2015). Given these issues, it is important for student services professionals to collaborate with a range of stakeholders to develop services and resources that more students will access as needed, including proactively.

One area of emphasis is the importance of integrating technology into mental health services. Counselling Services has coping skills seminars and they are now online and continue to be offered in person. Also, the promotion of certain apps can be helpful for students to informally assess several times during a term how they are doing. Panel members' discussions were about providing students with more education how to differentiate typical stress from indicators associated with mental health issues and concerns. The panel emphasized the importance of students identifying issues earlier and not

waiting until they have more difficulties that negatively affect them emotionally, academically, interpersonally, and/or in other domains.

### **Use of Technology for Monitoring and Treatment**

There is a continually growing list of applications that students can use to self-monitor their mental health symptoms, including mood and anxiety tracking apps. Applications are also available for online therapy. The University of New Brunswick Counselling Centre has identified a specific online resource that is CBT-based that is called “see Betty” - <https://appadvice.com/app/see-betty-cbt/1229537839> and has an inventory of other apps that may be useful:

<http://www.unb.ca/fredericton/studentservices/health-wellness/counselling/helpfulappslinks.html>

Recent research indicates the efficacy of online approaches to counselling (e.g., Jiang, Wu, & Gao, 2017), which may be supplemental to in-person appointments, and have the potential to be expanded. Also, randomized control trials and meta-analyses indicate support for online intervention for anxiety and depression (e.g., Andrews et al., 2010). As an example, a recent publication with 72 clients at a university counseling centre participated in a study that compared therapist-assisted online (TAO) intervention with typical intervention for anxiety with the results indicating that TAO had more positive results (Benton, Heesacker, Snowden, & Lee, 2016). This article outlined advantages of TAO compared to traditional counselling/therapy including resources are available to clients 24 hours a day/7 days a week. It is beyond the scope of this panel to research this method more in-depth.

### **Recommendation:**

1. Further reviews need to be completed to understand more about the parameters of online services and the feasibility of offering them to University of Waterloo students. While some may consider the option of online mental health services to University of Waterloo students while they are on co-op or on a leave from their studies and are in a different province or country, for

psychologists as mental health service providers, the College of Psychologists of Ontario requires that clients are in Ontario when they receive services.

### **A Focus on Strengths**

The panel acknowledges the importance of recognizing students' strengths in developing and providing mental health services. One approach to encouraging students to identifying their strengths is used by the University of Calgary (<http://www.ucalgary.ca/currentstudents/ucalgarystrong/cliftonstrengths>) and it can be applied to studying and to career planning. **The panel suggests that the University of Waterloo considers implementation of this type of approach.**

### *Human Resource Capacity for Counselling and Health Services*

#### **Appropriate Staffing Levels**

The MH Panel recommends viewing counsellor/psychologist positions as essential services. One of the services counsellors/psychologists provide is crisis appointments. Counselling Services needs to have sufficient clinical staff to meet the number of crisis appointments and required follow-up appointments. The University of Waterloo website indicates that there are 31,380 undergraduate and 5290 graduate students for a total of 36,670 students and 17% of undergraduate students and 37% of graduate students are international. In their Statement Regarding Recommended Staff to Student Ratios, The International Association of Counseling Services (IACS) recommends as an aspirational goal 1 counsellor for every 1000 to 1500 students depending on other services offered to students; for a population of 36,670 the recommended FTE of counsellors would fall between 24.5 and 36.7 FTE. For most of the Fall 2017 term, Counselling Services had 16.4 FTE in counsellors/psychologists in non-management positions instead of the recommended 24.45 FTE to 36.67 FTE. There are currently 2.3 FTE in unfilled psychologist positions due to recent staff resignations. In addition, there are 2.8 FTE in positions on leave, just recently dropping from 3.8 FTE for the first part of the Fall 2017 term.

In addition to services provided by counselling staff, management in Counselling Services also provide some clinical hours of service. There are 5 management positions at Counselling Services: 1 Director, 1 Associate Director, and 3 Manager positions. There is significant variability regarding the number of clinical hours per week in the five management positions. If we project for 0.5 FTE for clinical hours, then we could add 2.0 FTE to the current FTE available, which would increase 16.4 FTE to 18.4 FTE. When those on leave return to work and resume a full workload, the projected FTE is 22.2 FTE.

**Recommendations:**

1. Given the many unique challenges faced by students at UW, such as increased pressure of cooperative education and higher ratios of international students, the panel recommends that the University of Waterloo considers implementing the lower ratio recommended by IACS to have 1 counsellor/psychologist FTE for every 1000 students which would result in 36.67 FTE.
2. Ensure that any funding changes required to increase staffing or service provision do not result in an increase in student fees. UW administration implements a different funding model for additional counsellor/psychologist positions; although currently a percentage of the cost of the current counsellor/psychologist positions are paid for by student fees and the remainder by administration, the panel is not recommending an increase in student fees to fund the proposed additional counsellor/psychologist positions. The Student Services Advisory Committee and other student groups need to be active decision-makers in funding allocation for any additional counsellor/psychologist positions.

**Accounting for Employee Leaves:**

Consideration is needed to ensure that extended employee leaves do not result in gaps to service provision. When a counsellor/psychologist takes an extended leave, UW does not hire replacements until the employee on leave exceeds the 6 months. This is due to the requirement that they are paid

100% of their salary for the first six months on leave with funding replaced by long-term disability leave after six months. However, given the high demand for mental health services on campus such gaps are problematic.

**Recommendation:**

1. Develop a strategy to ensure a full complement of counsellors/psychologists are consistently available, particularly in instances of employee leaves.

**Ensuring skills and expertise**

When hiring Counselling Services' and Health Services' staff, it will be important to focus on hiring those with particular areas of expertise. Further, consistent feedback from students is that they want "culturally competent" counsellors/psychologists. Though there may be different definitions and understandings of the phrase "culturally competent", it is reasonable to interpret it as including counsellors/psychologists with diverse cultural backgrounds, including fluency in languages other than English. For example, in the 2012 University of Waterloo mental health review, one of the recommendations/points was to hire a counsellor/psychologist who is fluent in Mandarin. Other students have requested "faith-based" counsellors/psychologists, or clergy who can provide support on campus. These calls are echoed in other campus reports on mental health. For instance, Queen's University (Queen's University, 2012) recommends that faith-based support is incorporated into the range of overall health and wellness options. Some other students have requested counsellors/psychologists who have experience with the LGBTQ community, including providing clinical services to them.

**Recommendation:**

1. The University develop a cultural competency strategy to meet diverse student needs. Such as strategy should include hiring psychologists/counsellings with appropriate training and backgrounds to

support various cultures, as well as opportunities for collaborates with chaplaincy-based services in this process.

### **The Role of Psychologists in Counselling Services**

Psychologists play critical roles in supporting student mental health. In particular, psychologists communicate diagnoses of mental health disorders, a role that Master's-level counsellors and psychotherapists are not able to fulfill due to regulatory standards. Students who require accommodations for mental health issues require a diagnosis. Assessments provided by psychologists are required for accessing accommodations so it is recommended that Counselling Services maintain that service.

However, there has been a reduction in psychologist FTEs over the last 2 years. Counselling Services has had 4 psychology clinical staff resign in a seven-month period in 2017 and 1 psychologist resigned in 2016. Three of these positions remain unfilled currently for 2.3 FTE.

Counselling Services needs to hire more psychology clinical staff to be able to meet the demand for students who are seeking accommodations for mental health issues. Not only do they need to replace the 2.3 FTE still vacant due to resignations, they need to hire more psychology clinical staff for a significant proportion of the additional counsellor/psychologist positions that this panel is recommending. One approach is to hire psychology staff who are close to finishing their doctoral degrees. These staff will require a minimal amount of supervision per week by a psychologist while working full-time (the College of Psychologists of Ontario determines specific supervision requirements).

### **Stressors Identified by Counsellors/Psychologists**

Dr. Walter Mittelstaedt, C. Psych., Director, Campus Wellness stated in talking with this mental health experts' panel that it is important to consider the well-being of Counselling Services' staff in this PAC SMH process. Staff's well-being is important for the provision of necessary mental health services for

students. However, certain structures and processes within Counselling Services may risk staff well-being, such as the on-call system and the management structure. Feedback about stressors was provided, in many cases unsolicited, by numerous staff in counselling services. Members of the MH Panel synthesized this feedback into several key themes.

### **On-Call System:**

Counselling Services currently has a rotational on-call system that for some counsellors/psychologists is mandatory when they were hired, and for others it is voluntary participation. Some counsellors/psychologists have identified significant concerns with this on-call system because they are on call following a typical workday. One counsellor in Sept 2017 had 6 on-call incidents to which she had to respond in a week. This is not a sustainable system. As well, the Employment Standards Act will change soon to include a requirement that an employee is paid for three hours for each time they are on call regardless of whether they are called in. Instead of spending money in this way, it is recommended that additional funding be provided to hire more counsellors/ psychologists. From a review of numerous university and college counselling centre reports, none advocated for their counselling centre staff to be on call in a consistent way. In fact, Queen's University's report (2012) stated that their counselling centre staff is not on call and the importance of strong connections with community mental health services.

### **Recommendation:**

**The recommendation is to cease having any involvement by Counselling Services' staff in the on-call system and to only utilize community services, such as Here 24/7, Good to Talk, or the Emergency Department at Grand River Hospital.** More broadly, there needs to be clear limits of the services that Counselling Services provides and does not provide and this information needs to be communicated clearly to students.

### **Management Structure at Counselling Services:**

The changes associated/inherent with the new management system in the last two years have been significant. Prior to the summer of 2015, there was only the Director in a management role in Counselling Services. In the summer of 2015, an Associate Director was hired and then in June 2016, three manager positions were added. All counsellors/psychologists are required to register with a regulatory/licensing body in Ontario and they are autonomous professionals. For professionals with at least a Master's degree, some with a doctorate degree, who are not in one of the management positions, they experienced change of having one person in management to whom to reported to directly (the Director) to having three people in a management hierarchy (their Manager, the Associate Director, and the Director). Given the amount of formal education and professional training that counsellors/psychologists have attained, they do not need to report to three levels of management. A relevant parallel is physicians at Health Services, who report to one Director within their clinic, rather than three levels of management.

Several counsellors/psychologists have commented that their stress levels have increased due to this management change. Many of the practical outcomes of these management changes have resulted in fewer hours providing therapy to students. Specifically, the changes have resulted in increased staff meetings, administrative work, time spent speaking with various levels of management to make decisions, and inconsistencies between decisions made by managers. Other stressors identified by counsellors/psychologists are not having sufficient input in decisions that affect them, including regarding their schedule, the number of clients, and the severity and complexity of client issues. With increased urgent and crisis appointments, there is a concomitant increase in the need for ongoing follow-up appointments, without the built-in time in their schedules; this situation results in appointments being added in to an already over-stressed system. The allocation of counsellor/psychologist time is an ongoing important issue. Another recommendation is an evaluation

of the allocation of time for counsellors/psychologists; for example, examining how much time is spent in meetings and administrative work compared to direct clinical service.

**Recommendation:**

**The recommendation is that the University hires an external reviewer regarding the management structure and professional practice at Counselling Services, including the on-call system.** Goals will be:

(a) to review the management structure and recommend changes, (b) to understand the contributing factors to the resignation of psychology staff and to make changes to markedly reduce the likelihood in the future, (c) to identify stressors for counsellors/psychologists and administrative staff and make changes to reduce or eliminate them.

**Physician Services in Health Services**

A large number of students with mental health needs visit health services. Between 2015 and 2016 17.6% (n=4027) to 26.2% (n=7017) of visits to the student and family clinics were mental health visits. It is important that many physicians at Health Services have a specific practice area in mental health among their other areas of practice. In the last 2.5 years, a number of physicians with a practice area in mental health have left Health Services and currently there is less than 1.0 FTE physician positions with this practice area. This number is too low for the University of Waterloo's student population. **It is recommended that the University of Waterloo undertake an external review to ascertain the reasons that these physicians left and what specific changes need to occur to recruit and retain additional physicians with a focus on mental health.**

*Enhancing Service Provision*

**Collaborative Complex Care Team**

**The MH Panel supports recommendations made by psychiatry services at Health Services, University of Waterloo for Health Services and Counselling Services to develop a complex care team to respond**

**to students with more complex mental health issues.** The complex care team will include psychiatrists, mental health nurse, counsellors/psychologists, and a case manager; the inter-disciplinary team will have distinct roles in providing care to these clients in a more integrated and comprehensive way than what can be provided currently between professionals at Health Services and Counselling Services. Based on best practices, the complex care team will have established criteria for which clients will receive service from this team and it will include those who are at high risk for suicide. During the Fall 2017 term, Campus Wellness approved this approach with the goal of it being implemented in Winter 2018. One of the positions on this team will be a clinical case manager for which funding has been approved. Additional case managers may be needed as the implementation of this model progresses. This approach is supported externally by the Canadian Medical Association and Canadian Psychiatric Association (2016) and the College of Family Physicians of Canada (2011).

### **Stepped Care**

**The MH Panel recommends that stepped care approach be implemented within health and counselling services at the University of Waterloo.** Stepped Care is an approach to mental health care where care/response is adjusted in stages from low to high intensity, to help match the client's needs/condition. Treatment options are organized through a hierarchy and patients are triaged to the most appropriate level of support or step (O'Donohue & Draper, 2011). Stepped Care helps to encourage and empower patients to play an active role in their care (Stepped Care 2.0, 2017). Care providers and patients work collaboratively to identify the treatment option(s), encouraging a shared decision process in mental health care. Progress is monitored and patients can "step up" to higher intensity or "step down" the treatment options or components to the treatment. Therefore, intensity of treatment and care is matched with the patient's condition/ presenting concerns, and their current need (e.g., if a student arrives feeling isolated they may be referred to a group or peer support resources). The aim is to provide care that is personalized, and interventions at the right time and at appropriate

levels (Van Straten, Hill, Richards & Cuijpers, 2015; Seekles, Van Straten, Beekman, Van Marwijk, & Cuijpers, 2011). A stepped care approach to mental health service provision could involve the following elements (Australian Government; Franx et al., 2012):

- a. Stratification of the population into different ‘needs groups’. These groups can range from targeting prevention, through to those with severe, chronic, and complex conditions. This process may also be called patient differentiation, relying upon assessment of the patient and classification of severity of concern according to the stepped-care criteria. Similar approaches have been introduced as levels of care within a number of Canadian and U.S. jurisdictions (e.g., managed care systems). Several researchers at the University of Waterloo (John Hirdes and Chris Perlman) have developed assessment systems and decision support algorithms to inform classification of severity for these purposes. Assessment tools such as the interRAI suite of mental health and children/youth mental health instruments have been designed for these purposes and are in use in settings across Ontario, and internationally. The interRAI Canada research group is based in the School of Public Health & Health Systems at the University of Waterloo.
- b. Compiling and defining a comprehensive list of evidence based services that are available to respond to the spectrum of needs.
- c. Matching service types, based on intensity of need, to the treatment targets for each needs group and delivering services accordingly (e.g., self-help, psychoeducation, physical exercise).
- d. Outcome monitoring – Symptom severity is monitored. “Stepping up” to a more intense intervention is considered if there is an insufficient response.

An example of what an initial consultation within a stepped care model can include:

- Student is introduced to the stepped care model, whereby students are also provided basic psychoeducation about this method. This can be an important time to encourage student ‘buy-in’ (or understand and consent to) to this approach.
- Comprehensive assessment of the student’s needs, including clinical, functional, economic, academic, and social contexts.
- Collaborative development of a care plan with the therapist and student based on information from the assessment.
- Matching the student to the appropriate services (e.g., external referrals – academic advisor, accommodations, internal referrals – workshops, Therapy Assisted online (TAO) website.
- Setting a check-in session to assess progress and consider if a more or less intense step may be needed.

### **Expanding the Scope of Peer Support**

The University of Waterloo includes a number of peer engagement programs that provide student-led counselling and support. These include MATES, Glow, Student Success Office, and the Women’s Centre. There are also peer health education teams supported through campus wellness. These include Healthy Minds, a network of students who provide workshops to understand or remember how to better one’s mental health in stressful times, and the Recreation & Leisure Wellness Team, students working to help remove stigmatization around mental health. The existence of such services is important given that there is a growing recognition of the importance of peer support. However, an area lacking is peer support provided by persons with lived mental health experience.

Peer support involving persons with lived experience is a recommended practice within mental health services. The Mental Health Commission of Canada (MHCC) has identified peer support as an essential component of mental health services within their mental health strategy, relating to strategic

direction 3: “Provide access to the right combination of services, treatments and supports, when and where people need them” (MHCC, 2012). Evidence consistently demonstrates that peer support can improve mental health outcomes, reduce hospital visits, and improve quality of life (Nelson et al., 2006; O’Hagan et al., 2010).

The MHCC has produced clear guidelines for enhancing peer support through engagement of persons with lived experience. These guidelines focus on skills and attributes from lived experience, interpersonal communication, critical thinking, teamwork and collaboration, and ethics and reliability. Three key training themes are proposed: fundamentals of peer support, social and historical context of peer support, and approaches that promote effective peer-to-peer engagement.

#### **Recommendations:**

1. Peer support services at UW are enhanced to include support from persons with lived experience. This could include having a peer available during the intake process as well as anonymous drop-in groups. Peers should receive appropriate training and, as such, be reimbursed for their services. The design and training for peer support should follow the MHCC’s guidelines (MHCC, 2013). The Self-Help Peer Support service at the CMHA Waterloo Wellington may be a valuable resource for consultation given their strong training program and breadth of support services (<https://cmhawwselfhelp.ca/> )
2. Ensure that each Faculty includes peer support networks, including fellow students and alumni, to provide support for the marinade of pre-clinical issues, such as work-life balance, academic activities, and professional planning.

#### **Services that are Responsive to Preventing and Supporting Victims of Sexual Violence**

Considering the high rates of sexual violence in the general population and the university student community (Conroy & Cotter, 2014), and its significant negative effects on mental health (e.g.,

Campbell, Dworkin, & Cabral, 2009), it is important that the University of Waterloo has a clear mandate regarding prevention and intervention to sexual violence. The University of Waterloo is part of the “He for She” campaign and it hired Amanda Cook as “Sexual Violence Response Coordinator” in July 2017.

**More broadly, it is recommended that the University of Waterloo implements strategies to prevent sexual violence (e.g., DeGue et al 2014).** The University of Waterloo has informal protocols for responding when sexual violence occurs in residences. Counselling Services and Health Services provide professional services for students who have experienced sexual violence, including referral to St. Mary’s Hospital, Kitchener, as appropriate and based on students’ consent. It is recommended that the University of Waterloo develops more formal protocols for how to respond to incidents of sexual violence on campus, including in residence.

### **Screening and Assessment**

**The panel recommends review opportunities for enhancing screening and assessment practices in a variety of areas, including self-screening, person-centred suicide risk assessment, and assessment approaches available to first responders.**

### **Self-screening and Monitoring**

The purpose of screening is to detect cases of *something* that are/is previously unrecognized and cases that would not be otherwise detected, in order to allow for further assessment and treatment, if appropriate. The World Health Organization (WHO), states screening is appropriate when there is an important health problem that is prevalent in the population and when the health problem would not likely be detected without screening. In these situations, the entire population of interest would receive a screening tool that is highly sensitive and specific. In the U.S., trials of online screening systems have shown promise for promoting readiness to consider and engage in treatment (King et al., 2015). The

Electronic Bridge to Mental Health Services (eBridge) system includes personalized feedback and optional online counseling delivered in accordance with motivational interviewing principles.

### **Person-Centred Suicide Risk Assessment**

A number of best practices exist in screening for suicide risk assessment, a primary focus at intake at counselling services. The Ontario Hospital Association has developed a guide that outlines some of these practices to ensure that the screening process is comprehensive and person-centred (Perlman et al., 2011). A key component of this process is to ensure that the risk assessment does not solely rely upon a risk assessment tool. While a number of tools have been developed to assess for suicide risk, none have been found to accurately predict suicide. Instead, tools should be used as checklists to corroborate and inform clinical judgment, but not replace it. The process of risk assessment should be done in a way that is trauma-informed, building therapeutic rapport whenever possible. Risk should be clearly documented and communicated with relevant care partners.

### **Assessment by First Responders**

There may be opportunities to extend assessment beyond the context of counselling and health services. Campus police and other first responders commonly engage in situations involving mental health. There may be value in having police services utilize tools that are available and in-use by police in other jurisdictions to assess and appropriately triage persons with mental health needs. For instance, Waterloo Regional Police, Brantford Police Services, and some detachments of the OPP use the interRAI Brief Mental Health Screener and the HealthIM platform to assess persons apprehended for mental health reasons (Hoffman, Hirdes, Brown, Dubin, & Barbaree, 2016). This platform was developed at the University of Waterloo and is based at the Accelerator Centre (<https://healthim.com/>). These tools use algorithms to predict the level of acuity of the person and help support the officer's assessment of the

situation. Information can also be communicated from the officer's cruiser to the local hospital or community mental health provider.

### **Walk-In and Single Session Interventions**

There has been an increase in single session therapy approaches being used in counselling centres in Ontario (Hymmen, Stalker, & Cait, 2013). Approximately a year and a half ago, Counselling Services began offering walk-in appointments two days per week and single sessions during the week. Other university counselling centres in Ontario offer same-day appointments, usually based on urgency of the clinical issues. At Counselling Services, University of Waterloo, walk-in appointments are designed to provide an individual appointment with a counsellor/psychologist the same day. Single sessions are intended to be scheduled within a few business days for issues that are more contained and do not require ongoing counselling. It is important to differentiate use of the terms and type of service offered to assist clients in their understanding of services as well as for quality assurance and service evaluation. Walk-in appointments are not scheduled ahead of time and clients have a more urgent concern. Single sessions can be walk-in or scheduled (Bloom & Tam, 2015). Campbell (2012) described how single-session therapy focuses more on identifying clients' strengths and resources with the development of a plan for the client in session; this approach is different than longer-term counselling/therapy that relies more on counsellor/therapist expertise. Therefore, certain long-standing mental health issues are not amenable to this approach.

Although clients' evaluations of these walk-in and single session therapy services are generally very positive (Campbell, 2012), including evaluations at Counselling Services, University of Waterloo, caution needs to be used in interpreting these results due to methodological issues, e.g., no control groups (e.g., Stalker, Horton, & Cait, 2012). Campbell (2012) summarized a few controlled studies that demonstrated positive results for single-session intervention for specific phobia for example; however, therapeutic orientation may not be as important as non-specific factors though these have not yet been

identified. Single session intervention is identified as cost-effective. The mental health experts' panel suggests consideration of expanding walk-in and single session appointments at Counselling Services, University of Waterloo, along with clear delineation of type of appointment, and implementation of standardized research designs, such as control groups, for its evaluations. As well, it will be important to consider if clients who access walk-in and single sessions are also accessing other mental health services on-campus and off-campus, and the type and severity of mental health issues they are experiencing when evaluating these types of services.

### **Group Counselling and Workshops**

In response to increased demand at university counselling centres, some have focused more on groups and workshops, e.g., the University of British Columbia's counselling centre. One of the issues that arises at Counselling Services, University of Waterloo, is that groups typically start in the third or fourth week of the term and are closed, i.e., students cannot join after it has begun. To respond to this issue, Counselling Services is in the process of developing three-session groups that will be offered multiple times a term to allow students to attend if they want to join after the longer (6- to 8-session) groups have begun. **It is important to explore mechanisms of enhancing student engagement in group counselling and skills building workshops.**

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