Overcoming Help-Seeking Barriers and Service Demands on Canadian University Campuses and the Role of Campus Support Services

by

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Abstract

Across North America, the pervasiveness of psychological issues on university campuses is becoming increasingly concerning. As such, university counselling clinics and health centres are currently being taxed and staff and administrators are scrambling to keep up with the growing demands. While this is worrisome, it is somewhat overshadowed by the fact that most students (up to 90%) do not seek help for psychological concerns. Thus, while the majority of students are not getting the help that they need, universities are struggling to keep up with the relatively small number of students that are accessing services. Taken together, this suggests that the current structure of support services is not working. The purpose of the present study was to better understand why Canadian students are not seeking on campus support for psychological issues and further, to generate practical suggestions for how support services can be modified to overcome current help-seeking barriers and service demands on campus. The research questions included: a) What are the barriers identified by staff/administrators and students that prevent Canadian students from seeking help for psychological issues on university campuses?, b) What mechanisms are currently being used by universities to address the help-seeking barriers and service demands on their campuses?, and c) What policy and practice changes are still needed in order to address help-seeking barriers and service demands? A generic qualitative approach (interpretive description; Thorne, 2008) was employed as the methodological framework. A sample comprised of 23 staff and students from three Canadian institutions was recruited. Data was collected via

semi-structured interviews and analyzed utilizing the framework offered by Thorne (2008). Various themes outlining barriers to help-seeking and mechanisms to overcome these barriers emerged from the data. Conceptually, the "barriers" were organized into individual, structural, and systemic themes, while the "mechanisms" were organized into structural and systemic themes. Overlap between these areas is discussed. The findings are discussed utilizing related research as a foundation. In addition, practice implications are thoroughly reviewed and future directions are outlined.

Preface

This dissertation is an original work by Erica Irene Dunn. The research project, of which this dissertation is a part, received research ethics approval from the University of Alberta Research Ethics Board 1, "Overcoming Help Seeking Barriers and Service Demands on University Campuses," No. 32868, September 11, 2012.

Dedication

For my family.

Acknowledgements

I would foremost like to thank the many participants who offered their time in support of the present study. The nature of this project emphasizes the demands that come with being a university student or staff member. In spite of that, you all took time away in order to share your valuable stories, knowledge, and insights in support of research and the greater well-being of students. Please know how deeply this is appreciated.

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Chapter One

Introduction

"It is time for a renewal of thought, discussion and action about student health. Our expanding knowledge of the processes and paradigms of learning, emerging institutional commitments to student success, and a revised formulation of the elements of health itself demand that our facility-centered, service-oriented, illness-focused, and program-driven model of student health be reconsidered" (Silverman, Underhile, & Keeling, 2008, p. 4)

The psychological health and well-being of university students has come into question in recent years. Across North America, the pervasiveness of psychological issues seen on university campuses is becoming increasingly concerning (Eisenberg, Hunt, Speer, & Zivin, 2011; Hunt & Eisenberg, 2010). Researchers are finding that undergraduate and graduate students are currently struggling with addictions, anxiety, depression, self-harm, suicidality, transition issues, and general distress in overwhelming numbers (American College Health Association, 2011, 2013a, 2013b; Eisenberg, Gollust, Golberstein, & Hefner, 2007; Eisenberg, Hunt, & Speer, 2013; Hyun, Quinn, Madon, & Lustig, 2006; Stecker, 2004; Storrie, Ahren, Tuckett, 2010). As a result, our campus counselling and health centres are being taxed and university administrators are scrambling to keep up with the growing mental health needs of students (Kitzrow, 2003; Storrie et al., 2010).

Interestingly, despite the strain experienced by some campus services, research is also showing that many students "suffer in silence" (Storrie et al., 2010). In fact, it has been estimated that up to 90% of students with psychological issues fail to seek help (Rosenthal & Wilson, 2008). This resistance is occurring in spite of the fact that university campuses provide extensive and diverse support services including career and guidance offices,

disability services, counselling centres, health care centres, sexual assault centres, campus recreation facilities, ombudspersons, international student centres, financial support offices, gay and lesbian supports, and so on. The research repeatedly suggests that students forgo seeking help for psychological issues from on campus services because there are various barriers standing in their way. Stigma, cultural beliefs, a desire to deal with things "on their own," time, finances, gender, age, hopelessness, and knowledge of services are but a few of the possible factors that have been identified (Cellucci, Krogh, & Vik, 2006; Eisenberg et al., 2011; Eisenberg, Golberstein, & Gollust, 2007; Mitchell, Greenwood, & Guglielmi, 2007; Rosenthal & Wilson, 2008; Williams, Galanter, Dermatis, & Schwartz, 2008; Yorgason, Linville, & Zitzman, 2008).

Much of the research related to university student barriers to help-seeking is carried out on international campuses, including those in the United States, Europe, and Asia. Little research has been conducted regarding barriers to help-seeking at Canadian institutions. Although there is a strong likelihood that the barriers felt by students world-wide are pertinent to Canadian students, the Canadian university structure, culture, and expectations differ from other nations. For example, medical care in Canada is free and student services are often offered with little to no associated cost, differing from some American institutions. In addition, the differences in student diversity, admissions stressors, program design, campus culture, and attitude help to further differentiate Canadian campuses from those around the world (Ballingall, 2011; Laughlin, 2011). It is important to gain an accurate understanding of the barriers to help-seeking faced

by students studying on Canadian campuses in order to more adequately understand and address their needs.

In speaking about barriers to help-seeking, Joyce and Weibelzahl (2011) aptly point out, "the literature is strangely quiet on attempts to overcome these barriers" (p. 287). Clearly, understanding the barriers to help-seeking is only the beginning and effort also needs to be invested into overcoming both structural and psycho/social obstacles. Arguably, an important starting place lies in efforts to re-evaluate and perhaps redefine current approaches to support service delivery on university campuses. It is clear that current methods of offering support are not working because most students forgo accessing services, yet counselling and health centres are struggling to keep up with the small body of students that look for help (Kitzrow, 2003). As such, it is important to understand the potential voids in the services currently being offered and how the delivery and structure of these services can be modified in order to not only overcome barriers, but to better meet the growing demands and help-seeking preferences of the students. Conceivably, incongruence between support services and the needs of students is one contributor to the growing decline in students' psychological well-being.

Purpose of the Study

Mental health problems, mental illness, and distress are very real problems on Canadian university campuses (Cairns, Massfeller, & Deeth, 2010; MacKean, 2011; Patterson & Kline, 2008). Although statistics highlight the severity of the psychological concerns experienced by students (e.g., American College Health Association, 2011, 2013a), universities continue to struggle with understanding

how to effectively offer support (MacKean, 2011; Patterson & Kline, 2008). This is evidenced by the fact that campus mental health services (e.g., counselling clinics) are being taxed at a time when only small minorities of students who need services are accessing them (Kitzrow, 2003). Research conducted around the world highlights many barriers to help-seeking experienced by students (e.g., Eisenberg et al., 2011; Eisenberg, Golberstein, et al., 2007) and a small body of research is beginning to identify novel ways of restructuring support services in order to both overcome these barriers and service the growing numbers of students seeking help (e.g., Davis-McCabe & Winthrop, 2010; Joyce & Weibelzahl, 2011; Mitchell et al., 2012; Ryan, Shochet, & Stallman, 2010). However, virtually no work of this nature has been done in Canada. Thus, the purpose of the present study is to gain a Canadian perspective on the barriers that prevent students from seeking help for psychological issues and further, to better understand how university support services - including counselling clinics and health centres, as well as the various other aforementioned services - can help overcome these barriers and more effectively serve the growing number of students in need. The overarching goal is to provide an overview of barriers felt by Canadian students that prevent help-seeking for psychological issues and moreover, to provide an outline for how support services can be modified in order to overcome these barriers and meet the growing demands for service.

Research Questions

In order to better understand the barriers to help-seeking felt by Canadian students and to subsequently generate practical suggestions for how support

services can be modified to overcome the help-seeking barriers and service demands on campus, the present study answered three questions from the perspectives of university staff /administrators and students:

a) What are the barriers identified by staff /administrators and students that prevent Canadian students from seeking help for psychological issues on university campuses?

b) What mechanisms are currently being used by universities to address the help-seeking barriers and service demands on their campuses?

c) What policy and practice changes are still needed in order to address help-seeking barriers and service demands?

Study Significance

The present study is the first of its kind in Canada. As such, it provides Canadian university administrators with a starting place in understanding the barriers to help-seeking faced by students and, moreover, it gives administrators additional strategies for modifying support services in order to better address the needs, demands, and help-seeking preferences for today's students. Because the study incorporates data from staff/administrators and students from campuses across the country, the findings are representative of the potentially diverse needs in the Canadian university population. Through analyzing the national perspective on help-seeking and the role of university support services, this study is an important step forward towards tackling epidemic of mental health problems on university campuses and arguably contributes to the betterment of student well-being across Canada.

Context

Certainly, it goes without saying that the state of mental health on universities campuses is reflective of a larger national problem. More specifically, recent research (e.g., Statistics Canada 2013a, 2013b) has outlined that more than a third of Canadians meet the diagnostic criteria for a mental or substance use disorder at some point during their lifetime. In addition, when looking over the 12 months prior to data collection, Statistics Canada (2013a) found that the rates of both mood disorders and substance abuse disorders were highest for youth aged 15-24 (Statistics Canada, 2013a). Sadly, there is a national tendency for those struggling with psychological disorders to abstain from seeking help (Afifi, Cox, & Sareen, 2005). Moreover, while one in six Canadians have a perceived need for mental health care, 33% of these individuals feel their needs were only partially met or not met at all (Statistics Canada, 2013b). The most common barriers to access were features of the health care system, personal circumstances, or a desire to deal with things on their own (Statistics Canada, 2013b). Thus, it is not only universities that are having difficulty meeting the mental health care needs of the population, it the entire country that is struggling with this issue.

Researcher Interest

My interest in completing the present study grew out of two unique passions that I discovered and fostered during the tenure of my undergraduate degree: mental health and working with university students. As an undergrad, I worked as a "don" (i.e., resident assistant) for two consecutive years. Over the

course of this time, I lived with hundreds of first-year students, aiding them with their transition to university and supporting their mental health, practical, academic, relational, and physical health needs. During my time in this position, I came to understand the many ways in which university students struggle and, more importantly, how failing to seek the necessary assistance leads to significant difficulties with personal and academic functioning. I witnessed students leave university (both by choice and as a result of university policy) because they were not provided the support they needed; this affected me as I felt many of these students had the capacity to be successful in the post-secondary environment, yet by the time their difficulties were recognized, it was too late. Certainly, such experiences heightened my interest in strengthening support services for this population.

My undergraduate years were also spent immersed in psychology. With a major in honours psychology and a minor in sexuality, marriage, and family studies, I was repeatedly exposed to information that helped me understand the human spirit and the ways in which pain and suffering are experienced and exhibited by people. I was also provided specific information around clinical psychology, psychopathology, and mental illness, which ignited a passion for mental health. This, combined with an intrinsic desire to help others, led me into the field of counselling. Finally, thanks to the systemic focus of my minor subjects, I was also exposed to information that helped me understand the global influences on the health and well-being of individuals; this certainly influenced my conceptualization of the present study.

My passion for mental health and working with university students has culminated in the pursuit of a doctoral degree that has allowed me to complete the present study. I look forward to devoting my career to working with university students and attempting to make strides in bettering their mental health. Even though I believe the room to grow in this area is endless, I feel confident that the present study is an important and necessary starting point.

Overview of Dissertation

This dissertation is presented over five chapters. In the second chapter, the reader is provided a comprehensive literature review that details the current state of mental health on campus - including trends, current barriers to help-seeking, and attempts to overcome these barriers – as well as a snapshot of mental health on Canadian campuses. In the third chapter, the reader is provided an overview of the methodological framework that guided the present study and details around the data collection and analysis procedures are listed. The fourth chapter portrays the findings of the present study, documenting the results of the analysis and providing rich detail around each of the themes that were discovered. In the fifth chapter, the findings are triangulated within the context of current research and important practice implications are discussed. The conclusion can also be found in this chapter.

A review of particular terminology is important for all readers. First, because literature from around the world is being utilized, the terms “college” and “university” are used interchangeably in the literature review. This is reflective of international usage of the terms, particularly in the United States (US). However,

readers should note that Canadian university campuses are the focus of the present study. Further, the terms "support services" and "student services" are used interchangeably and denote non-academic campus units whose function is primarily to support students both academically and personally. While the specific services will differ from campus to campus, this often includes counselling services, a health centre, an ombudsperson, a career guidance centre, a disability centre, an international student office, and so on. Also, the terms "psychological concerns" and "psychological issues" are used to encompass mental health problems, mental illness or psychological disorders, and distress. For the purposes of the present study "mental health problems" is used to refer to problems associated with "the capacities … to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face" (Public Health Agency of Canada, as cited in MacKean, 2011, p. 11); this may include for example, anxiety. Next, "mental illness" or "psychological disorder" is used to refer to a diagnosable condition as defined the *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition* (DSM-5; American Psychiatric Association, 2013); this may include for example, Generalized Anxiety Disorder. And finally, "distress" is used to identify a threat to overall well-being, or "positive feelings of happiness and satisfaction" (New Economic Association, as cited in MacKean, p. 11); this may include for example, feeling stressed or overwhelmed.

Chapter Two

Literature Review

This chapter is used as a means of introducing readers to the current research related to the topic under investigation. Moreover, the literature review is used to highlight the complexity of the issues at hand and helps to effectively underscore the need for the current study. An overview of the changing post-secondary climate is initially provided, along with a thorough review of the current mental health issues plaguing university campuses. A review of support services available on campus and help-seeking tendencies and barriers is also provided. This chapter closes by offering a summary of the related Canadian research.

The Changing Post-Secondary Climate

More young Canadians than ever are pursing post-secondary education (Public Health Agency of Canada, 2011). In fact, statistical data from the Public Health Agency of Canada (2011) suggests that "the percentage of Canadians aged 25 to 34 years who completed post-secondary education increased by 16% (from 40% to 56%) between 1978 and 2008" (pp. 4-5). Relatively speaking, these numbers are exceptional; Canada has the second-highest number of young adults finishing post-secondary education (next to Korea) in comparison to all other Organization for Economic Co-Operation and Development (OECD) countries, including the United States, Japan, the UK, and Australia (Public Health Agency of Canada, 2011). Additionally, Statistics Canada (2009) data shows that the increases in post-secondary enrollment are consistent across apprenticeships,

colleges, and universities. Thus, it can be concluded that campuses across Canada are growing.

Just as the number of young people studying on college and university campuses is on the rise, the demographics and personal characteristics of students across both Canadian and international campuses also seems to be changing (Cairns et al., 2010; Kitzrow, 2003; Prescott, 2008; Stallman, 2010; Stewart & Bernhardt, 2010; Storrie et al., 2010). For example, Stewart and Berhardt (2010) looked at differences in self-assuredness, impulse control, achievement assets, psychological health, and narcissism between 2004-2008 undergraduate and graduate students and pre-1987 undergraduate students. In this study, the authors found that, in comparison to the pre-1987 students, the 2004-2008 undergraduates had significantly worse psychological health, academic motivation and ability, and impulse control, and significantly higher self-esteem, competitiveness, envy, entitlement, and sense of being underappreciated. Additionally, in comparison to students in the past, the current generation of university students are more diverse, have access to a larger number of medications, come from more protective home environments, faced higher expectations during their adolescent years, are more technologically savvy, are forced to deal with more familial break-ups, and face more stress and well-being issues than ever before (Kadison, 2006; Kadison & DiGeronimo, 2004; Kitzrow, 2003; Storrie et al., 2010). Finally, in reflecting on changes observed throughout twenty-five years as the chief of the Mental Health Service at Harvard University, Richard Kadison suggests that, unlike previous generations, “many in this college generation have been raised in a culture of

conformity and high expectations" (Kadison & DiGeronimo, 2004, p. 43). As such, there is a tendency for students to define their self-worth based on academic achievement (Kadison & DiGeronimo, 2004). This thinking not only creates exceptional stress for the incoming generation of students, but also sets them up for a downward spiral when they do not experience the same successes they once enjoyed in high school (Kadison & DiGeronimo, 2004).

Certainly, the argument can be made that the changing trends in the university population are simply reflective of the differences between current and previous generations that are observed on a more global stage. For example, researchers (e.g., Twenge, 2006; Twenge, Konrath, Foster, Campbell, & Bushman, 2008) have found that narcissism, entitlement, and confidence stream through what has been termed "generation me" at shockingly high rates. Yet, these same researchers have found that despite this façade of confidence, young people tend to be more depressed, anxious, and lonely than ever before (Twenge, 2006). Yes, the current population of university students are really just a subset of this so-called "generation me," yet some researchers are finding that the distress felt by university students is even worse than that found in the general population (Stallman, 2010). Although not supported by American studies, an Australian multi-university study by Stallman (2010) reported that students are significantly more distressed and have more mental health problems than the general population. Looking at this phenomenon from a more local perspective, results from the recent National College Health Assessment Survey (NCHA) conducted at the University of Alberta in 2011 found that 34% of students felt "so depressed

it was difficult to function" (University of Alberta Wellness Services, n.d.). Although different measures are used, this number is extraordinarily higher than the national average (Public Health Agency of Canada, 2011). More specifically, a 2011 report from the Public Health Agency of Canada reports that "4.5% of all Canadians aged 15 years and older met all measured criteria for having a major depressive episode in the previous 12 months" (p. 12). Sadly, depression is one of many threats to functioning felt on university campuses; a thorough overview of the mental health crisis is subsequently provided.

Collectively, this information suggests that university students are a particularly vulnerable and at risk population. Not only are they members of a generation that generally tends to thrive off of competition, entitlement, and confidence, despite lower motivation, impulse control, and academic ability, but they are also more prone to distress, higher expectations, and psychological issues than their same-aged non-student peers. This finding helps to prioritize the study of university students in Canada.

Mental Health and Well-Being: A Sad State of Affairs on University Campuses

Concern around university student mental health has surfaced in recent years. Certainly, the emphasis placed on mental health by the World Health Organization (WHO) combined with the more recent tragic events at Virginia Tech, Northern Illinois University, Dawson College, and other colleges and universities worldwide have highlighted the need for increased focus on mental health on university campuses (Blanco et al., 2008; Eisenberg, Golberstein, et al.,

2007; Storrie et al., 2010). Arguably, the transition to university comes at a time when, developmentally, a young person is already experiencing a heightened number of physical, hormonal, and emotional challenges, including, for example, identity development, relationship and sexuality issues, and body image pressure (Kadison & DiGeronimo, 2004). In spite of this, however, there is also strong agreement that the number and severity of mental health and well-being issues on university campuses that extend beyond "normal developmental issues" is becoming problematic (Cairns et al., 2010; Eisenberg et al., 2011; Hunt & Eisenberg, 2010; Kadison, 2006; Storrie et al., 2010; Zivin, Eisenberg, Gollust, & Golberstein, 2009). Because of these findings, many researchers have tried to understand the what, why, and how of the current mental health epidemic that plagues university campuses. An overview of the collective findings is in the next section.

What is happening? In recent years, several studies have suggested that the utilization of mental health services on university campuses is increasing, as is the number and severity of the psychological problems among students (e.g., Benton, Robertson, Tseng, Newton, & Benton, 2003; Gallagher, 2010). Currently, there is uncertainty as to whether this observed trend is the result of increased help-seeking among students, increased admission of students with mental health problems, increased mental health problems among the young adult demographic, generally, or a true increase of mental health problems in the university population that result from environmental factors specific to the university climate (Hunt & Eisenberg, 2010). In reality, research is showing

support for each of these hypotheses. For example, in a review of the related research on the topic, Hunt and Eisenberg (2010) indicate that a) research supports the notion that young adults have more favourable attitudes towards help-seeking, b) there may be a "moderate increase" (p. 6) in mental health disorders among this population on a global scale, and c) they personally suggest that the intervention received during childhood and adolescence in combination with the availability of psychotropic medication has allowed many students with pre-existing psychological disorders to attend post-secondary schooling. Similarly, Kitzrow (2003) speculates that the observed increases in counselling utilization, psychological concerns, and symptom severity might be reflective of the increasing diversity of the college population, the current demographics of students, and "cultural factors such as divorce, family dysfunction, instability, poor parenting skills, poor frustration tolerance, violence, early experimentation with drugs, alcohol and sex, and poor interpersonal attachments" (p. 169).

In spite of all the hypothesizing about the "why," there are two agreed upon facts across the literature that summarize the current state of affairs on university campuses: many students are struggling with psychological issues and despite the increased utilization of counselling services, many students fail to seek help. More specifically, research highlights that an overwhelming number of university students across North America are battling drug, alcohol, and gambling addictions, feeling depressed or anxious, coping with psychological disorders, engaging in self-harm and contemplating suicide, and are overwhelmed by stress, transition issues, acculturation pressure, and fatigue (Clearly, Walter, & Jackson,

2011; Cokley, Hall-Clark, & Hicks, 2011; Drum, Brownson, Denmark, & Smith, 2009; Eisenberg et al., 2013; Eisenberg, Gollust, et al., 2007; Garlow et al., 2008; Gollust, Eisenberg, & Golberstein, 2008; Kitzrow, 2003; MacKean, 2011; Serras, Saules, Cranford, & Eisenberg, 2010; Weinstock, Whelan, & Meyers, 2008). Moreover, while many students are coming forward with these issues, the reality remains that most students avoid seeking help (Zivin et al., 2009). A more thorough overview of help-seeking tendencies and barriers to help-seeking for psychological concerns is provided later in this chapter; for now, let's take a closer look at the problems.

Substance use and addiction issues. Drugs, alcohol, smoking, pornography, and gambling are prevalent issues on university campuses (Buckner, Ecker, & Cohen, 2010; Low, 2011; Twohig, Crosby, & Cox, 2009; Wechsler & Nelson, 2008; Weinstock et al., 2008). In many cases, student interaction with these substances quickly excels to a problematic level or a full-blown addiction. For example, in a study examining undergraduate men, it was determined that approximately half the sample (49%) viewed pornography and 58% of those of who viewed it found they experienced problematic outcomes, including pain and injury to the self and others, relationship problems, guilt, shame, and academic and job issues (Twohig et al., 2009). Similarly, in a review of the literature related to on campus gambling, Weinstock and colleagues (2008) noted that 3% to 6% of students "meet diagnostic criteria for pathological gambling," and that such behaviour results in "poorer academic performance and greater risk taking, including heavy alcohol consumption, nicotine use, illicit drug

use, and unprotected sex" (p. 513). In Canada, the 2004 Canadian Campus Survey (Adlaf, Demers, & Gliksman, 2005) suggested that 61.5% of undergraduates had engaged in gambling behaviour at least once since the outset of the school year. Moreover, the same report suggests that "7.9% of all students were identified to be at risk for developing serious gambling problems" (Adlaf et al., 2005, p. iv), with male students posing a greater risk than female students.

Arguably, the statistics on drug and alcohol abuse are more concerning. In 2003, Ham and Hope published a comprehensive literature review on problematic drinking on college and university campuses. In their review, some particularly pertinent statistics were identified. Namely, across the research, some studies have found that over 80% of students consume alcohol (Johnson, O'Malley, & Bachman, 2000, as cited in Ham & Hope, 2003), 44% of students are binge drinkers (Wechsler, Molnar, Davenport, & Baer, 1999, as cited in Ham & Hope, 2003), 13.1% of students meet diagnostic criteria for alcohol abuse, and 11.4% meet criteria for alcohol dependence, based on *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition* (DSM-IV; American Psychiatric Association, 1994) criteria (Clements, 1999, as cited in Ham & Hope, 2003). In Canada, the 2004 Canadian Campus Survey stated that "32.0% of undergraduates reported hazardous or harmful patterns of drinking according to the World Health Organization's Alcohol Use Disorders Identification Test" (Adlaf et al., 2005, p. iii). Alternately, when looking at the illegal use of drugs and prescription medication, researchers have found that not only do many students use marijuana, but 10.1% and 14.5% of past-year users meet DSM-IV criteria for cannabis use

dependence and abuse, respectively (Caldeira, Arria, O'Grady, Vincent, & Wish, 2008). Meanwhile, 34% of students admit to illegally using ADHD stimulant medication (DeSantis, Webb, & Noar, 2008), and 37.5% report "past-year illicit drug use" (Caldeira et al., 2008, p. 368). The consequences of these statistics are startling as students who use and abuse drugs and alcohol are seen to have concentration difficulties, increased absences from class, academic difficulty, co-morbid substance use and abuse, relationship difficulties, sleep difficulties, comorbid mental health problems, self-injurious behaviour, memory loss, and neurocognitive deficits, and death as a result of motor-vehicle accidents is also unfortunately quite common among this population (close to 1,700 deaths per year in the US; Buckner et al., 2010; Caldeira et al., 2008; MacKean, 2011; Serras et al., 2010; Wechsler & Nelson, 2008; Zeigler et al., 2005).

Students seek out substances for various reasons, some of which are specific to the campus culture. For example, when speaking specifically about alcohol, Wechsler and Nelson (2008) suggest that "membership in a fraternity or sorority, belief that most friends binge drink, drinking to 'fit in,' easy access to alcohol through social affiliation, low-cost alcohol, and attending a college with a high rate of binge drinking [are] all independently associated with first-year students taking up binge drinking" (p. 484). Alternately, DeSantis and colleagues (2008) note that many students turn to stimulant medication in order to enhance their ability to focus, to stay awake in order to study, and to help enhance academic performance. Beyond these academic and college-specific motivators, Ham and Hope (2003) reported that several additional factors that are related to

problematic drinking among student, including gender (males are heavier drinkers), ethnicity (Anglo-Americans face particular difficulties with alcohol), personality traits (including sensation seeking and neuroticism), and drinking behaviours during one's high school years.

Clearly, there is a significant substance use and abuse problem on university and college campuses. Interestingly, however, many students fail to see their substance use as a problem (Caldeira et al., 2009; Wu, Pilowsky, Schlenger, & Hasin, 2007). In a study by Caldeira and colleagues (2009), it was found that close to half the sample of third-year undergraduates met DSM-IV criteria for a substance abuse disorder at least once during the previous three years, yet only 3.6% felt they required help for this issue. Meanwhile, only 16% were encouraged by others to seek intervention (Caldeira et al., 2009). This highlights the tendency for college students to fail to see a problem with excessive drinking and drug use. Further highlighting the depths of this problem on university and college campuses specifically, Blanco and colleagues (2008) also found that "college students [are] significantly less likely to receive … treatment for alcohol or drug use disorders than their non-college-attending peers" (p. 1429).

Depression and anxiety. Depression and anxiety are two of the most common mental health problems faced by male and female students on university and college campuses across North America (American College Health Association, 2011, 2013a). The 2013 NCHA (American College Health Association, 2013a) suggests that 51.0% of students felt "overwhelming anxiety"

in the previous 12 months while 31.3% of students "felt so depressed that it was difficult to function." Meanwhile, 12.9% of students have been diagnosed or treated by a professional for anxiety in the previous 12 months, while 11.0% of students have been diagnosed or treated for depression (American College Health Association, 2013a). In addition to this, the 2013 NCHA data also shows that 9.4% of students experienced anxiety-related psychological disorders, including, for example, Obsessive Compulsive Disorder (OCD) and specific phobias (American College Health Association, 2013a). University-specific estimates show similar statistics. In a study conducted with more than 5,000 students at the University of Michigan, it was determined that over 15% of undergraduate students and 13% of graduate students experience depressive or anxiety disorders (Eisenberg, Gollust, et al., 2007), while a smaller study conducted with medical science students in Arkansas showed that 25% to 35% of respondents are experiencing depression (Stecker, 2004). More striking is a study of over 9,000 students conducted in Atlanta that suggests a majority of the sample (83.5%) experienced at least mild depression, with 30.6% showing moderate symptomology, 16.6% showing moderately severe symptomology, and 6.6% showing severe symptomology (Garlow et al., 2008). Finally, in a study closer to home, the data from 2011 NCHA (as cited in Everall, 2013) conducted at the University of Alberta show anxiety and depression symptomology in 52% to 65% of the student body, respectively. To contextualize such numbers, this suggests that between 19,760 and 24,700 of the 38,000 students at the University of Alberta are experiencing symptoms of depression and anxiety.

While depression and anxiety have plagued North American campuses for decades, longitudinal research suggests that the prevalence of both disorders is growing on campuses (Benton et al., 2003; Buchanan, 2012). According to Benton and colleagues (2003), the incidence of depression seen in a university counselling clinic at Kansas State University roughly doubled between 1988 and 2001, growing from 21.1% of clients to 46.67%. The same study documented similar findings with respect to anxiety, noting growth from 36.26% of clients to 62.87% of clients. Moreover, by 2001, anxiety was the single-most common problem faced by clients in the clinic, overtaking relationship problems (Benton et al., 2003). These findings are particularly pertinent given the impairment associated with these disorders.

Research examining the relationship between academic success and depression and anxiety (e.g., Eisenberg, Golberstein, & Hunt, 2009) highlights the negative implications that these problems can have for students. In particular, Eisenberg, Golberstein, and colleagues (2009) suggest that depression and anxiety are predictive of decreases in GPA and university drop-out. Further, in a review of the literature, Buchanan (2012) highlights that, across the college population, depression "has been associated with … acute infection illness, increased levels of smoking, increased alcohol consumption, increased levels of anxiety, increased self-injurious behaviors, decreased academic productivity, withdrawals from college, suicidal ideation, and suicide" (p. 22). Similarly, anxiety is associated with increased stress, depressed feelings, suicidal thoughts, and other comorbid

problems, including body dysmorphic disorder, eating disorders, and substance abuse (Anxiety Disorders Association of America, 2012).

Other psychological disorders. While depression and anxiety are common psychological issues faced by students, many students also suffer from other serious psychological disorders (Blanco et al., 2008). In fact, Blanco and colleagues (2008) suggest that close to half of college students (45.79%) meet criteria for a psychiatric diagnosis. This certainly includes substance use disorders, depression, and anxiety disorders, as previously touched upon, but Blanco and colleagues (2008) and other researchers (e.g., American College Health Association, 2011, 2013a; Kadison & DiGeronimo, 2004; Kitzrow, 2003; May & Stone, 2010; National Eating Disorders Association, 2006; Weyandt & DuPaul, 2006; White, Ollendick, & Bray, 2011; Zivin et al., 2009) also suggest that many students experience personality disorders (17.68%), attention deficit hyperactivity disorder (ADHD; 2%-4%), bipolar disorder (3.24%), autism spectrum disorder (ASD; 0.7% - 1.9%), eating disorders (18%-20%), schizophrenia (0.2%), sleep disorders (6.1%), and learning disorders (LD; 3%-9%) and that comorbidities between these disorders certainly exist. Various factors are influencing the prevalence (and in some cases, the growing prevalence) of these disorders on university and college campuses. As touched upon previously, researchers (e.g., Hunt & Eisenberg, 2010; Kitzrow, 2003; Much & Swanson, 2010) suggest that early intervention and treatment attained in childhood and adolescence and the increased availability of psychotropic medication offers students the support needed to attend post-secondary schooling.

Beyond this, it is also acknowledged by some (e.g., Kadison & DiGeronimo, 2004; Kitzrow, 2003; Zivin et al., 2009) that many of the psychological disorders highlighted above (e.g., Bipolar Disorder, Schizophrenia) have later onset and thus may appear at the developmental period that happens to coincide with the beginning of one's college or university career. Further, although - as Hunt and Eisenberg (2010) point out - there are mixed reviews among the literature around the relationship of college-specific factors and psychological disorders, moderating relationships between these variables and personality traits (e.g., perfectionism) has received some support. Arguably, the diathesis-stress model, which posits that "individuals inherit tendencies to express certain traits or behaviors, which may then be activated under conditions of stress" (Barlow & Durand, 2005, p. 36) may also contribute to the prevalence of such disorders, as students with predispositions to psychological difficulties and limited coping abilities (Blanco et al., 2008) may be quite literally "set off" by the novel environmental stressors associated with the academic environment.

Because a thorough discussion of the academic, emotional, social, and physical implications of each psychological disorder is beyond the scope of the present paper and disorder-specific research is quite limited, a thorough breakdown of implications will not be provided. However, it is important to understand, based on the current research, that students with mental health disorders on university and college campuses are facing chronic struggles in various realms of their life, including reduced academic success (e.g., reduction in GPA), prolonged degree attainment, drop-out, decreased organizational ability,

difficulty developing study skills, medical issues, relationship problems, and social difficulties (Eisenberg, Golberstein, et al., 2009; Hunt & Eisenberg, 2010; Kadison & DiGeronimo, 2004; Kitzrow, 2003; May & Stone, 2010; Weyandt & DuPaul, 2006). From this, one can ascertain that despite its already challenging nature, post-secondary education is particularly difficult for those students who are also battling a psychological disorder.

Self-harm and suicide. Schwartz (2006) highlights the seriousness of suicide on college campuses, stating "suicide is considered the second leading cause of death among students at American colleges and universities and the third leading cause among persons of traditional college age" (p. 341). As such, suicide and self-harm or self-injury, defined as "the inflection of physical harm to one's body without suicidal intent" (Serras et al., 2010, p. 119) are considered very real problems on university campuses. In the 2013 NCHA (American College Health Association, 2013a), it was reported that in the previous 12 months, 7.4% of students considered suicide, 1.5% of students attempted suicide, and 5.9% of students engaged in self-harm, including cutting, burning, bruising, and other self-injury. Alternate studies have found even higher statistics with respect to self-harm. For example, Serras and colleagues (2010) operationalized self-harm as engaging in cutting, burning, banging of the head and other body parts, scratching, punching, pulling one's hair, biting, interfering with wound healing, carving into the skin, rubbing sharp objects on the skin, or punching or banging an object with the intention of causing pain. With this expanded

definition, the researchers found that 14.3% of students engaged in self-harm over the previous 12 months.

Students coping with psychological disorders, including eating disorders, depression, schizophrenia, anxiety disorders, substance use disorders, and bipolar are at risk for suicide and self-harm behaviours (Drum et al., 2009; Serras et al., 2010; Zisook, Downs, Moutier, & Clayton, 2012). While suicidal and self-harm behaviours are often seen as coping mechanisms, self-harm is also considered a means of releasing pain, an attempt at feeling something in an otherwise numb existence, an attempt at self-punishment, or is symptomatic of a particular disorder (Kadison & DiGeronimo, 2004). Meanwhile, suicidal behaviour is more directly associated with helplessness and hopelessness and is particularly prevalent among students "who come into the college with pre-existing mental health problems and those who develop mental health problems during the college years" (Kadison & DiGeronimo, 2004, p. 148). For those with pre-existing conditions, the desire to commit suicide comes with the newfound loss of routine and sleep and the increased academic pressure; for those who develop disorders during their tenure at university, the lack of awareness of symptomology and symptom severity combined with failure to seek help can leave students to contemplate suicide (Kadison & DiGeronimo, 2004; Zisook et al., 2012). Sadly, despite the severity and potential lethality of self-harm and suicidal ideations, students again fail to seek support (Gollust et al., 2008; Zisook et al., 2012). This only further highlights the disconnection between campus support services and

the current needs of students, even in circumstances where students are dealing with life-threatening issues.

Transition issues. The period of time between the late teens and early twenties, termed as "emerging adulthood" (Arnett, 2000) is a unique time in one's life. For many 18 to 25 year olds, this is naturally a transition period, characterized by identity exploration and growing independence and responsibility, which can be both enjoyable and stressful (Arnett, 2000). As such, it comes as no surprise that one of the major stressors that detracts from the well-being of students is the transition from high school to university (Ames et al., 2011; Chow & Healy, 2008; Cleary et al., 2011; Johnson & Schelhas-Miller, 2000; Parker & Duffy, 2005; Scanlon, Rowling, & Weber, 2007). As Kadison (2006) highlights, "many students arrive on campus having difficulties adjusting to the lack of structure in a college community and having minimal skills to create balance in their lives" (p. 338). These difficulties are often compounded by a series of new issues, including moving away from home for the first time, loss of friendships, loneliness, roommate conflicts, adopting new learning methods, and lost identify / changing self-concept (Cleary et al., 2011; Parker & Duffy, 2005; Scanlon et al., 2007). These stressors, combined with a newfound sense of autonomy, often leave many students overcommitted to activities, participating in late-night social events, sleep deprived, overwhelmed, engaged in risky behaviours (e.g., substance use), and stressed (Kadison, 2006; Parker & Duffy, 2005). This, in turn, makes students "more vulnerable to depression, physical problems, and impaired concentration and memory, which triggers more work and

less sleep as a result of trying to catch up" (Kadison, 2006, p. 338). Such cycles can lead students to experience anxiety and diminished productivity, miss class, and hand in assignments late (Ames et al., 2011; Clearly et al., 2011).

A simple survey of university websites indicates that universities across Canada and the US are well-aware of the transition difficulties faced by students. Many have designed transition programs and continue to post helpful resources for parents and students related to the transition between high school and university. However, the research (e.g., Low, 2011) continues to suggest that first-year students can be accounted for in many of the statistics outlined previously. Moreover, like their peers, first-year students are often unaware of support services or simply fail to seek intervention, with stigma serving as a particularly large barrier for the younger students (Eisenberg, Downs, Golberstein, & Zivin, 2009). This again highlights the potential incongruence between current support services and the needs of students, including those in the pivotal transition year.

Another important transition faced by university students is the transition from university life to the "real world" (Johnson & Schelhas-Miller, 2000). This, like the transition to university, is a time characterized by stress and disappointment (Johnson & Schelhas-Miller, 2000). While the difficulties associated with this transition are often experienced post-graduation, universities offer the support of career guidance offices on campus (Johnson & Schelhas-Miller, 2000). However, in spite of the fact that many students indicate awareness of career services on campus, many fail to seek the support offered (Fouad et al.,

2006). Thus, although not as pertinent to the topic at hand, the transition "out" of university may also be important for university support services to consider.

Minority groups. As previously discussed, the diversity on university and college campuses across North America is growing (Kitzrow, 2003). Based on the data outlined in the 2013 NCHA survey (American College Health Association, 2013a), it is clear that there is vast diversity in the ethnic backgrounds and sexual orientations of students. In particular, the NCHA study (American College Health Association, 2013a) highlights that 8.9% of all students identify as either gay/lesbian, bisexual, or unsure; meanwhile, across American campuses, 43.2% of students identify as Black, Hispanic, Asian or Pacific Islander, American Indian, Alaskan Native, Native Hawaiian, biracial, or other. Such cultural diversity is also identifiable on university campuses across Canada (Statistics Canada, 2011). For example, Statistics Canada (2011) reports that international students from Asia, Europe, and Africa represent up to 19% of the total university student population in some provinces.

Despite the growing presence of minority groups on campus, the research highlights that students affiliated with a particular minority group face unique challenges (Cokley et al., 2011; Kerr, Santurri, & Peters, 2013; Loya, Reddy, & Hinshaw, 2010; Oswalt & Wyatt, 2011; Tung, 2011). Certainly, these minority groups face unfortunate discrimination, leading to an increased risk for psychological concerns - namely depression - and subsequent academic problems (Cokley et al., 2011; Oswalt & Wyatt, 2011; Tung, 2011). Additionally, when looking specifically at homosexual and bisexual students on campus, Oswalt and

Wyatt (2011) found that lesbian, gay, and bisexual students face ridicule, harassment, and sometimes physical violence, leaving them to feel uncomfortable in their school environment and more likely to seclude themselves and disengage from their campus community. Moreover, using 2009 NCHA data, Oswalt and Wyatt (2011) also uncovered that non-heterosexual students experience greater stress and higher rates of depression, anxiety, and panic attacks in comparison to their heterosexual peers, which of course has negative implications for their academics and interpersonal relationships. Similarly, Kerr and colleagues (2013) examined 2008 and 2009 NCHA data and noticed the tendency for bisexual and lesbian woman to struggle with various mental health issues – including depression, anxiety, and self-harm – to a greater extent than their heterosexual peers.

International and ethnically diverse students also face unique challenges (Cokley et al., 2011; Tung, 2011). For international students, acculturation pressures are prominent and transitioning to a novel education model with lower than anticipated achievement can contribute to the development of mental health issues that negatively impact overall adjustment to campus life (Tung, 2011). Moreover, while overt racist behaviour and racial conflicts continue to plague college communities (Ancis, Sedlacek, & Mohr, 2000), covert racial slights (i.e., "racial microaggressions") are also becoming highly problematic in the social, academic, and public settings of college campuses (Smith, Allen, & Danley, 2005). Beyond these unfortunate realities, ethnic minorities are also more likely to have "lower incomes [and] live in less desirable areas" (Cokley et al., 2011, p.

244), which naturally deters from one's overall well-being. Unfortunately, despite these added stressors, the tendency to seek help among some minority groups (e.g., South Asian) is even lower than their Caucasian peers (Loya et al., 2010). This only further supports the notion that services need to be redesigned in order to better meet the needs of the students, particularly those in dire need.

General distress. The research tells us that many students have identifiable mental health problems, diagnosable psychological disorders, or experience psychological difficulty in relation to their membership to a specific group (e.g., first year students). However, there remains an overwhelming number of students on North American campuses who experience general distress that is not as categorical as some of the other challenges addressed previously (Kitzrow, 2003; MacKean, 2011; Stallman, 2010; Storrie et al., 2010). For example, the 2013 NCHA (American College Health Association, 2013a) highlights the prevalence of many indicators of distress. Specifically, according to this survey, 83.7% of students felt "overwhelmed by all [they] had to do" in the previous 12 months, while 79.1% felt exhausted, 37.0% felt overwhelming anger, 41.7% felt they have more than average stress, and 48.3% found three or more of: academics, career-related issues, death of a family member or friend, family problems, intimate relationships, other social relationships, finances, health problem of family member or partner, personal appearance, personal health issues, sleep difficulties, or other to be "traumatic or very difficult to handle" in the previous 12 months, with academics being the most commonly reported (American College Health Association, 2013a). Similarly, across Canada,

students and university administrators identify sleep deprivation and stress as the most common health issues or challenges faced by students, next only to mental health issues (Patterson & Kline, 2008). Certainly, some students endorsing such items might simply be commenting on symptomology related to an underlying psychological disorder; however, because of the great disparity between these high statistics and those reflecting the prevalence of psychological disorders, it is clear that many non-pathological students are also endorsing these feelings.

Feelings of stress and being overwhelmed have root causes that may or may not be related to university life (Ross, Niebling, & Heckert, 1999; Toews et al., 1997). For example, in a study examining sources of stress among college students in the US, it was determined that intrapersonal factors, namely changes in sleeping and eating habits and taking on new responsibilities, were the greatest source of stress faced by students (Ross et al., 1999). Other major stressors established in this study were changes in social activities, roommate conflicts, financial difficulties, employment, public speaking, increased workload, lower than expected grades, and technological problems (Ross et al., 1999). Similarly, in a study conducted with Canadian medical students, residents, and graduate science students, common stressors included the volume of material covered and time available to learn it, exams, self-expectations, and feelings of incompetency (Toews et al., 1997). Finally, in their book, *College of the Overwhelmed: The Campus Mental Health Crisis and What to Do About It,* Kadison and DiGeronimo (2004) discuss some of the other common sources of stress experienced by students, including jobs, relationships, and social pressures. In particular,

Kadison and DiGeronimo (2004) point out that many students are forced to work in order to offset the cost of their education and avoid substantial debt post-graduation. Meanwhile, students are also faced with the pressure of conforming to perceived norms around liberal sexual behaviour and developing relationships through stressful means, including "clubbing, taking drugs like Ecstasy … and partying until dawn" (Kadison & DiGeronimo, 2004, p. 17). Moreover, relationships are a critical aspect of college life and relationship dissolution can be devastating and stressful for students (Johnson & Schelhas-Miller, 2000). Collectively, this literature suggests that stressors on university campuses are both inter- and intra-personal, as well as environmental (Ross et al., 1999).

Although not necessarily pathological, general feelings of fatigue and stress and being overwhelmed have very real implications (Kitzrow, 2003; MacKean, 2011; Patterson & Kline, 2008). Kitzrow (2003) notes that distressed students have "higher test anxiety, lower academic self-efficacy, and less effective time management and use of study resources. They [are] also less likely to persist when faced with distractions or difficulty and less likely to use effective learning strategies such as seeking academic assistance" (pp. 169-170). Similarly, Storrie and colleagues (2010) suggest that distress has a negative impact on academic performance and interpersonal relationships, and can lead to psychological disorders, including depression.

How Are Students Being Helped?: Availability of On Campus Services

In light of the so called "campus mental health crisis," campuses across North America are seeing an increased utilization of mental health services

(Kitzrow, 2003; Voelker, 2003). Moreover, because of the growing influx of students with pre-existing psychological difficulties, the demand for ongoing care is high and questions over who manages the care of these students exist (i.e., psychiatrists, GPs, etc.; Baverstock & Finlay, 2003; Kadison & DiGeronimo, 2004). As such, colleges and universities are struggling to meet the growing needs of the students, albeit at a time when most students forgo seeking intervention. Prescott (2008) further highlights the current struggles universities are facing, noting that the "International Association of Counselling Services recommends a ratio of one full-time counsellor for every 1,500 full-time-equivalence students, yet the average ratio according to a 2007 survey was one counsellor per 1,969 students" (p. 264). Moreover, in order to cope with the growing demands and the limited number of service providers, many colleges and universities have adopted a brief therapy model, turned to group therapy approaches, or placed limits on the frequency and number of counselling sessions each student can have (Kitzrow, 2003). In addition, denying service or referral to off-campus resources has also become common (Kitzrow, 2003).

Students with mental health problems, mental illness, and/or general distress often become the responsibility of counselling services, disability services, or health services (MacKean, 2011). According to MacKean (2011), disability services function to "assist students who require academic accommodations as a result of illness" (p. 29), and focus on attaining the greatest academic success for those students who might otherwise have a disadvantage. Meanwhile, MacKean identifies counselling services as a composition of

"professional counsellors and/or licensed psychologists, providing a range of mental health services to support student academic success and retention" (p. 29). Such services may include assessment, crisis management, and individual, group, family, and couple therapy (MacKean, 2011). Finally, health or medical services are identified as "…a team of nurses, family physicians and psychiatrists. Their role as mental health service providers include diagnosing mental disorders, navigating the intersections of physical and mental illness, recommending and prescribing medications, and monitoring treatment progress" (MacKean, 2011, p. 30). To provide comprehensive care and to maximize the cost-to-benefit ratio of resources, health services and counselling services are integrated on roughly one-third of university campuses, while other universities have these centres function independently (Eells & Schwartz, 2010).

While disability, counselling, and health services function as the primary service providers for students with mental health problems, mental illness, and/or distress, university campuses are also laden with a plethora of other student services. When surveying large Canadian university websites, for example, one can quickly see that many other support services are virtually universal across campuses including international student services, career and guidance services, LGBTQ support services, academic support centres, and so on. With this in mind, some Canadian universities are beginning to see the need for some of these additional services providers to play an intricate role in maximizing the psychological well-being of the student body. For example, Carleton University (2009) has identified a range of "key players" in supporting distressed students.

These include Health and Counselling Services and the Centre for Student Disabilities, but also incorporate the Office of Student Affairs, the Office of the Associate Vice-President (Students and Enrolment), Department of University Safety, Student Academic Success Centre, Department of Housing, Equity Services, the Office of the University Secretary, the Educational Development Centre, and the Students' Association. Carleton has assigned specific tasks to each of these bodies, including the development of risk management policies and practices (Office of Student Services), ensuring an overall positive experience (Office of the Associate Vice-President), ensuring safety and responding to student safety threats (University Safety), managing academic difficulties (Student Academic Success Centre), monitoring and providing direct support for on campus students (Housing), maintaining a safe and welcoming environment (Equity Services), maintaining student privacy (University Secretary), educating faculty (Educational Development Centre), and acting as a counselling referral service (Students' Association). Beyond this, Carleton also suggests that staff within each of these service areas has a specified amount of training to recognize and intervene when students are in distress. For example, the university proposed that all front-line faculty and staff are provided workshops and necessary materials to identify and refer students who are in urgent distress (Carleton University, 2009).

Other researchers (e.g., Eells & Rockland-Miller, 2011; Mowbray et al., 2006; Tinklin, Riddell, & Wilson, 2005) also acknowledge the need for universities to branch out from the traditional three support service providers

when attempting to help students who are psychologically unwell. For example, Mowbray and colleagues (2006) believe that campuses should adopt a "no wrong door" (p. 233) policy, whereby all campus services accept students seeking mental health support and help to provide appropriate intervention, referrals, and guidance. Alternately, Eells and Rockland-Miller (2011), suggest that mobile assessment teams, comprised of university administrators, and members of counselling services, campus safety, student affairs, residence, health services, academic affairs, and so on should be a staple on campus in order to "assess behaviour and support troubled students … [aid with] crisis management … and [address] both behavioural intervention and threat assessment" (p. 13). Hypothesizing new approaches to treatment as these researchers have done is important for today's campuses because counselling, health, and disability services are currently being exhausted by the small minority of students who seek help (Kitzrow, 2003; Voelker, 2003). Moreover, stigma towards help-seeking, while still prevalent, has slowly declined, leading to an increased utilization of services (Hunt & Eisenberg, 2010); if this trend continues, universities need to think about ways of capitalizing on all of their current resources in order to support students.

Help-seeking and Service Utilization of Students

Students who seek support for psychological concerns do so through a variety of outlets (Eisenberg et al., 2011; Eisenberg, Golberstein, et al., 2007). For example, accessing therapy and/or medication is common for help-seeking students (Eisenberg et al., 2011; Eisenberg, Golberstein, et al., 2007). Investment

into these modalities of treatment is often enhanced when the student has positive ideas about the effectiveness of the approach, they feel they need intervention, and/or they have close family members or friends who are seeking similar intervention (Eisenberg et al., 2011; Eisenberg, Golberstein, et al., 2007). Medical doctors and religious leaders also serve as important sources of help for distressed students, further highlighting the need for a diverse series of professionals on university campuses (Amstadter et al., 2010). Beyond this, research also shows that, rather than seeking formal intervention, many students instead turn to informal sources of help, including a family member or friend because they trust these individuals more readily (Buscemi et al., 2010; Donato, 2010). Buscemi and colleagues (2010) also note that sources of help that are both informal and anonymous, such as the internet and information pamphlets, are also seen as effective in the eyes of university students.

Despite the above research, there is sound agreement across the literature that only a small number of students seek help for mental health problems, mental illness, and general distress and this trend is consistent across gender, sexual orientation, ethnicity, and graduate and undergraduate students in several countries around the world, including Canada, the US, the United Kingdom, and Australia (Eisenberg et al., 2011; Garlow et al., 2008; Hunt & Eisenberg, 2010; Hyun et al., 2006; Masuda & Boone, 2011; May & Stone, 2010; Quinn, Wilson, MacIntyre, & Tinklin, 2009; Reavley, McCann, & Jorm, 2012; Storrie et al., 2010; Zivin et al., 2009). In some studies, the numbers are startling. For example, in a review of the literature, Storrie and colleagues (2010) found multiple studies

citing that 90% of students do not seek counselling intervention for psychiatric disabilities and/or significant distress. Similarly, in an investigation done by Garlow and colleagues (2008) in the US, it was determined that 85% of students with moderately severe to severe depression were not receiving treatment, while 84% of students with current suicidal ideations were also failing to seek treatment. Alternatively, Blanco and colleagues (2008) found more promising results, with 34.11% of college students seeking treatment in the previous year for mood disorders. However, this same study profiled treatment seeking behaviours of students with anxiety disorders and alcohol or drug disorders, displaying disappointing statistics of 15.93% and 5.36%, respectively (Blanco et al., 2008). Similar attitudes towards help-seeking are seen in students with academic problems and relationships problems (Joyce, Ross, Vander Wal, & Austin, 2009). Finally, in a study of over 14,000 students across 26 campuses in the US, Eisenberg and colleagues (2011) found that, although use of medication and therapy varies across campuses, the trend remains that help-seeking is still quite low.

This tendency to avoid intervention and "suffer in silence," so to speak, is somewhat puzzling given that students tend to have a positive outlook on intervention (Joyce et al., 2009). For example, in a study by Turner and Quinn (1999), 96% of students "indicated a willingness to consult with mental health providers for problems of serious mental illness" (p. 369). Additionally, in the 2011 NCHA, 71% of students at the University of Alberta reported they would seek help if they needed it, yet so few do (Brown, 2011). Certainly, in light of

these finding, researchers (e.g., Eisenberg et al., 2011; Stuart, 2011) have put great effort into trying to understand the barriers to help-seeking for psychological issues.

Barriers to help-seeking. Researchers have identified various barriers to help-seeking among the university and college population. The most notable barrier is stigma, although the nature of the problem, skepticism, perceived need, knowledge of services, cultural beliefs, hopelessness, gender, and age are all influential on a student's decision to seek help (Eisenberg et al., 2011; Eisenberg, Downs, et al., 2009; Eisenberg, Golberstein, et al., 2007; Mitchell et al., 2007; Rosenthal & Wilson, 2008; Williams et al., 2008; Yorgason et al., 2008). Unfortunately, however, much of the research focused on understanding the barriers to helping seeking is done internationally and thus, little is known about Canadian barriers to help-seeking. A review of the work completed internationally is provided.

Stigma. Stigma is one of the most pronounced barriers to help-seeking on university and college campuses (Eisenberg, Downs, et al., 2009; Masuda & Boone, 2011; Quinn et al., 2009; Storrie et al., 2010; Stuart, 2011; Yakunina, Rogers, Waehler, & Werth, 2010). Certainly, stigma is a universal barrier found among the general population and continues to prevent people around the world from seeking intervention for psychological issues (Eisenberg, Downs, et al., 2009). However, at the university or college level, stigma is particularly problematic as students associate psychological problems with weakness and believe that this could potentially impact them on an academic and/or career level

(MacKean, 2011; Quinn et al., 2009; Storrie et al., 2010). Stigmatizing attitudes seem to be especially prominent with males, students with fewer years of education, and younger students (Reavley et al., 2012). Interestingly, in a study examining stigma specifically, Eisenberg, Downs, and colleagues (2009) found that students often have higher perceived stigma than personal stigma, yet personal stigma is what holds students back from seeking help; perceived stigma was found to have no relationship with help-seeking. Although further research is needed, the work of Eisenberg, Downs, and colleagues suggests that students' failure to seek help is related their own "stereotypes and prejudices" (p. 523), rather than the perceived beliefs of others. This suggests that stigma may need to be redefined as an individual rather than systemic barrier to help-seeking (Eisenberg, Downs, et al., 2009) and as such, may impact how to approach stigma reduction in the future.

Sadly, stigma around help-seeking is particularly problematic for students of racial and ethnic minorities who also experience discrimination (Cheng, Kwan, & Sevig, 2013). In fact, as Cheng and colleagues (2013) point out, "the more [racial and ethnic minority] students perceived discrimination, the more likely they were concerned with being stigmatized by others for seeking psychological help" (p. 108). This not only verifies the challenge of stigma, but helps us to understand how the experience of stigma may vary among minority groups and contribute differently to help-seeking depending on the population.

Knowledge and perceived need. Another important factor influencing help-seeking is knowledge around psychological problems and perceived

need/urgency (Eisenberg et al., 2011; Furnham, Cook, Martin, & Batey, 2011; Zivin et al., 2009). When looking at studies examining "mental health literacy" (e.g., Furnham et al., 2011), it becomes quite clear that students on university campuses have little knowledge of mental health disorders. More specifically, while some students have heard of certain disorders, most have little understanding of their definition or symptomology. In a study by Furnham and colleagues (2011), it was found that at least 75% of the total sample was able to identify eight of a potential 97 disorders from the *Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition - Text Revision* (DSM-IV-TR; American Psychiatric Association, 2000). Moreover, in the same study "when asked whether they could define or describe the disorder and their symptoms there were only nine disorders [of the 16 most well-known] where over half of these participants said yes" (Furnham et al., 2011, p. 205).

The barrier of limited knowledge is compounded by perceived need for treatment. For example, in a two-year follow-up study by Zivin and colleagues (2009), it was determined that 74% of students with a mental health problem (i.e., depression, anxiety, eating disorder, self-injury, suicidal thoughts) at baseline did not perceive a need for treatment at baseline or at follow-up two years later. The same study also found that 49.87% of students with a mental health problem at both baseline and follow-up still did not perceive a need for treatment (Zivin et al., 2009). This may speak to the fact that students are simply unaware of the boundary between healthy and unhealthy symptomology and further, it may also suggest that many students have yet to develop an appropriate threshold for

psychological discomfort. Finally, in a study by Eisenberg and colleagues (2011), it was identified that close to half of students think that stress is normal and therefore did not seek help. The same study (Eisenberg et al., 2011) also showed that failure to seek formal intervention results from students' preference to handle things by themselves (54.9%), having multiple other supports (33.2%), believing the problem will go away (26.4%), skepticism over treatment effectiveness (27.4%), limited time (43.4%), or limited money (33.2%).

Demographic barriers. Help-seeking also varies across different demographic variables. Although not supported by Rosenthal and Wilson (2008), a much larger study conducted by Eisenberg and colleagues (2011) found that ethnicity and gender play a key role in help-seeking. According to their data, they found "lower use of both medication and therapy among men than among women and among Asians, Blacks, and Hispanics than among Whites" (Eisenberg et al., 2011, p. 304). Alternate researchers have attempted to make sense of these differences and have found that conformity to traditional masculine norms is associated with greater stigma toward help-seeking (Steinfeldt & Steinfeldt, 2012), and that certain cultural groups (e.g., Asian Americans) have a preference for covert intervention with respect to mental health issues (Ruzek, Nguyen, & Herzog, 2011). Eisenberg and colleagues (2011) also found strong negative correlations between service use and age and religiosity and found a weaker correlation between heterosexuality and service utilization when compared to bisexual and gay/lesbian sexual orientations. Limited research has been conducted to better understand these relationships.

Symptom severity. Another influential factor related to help-seeking is the severity of the symptomology associated with the particular psychological problem (Rosenthal & Wilson, 2008; Williams et al., 2008). For example, Rosenthal and Wilson (2008) determined that students with greater distress were more likely to seek intervention, while Buscemi and colleagues (2010) determined that there is a positive correlation between depression symptomology and help-seeking. However, like previous researchers, Buscemi and colleagues (2010) also found a preference for informal over formal intervention. Unfortunately, this trend between symptom severity and help-seeking does not hold true for suicidal students (Yakunina et al., 2010). In fact, according to Yakunina and colleagues (2010), researchers have repeatedly found a "help-negation" effect, characterized by a negative correlational relationship between ideation and help-seeking. In this population, there is preliminary evidence that suggests stigma, help-seeking attitudes, and social support may mediate the help-negation effect (Yakunina et al., 2010).

Systemic barriers. Certainly, there are also systemic influences that impact help-seeking. Particularly important is knowledge of services that are available (Eisenberg, Golberstein, et al., 2007). When Eisenberg, Golberstein, and colleagues (2007) surveyed students at a Michigan university, it was determined that only 49% of the entire sample knew where to go for professional help, while only 59% knew the university offered students free counselling. Moreover, the same study found that, of the students who were anxious or depressed and not currently seeking treatment, only 32% knew where to go for

services and 53% knew the university offered students free counselling (Eisenberg, Golberstein, et al., 2007). Also influential at the systemic level, particularly for graduate students, is relationships with others including supervisors (Hyun et al., 2006). According to Hyun and colleagues (2006), "better relationships with advisors contributed positively to emotional well-being and to utilization of services in students with mental health needs" (p. 260). Eisenberg and colleagues (2011) also identify that relationships with others are important, noting that family members, friends, and other people are often influential on a student's desire to seek help.

Attempts to overcome the barriers. As previously mentioned, researchers have successfully identified many barriers to help-seeking but little work has been done to understand ways of overcoming these barriers. However, a handful of research teams (e.g., Joyce & Weibelzahl, 2011) have piloted new ways of offering interventions in order to overcome current barriers to help-seeking and to offer treatment through preferred modalities. Of the most prominent seem to be curriculum infusion and utilizing technology as a vehicle for intervention and prevention (Davis-McCabe & Winthrop, 2010; Joyce & Weibelzahl, 2011; Mitchell et al., 2012; Ryan et al., 2010).

Today's generation is constantly immersed in technology. An in-depth investigation of internet use by Horgan and Sweeny (2010) discovered that most students use the internet regularly and close to one-third of the sample turned to the internet when seeking information about mental health. Moreover, the same study also established that "68% of participants … would use the internet for

mental health support if they needed to" (Horgan & Sweeny, 2010, p. 117), clearly identifying the internet as an avenue for intervention or prevention efforts. Interestingly, students who have identifiable distress have also acknowledged interest in online support (Ryan et al., 2010). In fact, according to Ryan and colleagues (2010), close to 60% of students with severe levels of distress would use online programming as a means of help-seeking if it were available. As such, it comes as no surprise that researchers have piloted computerized intervention, including computerized cognitive-behavioural therapy (CBT) and computerized lifestyle management programs (e.g., Davis-McCabe & Winthrop, 2010). In qualitative follow-up, students using computerized interventions reported positive results, indicated feeling encouraged about handling their issues, and enjoyed the flexibility and anonymity it offered (Davis-McCabe & Winthrop, 2010).

Another form of technology that is compelling to today's students is texting. Again, researchers have started to pilot the use of texting as a means of encouraging help-seeking (Joyce & Weibelzahl, 2011). In a preliminary study involving intermittent text messaging to students, Joyce and Weibelzahl (2011) found that students are receptive to text-messaging that promotes help-seeking and that, in some cases, students made the effort to seek help after receiving an encouraging text.

Finally, universities have tried to overcome barriers to help-seeking through incorporating positive messaging around mental health within the course curriculum (Mitchell et al., 2012). For example, in the US, universities have started to work with faculty members in order to "develop mental health

promotion programs in their courses" (Mitchell et al., 2012, p. 22). For example, in an applied marketing course, instructors assigned students the task of designing mental health marketing campaigns (Mitchell et al., 2012). While this strategy did not necessarily enhance help-seeking on campus, it helped to connect faculty and student services and incorporated the faculty into the fight against mental health stigma and the promotion of service utilization (Mitchell et al., 2012). Arguably, given the fear that students have around admitting distress and the resultant implications on their academic and career goals (MacKean, 2011; Quinn et al., 2009; Storrie et al., 2010), positive messaging around distress and help-seeking from faculty may be especially beneficial. Clearly, more research is needed in this area.

A Canadian Perspective on the Problem

Canadian universities are not immune to the mental health crisis (MacKean, 2011; Patterson & Kline, 2008). In fact, since the original conception of the present project, the American College Health Association (2013b) has released a National College Health Assessment that profiles the findings from 32 Canadian institutions. The findings in this report highlight many concerning statistics around the mental health of Canadian students, some of which surpass those identified above (American College Health Association, 2013b). Despite these statistics, however, there is very little Canadian research related to help-seeking barriers faced by Canadian students and institutions are guiding practices based on American research. This is particularly troubling because, although similar, American and Canadian students are not the same (MacKean, 2011). In

particular, systemic differences exist between the two, as discussed in the introduction, and more importantly, the psychological issues faced by students across the two countries are also different. For example, using the 2009 NCHA data from Ontario universities and the 2010 NCHA data from US colleges, MacKean (2011) found rather large differences. For example, 37.7% of Canadian students reported that stress was affecting their academic performance, whereas 26.9% of students in the US reported the same problem. Similar differences were also found in hopelessness and depressive feelings (MacKean, 2011).

Despite these differences, Canadians are very aware of the psychological issues on campus and efforts towards reducing psychological concerns are underway. For example, the last several years have seen the production and release of mental health strategy documents commissioned from large Canadian institutions such as Queen's University (2012), the University of Alberta (Everall, 2013), Carlton University (2009), and the University of British Columbia (UBC; UBC Vancouver, 2012). Additionally, "The Jack Project," an initiative started by Kid's Help Phone and the father of a student who committed suicide at Queen's University, has begun their own pilot project across Canadian high schools and universities, with a goal to "educate, empower, and engage young people, educators, and parents through outreach programming and online resources" (see http://www.thejackproject.org/the-pilot). Finally, other researchers have gone to students and administrators to gain recommendations for changing student services in order to make Canadian university and college campuses healthier places (Patterson & Kline, 2008). From this, a desire for more staff, more space,

more service providers, and more health promotion on campuses was communicated (Patterson & Kline, 2008).

Clearly, Canadians know they have a big problem on their hands. This is evident in reading the headlines from national reputable Canadian magazines, such as *Maclean's*, which have gone from "Is there a mental health crisis on campus?" (Dehaas, 2011) to "The mental health crisis on campus" (Lunau, 2012) over the course of the last few years. Yet, despite the fact that Canada has many university campuses that are among the top in the world academically, they continue to struggle in developing and maintaining a healthy environment from which students can flourish both professionally and personally. Moreover, because of the limited research done on Canadian campuses, there is ambiguity around what changes are needed in order to make Canadian campuses healthier places for students. The aim of the present study is to begin to add some clarity to this dilemma and subsequently help to define how current support services can be modified in order to better meet the needs of students.

Implications of the Research

The mental health crisis is a significant problem on campuses around the world. The research is displaying startling statistics. For example, Hyun and colleagues (2006) identify that 75% of graduate students "reported having had an emotional problem that interfered in their daily functioning" (p. 260), and Kitzrow (2003) notes that "5% of college students prematurely end their education due to psychiatric disorders" (p. 170). In light of these statistics,

universities are trying to understand how to help their students in an effort to both promote psychological well-being and to enhance student retention.

Currently, universities are relying heavily on disability services and counselling and health centres to treat the growing influx of psychological concerns on university campuses, creating great strain on these services (Kitzrow, 2003; Voelker, 2003). As such, treatment models have been modified and only severe students are being seen, leaving many students to flounder (Kitzrow, 2003). This is particularly troubling in light of the fact that most students are not seeking help for their psychological issues and many distressed students are not even aware of the psychological support services available on their campuses (Eisenberg, Golberstein, et al., 2007). Collectively, this suggests that the current structure of support services is failing and this is reflected by the statistics, which only seem to be getting worse (Benton et al., 2003; Buchanan, 2012).

While research is clearly needed in order to better meet the mental health needs of students, Canadian universities and researchers are only starting to scratch the surface. Moreover, very little work has been done to specifically understand Canadian student barriers to help-seeking and how the various on campus support services can help support counselling and health services in combatting the growing mental health epidemic on universities campuses. As such, the psychological health of Canadian students is not being fully attended to and it is imperative that efforts are invested in order to counteract the startling trends on university campuses.

Chapter Three

Methodology

This chapter provides a comprehensive overview of the methodological process employed in completing the present study. A qualitative framework was adopted for this study, with interpretive description (Thorne, 2008) serving as the guiding methodology. Information pertaining to this methodology, as well as an overview of participant selection, data collection and analysis, ethical considerations, and rigour is subsequently provided.

Qualitative Research and Interpretive Inquiry

There are significant theoretical and epistemological differences between qualitative and quantitative research (Crotty, 1998). Unlike quantitative research, the qualitative domain has offered social scientists a way to better understand the "multiple constructions and interpretations of reality that are in flux and that change over time" (Merriam, 2002, pp. 3-4). As such, researchers often turn to the qualitative domain when they are seeking an in-depth understanding of complex human phenomena, experiences, and meaning-making (as in the present study; Richards & Morse, 2007).

Interpretive inquiry is a rather hefty branch on the proverbial qualitative inquiry tree (Merriam, 2002). Unlike other schools of qualitative inquiry (e.g., postmodern, critical) that have alternative underlying goals (e.g., deconstruction), interpretive inquiry seeks to gain understanding, or as Merriam (2002) states, "understand the meaning people have constructed about their world and their experiences" (pp. 4-5). Traditionally, researchers have focused on broadly

accepted interpretive methodologies to inform their work, including grounded theory, phenomenology, ethnography, narrative, and case studies (Merriam, 2002). More recently, however, more generic approaches have also come onto the scene (Caelli, Ray, & Mill, 2003; Merriam, 2002). Although each type of interpretive inquiry answers different research questions, the traditional and generic schools all seek to understand meaning through an inductive investigation that ultimately produces "richly descriptive" findings (Merriam, 2002, p. 5).

Basic / Generic Interpretive Qualitative Research

Over time, researchers have come to realize that important qualitative research is being done outside of the frameworks offered by the traditional schools (e.g., phenomenology; Caelli et al., 2003; McLeod, 2001). This is not surprising because, as Caelli and colleagues (2003) point out, "there are a growing number of clinical researchers who have good clinical questions that can only be addressed through a qualitative approach" (p. 2), yet not all research questions fit within the confines of the traditional schools. As such, generic or basic qualitative inquiry maintains the criteria discussed above – "the researcher is interested in understanding how participants make meaning of a situation or phenomenon, the meaning is mediated through the researcher as instrument, the strategy is inductive, and the outcome is descriptive" (Merriam, 2002, p. 6) – yet has less rigidity than some of the traditional schools. In fact, some (e.g., McLeod, 2001) argue that the foundation of the generic approach is what ties all qualitative schools together and the more traditional schools have adapted the generic approach or "emphasized particular aspects for their own purpose" (p. 130). At

the same time, the generic approaches have been attacked for their supposed lack of philosophical or theoretical guidance (Caelli et al., 2003). Sally Thorne tried to combat this critique through the development of a generic approach termed interpretive description, which "requires explication of theoretical influences and an analytic framework that locates the interpretation within existing knowledge" (Caelli et al., 2003, p. 5).

Interpretive Description

Originally described by Canadian nursing researchers Thorne, Kirkham, and MacDonald-Emes (1997), interpretive description (ID) is a unique "non-categorical" (i.e., generic; p. 169) approach to qualitative research. ID was first developed as a means of overcoming the theoretical divide that separated the traditional schools of qualitative research and the nursing discipline (Thorne, 2008; Thorne et al., 1997). More specifically, Thorne felt that the principles underlying methodologies such as ethnography, grounded theory, and phenomenology were not as relevant to the nursing discipline as they are to the disciplines in which they were founded, including anthropology, sociology, and philosophy (Thorne, 2008; Thorne et al., 1997). Over time, she noticed that nursing researchers were trying to establish ways of adapting or combining traditional approaches to qualitative research in order to answer nursing-related questions and provide valuable knowledge to the field (Thorne, 2008; Thorne et al., 1997). However, the eccentric methodological risks taken by her colleagues were often criticized and Thorne saw the need to outline a new way of thinking about nursing research that was not as theoretically empty as some of the

approaches used by her colleagues (Thorne, 2008; Thorne et al., 1997). Moreover, Thorne felt the need to contribute not only to the science of nursing, but also to the clinical or applied focus of the discipline – an important feature that separated nursing from the more theoretical disciplines mentioned previously (Thorne, 2008; Thorne et al., 1997). As such, Thorne sought to delineate a systematic process that remained respectable among the research community and that led to the development of new knowledge, and, more importantly, the development of "useable" (Thorne, 2008, p. 16) knowledge (Thorne et al., 1997).

Since her first writings on the topic, Thorne has gone on to provide a thorough description of her approach (e.g., Thorne, 2008; Thorne, Kirkham, & O'Flynn-Maggie, 2004). In these works, Thorne and colleagues (2004) posit that ID is a method focused on investigating a "clinical phenomenon of interest … for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding" (p. 5). To further differentiate ID from the more traditional schools of interpretive inquiry, Thorne et al. (2004) highlight the applied focus of the methodology, stating that ID "investigators are rarely satisfied with description alone and are always exploring meanings and explanation that may yield application implications" (p. 6). Finally, to argue against the criticism that more generic approaches (such as ID) lack a philosophical and theoretical backing (Caelli et al., 2003), Thorne and colleagues (2004) have explicitly identified that ID has "a philosophical alignment with interpretive naturalistic orientations" (p. 5). As such, Thorne et al. (2004) highlight flexible alignment with a

constructivist theoretical stance, fuelled by relativist and subjectivist philosophical ideals. Thorne (2008) also very clearly suggests that researchers who employ ID need to consider "theoretical allegiances" (p. 64) associated with their discipline, how their discipline shapes how they see and interpret the world around them, and the personal factors that will inevitably influence them as they engage in research.

Although ID is relatively new to the market of qualitative methodologies, many researchers have adopted the approach, using it to guide their methods in both the nursing discipline (e.g., Paterson, Duffett-Leger, & Cruttenden, 2009) and in other disciplines (e.g., Holt, Kingsley, Tink, & Scherer, 2011; Rostam & Haverkamp, 2009). The continued use of ID in nursing is understandable given the disciplinary affiliation of Sally Thorne and the emphasis placed on the nursing discipline in many of Thorne's writings (e.g., Thorne, 2008; Thorne et al., 1997). However, researchers in alternative fields such as counselling, physical education, and other health disciplines are seeing the immense value in employing ID because of the focus on generating "discipline-related practical knowledge to explain and understand complex clinical issues in order to develop appropriate intervention and assessment tools" (Rostam & Haverkamp, 2009, p. 102). Because of this underlying focus, ID can arguably be presented as a valuable approach to qualitative research in any applied discipline.

Justification for the use of interpretive description. Through answering the aforementioned research questions, the present study sought to better understand barriers to help-seeking felt by Canadian students and subsequently

aimed to generate practical suggestions for how support services can be modified to overcome current help-seeking barriers and service demands on campus. As such, the overarching goal was to gain understanding and more importantly, to garner suggestions and recommendations for ways to change current practices on university campuses in response to the current epidemic of psychological concerns. The focus and goals of the present study aptly coincided with those discussed by Thorne and colleagues (2004) – to generate new knowledge that has "application potential" through identifying "what is common within a clinical phenomenon" (p. 7). Here, the clinical phenomenon under investigation was the mismatch between the current model of support service provision on university campuses and the needs of students. The goal was to *apply* the findings of the present study through modification of current practices on university campuses. In particular, just as Thorne et al. (2004) suggest, the goal of the present report was to provide information that "would be rendered accessible to the practice of the discipline for the purpose of informing clinical reasoning [and] extending the available insight for practice decisions" (p. 7).

While the goals of ID and the present study were nicely congruent, it is also important to highlight the philosophical synergy between counselling psychology (my discipline) and nursing (as identified by Thorne et al., 2004). As mentioned above, ID is founded in subjectivist epistemology and relativist ontology, which is reflective of its constructivist theoretical stance (Thorne et al., 2004). The constructivist stance is astutely in line with the ideals of counselling psychology – a field focused on understanding individuals' constructions of

reality. Moreover, in the last decade, counselling psychology has seen growth in the use of constructivist-based qualitative research (Ponterotto, 2005). This is happening not only because of the congruence between constructivism and the discipline of counselling psychology, but also because counselling researchers are seeking to broaden the "professional knowledge and societal impact" (Ponterotto, 2005, p. 127) of their work. As a result, there has been a rise in interpretive inquiry grounded in the constructivist framework across the discipline (Ponterotto, 2005), only further supporting the use of ID in this study.

Finally, when looking at the use of ID in psychology and more specifically, counselling, we see a growing use for and acceptance of the methodology. In particular, researchers have turned to Thorne's ID methodology to study such topic areas as the challenges associated with childhood sport participation in low-income families (Holt et al., 2011), elite athletes' experiences with emotion (Cole, 2011), Iraqi experiences of North American media coverage of the war in Iraq (Rostam & Haverkamp, 2009), and the patterns and practices of art therapists working with dementia patients (Burns, 2009). The present study contributed to this growing use of ID in applied disciplines outside of nursing, therefore making important methodological contributions as well as the stated clinical contributions. More specifically, the present study highlighted how ID can be effectively utilized in the context of counselling psychology research in order to inform and advance clinical practice.

Study Design

In the preface of her book, Thorne (2008) warns her readers that she does not provide "explicit 'how to' direction" (p. 18). However, she provides effective information around "the conceptualization and implementation of research" (Thorne, 2008, p. 18) that can guide novice and seasoned researchers utilizing ID toward credible findings. As such, the present study was modelled after the suggestions, ideas, and theorizing provided by Thorne (2008) and Thorne et al. (2004).

Sample and setting. Thorne (2008) argues that the concept of representation is more effectively captured in quantitative rather than qualitative research. Instead, she suggests that "we need to find ways of thinking about the sample subsets we create for the purpose of answering any research question, come up with rational arguments about why they are worth attending to, and estimate what angle of opinion or perspective they are likely privileging or silencing" (Thorne, 2008, p. 88). With this in mind, the present study was conducted on three Canadian university campuses, one located in British Columbia, one located in Alberta, and the final located in Ontario. The specific universities were selected because they collectively made up some of the largest English-speaking universities in Canada, while also housing a wide demographic of students, including undergraduate, graduate, and professional students, international and Canadian students, and on campus and commuting students. All universities expressed interest in and support of the study prior to recruitment.

While the inclusion of the chosen universities creates a focus on the needs of large metropolitan campuses, the findings from such universities were thought to also aid in informing practice at smaller universities with only a subset of the population represented by the universities in the present study. More simply, because the present study highlighted strategies that help widely diverse populations, practitioners and administrators can pull appropriate ideas from these strategies to serve less diversified populations.

Sampling approach and recruitment. Qualitative research often relies on purposeful sampling and ID is no exception to this (Patton, 2002; Thorne, 2008). Purposeful sampling is the act of seeking out "information-rich cases … [from] which one can learn a great deal about issues of central importance" (Patton, 2002, p. 230). The sample in the present study was purposefully comprised of both university staff/administrators who oversee and participate in support service provision and full-time students at the selected universities. While Thorne (2008) suggests that it is virtually impossible to access "the full complement of people who have encountered a particular phenomenon" (p. 88), she suggests building a sample with "an auditable set of angles of vision" (p. 89) and one that has "an awareness of expected and emerging variations within the phenomenon under study" (Thorne et al., 2004, p. 6). Accessing both staff/administrators and students helped to effectively capture unique, yet important variation around the topic of interest. Moreover, both groups were considered to be information-rich as they represented both the provision and utilization ends of support services.

Accessing the staff/administrators and students was approached utilizing different methods. In order to access staff/administrators that had extensive experience with the topic at hand, snowball sampling (Patton, 2002) was utilized. More specifically, senior administrators who oversaw student services at each university were approached via email and asked to participate in the present study. Regardless of their decision to participate, these individuals were also asked to recommend appropriate staff to be included in the study; this ensured that information-rich cases were approached for the study therefore enhancing the quality of the data. The recommended participants were then contacted via email in order to determine their interest in participating. Sampling occurred in this manner until the desired number of interviews was completed.

Access to students was approached using an alternate method of purposeful sampling known as purposeful random sampling (Patton, 2002). Because it was challenging to determine which students were the *most* information-rich, purposeful random sampling of students at each university, or selecting students without any "advanced knowledge of how the outcomes would appear" (Cohen & Crabtree, 2006), offered a feasible way of accessing the information of interest, while still maintaining the credibility of the study (Patton, 2002). In order to effectively access the student population, information about the study was relayed to the students through a variety of methods. Posters (see Appendix A) that provided a brief synopsis of the study and my contact information were displayed in high-traffic areas to solicit participants. Additionally, social media sites including Facebook and Twitter, on campus

listservs and blogs, and the online classified site "Kijiji" were utilized to advertise the study (see Appendix B). Interested participants contacted me via phone or email, after which I provided a more thorough overview of the study using the information form (see Appendix C). If the student then decided to participate in the study, an agreeable time to complete the interview was established. Sampling occurred in this manner until the desired number of interviews was completed.

Inclusion / exclusion criteria. In order to gain the most valuable data, specific criteria for inclusion / exclusion of participants was established prior to the outset of data collection. In particular, only full-time students who attended on campus courses were included in the present study; part-time students or distance education students were excluded. Both undergraduate and graduate students were eligible to participate. Establishing this distinction prior to data collection was considered important because it eliminated students who did not have consistent or regular access to the support services available on campus, while still maintaining room for exploration with the majority of the student body who could collectively access many of the same services. With respect to university staff/administrators, only those individuals directly involved in support service provision or administration of student services were contacted. This was decided because the nature of the research questions demanded knowledge of current approaches to student service provision and it was thought that faculty and staff with a portfolio that did not include administration or provision of student services would not have the appropriate knowledge to answer the research questions.

Sample size. Generally speaking, qualitative research promotes the use of smaller samples (relative to quantitative studies) focused around "information-rich cases for study in depth" (Patton, 2002, p. 230). ID supports this notion, suggesting that the approach "can be conducted on samples of almost any size" (Thorne, 2008, p. 94). Thorne goes on to highlight that most research studies utilizing an ID framework build samples ranging from 5 to 30 participants, which is consistent with a survey of research employing ID as the guiding methodological framework (e.g., Audulv, Asplund, & Norbergh, 2011; Paterson et al., 2009; Rostam & Haverkamp, 2009). As such, in the present study, 23 participants were purposefully sampled. This allowed for an effective scope of data from each university campus (6-9 interviews per campus; 2-6 staff/administrators per campus and 3-5 students per campus) thus ensuring that inter-campus variation was highlighted. Moreover, a sample of this size was also considered financially and practically feasible for a project of this nature (i.e., dissertation research) and allowed for in-depth rather than surface-level understanding of each participant's experience. Finally, once all interviews were completed, the data was reviewed and considered to have sufficient detail and depth to answer the research questions guiding the present project.

Description and demographics of sample. Prior to participating in the present study, all staff/administrators and students completed a demographics form (see Appendix D). For students, the completion of this form ensured registration in the stated university. In all cases, students were studying full-time at their respective institutions. For staff/administrators, this form ensured that

working directly with students was central to their role at their respective campus. In all cases, the staff participants answered "yes" to the question, "is student services an important part of your portfolio?"

Demographics of sample. As mentioned, a total of 23 participants participated in the present study. The student sample (n=12) was comprised of both males (n=3) and females (n=9). The students ranged in age from 19 to 32 years (mean=23.3 years) and represented various levels of academic experience (9 undergraduate students; 2 graduate students; 1 student in a professional program). Five participants attended an alternate institution prior to attending their current institution.

The staff/administrator sample (n=11) was also comprised of both males (n=2) and females (n=9). This group ranged in age from 31 to 61 years (mean=48.4 years). One participant declined to provide her age. All participants reported that they were involved in university administration between six months and 27 years (mean=14.4 years); collectively, 158.5 years of experience in university administration were accumulated by the collective sample. All participants were asked to identify their highest level of education. One participant identified a bachelor's degree as her highest level of education, while five identified a master's degree, and five identified a doctorate degree. Finally, some of these participants held additional professional designations. Two participants were registered psychologists, one participant was a certified family physician, and one participant was a certified health education specialist.

Data generation and analysis. In the present study, data was primarily collected via individual semi-structured interviews conducted in-person, over the phone, or via video-conferencing technology. Data was concurrently analyzed utilizing the suggestions outlined by Thorne (2008) and Thorne et al. (2004).

Informed consent. Once participants expressed interest in the present study, they were provided a thorough overview of the study via email (see Appendix C), including information about the purpose, methods, and goals of the study. The participants were encouraged to contact me at any point prior to participation and/or throughout the study if they had any questions. Upon meeting with the participant in-person, informed consent was obtained verbally and through the signing of a written informed consent form (see Appendix E) that I explained to the participant. For interviews that occurred over the phone or via video-conferencing software (i.e., Skype), participants were emailed the informed consent form prior to the scheduled interview date. The form was then reviewed before the start of the interview and participants were asked to sign and return it via email or mail at their earliest convenience. For such interviews, verbal consent was considered sufficient in order to proceed with data collection.

Data collection procedure. Data was collected using semi-structured interviews. Interviews are one of the most widely-used methods of data collection in qualitative research (Patton, 2002), and Thorne et al. (2004) agree that interviews can help to "articulate a coherent and meaningful account of the experiential knowledge" (p. 5). Semi-structured interviews are considered particularly appropriate in ID, as Thorne (2008) suggests that the most effective

interviews are ones where the researcher focuses on building rapport and works "to elicit depth and clarification of threads within the account, and to foster elaboration, clarification, and even correction" (p. 129). With this in mind, a general interview guide was constructed prior to the start of data collection. A unique interview guide was generated for interviews with both students (see Appendix F) and staff/administrators (see Appendix G). In both cases, the interview guides served to promote open discussion around the research questions, while also allowing for follow-up questioning, probes, and natural communication. Moreover, because data collection and analysis were concurrent, the nature of the interview questions changed throughout the course of the project. In particular, as analysis progressed, additional questions were posed to the participants that reflected the ideas that were surfacing from the existing data.

Interviews were arranged at a mutually agreeable time. Fourteen interviews were completed in-person, eight interviews were completed over the phone, and one interview was completed via video-conferencing software (i.e., Skype). In-person interviews occurred in private, confidential settings including the private offices of the participants, vacant meeting rooms, or counselling rooms in an on campus counselling clinic. Phone and Skype interviews occurred in a location that was deemed comfortable and confidential by the participant; for such interviews, I was located in a private office.

Prior to the outset of the interviews, all participants completed the aforementioned demographics form (see Appendix D) and consent was established as described above. Once these matters were attended to, the

interviews commenced. All interviews were audio-recorded and lasted between 35 minutes and one hour and 20 minutes. At the completion of each interview, the student participants were provided contact information about the mental health services available on their respective campus and within the surrounding community. This information was emailed when interviews were completed over the phone or via Skype. In addition, each participant was provided a $20 gift certificate to a well-known coffee shop as remuneration for his or her participation. In the cases where interviews were completed via telephone or Skype, the gift card was sent to the participants via email or mail, as per the participant's indicated preference.

While interviewing served as the primary method of data collection, Thorne and colleagues (2004) also note that ID "often involve[s] multiple data collection strategies" (p. 5). As such, a reflexive journal was kept, documenting observations and ideas generated throughout the data collection and analysis process; this journal served as an additional source of data. Further, as mentioned, demographic information was collected. Although this and the journal were not individually analyzed, they were helpful in understanding the make-up of the sample and tracking my thought processes, which collectively contributed to the richness and rigour of the findings. Finally, it can be noted that completing data collection across several university campuses was thought to diversify the data and avoid "naïve overemphasis" (Sandelowski, 2002, as cited in Thorne et al., p. 6) on one particular campus.

Data analysis. Following the completion of interviews, the audio files were sent to a transcriptionist and transcribed verbatim. The use of a transcriptionist increased the proficiency of data analysis. However, to avoid lost engagement in the data, as warned by Thorne (2008), I checked all transcripts for accuracy through re-listening to the audio recordings and simultaneously correcting the transcripts. This allowed for further immersion into the data and provided me with additional opportunities to make process notes in the reflexive journal. Once transcribed, the analysis process was informed by the framework provided in Thorne (2008) and Thorne et al. (2004).

Like many qualitative approaches, ID promotes analysis that involves a gradual process of making sense of the data through coding and categorizing, eventually leading the researcher to find patterns, themes, and concepts within the data (Thorne et al., 2004). Thus, following the transcription of interviews, an inductive process of coding was subsequently completed using the research questions as a guiding framework. Here, I electronically applied a brief label to unique segments of data that spoke to the research questions in such a manner that allowed for the "gathering together [of] data bits with similar properties and [consideration of them] in contrast to other groupings that have different properties" (Thorne, 2008, p. 145). Although Thorne (2008) does not identify specific tasks required for successful coding, she cautions against "excessive precision" (p.145) and suggests that one apply a coding scheme that is "broad-based" (p. 147). In line with these suggestions, I approached coding with an

open-minded and curious state, generating approximately 560 codes across the 23 transcripts.

Once the data was coded, the next step of analysis involved grouping similar codes and considering patterns and relationships among them (Thorne, 2008). I completed this task manually, examining the collective group of codes that responded to each of the research questions and manually grouping codes that exhibited similarities into several categories. As analysis continued, the various categories housing the collections of codes were continually refined and broader themes were slowly generated, as the relationships between the categories were examined, pondered, and repeatedly questioned both intellectually (e.g., "does this relationship make sense?") and reflexively (e.g., "why am I seeing this?" or "Am I seeing this because of a particular bias?"). This ongoing process occurred in response to Thorne's (2008) suggestions, outlining that analysis in ID is an iterative task that involves "listening, observing, writing, thinking, listening, writing, thinking, and writing again" that slowly leads to "meaningful and grounded conceptualizations" (p. 162).

Although this process of analysis resembles many analytical approaches in various schools of qualitative research, the crux of ID analysis is realizing the interpretive power held by the researcher (Thorne et al., 2004). In particular, Thorne and colleagues (2004) highlight that "regardless of the explicit sequence of steps that might be employed, it is essential to recognize that the researcher, not the recipe, is driving the interpretation" (p. 11). As such, when determining the relationships between groupings of codes, it was imperative that I was self-

reflective and that I "continually find ways to confirm or challenge the basis upon which [my] mind is making linkages between the pieces and parts within the data" (Thorne, 2008, p. 158). Thus, I chose to maintain a reflexive journal that highlighted decision-making processes and reasoning behind the relationships identified within the data; I also reviewed and discussed all analytical decision making with my supervisor. Moreover, adopting a willingness to critique findings and examine information that did not fit within the identifiable relationships also strengthened my analysis (Thorne, 2008). In many cases, this critical lens served to generate additional categories and themes or consider how particular codes may be reflective of idiosyncrasies within an alternate category or theme.

As mentioned previously, the data collection and analysis processes occur simultaneously in ID (Thorne et al., 2004). As such, once analysis began to unfold as described above, subsequent data collection served as a means of challenging existing analysis and findings. This process helped to verify, reconceptualize, or negate findings as they were interpreted (Thorne, 2008; Thorne et al., 2004). For example, after the first set of interviews were completed, a theme around misunderstanding of mental health symptomology started to emerge; this was later transformed into inadequate knowledge of mental health, generally. This modification further encapsulated a global lack of awareness, rather than a specific lack of awareness.

The final aspect of data analysis in ID is bringing the relationships interpreted among the data together at a conceptual level (Thorne, 2008). Here, I

was challenged to think about the relationships identified and methods of organizing those relationships in a manner that evoked a novel way of thinking about the phenomenon under investigation (Thorne, 2008). Thorne (2008) suggests that concepts are best portrayed by the "words and signifiers" (p. 173) provided to them and represent higher-order understanding that goes beyond the "self-evident" (p. 175). At its finest, the conceptual portrayal of the interpreted findings should "powerfully capture the important elements within the clinical phenomenon in a manner that can be grasped, appreciated, and remembered in the applied context" (p. 169). At this point in analysis, I was particularly struck by the systemically oriented nature of the emerging findings. Thus, I felt that portraying the relationships among the data within the context of the global system (i.e., portraying the individual, structural, and systemic elements as well as the interrelationships between these respective areas) served as an effective way to not only understand the data, but also offered novel, practical, and most importantly, a useable structure to understand the findings. Moreover, through portraying the findings in this way, the ultimate goal of ID was reached – portraying "a thematic structure for showcasing the main elements of the phenomenon in relationship with one another, if not within a new conceptual or theoretical schema" (Thorne, 2008, p. 165) – and data analysis was considered complete.

Once analysis was completed, a summary of the findings was sent to all participants. All participants were invited to review the findings, share feedback, and/or request a more thorough overview of the findings. While some

participants requested the thorough overview of findings, no participants requested changes to the presentation of the findings. This further enhanced the rigour of the project, as discussed in subsequent sections.

Ethical Considerations

The present study was reviewed and received ethical clearance by the University of Alberta Research Ethics Board 1 as well as the ethical boards that corresponded with the other institutions that were included in the sample. All guidelines offered by each university's research ethics boards were strictly followed. In particular, participants were provided comprehensive information about the study via the Information Form (see Appendix C) and in person, prior to outset of the interview. Participants provided consent to participate both verbally and in writing (see Appendix E). Moreover, participants were encouraged to ask questions and/or state concerns throughout their involvement in the study. Participants were reminded of their right to withdraw from the study at any point prior to data coding (where all data would be collapsed into one document).

Confidentiality and anonymity were ensured to all participants. All electronic files were password-protected and stored on an external storage device. Subsequently, all electronic and hard data were securely stored in a locked cabinet that remains in a locked office. Confidentiality was further assured through the use of a confidentiality agreement with the hired transcriptionist (see Appendix H). Finally, in order to ensure anonymity, participants self-selected their pseudonym prior to completing the interview; this pseudonym was used for all data storage and retention.

Finally, it can be noted that some students spoke about their own psychological issues when discussing their relationship with university support services and student barriers to help-seeking. Having anticipated this as a possibility, certain safeguards were put in place and made known to the participants prior, during, and following participation. This included a) a thorough discussion at the outset regarding the nature of the study, foreseeable risks, and expectations for participation, b) offering participants the chance to withdraw from the study, and c) providing participants with contact information for myself and my supervisor, as we are both trained in counselling psychology and could aid participants in finding appropriate resources. In addition, all student participants were provided a list of campus and community-based resources that they could access should they have experienced any distress. No participants disclosed distress as a result of participation in the study.

Rigour

Although various approaches for evaluating rigour in qualitative research have been suggested (Patton, 2002), there is little agreement regarding which approach holds the highest credibility (Lincoln & Guba, 2000; McLeod, 2001). The present study was evaluated through two sets of criteria.

Thorne's (2008) criteria. In Thorne's (2008) overview of ID she offers a series of criteria to evaluate an ID study, including epistemological integrity, representative credibility, analytic logic, and interpretive authority. The alignment of the present study with these criteria is subsequently outlined.

Epistemological integrity. Thorne (2008) describes epistemological integrity as "a defensible line of reasoning from the assumptions made about the nature of knowledge through to the methodological rules by which decisions about the research process are explained" (pp. 223-224). Certainly, from an epistemological standpoint, ID generally, and the present study specifically, followed a subjective framework; there is no objective truth and as such, findings were constructed rather than revealed (Thorne, 2008; Thorne et al., 2004). In the present study, epistemological integrity was preserved through stating the epistemological framework at the outset of the study, the openness of the research questions, the application of an inductive data analysis strategy, and my ongoing personal reflection of bias throughout the completion of the study.

Representative credibility. Thorne (2008) suggests, "qualitative studies ought to show representative credibility such that the theoretical claims they purport to make are consistent with the manner in which the phenomenon under study was sampled" (p. 224). In the present study, findings were considered to be primarily reflective of the three campuses from which the data were collected. However, because the data were collected from unique campuses across the country, the findings were also triangulated with current literature (in the discussion chapter) in order to portray their applicability to other Canadian universities.

Analytic logic. Thorne (2008) states, "we expect reports of all qualitative studies to reflect an analytic logic that makes explicit the reasoning of the research from the inevitable forestructure through to the interpretations and

knowledge claims made on the basis of what was learned in the research" (pp. 224-225). As Thorne supports, a natural way to highlight the researcher's process of making decisions and analytical compromises is through the maintenance of an audit trail and the provision of thick description of the findings. In the present study, both of these conditions were deliberately adhered to.

Interpretive authority. Thorne (2008) outlines, "we need assurance that a researcher's interpretations are trustworthy, that they fairly illustrate or reveal some truth external to his or her own bias or experience" (p. 225). Interpretive authority was assured through the maintenance of a reflexive journal in which I documented my thought process that guided data collection and analysis. In addition, the participants were each sent a document that outlined the findings following the completion of analysis. During this time, they were provided an opportunity to comment if the findings did not accurately reflect their position toward the research questions. This ensured that the findings were in fact reflective of the participants' ideas, rather than my personal truth grounded in my own biases.

Alternate criteria for rigour. A researcher cannot begin to evaluate a study using Thorne's (2008) criteria until data analysis is finalized. However, because it was necessary to consider rigour in the formulation and completion of the present study, Thorne's approach served as an adjunct to the well-accepted criteria developed by Lincoln and Guba (1985), which includes consideration of credibility, transferability, dependability, and confirmability. The criteria offered by Lincoln and Guba (1985) have "been fundamental to the development of

standards used to evaluate the quality of qualitative inquiry" (Morse, Barret, Mayan, Olson, & Spiers, 2002, p. 3).

Credibility. A credible study is one where the findings adequately reflect and represent the intended ideas, meanings, and stories of the participants (Trochim, 2006). Consequentially, the best determinants of credibility are the participants (Lincoln & Guba, 1985). In order to ensure credibility in this study, member checks were employed, as described previously (Cohen & Crabtree, 2006). The participants did not report any incongruence in the findings in response to the member checks.

Patton (2002) also speaks to this criterion, suggesting that the use of precise and thorough methods can greatly enhance credibility. To meet this requirement in accordance with the suggestions of Patton (2002), the present study a) employed a systematic approach to data analysis (as outlined above), b) considered and investigated negative cases (i.e., those cases that deviated from the developing findings), and c) employed triangulation procedures through the use of multiple participants and through triangulation of the findings with alternative literature from the field (see chapter five). Finally, given that this project was completed over a two-year period, there was considerable immersion in the topic area; this prolonged engagement also enhanced the study's credibility (Cohen & Crabtree, 2006).

Transferability. Transferability refers to the usefulness of the study in alternative contexts (Trochim, 2006). The study's usefulness is often best determined by those individuals who are seeking to apply the findings elsewhere

(Trochim, 2006). As such, in accordance with the recommendations of Cohen and Crabtree (2006), the findings of this study are relayed to the receiving audiences through rich and detailed descriptions, allowing all readers to make an appropriate evaluation of the relevancy of the findings.

Dependability. Dependability speaks to the replicability of the study in the context of a constantly changing research environment (Trochim, 2006). Dependability can often be determined through the availability of an audit trail (Cohen & Crabtree, 2006). An audit trail is simply a compilation of documents related to data generation and analysis, including researcher notes that describe and justify their decisions (Cohen & Crabtree, 2006). As such, an audit trail of this nature was maintained in the present study in order to enhance the dependability of the study.

Confirmability. Confirmability speaks to objectivity of the study, ensuring that the findings are grounded in the data, rather than the researcher's biases (Lincoln & Guba, 1985). Cohen and Crabtree (2006) suggest that effective methods for enhancing confirmability include maintaining an audit trail, performing triangulation, and engaging in reflexivity. In the present project, an audit trail was maintained such that a peripheral reviewer would be able to understand how the findings were generated. Just as triangulation of sources and findings was used to enhance credibility, the completion of this task also aided in enhancing the confirmability of the study (Crabtree & Cohen, 2006). Finally, a reflexive journal (Lincoln & Guba, 1985) - documenting thought processes, ideas,

potential biases, emotional responses, and intentions - was kept in order to maintain a reflexive stance throughout the project.

Conclusion

In order to answer the research questions outlined in the introduction, the present study employed a generic qualitative framework. In particular, interpretive description was utilized to guide the general formulation of the study, as well as the data collection and analysis procedures. Careful consideration was provided to all aspects of the study in order to ensure that the findings were both rigorous and clinically relevant/applicable.

Chapter Four

Findings

A total of 23 individuals participated in the present study. While each participant shared unique ideas based on their knowledge and personal experience in either a staff or student capacity, there were certainly consistencies within the data that allowed for the generation of themes and concepts. The present chapter is utilized to provide an overview of the participants and subsequently profile the conceptual linkages among the information.

Overview of Participants

As previously noted, the sample was comprised of students and staff/administrators. The students were at various points in their academic careers, ranging from first year to graduate level study with eight years of university experience. Meanwhile, the staff/administrators represented various realms of support services (e.g., unit leaders, front line staff, or senior administrators) and possessed between six months and 27 years of experience in university administration. The exact roles of the staff/administrators cannot be discussed in order to protect confidentiality. All participants were recruited from three large metropolitan Canadian institutions that housed a diverse student population. An overview of the participants is provided in Table 1.

Participants were asked various questions in accordance with the interview guide (see Appendices F and G) to discern their personal thoughts around barriers to help-seeking faced by university students, current mechanisms utilized to handle barriers and service demands, and policy and practice changes still

Table 1

Overview of Staff / Administrator and Student Participants

Staff/administrators (n = 11)			Students (n = 12)		
Pseudonym	Institution	Years of experience	Pseudonym	Institution	Year of study
John	1	12	Anna	1	4
Snooks	1	3	Chris	1	3
Kate	1	24	Wendy	1	5
Crystal	2	8	Kathryn	1	3
Pam	2	26	Cindy	1	6
Annette	2	14	Moe	2	6
Jackie	2	13	Charles	2	8
Margaret	2	19	Connor	2	3
Anne	2	12	Maggie	3	3
Mel	3	0.5*	Lela	3	8
Joe	3	27	Jessica	3	2
			Sarah	3	3

*Participant possesses years of related experience in a non-university context

needed in order to handle these two issues. In many cases, the information shared by the participants in response to these questions overlapped. Naturally, however, in completing the interviews it became evident that each institution was at a different place in their journey of grappling with the mental health issues present on their campus. As a result, it was common for participants associated with one institution to describe a "current mechanism" being utilized to handle barriers and service demand issues, while participants from a different institution identified the same mechanism as a "policy or practice change still needed." This, of course, influenced the presentation of the findings, as described in the forthcoming sections.

Student participants were adept in identifying barriers to help-seeking. Many spoke from their own experiences, sharing the barriers they personally confronted when exploring support services on campus. It was challenging,

however, for students to identify the mechanisms utilized by their respective universities in overcoming barriers and dealing with service demands likely as a result of their limited time on campus, lack of involvement in the broader functioning of the university, or the slow pace of change on university campuses relative to their collective time spent on a campus (i.e., four years). Students were quick to identify potential changes the university could make within the services or across the university as a whole in order to address barriers and service demand issues. Typically, students offered concrete ideas that would have promoted or accelerated their own journey to help-seeking. In some instances, students had difficulty identifying policy changes needed as a result of their unfamiliarity with university policy, generally. Interestingly, however, the concrete changes endorsed by students were in many ways an extension of the ideas brought forth by the staff/administrators.

Staff/administrators were able to speak about barriers to help-seeking based on their personal experiences, their work with students, and their understanding of the pre-existing research in this area. Many of the barriers identified by staff/administrators were consistent with the ideas mentioned by students. Moreover, staff/administrators were able to recognize mechanisms utilized by their respective institutions and policy and practice changes still needed with respect to overcoming barriers and meeting service demands given the relationship between this information and the primary tasks associated with their positions. The ideas discussed expanded beyond the scope of those shared by the students, likely because staff/administrators had a strong understanding of

the systemic functioning of the university and the fiscal and administrative tasks required in implementing changes within support services and the global university community.

Presentation of Findings

As stated, each participant was asked to identify barriers to help-seeking faced by students, current mechanisms being used by their respective institution to overcome barriers and meet current service demands, and policy and practice changes still needed to address these issues. The findings were conceptually separated into "Barriers" and "Mechanisms to Overcome Barriers & Meet Service Demands" and are sequentially presented in this manner. The relationship between these two areas is identified at the conclusion of this chapter.

As previously mentioned, the data analysis requires the researcher to bring the data together at conceptual level for application purposes. At the conceptual level, the barriers and mechanisms reported by the participants were best understood when organized into individual, structural, and systemic themes. The "individual" theme spoke to the students specifically, the "structural" theme spoke to the support services, and the "systemic" theme spoke to the collective whole of the university. The conceptualization of the three broad themes accurately fit with the nature of the problem. In particular, because the problem exists within the university system as a whole, it was logical that exploration of the problem as well as "solutions" to the problem fell both in the micro (individual and structural) and macro (systemic) elements of the university. In other words, the *individual* and *structural* elements existed among the larger

system and each of the three areas contributed to the problem and corresponding mechanisms to handle the problem.

Barriers to Help-seeking

As stated, barriers were categorized as individual, systemic, or structural and in some cases fell into two of these three areas. Facilitators to help-seeking were also highlighted by participants. The individual barriers identified included developmental period of life; normalizing, denial, and avoidance; and fear and uncertainty. The structural barriers included service deficiencies and communication deficiencies. Inadequate knowledge about mental health was considered an individual and structural barrier. The key systemic barrier was the university climate, while stigma and shame was considered a systemic and individual barrier. Two help-seeking facilitators were also endorsed. Facilitators to help-seeking were recognized by participants as mechanisms that naturally promoted help-seeking on campus that were not deliberate on the part of the university. These included external support, which was considered both individual and systemic, and acceptance that help is required, which was an individual factor.

A diagrammatic portrayal of the barriers is provided in Figure 1. The overlapping circles used in this figure highlight the mutual and inter-related influences of each of the individual, structural, and systemic barriers; these three areas were continuously in play and directly or indirectly influenced one another at any given time. For example, the tendency for individuals to deny mental health problems, along with the limited acknowledgement of mental health at the

systemic level, and the failed communication efforts around mental health at the structural level all mutually influenced each other.

Figure 1. Barriers to Help-Seeking

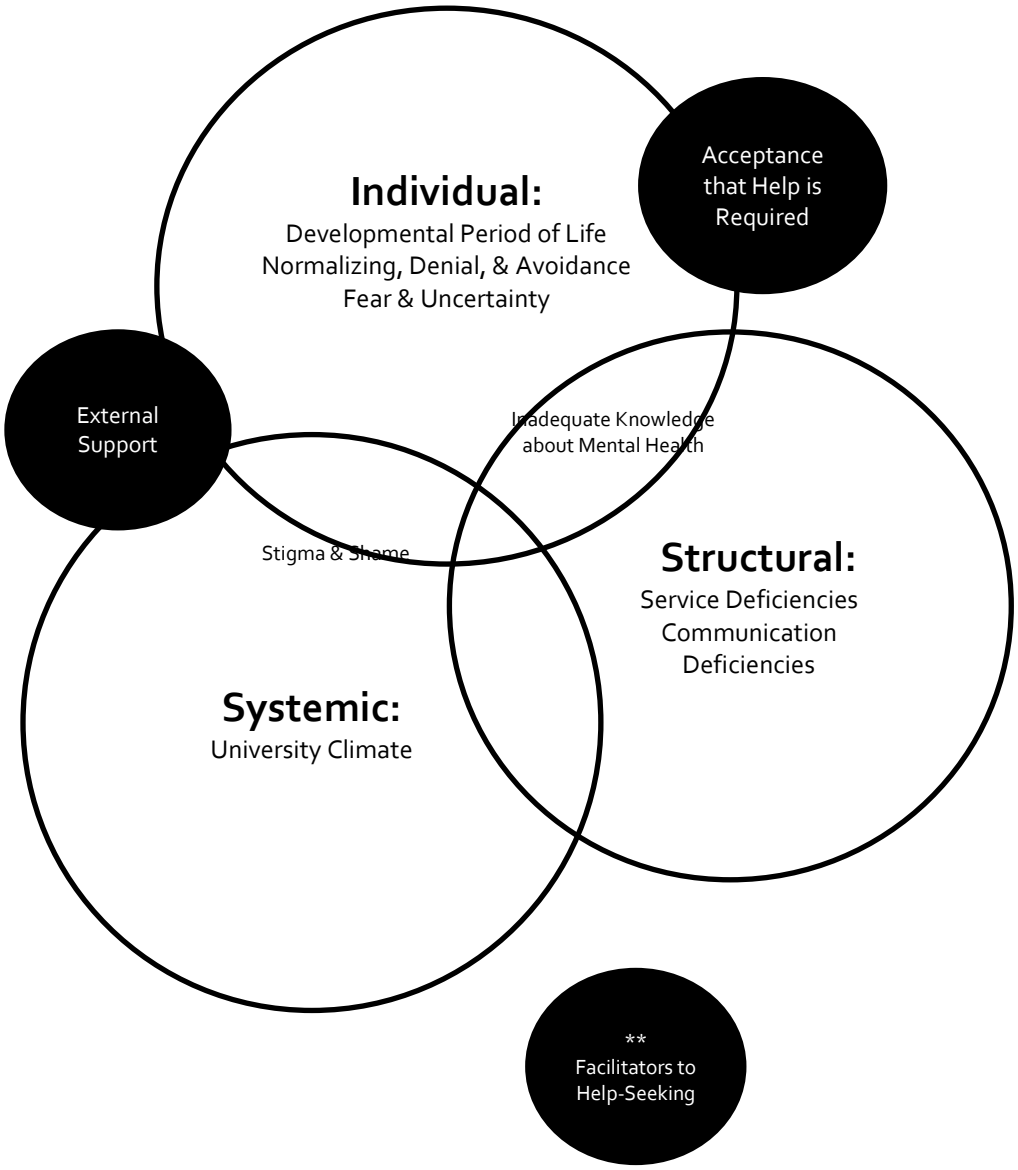

Figure 1. Diagrammatic overview of the individual, structural, and systemic barriers and facilitators to help-seeking.

Individual barriers. The individual barriers recognized by participants spoke to the factors that were specific to the students and prevented help-seeking

for psychological issues. These included developmental period of life; normalizing, denial, and avoidance; and fear and uncertainty.

Developmental period of life. The participants highlighted that the developmental period associated with entrance to university was certainly a challenging time in a young person's life. In particular, the period of young adulthood (i.e., ages 18-25) that coincides with the typical undergraduate years was recognized as a time when individuals are taking on independence and responsibility for their own care for the first time in their life. As such, the participants noted that students experienced difficulty when they tried to independently recognize personal challenges, decide whether help was necessary, and navigate systems for the first time. Margaret acknowledged this, noting that help-seeking had to be intrinsic:

> So what I see is students who, for the first time, are in the position on their own to make a decision about help-seeking as opposed to being tapped by a counsellor or a teacher or a parent or a sibling. This is a natural part of being and developing to be an adult.

Jackie shared similar observations, while also highlighting that students were in a specific developmental period where they may not have learned to ask for help:

> Students [are] coming straight from high school where someone has come to them with everything … 'here's what we think you need next.' And then suddenly it's like, okay now I need to do that for myself. And being an advocate for yourself and asking for help is a skill I think that some students are lacking.

Unfortunately, just as young adulthood coincides with the development of independence and responsibility, it also tends to be the age of onset for particular mental health issues. Because of this, the participants felt that the general novelty of some mental health issues made them difficult for students to identify as

problematic. These factors, combined with the fact that maturity and self-awareness were still developing, were considered common reasons for failing to access help on campus. Pam encapsulated how these issues collectively played out and the magnitude of these issues on a university campus:

> So 18 year olds that come to [the institution] and probably more than 90% may not even know that they have a mental health disorder until they're 19 or 20 because it's the first episode that they've had. So first of all, it's people who are not used to managing a health system on their own. It's people who never had this kind of problem before, and it's also people who've never had an experience at a university before. So when you have those three together, those will always be new for about 8,000 students every year.

Normalizing, denial, and avoidance. The participants noticed that students tended to have difficulty admitting that a psychological issue was in fact a problem that required intervention or external support. More specifically, the participants highlighted that students did have a sense that a problem existed, yet they utilized a variety of mechanisms to minimize the severity, including normalizing, denial, or avoiding the problem(s). One way this process occurred was through cognitively normalizing the experience of suffering. In particular, the participants reported that students diminished the magnitude of their experiences through making the internal argument that their challenges were normal and simply part of their identity of being a university student. Moe aptly acknowledged this trend, stating that students tended to rely on the belief that "I'm in university, I'm going to feel awful for four years. 'Cause that's what you do." Anna further endorsed this issue, sharing how she too tried to normalize her experience of suffering:

> For me it was a week of being highly stressed out or two weeks and I would have panic attacks every now and again, but I just dusted myself off, carried on and I was like, 'no, I'm fine' and just kept telling myself, 'stress isn't a problem. Everybody gets stressed.'

Another way in which in this process of minimization appeared to occur was though denial, failing to admit that a problem existed, and/or making excuses for the symptomology. For example, when asked about what prevented students from seeking help, Annette highlighted that "anecdotally, we learn about students not really wanting to admit or self-identify that they have a problem that would be of a mental health nature." Lela verified this from a student's perspective and highlighted that such behaviour seemed to exist everywhere, noting "I think regardless of if you're on a university campus or not, realizing that you have a problem and admitting that is an issue for all people." However, when thinking about the impact this had on help-seeking, John spoke about the challenges for service providers:

> There are another group of people who are totally in denial. Who think that they're just having a bad day but actually they're fine and if you ask them how they're doing they say they're fine. And those are the ones that are harder for us to help.

A final mechanism students used to minimize their psychological challenges was avoidance of the problem and carrying the belief that it would simply go away on its own. Kathryn acknowledged this, reporting that some students attached a sense of transience to their psychological challenges:

> Perhaps the idea that this is impermanent. If I just push through it, it'll be over. That's probably one of those things [that is] similar to how we view sleep. I'll sleep after finals, I'll be fine, I'll sleep after finals. The idea that if it's not permanent then I don't need to get it treated.

From her own work with students, Pam made a similar observation, noting that avoidance occurred because students were simply too busy to seek help:

> There's the issue of 'if I don't talk about it it'll go away' or 'I don't have time to talk about this because I'm too busy and I will deal with this when school is over, when the summer comes, whatever, because I've got this exam tomorrow or I've got this exam next week.'

Many other participants also acknowledged that students avoided dealing with the problem because of the strenuous nature of their schedule. For example, when asked why she did not seek help for the psychological challenges she was facing, Maggie expressed denial and indicated that time was also an issue for her personally, stating "I just didn't want to spend more time for something I don't need and I had enough on my plate."

Fear and uncertainty. The participants reported that students faced fear and uncertainty in their journeys towards help-seeking. Help-seeking was considered a skill and, as mentioned above, the developmental period associated with the undergraduate years made it challenging for students to know *how* to ask for help. In addition to this, the participants acknowledged that students faced uncertainty around the severity of their psychological issues, worrying whether the magnitude was great enough to warrant help-seeking. John endorsed this challenge, observing that students (and staff) often compared their problems to others' problems:

> Most people probably think, 'well there are people that are a lot sicker than me.' I just don't think people think that the service is designed for them. And I see that for staff as well. People think, 'I'm not that bad yet.'

Kathryn recognized this tendency and noted how extreme students felt psychological issues needed to be in order to seek help:

> But it's the idea that only when you are in a crisis point, only when you are way too far, only when you cannot handle anymore that is when you need to get treated. It's not the idea of sustaining health, it's the idea of very much treating the crisis. Which is – if we never went for checkups and we only went to the doctor if something serious – when all hell had broken loose. Yes. Like when we go to the doctor and say hey, my arm is broken, I can't feel my leg, and I've gone blind.

There was also some fear generated around the process of help-seeking. For example, some students reported that the process of asking for help generated anxiety. Kathryn acknowledged this, stating "I can be quite introverted. I do not like asking for help, largely because it's somewhat anxiety invoking. There's undoubtedly a section of the population who feel likewise." In addition, some students feared they were burdening others by seeking help. For example, Connor indicated that he did not turn to professors for help because he felt like their plates were already quite full, sharing "professors have a ton on their plate, so I feel kind of scared and I feel a lot of other students, classmates feel concerned that they're just taxing the professor's time." Meanwhile, it was also observed that fear manifested as an absence of confidence or comfort around help-seeking. For example, Snooks observed this in her work with students, noting "I think overall the biggest area tends to be students having the confidence to seek out the resources or the comfort with connecting to the resources." Sadly, this limited sense of confidence left students feeling isolated and alone, or as Chris stated, "The world is so positive out there … it's pulling, it's asking you to go, but you don't have the courage to go, so that you are forever stuck in this dark, lonely place."

Students were also uncertain about finding a solution to the problem. In some cases, the students disclosed that they did not seek help because there was no "cure" or promising way of resolving their issues. Chris spoke about this uncertainty, stating "some people believe they cannot be cured so nobody wants to spend money on that or waste time on that." Meanwhile, Wendy also discussed this uncertainty relative to a physical health issue, noting that the inability to cure a mental illness detracted from her rationale for help-seeking:

> On one hand I think that mental disorders … you shouldn't see them any differently than if someone has cancer or something, it's not someone's fault. But if there isn't … like you find out you have cancer so that you can go to the doctor and hopefully cure it. But if you find out you have something and there's nothing you can do about it, then you may or may not be just as well not even finding out about it.

Finally, along similar lines, the participants indicated that there was great fear around having a diagnosis. In some cases, students chose not to seek help simply because they did not want to live with the shame and uncertainty that comes with that. Wendy encapsulated this effectively, stating:

> One of the biggest things I would think [is] preventing people from coming forward is that they don't feel like they want to put a label on it … For me, it's that. I think at some level, it's a fear of being discriminated against. Another level you don't know where you should go with that.

Structural barriers. The structural barriers endorsed by participants spoke to the factors that were specific to the support services and prevented students from seeking help for psychological issues. These included service deficiencies and communication deficiencies.

Service deficiencies. The participants reported that many features of the services prevented students from seeking help. One of key issues identified by

participants was an inability for services to meet the diverse needs of the student body. Participants stated that services did not meet the needs of various minority groups (e.g., LGBT students), commuting students, students from diverse cultural groups, international students, ESL students, and even the needs of both male and female students. For example, Margaret discussed the gender challenges in the context of the greater university population:

> Having looked at the data somewhat recently, one of our major issues certainly still remains gender, in terms of help-seeking behaviors. So we see many more women approaching help. So when you still are dealing with faculties that are constituted of different gender ratios, so I think particularly applied science and engineering. We probably have 80% are still men at this campus.

Mel also acknowledged the challenge of meeting the needs of all students and the corresponding difficulties associated with overcoming these challenges:

> We have a very diverse student body. So that's particularly relevant here in [our city]. And I think that it's very hard to come up with support services that are reflective and appropriate and a good fit for everyone because we have so much diversity … I could see why a lot of those students who identify in that way would not necessarily feel like it's a good fit for them or even feel it's a safe fit for them.

Of course, the westernization of support services (i.e., individually-oriented and scientifically-rooted) was also considered to be an important barrier that delimited students of various cultural groups from seeking services. Lela observed this as a student:

> I think that [services] are westernized and insensitive to cultural differences and it just comes from also working with students who have accessed different services … [There are] very non-personal models of engagement that a lot of students just couldn't jive with.

There were also many practical issues associated with support services that prevented students from seeking help. In particular, participants reported that

the operational hours, session limits, cost, waitlists, location, physical space, and regular staff turnover were all issues that prevented students from accessing services. For example, as a student, Jessica acknowledged how the location of the campus counselling clinic served as a barrier, stating "it's kind of on the farther end of the campus. So most students don't really want to go all the way there," while Moe stated that the hours of operation for her campus' clinic were outside the availability of students, claiming "they're only open daytime hours. Students are busy daytime hours!" Meanwhile, Joe reported that the waitlists were not only a barrier, but a significant problem for university students, stating:

> Although a few weeks in the broader community is not a long time to wait for a medical or a mental health appointment, when you're talking about a 13 week semester basically, if you're going to be waiting four or five or six weeks from start to finish from when you first approach us for help, that could be half a term. You lose your term.

Sadly, while administrators tried to compensate for waitlists, students became very aware that services were taxed and this served as an additional barrier in their journey toward help-seeking. Furthermore, Moe discussed the challenges associated with session limits, noting that once a session limit was reached, students were often referred to the external community, which, in her experience, disrupted progress:

> And then at the end of that six weeks when I was at the point where I was saying 'yes, I will make an effort to not do destructive or harmful behaviours,' they were like, 'well we're going to refer you out now.' I was like – 'what?' Here I just felt this relationship with this person that I trust and I called the counselling working alliance [and] they're like 'yeah, we're going to refer you out' and I go, 'oh, wonderful.'

Once students were referred to the external community, participants recognized that the cost associated with services then served as a significant barrier, making help-seeking unattainable.

Another barrier associated with the services was the modality through which support was offered. In some cases, the participants reported that universities have expanded programming to include such facets as peer-to-peer counselling and group therapy. However, it was acknowledged that students struggled with some of these options, largely due to concerns for confidentiality and anonymity. Maggie shared this, stating "I prefer to be by myself … and I'd rather have individual sessions than actually let people know that I am going to session and I know with group sessions, people would know and ... I try to avoid [that]." In addition, other students felt that these modalities of support simply did not fit with their presenting concerns. Anna reported this, stating:

> There are the various support groups and that's great that they have support groups for social anxiety and getting over break-ups and things like that. Like support groups are great. I'm all for that, but sometimes you really do need the one-on-one counselling. I could have talked about my anxiety in front of a group, but it helped more to have that one-on-one attention and be able to speak out all my frustrations.

Beyond this, participants indicated that in some cases, students struggled with face-to-face interactions in general (with a professional or otherwise), which challenged many of the pre-existing modalities of support. Pam highlighted this when speaking about her own challenges finding the right "fit" for students:

> We have to have a wide variety of openings and they can't all be people. And that's not because of the staffing cost, take that right out. But to talk to another person about it is a barrier in and of itself. So they need a web program, they need a peer support, they need to be able to do an anonymous Twitter to somebody.

Participants also acknowledged that, upon seeking help, students often experienced challenges with staff and service providers; this, of course, prevented future help-seeking. In particular, it was shared that students often felt mistreated, put-down, or that their service provider was incompetent to handle their needs. Connor reported that he had a negative experience with a service provider:

> The guy who I dealt with was just the complete opposite [of my previous counsellor]. It was all about put on a happy face and just think of the here and now and I said 'you know what, that's not working. That has never worked.' And he proceeded to tell me that it takes a long time to get to the root and to get everything figured out and I understand that, but for him to just ignore important aspects really grinded my gears.

Further, participants noted that support staff in support offices also generated barriers, as they were often the first point of contact prior to seeing a service provider. Unfriendly, unhelpful individuals in these roles deterred students from accessing the resources at a particular support office.

A final deficiency identified by participants was the negative reputation that services acquired and that students spread. Kate observed this, stating "I think rumours get out there oh, there's a two month waiting list, you can't get in, so why would you go." Along with some of the challenges described above, the reputation of services was also weakened by perceived lack of coordination and a challenging referral processes that led students to get bounced from one service to the next, without ever accessing the "right" body to help them. Sarah acknowledged this, stating "you just keep on constantly getting re-directed so you go to one source and they'll refer you to one other source and it just keeps going like that which can be discouraging." These collective experiences weakened the

reputation of services and led students to lose confidence and trust in service providers and the ability for services to help.

Communication deficiencies. The participants indicated that many aspects of communication (or lack thereof) also served as barriers to help-seeking. One of the key issues endorsed by participants was the absence of advertising and direct communication with students. In particular, it was reported that the lack of information about the types of support services offered was a problem. Cindy noticed this when asked what she would identify as a barrier to help-seeking, stating "I guess, maybe lack of knowledge, what's available too. Because when I was looking I had to go and find it myself. I never saw ads for it." Anna echoed this, stating that the lack of advertising of services and her tendency to normalize suffering inhibited her from seeking help for years:

> Well, my first year on campus … I wasn't really aware of what kind of services were available to me … And then second year, I was doing pretty well and I'd have my moments every now and again. I had, I think, all of one anxiety attack that year. And I was like, people get anxiety attacks all the time. It's no big deal. I'm fine and things like trying to over-justify it and I still didn't really know that there were psychological services on campus. It wasn't until third year when I noticed in the elevator, actually. They had a poster that said the hours and where it was. And then in the back of my mind, I started going well maybe I should check it out.

Compounding this inadequate advertising, the participants also reported that there was no communication with students around how the services function or how to access services, leaving students confused about the process of help-seeking, where to go, and what to expect once they sought out the assistance of support services. Wendy acknowledged this, stating:

> If I thought I had a problem I wouldn't even know who to talk to and there's psychiatrists and psychologists and counsellors and I don't know

> who does what. So that's also very confusing, I don't [know]... where to even start.

Mel also acknowledged this problem, as she reported that even when students reached out, they were still unsure about how the services functioned:

> Even if it's promoted and even if there's some knowledge of it I think sometimes there's not enough knowledge about what that actually means. I don't think it's a given of what counselling is because every student I see still, you know, I go through with them what they can expect and a lot of them say yeah, they had no idea of what to expect so it was a big risk.

Another important element of this confusion was around the long-term impact that help-seeking had on the lives of the students. In other words, just as students were confused about the process of help-seeking, they were simultaneously confused about whether or not seeking help would affect them academically or professionally. Pam endorsed this challenge, indicating:

> If somebody finds out that I'm depressed it means that I will not be able to [get] into medical school, it may mean that I am not going to be allowed to stay in class if they find out that I've got anxiety, maybe they're going to kick me out of this nursing program.

Naturally, this confusion and lack of awareness about the services and their functions only further exacerbated the uncertainty described previously.

Interestingly, staff/administrators felt that the services and their functions were readily advertised on campus, but realized that the message was not getting through to students. For example, in talking about her experiences, Crystal stated:

> I hear a lot of students say they didn't know about services that were available. In spite of the fact that we do a really comprehensive orientation around what is available and still it goes often unnoticed for quite some time.

The lack of uptake from students was acknowledged as an ongoing challenge across all campuses. For example, Joe shared his frustrations with the barrier of communication, stating:

> We did focus groups with students and they say you know it'd be really good if there were stress management workshops, well there are stress management workshops! And we advertise them all over the place but they don't seem to know about them.

An additional challenge associated with communication was the inconsistency in messaging across the campus. In particular, participants reported that communication between support service units and between support services and faculties often differed. This exacerbated the issues associated with service reputation and constant redirection described previously. Lela indicated that this was a significant concern on her campus, sharing that the communication within her department did not accurately reflect the realities of the campus:

> [In my] large faculty, we have an actual go-to office. And they model themselves and advertise themselves as being 'okay, well if you have any issues you come to us and we'll know where to direct you.' The reality of that is that the people – they push papers and they deal with all the administrative work, but they're not aware of services university-wide. And so you have a lot of students who go there who are misdirected, misguided, aren't given the proper advice about things ... So that's a huge problem the fact that you do have departments and faculties that do have administrative people who aren't aware of what else is going on in a university. And as a result they misdirect students, as to where to go to access certain things.

Communication was also threatened by issues of timeliness. In other words, the university attempted to share information with students at a time when it could not be readily received for various reasons. For example, the participants indicated that communication about services was offered to students at a time

when it was simply of little interest or was not relevant. Pam endorsed this challenge, stating:

> So one of the issues on communication is always relevance. So if you're a healthy person who's never thought that you would ever get ill in your life, which is a typical 18 year old, why would you care with the [support services], right? So we have a relevance issue.

Participants also reported that information was often shared at a time when students were saturated with information about the university, making it challenging to absorb. Anna recognized this as a challenge, noting that a plethora of communication was offered in first-year orientation, making it challenging to remember the information about support services at a later date:

> They try to tell you everything first day, but there's so much coming at you. It's just like, 'go over here to get to counselling; go over here to do this; go over to do that' and it gets to the point where you don't know what information you need and what you don't need.

A final challenge associated with communication was the palpability of the modalities of communication used. Participants reported that there was little variety in the chosen methods of communication and that some of the less personal methods (e.g., websites) were difficult to navigate or often not updated. For example, when discussing their school website, Anna reported "that's a huge problem, actually. Going online and being like, what are their hours? Winter hours from 2011? Okay I'll just give them a call I guess," while Jessica noted that "it's a bit tricky to even find the counselling link." In addition, some students were simply dissatisfied with the quality of certain communication modalities. Cindy acknowledged this, noting that social media was not necessarily an effective method of communication, despite common trends, stating "I don't

follow the [University's] Twitter. I don't really get Twitter or the Facebook pages, I don't find that they're very helpful. They're just this little information thing and it's very vague."

Systemic barriers. The systemic barriers identified by participants spoke to the factors that stemmed from the university environment as a whole and prevented students from seeking help for psychological issues. The main systemic barrier endorsed was the university climate.

University climate. The participants acknowledged that several elements of the university climate prevented students from seeking help. One of the most commonly recognized barriers was the competitive and stressful nature of the university environment. Many participants stated that being at university forced students to feel like they must maintain a competitive status and keep up with the academic demands placed upon them. Admission of a psychological problem (via help-seeking) only diminished their capacity to reach these goals. Sarah experienced the university climate in this manner, stating:

> It is competitive and especially when the professor would say 'okay, this is the class average' and everyone kind of wants to go over that. So that's also another thing which takes me back to the point of weakness, like students don't want to be seen as weak or any less capable than other students, if anything they want to be on top.

Additionally, rather than promoting health and well-being, the participants acknowledged that the university environment normalized stress and persistent busyness and failed to place value on self-care, which encouraged students to normalize their suffering (as mentioned above) and fail to see the value in wellness or help-seeking. Kathryn spoke to these challenges, stating:

> Depression and stress, yes, on a social level it's become more normalized. But *particularly* on university campuses where it's always work harder, work faster and things like sleep and eating get really pushed to the side. Even to the point of prescription drug abuse like Adderall, that sort of thing.

Further contributing to this problem was the tendency for faculty to reinforce this messaging through their own behavior, which portrayed stress as normal and failed to address the need for and value of self-care and/or help-seeking.

Participants also reported that the absence of a sense of community served as a barrier to help-seeking. In particular, the lack of opportunities for interpersonal connections on campus and resultant tendency for students to isolate themselves not only prevented students from disclosing their challenges to others, but inhibited discussions about help-seeking and mental health generally. Jessica endorsed this tendency for students to exist in isolation, sharing:

> Everyone's doing their own thing … They get off the bus, they go straight to class, no one really interacts … everyone's so into their own thing. Not even paying attention to anything else. Even how people walk … they're just texting, whatever, and they just go to class.

Touching upon his own experiences, Conner acknowledged how the absence of interpersonal care on campus, along with the tendency to normalize suffering, negatively affected mental health:

> If I tell anybody that I have anxiety, that I am depressed, it could go one of a couple ways … one, people are bound to say 'well, you're in university, what did you expect?' Number two, they have their stress so they don't want to talk to you about your stress. It's just like suck it up and deal with it.

Also contributing to this absent sense of community was the distant presence of faculty. In other words, the participants indicated that faculty were uninvolved in wellness promotion and offered little support to students. This was largely

because they had little understanding or formal training in how to help students, or as Margaret stated "they're not paid to do this, they're not expert in this, they're not even informed enough to do this." As a result, however, this distance prevented students from approaching them with concerns, or as Maggie stated "personally, I wouldn't seek faculty for health issues or psychological issues … Plus for huge classes, I wouldn't imagine a faculty being able to accommodate those students in their class." Margaret acknowledged how detrimental the absence of faculty-student connection was, noting that faculty served as a wonderful access point to students, yet offered little support:

> Don't get me wrong, this is not a critique on faculty members, it's a flaw in the system that the primary point of access, that the person on this campus that will have the greatest impact on our students is also not well positioned to support students in these matters.

A final element of the university climate that grossly inhibited help-seeking was the tendency for the university to be portrayed as an environment that was unforgiving of psychological problems. The participants recognized that students believed universities are not there to help them, do not support students with mental health disorders, and are inconvenienced when a student reported having psychological struggles. Anne shared this perspective, stating:

> I think one of the phenomena is that students don't really believe, deep in their soul, that universities are here to help and support. And they feel they are here to be evaluated and judged and get rid of the ones that can't pass the muster, so any sign that they might be struggling is something they need to hide from the university and then the university would be the last place they would disclose it.

Similarly, Wendy reported that she has seen the university endorse these ideas when reflecting upon the experiences of a classmate:

> I know they've said that regardless of what kind of sickness you have, you're still expected to just keep up with the same amount of course work and everything. There was a student last year who got very sick. And I don't know... no one ever said what it was, but he was in the hospital for an extended period of time and they didn't really relax any of the deadlines or any of that.

Unfortunately, this mentality led to a global sense of discomfort across the campus around mental health or as Connor stated "I mean people don't want to understand, they don't want to confront the elephant in the room."

Individual/systemic barriers. The individual/systemic barriers endorsed by participants spoke to the factors that were specific to students and also stemmed from the university as a whole that prevented students from seeking help for psychological issues. In this case, stigma and shame crossed into both of these areas, as they were seen to exist both at the level of individual perception and systematically within the culture of the campus.

Stigma and shame. Almost all of the participants indicated that stigma and shame were central barriers that prevented students from seeking help. In many cases, the students personally reported that the stigma and shame personally prevented them from coming forward. Chris endorsed that this was certainly present for him, stating:

> People will just think you are crazy. You know, mental illness equals crazy. There's so many spectrums, so many different disorders of people, people lump it with crazy, retarded. And for me, it's social anxiety. When you have social anxiety you think [about] things so much. You know, if people don't judge you, you think they are judging you. So the fear or the shame is multiplied.

Kathryn also spoke about her own observations around stigma and the associated judgements that came with psychological problems:

> We as the society are not very open about mental health issues. Depression is somewhat okay, but then there's this sort of judgement attached to being depressed, like 'why are you sad all the time? Why can't you be happy? Why can't you be extroverted?' It's that there's that sort of feeling of failure that comes along with being mentally ill. Regardless of whether or not you are the cause of your mental illness, there is that judgement there. When it comes to more unusual, less common types of mental illness the stigma, again, is very much there. Things like schizophrenia, things like bipolar disorder – there is still that stigma attached. We're more willing to talk about it than in some segments of society, but there's still this sort of idea that these aren't the kind of people you want to be around, these people aren't normal – 'cause it's THOSE people, THAT kind of person. There's still that sort of attachment to it.

Participants reported that the fear of being stigmatized was so strong that they even feared running into someone near the campus counselling clinic as this could have exposed their psychological problems. This suggested that the stigma and shame that came with the physical act of walking into a support service office was, in itself, a barrier that students had to overcome. Chris recognized this, stating:

> But even though nobody knows me, I do have classmates, just a small number of classmates. So even that small number makes me feel afraid of going to seek help. So I had to walk around the Centre, like just look at the room, then walk past a few times before having the courage to walk in. So it's the shame of being tagged that you have a mental illness. That's why people do not dare to go into the Centre.

In talking about the experience of stigma, some participants reported that students believed judgement and discrimination around mental illness existed within their university community, yet in some cases, students did not have evidence to verify these perceptions. For example, when asked about barriers to help-seeking, Cindy noted that a central barrier was stigma, stating, "I think there's like a really big stigma about even having anything because definitely with my generation, people are just like, 'oh, you're being emo.' And, 'girls are

crazy.'" Yet, when asked about her personal experience of stigmatization, Cindy also stated:

> [It's] just an assumption. Nobody's ever said those things to me. Even after I was able to talk to friends about how I'm feeling, they're really supportive and it definitely wasn't like, 'oh, you're just like being a baby. You just need to suck it up.'

Based on the accounts given by participants it was evident that the individual perception of stigma was strong, which certainly contributed to the global sense of stigma felt within the greater system of the university. Kathryn also spoke to this, stating that stigma was often generated internally because of the broader stigma that was perceived systemically:

> We do internalize these stigmas. It's not necessarily that other people are judging us, it is that we are aware of it and we are judging ourselves often. And when we feel that we can't talk about these things, when we feel that we are revealing weakness we keep them to ourselves. And that can be even worse because the inability to express these things is very damaging.

Many participants compared the stigma felt on campus to that experienced in the broader society, noting that stigma will undoubtedly exist in a sub-community if it also exists more globally. Interestingly, however, some participants reported that stigma was even greater among the university population for many of the reasons identified previously. For example, Anne discussed the challenge of being stigmatized in the competitive sphere of the university:

> I would say added on to that is that sense that they had to compete to get here, they still need to compete to stay or they sense that. And so in addition to the stigma of maybe having a condition or being diagnosed is also that they might not belong. And so I think there's an added weight to the stigma.

Individual/structural barriers. The individual/structural barriers endorsed by participants spoke to the factors that were specific to both students and support services and prevented students from seeking help for psychological issues. In this case, inadequate knowledge about mental health crossed into both areas; the absence of knowledge reflected a deficit on the part of the students and also a failed area of communication/information giving on the part of support services.

Inadequate knowledge about mental health. The participants reported that students had very limited understanding of mental health disorders and symptomology, generally. Kathryn recognized this trend, stating:

> Most people, even people who are quite educated, do not understand what mental illness is. It's very obvious in our humour that we do not understand what mental illness is. People do not know what schizophrenia is, people do not know what multiple personality disorder is, people do not know what obsessive compulsive disorder is. Even things that people have a very good general idea of, like Tourette's and stuff like that, people do not understand these disorders. They don't understand what they are or what they mean or even how common they are. There's very much the perception that normal people don't have those. Which is not the case.

This lack of knowledge was problematic because it prevented students from identifying and subsequently treating the problem. Wendy acknowledged that she personally experienced this confusion:

> You have no way of knowing if it's just you or if it's actually something wrong. And so you're like, 'oh well, I'm just a procrastinator. I'm just not a big fan of bars,' or something. Right? That it might actually be something more, but because you don't know and then there's all these other [barriers] stopping you, you don't know that you should talk to someone.

Moreover, because students were unfamiliar with mental health symptomology, they also reportedly could not understand that the problem itself may have been

holding them back from seeking help. For example, some participants reported that their mental state was so disoriented as a result of their disorder that they were not able to source psychological support, or as Moe shared, “I was not in a mentally able state to take myself to service … seeing as how I was in a no life, no go sort of state of mind.” Similarly, Anne reported how the experience of anxiety itself, which was incredibly common among the student body, held students back from seeking help, stating “part of it, I think, is the condition itself. So if students are overwhelmed with stress and anxiety often that has just another effect of making them feel helpless. So that in itself can stop help-seeking behavior.”

Finally, inadequate knowledge around mental health disorders and symptomology also prevented students from realizing the true severity of their issues. Ultimately, this limited knowledge significantly heightened the threshold of suffering that students experienced before help was sought; or, in other words, students felt they had to wait until their problems were detrimentally severe before they felt they were in need of help. John recognized this challenge:

> I would say that the students get in so deep they can't see the forest through the trees. They think it's just part of who they are, they've always been that way. And they don't understand the differences between their personality and they just don’t think it’s fixable. What I've seen is students say I'm fine, I don't need it. And then get in so bad that they lose perspective on what normal is.

This behaviour, of course, challenged the intervention process as help for students at this level of need shifted to resemble immediate crisis management rather than support or early intervention. Sadly, crisis management has become a large focus for campus counselling clinics as a result of the practical issues identified

previously (e.g., heightened service demand, waitlists, etc.) and the lack of awareness from students as discussed here. Joe spoke to this dilemma, stating:

> And it's almost becoming to the point where we're only seeing crisis situations, which is not what the original idea was behind the counselling service here. The original idea was to see students at a time when they weren't in crisis necessarily but if you could do some developmental work with them and avoid the crisis stuff really. And help them figure out who they are and where they're going and what they're about and so on. We rarely can do that anymore and we rarely can do educational sessions like that like group sessions and so on because we're so busy dealing with really serious crisis situations.

Facilitators of help-seeking. Amidst the discussion around barriers to help-seeking, participants also recognized mechanisms that naturally encouraged help-seeking. Discussion of such mechanisms was not surprising, given the knowledge that services remain taxed despite the plethora of barriers to help-seeking identified. The central facilitators endorsed by participants were acceptance that help was required and external support. In both cases, these mechanisms were not specifically a result of efforts generated by the university to promote help-seeking. They were both considered to fall within the "individual" area as they related to mechanisms that were specific to the student. External support touched onto the systemic area as this facilitator spoke to interpersonal relationships, including those with university staff and faculty, as subsequently described.

Acceptance that help is required. Although it was certainly not always the case, the participants acknowledged that some students came to realize that help was required to cope with their psychological issues. In some cases, this acceptance came when students realized they had nowhere else to go, while others

held an intrinsic motivation to change. Chris indicated the latter was a reality for himself, stating:

> I just had a lot of intrinsic motivation to just get better; for personal growth, I needed to change. And I saw this opportunity that, well, it's free and that's what I came here for, to get better and to make friends but somehow I couldn't really make friends with my social anxiety. So I had to really work this problem and have a good time.

Similarly, other participants reported that some students simply recognized the seriousness of their challenges and subsequently accepted that they need to seek help. Lela reported that she had such a realization, sharing "I just realized within myself that, to be a more productive me, I needed to possibly seek out some help." Finally, participants also reported that some students sought help in the past (prior to entering university) and this contributed to their comfort level in seeking services during their tenure as a student. Kathryn confirmed this as her experience, sharing:

> It was a fairly easy decision. But again, I've had quite a lot of history with seeking out that sort of help. So I think that would be why it would be somewhat easier. I've already adjusted to the idea of needing help.

External support. Participants reported that the presence of supportive others in the lives of students certainly promoted and supported help-seeking. These external encouragers were stated to be family members, friends, peers, partners, faculty, or university staff. Anna shared how encouragement from her partner and family were a driving force in her journey toward help-seeking:

> I talked to my boyfriend and he said you really should go. And I talked to my parents and they said you're crying about this, you really need to go get help if you think it will make things better for you and then I ended up going and for me it just really helped knowing that people were going to be understanding.

Meanwhile, Sarah disclosed that her choice to seek help was directly a result of a supportive faculty member. Had this faculty member not encouraged or promoted help-seeking, her decision may have been different:

> Initially I did dismiss it 'cause it's not something that I would have thought of 'cause I'm just like, 'okay, I can deal with whatever it is that I'm dealing with on my own.' But then one time in my introductory psychology class, the professor was very nice and she told the entire class that they give really good services and she encouraged it. So after some further encouragement I'm like, 'you know what, I'll just give it a try and I'll see how it goes.'

These experiences spoke to the value of social support and heightened the fact that all parties on a university campus could certainly contribute to the process of help-seeking. This is further explored in the following section.

Mechanisms to Overcome Barriers and Meet Service Demands

The mechanisms for overcoming barriers and meeting service demands were an amalgamation of the participants' responses to the latter two research questions, including mechanisms currently being used by universities to addresses barriers and service demands and policy and practice changes still needed. The data did not allow for artificial separation to uniquely answer these two research questions and instead a global understanding of mechanisms to overcome barriers and meet service demands was generated. This was a reflection of the fact that data was collected from three unique institutions and "current mechanisms" to some institutions were "ideas for change" in other institutions.

Mechanisms for overcoming the identified barriers and meeting service demands were categorized as structural or systemic. The structural mechanisms included expanded focus of services, collaboration between services, diversity

across services, enhanced coordination of services, implementation of practical changes, focus on making services more personable and approachable, and coordinated, diverse, and strategic communication. The systemic mechanisms included write / rework policy to support mental health and broad, thoughtful systemic changes. The latter was further broken down into prioritize mental health, involve everyone in mental health, build a community of caring and acceptance, and increase value on wellness. The diagrammatic portrayal of the mechanisms is offered in Figure 2. Although no mechanisms overlapped between the structural and systemic areas, the two were certainly related as one (structural) existed within the other (systemic); thus, the two broad themes were portrayed with nested circles.

Structural mechanisms. The structural mechanisms endorsed by participants spoke to the factors that were specific to the services and were useful in terms of overcoming the identified barriers and meeting the current service demands. These included expanded focus of services, collaboration between services, diversity across services, enhanced coordination of services, implementation of practical changes, focus on making services more personable and approachable, and coordinated, diverse, and strategic communication.

Expanded focus of services. The participants highlighted that services, namely counselling and health clinics, have historically been focused on intervention strategies and crisis management for those who were struggling with more severe psychological issues. However, the participants suggested that expanding the focus of support services to include efforts around prevention and

Figure 2. Mechanisms to Overcome Barriers and Meet Service Demands

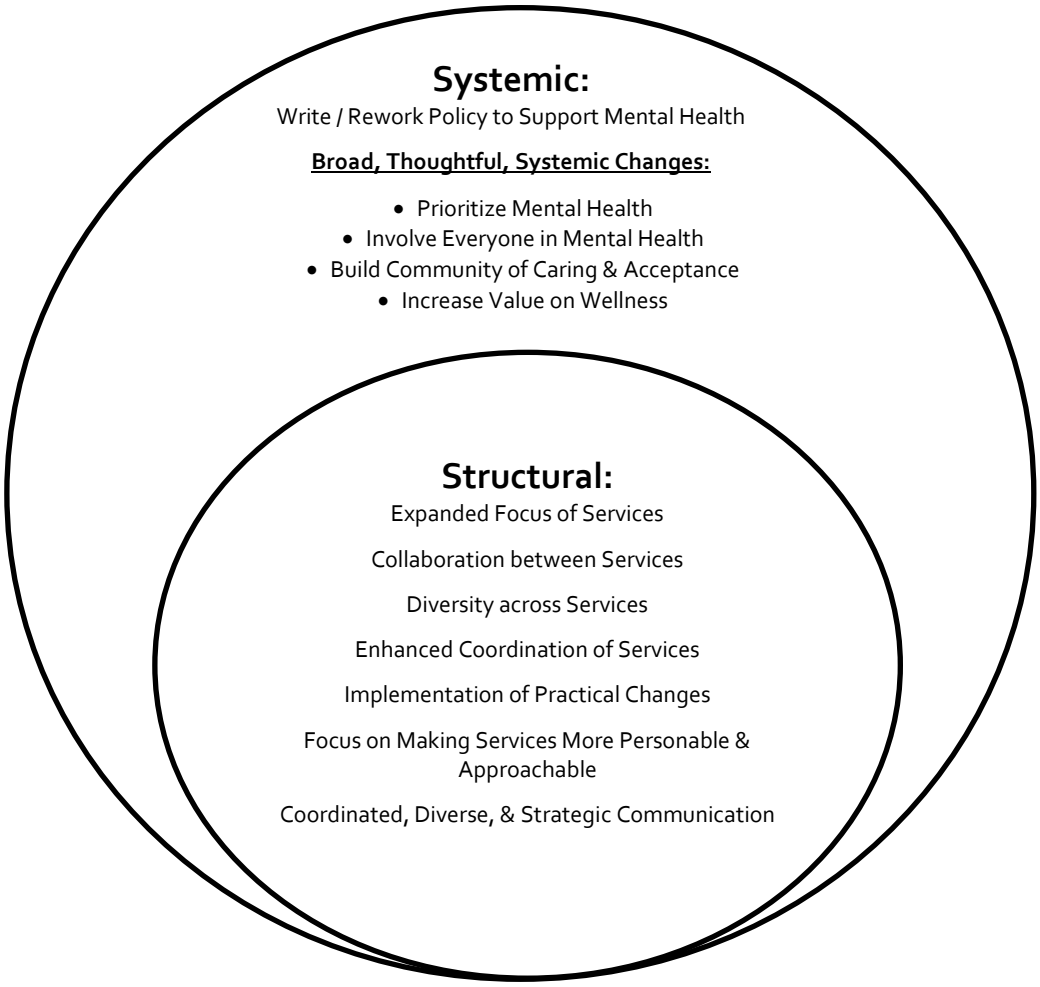

Figure 2. Diagrammatic overview of the structural and systemic mechanism to overcome barriers and meet service demands.

early intervention via education, student capacity building, promotion of wellness, and implementation of early intervention services may help to prevent students' psychological issues from developing, intensifying, or spiraling out of control. Moreover, because these strategies do not necessarily have to come from

counselling or health clinics alone, this may serve to alleviate part of the service demand challenge. Efforts in this direction have been made by some campuses. For example, when Jackie was asked about how her campus has been trying to overcome the service demand challenge, she spoke directly to this:

> [We are] having a bigger focus on the prevention, education and awareness piece of the puzzle. So that we're helping students to be more resilient from the outset. And you're not going to get everyone, I know there are still going to be students who experience mental illness because that's just going to happen, regardless if they were at university or not. And so, it's not about that, I think it's more about these other students that just don't have the skills or the coping mechanisms or aren't taking care of themselves. You could only skimp on sleep or live off Kraft Dinner for so long before it starts to impact your ability to function. And so, that side of the things I think, having a bigger focus on prevention, education, awareness. And making it integrated in so it can't just be the counselling and the student health education people that are out there spreading this information.

Further, Mel also reported that prevention and promotion of wellness was a central strategy that needed to be explored when examining and expanding the focus of support services as consideration of these variables was considered a central element of positive mental health:

> If we change our lens around it, if we go together it's a wider lens, it's not about [only] prevention, it's about promoting wellness. You know, mental health is not just the absence of mental illness, it's about promoting wellness, I think people are getting that but we're still a ways away from that unfortunately.

Finally, one of the key early intervention strategies that was implemented on one campus and was being sourced on another was an online computer program for staff and faculty that was used to identify students who were having difficulties. The program allowed any staff or faculty member to log a concern regarding a specific student and a case manager affiliated with student services followed-up

with students when it was deemed necessary. Certainly, a program of this nature could aid in identifying students who are struggling earlier in order to avoid problems spiraling into crises. Jackie acknowledged how this program would not only contribute to student well-being but aid in handling the service demand as well:

> So, helping students get on track sooner so that it doesn't take more resources to help them get back on track … Because if they end up in a downward trend and we don't find out until it's a crisis then how much support [will that one student ultimately need]? That student who maybe only needed to attend group sessions to learn how to manage their stress, now needs six counselling sessions and visits to the doctor and a prescription and support in residence. So to get that student back on track is going to take so much more time and energy and resources on behalf of the university and the student as well than if we can catch it earlier.

Collaboration between services. The participants acknowledged that mental health and psychology tended to fall in the laps of counselling and health clinics. However, it was suggested that stronger collaboration between support services be fostered such that all services recognize their responsibility for mental health and well-being, or as Margaret stated, "mental health must be something that every single unit considers in the design of their services, their intentions to support students and the ways in which they structure themselves." Indeed, a global focus on mental health from all support services would not only disperse the load of helping and supporting students, but subsequently detract from the service demand challenges via generation of a healthier student body.

When discussing service collaboration, the participants suggested that all support services exist under one umbrella. This would allow the services to become more integrated and subsequently establish common goals around health

and wellness, or as Mel stated, “I definitely think maybe they need a giant umbrella and then they all work under that umbrella so that they can organize goals.” Through defining common goals, all services would be able to recognize how they could individually contribute to mental health and wellness and share in the roles of support and prevention. Jackie acknowledged how effective this level of collaboration has been on her campus when speaking about the student exchange unit:

> A really good example is with our [exchange program]. We started working with them three or four years ago on helping to better prepare their students when they're going on exchange. And getting the students to think about their mental health and physical health and what kinds of things they might experience. I'm sure that most of those kinds of programs are going to talk to their students about culture shock they might experience and an adjustment to living in a new culture. But we brought in some programming as part of the preparation for them going away to start really thinking about their health. Like, what kinds of things do they do for themselves now and how is that going to change when they're living in this new place that they're going to be in. How are they going to make sure they have what they need to stay healthy?

In order to work collaboratively, it was also reported that support service providers needed to have a stronger understanding of the tasks and capacities that each other offers. Through attaining this knowledge, services could become more adept at working efficiently and productively together. Annette highlighted this, sharing that it would be essential to understand each unit’s role in order to provide timely and effective service:

> When it comes to supporting a student, no matter where they turn to for support, we’re only as effective as we’re able to really, very effectively and in a timely way, connect them to the right resources as soon as possible. And so that does require that we are working very closely together and in a very collaborative way.

Of course, in order to establish this level of understanding and subsequent ability to collaborate, ongoing and regular communication across all units would be necessary. Annette shared that scheduled communication between support service units occurred on her campus, stating:

> We have weekly meetings. All of the directors of the units meet weekly for an hour and a half to address new initiatives, updates. We do round tables, what's new, what do we want our colleagues to be aware of. And we also engage in a strategic planning process where we're identifying our priorities and those then inform our collective work over the upcoming year.

Finally, it was indicated that that collaboration between services must also extend to other student-oriented departments on campus including, for example, the academic advising offices and the registrar's office. Collaboration at this level would ensure that students are directed to appropriate resources, regardless of whom they seek out as their first point of contact. Snooks discussed the importance of collaboration with the registrar's office on her campus, noting that this particular office was often the gateway to accessing services and overcoming barriers around knowledge of services:

> They are amazing in the work that they do. But most people would say, 'well that's not in their job description. You're just supposed to be taking that withdrawal form,' or something like that. But if they're human beings and they have communication with the student often, they end up being that first-line responder who's suggesting, 'here's some alternatives,' or, 'go check this or why don't you go talk to so and so.'

All together, these efforts for collaboration would not only aid in dealing with service demands, but allow for effective communication with students. The latter may help to foster confidence in support services as students would end up in the "right spot" sooner and avoid being constantly redirected.

Diversity across services. Participants repeatedly highlighted the need for diversity among services. For example, the participants reported a need for greater diversity in the services and programming available on campus that support mental health. Participants recognized the need for related student groups, peer-to-peer programming, and online programming; other campuses even implemented pet therapy! The participants agreed that through offering diversified programming and services, the opportunity to reach more students would certainly be heightened. Pam touched upon this:

> Where we can change is once people have recognized there's an issue, have a variety of ways of offering support, such that it's the least worrisome. And it comes in ways that a student might find more palatable. So would a peer be a better choice to talk to? Would an online program be a better choice to talk to? Would a doctor be a better choice to talk to? Would a psychologist be a better choice to talk to? Would my trusted professor whom I really admire be the person to talk to? We have to have a wide variety of openings.

Such programming might be initiated by various student service units (counselling services or otherwise) and may contribute to prevention and/or promotion of wellness, provide the necessary education to promote further help-seeking, and/or serve as an adjunct to intervention services.

The participants also called for increased diversity among the professional service providers and/or support providers. For example, as a way to spread financial resources, some participants suggested that employing a range of helping professionals might be of value; this may include social workers, physicians, psychologists, certified counsellors, and graduate students (paid interns or practicum students). For example, Annette noted that at her institution, the counselling clinic was comprised of "six psychologists, 3.6 counsellors, six

full time doctoral interns, and usually between four and five practicum students and each of those are here at .5 FTE."

Finally, modifying and designing programming while considering the collective needs of the diverse student body was identified as fundamentally important. Foremost, it was indicated that services needed to be culturally sensitive. One way that a campus had enhanced cultural sensitivity of programming was through connecting struggling students with a peer supporter from the same culture, via peer-to-peer programs. Crystal outlined the value of this:

> It just seems like a student being able to talk to another student and just have somebody hear them, listen to them, makes a lot of sense. Especially around if there are students experiencing that stigma. So then speaking to another student, especially if there are some cultural similarities, might be a really great approach.

Jackie also acknowledged that providing students with a series of service options would be important in terms of being culturally sensitive, as some cultural perspectives around help-seeking differ from traditional westernized values:

> In a campus like [this], where it's so diverse there are some cultural issues that come into play in terms of different perceptions of mental health and if it's okay to go see a counsellor or not within certain cultural groups. And also, whether people's preconceived ideas about what that means. And maybe biases against talk therapy or what they perceive to be happening over in some place like counselling services. So, the other thing that's really important to do is give students options.

Finally, particular student groups were recognized as needing consideration when it comes to program development. These groups included international students, graduate students, graduating students, first-year students, students of minority

groups, and commuting students. Programming tailored specifically to the needs of these students was recommended.

Enhanced coordination of services. The participants agreed that services should be more coordinated. In particular, various strategies were identified in order to allow for stronger management of the care of students. For example, the participants indicated that having a streamlined referral process between services might serve as way of enhancing coordination and alleviating barriers. On one campus, the counselling and medical clinics were aligned such that psychologists referred students directly to psychiatrists (alleviating the intermediary step of consulting with a general practitioner) and physicians referred students directly into group therapy programs (alleviating the intermediary step of consulting with a psychologist). Combined with this level of coordination, the two offices also used the same diagnostic measures for common psychological issues, such as anxiety and depression, to ensure consistent treatment decisions were made. Meanwhile, on an alternate campus, John also highlighted the importance of a streamlined referral process, noting that the use of a paper referral allowed service providers on his campus to see where students came from and allowed referees to determine whether follow-up had been made by the student:

> We used to say, 'yeah, you might want to go down there' and now we actually get paper referrals. So we can see if the student actually did follow up. Or we can see the route they came when they walk in with that piece of paper.

Meanwhile, participants also recognized that some students presented with more complex issues and required coordinated care that involved several service units. In such cases, the participants agreed that having a designated person (i.e., a

case manager) responsible for coordinating such care would be valuable. Pam highlighted some of the typical responsibilities of such a person, indicating:

> Say a student goes into hospital, that student will be visited by the case manager and their return to studies is supported by the case manager. And that case manager may involve different aspects. So, [they] might touch base with the faculty, might touch base with counselling, might touch base with [the health clinic]. There's a wide variety.

Participants also felt that service providers could be more thoughtful and purposeful when developing methods of responding to reoccurring psychological challenges that students presented with. For example, some participants agreed that utilizing empirically-supported treatment protocols could enhance the efficiency of intervention, while others felt that maintaining a crisis-response protocol to guide actions during crisis situations was a necessity. Finally, participants also noted that coordination could be enhanced through developing group programming that specifically targeted the most common challenges experienced by students. Annette spoke to this, while also acknowledging that having open access to group programs was essential in order to avoid waitlists:

> We've also redesigned our group programs so that all of our groups, first of all, are targeted toward the most common presenting concerns. Those are anxiety, depression and stress, relationships, emotional regulation, that type of area. We used to have groups that - you sign up for groups, group runs when you get enough people. But the problem with that is then you've got this wait list of people who haven't actually got into that group and they're waiting for the next group. So it's not really accessible. And then in any given term, it doesn't take long before the term is up and you're into exams and you still haven't necessarily got the kind of support that you need. So, all of our group programs now are ongoing rolling, so there's no kind of start or stop, they continue throughout the term and a person can enter at any point.

A final aspect of service coordination discussed by participants was around timely accessibility. In particular, the participants reported that

coordinating services in such a fashion that they become more easily accessible by students was especially important, given that students have "got 12 weeks to get through this term. And not getting through a term isn't the end of the world, but it is quite devastating" (Pam). John recognized that working with pre-established communities on campus (e.g., student groups) might be one avenue to accomplish getting students into services more rapidly:

> Even services we may not think of like athletics, where we see coaches that actually build a community and as leader of that community they should be a liaison, I think. Some of the student group things that are very organized, like the one that comes to mind [a singing group], those kids in that thing are a pack. So there should be somebody in there that knows the link to services. And every time you've got smaller communities, so a bite-size community feeding up to the people who know what to do.

Similarly, another avenue that was being explored was bringing services closer to "home" (i.e., the students' home departments or faculties). Mel identified how valuable this has been in terms of encouraging help-seeking and allowing for continuity of care:

> Faculty-specific support is important. So even if it's not like an official counsellor or a professional counsellor 'cause that may or may not be possible. But at least someone who you can confidentially go to I think that that's critical. Who doesn't have a dual role. You don't have any academic repercussions of any sort – I mean, there's other people here who are offering support but they also have dual functions including denying petitions or [other] powerful things. So that's not necessarily a safe access person so I think having that within each faculty, I mean of course budget's always the issue, but having that within each faculty, it just allows that person to also be aware of what's going on, be able to monitor students also.

Implementation of practical changes. Just as participants noted that practical issues served as a barrier to help-seeking, the participants also felt that implementing practical changes to services would serve as a means of both

overcoming barriers and meeting service demands. Some of the practical changes endorsed included: a) triaging clients at the counselling clinic and having a speedy intake process to ensure that more chronic clients are treated immediately and referrals to alternate resources are made where possible, b) offering services with expanded hours (rather than 9 to 5) or considering 24/7 support to better serve students and respect their availability, c) expanding resources (i.e., staff and professionals available) in order to serve a greater number of students, d) minimizing or eliminating cost for students to ensure that services are accessible; this includes consideration of reimbursement for off-campus support, e) offering rapid access to services (i.e., walk-in services), in order to ensure that students are provided intervention at the moment they choose to seek it out, f) adopting a brief counselling model as to see more students, and g) considering the location and physical space of the services. The participants agreed that changes of this nature would not only enhance the level of customer service offered to the students, but would also allow for institutions to do more with pre-existing manpower, or as Anne said "to do more with the same."

In some cases, campuses had already implemented these practical changes and were able to speak to the many benefits in terms of quality of care. For example, Annette recognized that using a triage system allowed for better use of resources:

> Prior to triage, we had narrow opening to appointments. We had maybe four or five drop in a day, plus we had all scheduled. That can become a bottle neck for appointments. You've got a wait list. When you open up that bottle neck you've got now a lot of people coming in. Now, the interesting thing about that is things do balance out because you get far more students coming in at the time when they actually want to come in.

> So the chances that you're going to be catching them earlier is there. And so the amount of time and resources that goes into that can be less. But nevertheless, you still have a lot more people coming in. So a couple things that we've done, one is we've really spent time as a staff group really articulating and really explicitly sort of defining what our treatment model is, what our service model is.

Similarly, Pam spoke to the benefits of using an online 24/7 booking system at the health clinic on her campus and shared how this helped to alleviate barriers by enhancing the accessibility of services:

> [We] have a really amazing online system. So that is a booking kind of tool where students can go and book their appointment or cancel their appointment and this can be done 24-7. They can choose the doctor they want to see, or just choose male or female. They can read their test results online. Yeah, they can get secure messages from their physician. So it's pretty amazing and it eliminates that, 'well I guess at 9 a.m. I'd better wake up and make that phone call and see if there's any appointments.' They could literally go on at 11 p.m. and see that, 'oh, I can actually go tomorrow when it fits my schedule,' and to me that's an accessible tool.

However, just as universities were trying to consider ways to effectively use resources and do more with the manpower they had, many participants reported that an increase in amount of staff would prove to be beneficial. Anna spoke to this directly, noting how breaking through barriers has only led to further saturation of an already taxed system and thus, increasing the number of staff would prove as a valuable, albeit difficult, solution:

> Well, I definitely think that they do need to hire on more counsellors or have more options available because the people that they have right now they are starting to get overwhelmed and if you try to advertise it more and try to make it more available you've got to have somewhere to put the people otherwise there's no real point, right?

The ideas around where to locate services varied greatly, with little agreement among participants around the ideal solution. Some individuals felt that services needed to be located in a centralized spot, whereas others felt that

decentralization would serve to benefit the greatest number of students. Meanwhile, some participants felt that services needed to be located in an area that was easily accessible by all students, while others felt it was necessary to have services located outside of common areas in order to enhance the students' sense of confidentiality. Joe spoke about some of the challenges that extended from this debate, noting that the solution may lie more in the systemic rather than structural domain:

> Centralized versus de-centralized services, I guess that's the biggest question I have … I think there are pros and cons to both. Some students have talked to us about like one stop shopping, kind of like having all student services in one area and so they don't have to go too far from one to the other, if they need this and they need that. Again, that would be nice I guess but there's also some cons to that too. I mean sometimes people would rather the counselling centre not be right in the middle of everything else. Sometimes they'd rather it be somewhere else. Other students would prefer that it would be right next door to the coffee shop. It's really hard to know. But I don't think – for me anyway, I don't think that the answer lies in whether it's centralized or de-centralized, I think the answer again comes back to the overarching commitment of a campus to mental health promotion and once you have that, however you're structured, the obstacle is getting the commitment from the university to have an overarching commitment and priority for mental health.

Finally, there was also repeated disagreement on how the physical space of support offices should be arranged. Naturally, it was agreed that the support offices should be welcoming, or as Anna stated "nice and open … very bright … have positive messages everywhere and the secretaries and people are positive people." However, students expressed a desire for more confidentiality in waiting areas of support offices, while staff suggested that such adjustments may only support or intensify pre-existing stigma. For example, Sarah noted that she struggled with the limited sense of confidentiality found within the support

offices, stating "when you're sitting there you're all looking at each other and you all know that you're seeking counselling, which [is] something that some people might be ashamed of." However, Crystal highlighted that altering the physical space to enhance confidentiality would only further stigmatize the issue, stating, "I guess if we're really changing our messaging around mental health, then I feel like hiding something further like in terms of a changing of physical space … It kind of further stigmatizes the issue."

Focus on making services more personable and approachable. The participants agreed that finding ways to make the services more personable and approachable would serve as an effective way to encourage help-seeking among students. The main route to achieve this was thought to be via the staff and service providers in the units. The participants agreed that promoting an environment where staff and service providers appeared emotionally available, culturally sensitive, absent of judgement, and warm would not only make the services more appealing to students, but also allow for positive experiences with services to be generated (ultimately contributing to a positive overall reputation among the student body). As a student, Kathryn discussed the importance of having service providers who genuinely care:

> I'm not a particularly warm human being myself, but I certainly appreciate just having someone there to care. Which is, especially with mental health, so very important …'Cause human beings, again, very social creatures, we need somebody to care.

Snooks also spoke about the importance of compassionate staff members and how this can contribute to the overall care of students:

> The front desk is everything. You've got to have the right person who doesn't pass judgement, who is open, and who doesn't present as gruff and bureaucratic. It's a delicate balance between being serious and being open…being focused and being open and flexible.

Along with maintaining staff that are caring and supportive, the participants also acknowledged that the premise from which support services work would also contribute to their overall approachability. Notably, it was recognized that working from a strength-based, rather than a deficit-based model served as an important route to connecting with students. Snooks spoke to this, identifying that focusing on positivity can be a nice change from the traditions of academics:

> And I think that's really important, that we work from a premise of hope. Sometimes that's what I end up doing is a lot of giving them hope and reaffirming their assets not their deficits. So I think that there's so much within an academic environment … it so easy to do that deficit assessment critique piece and I think sometimes we forget or we're afraid to celebrate or focus on the positive and I think that's key. I mean, for us within student services that's key. But we need to build that within. I mean we really need to build that in right across the board.

Finally, the participants acknowledged that certain elements of the structure and processes of support services made them more approachable. For example, a few of the participants suggested that the names of support offices were important to consider; on one campus, an academic support centre was thought to be more appealing when titled a "Success Centre." In addition, maintaining an inviting physical space, as discussed previously, was also thought to contribute to the approachability of services.

Coordinated, diverse, and strategic communication. Extending from the discussion around communication barriers, the participants also acknowledged

many ways in which communication on campus could be altered to better promote help-seeking. Of course, in all cases, the participants agreed that *more* communication was needed and increased advertising / promotion of services was essential. Several ideas to make communication more strategic and coordinated were presented. First, the participants generally agreed that the methods of communication needed to be diverse. In particular, the participants felt that the same message was best sent through multiple avenues, or as Moe stated, "I think the best way to reach students is every way that you can possibly think of." Some of the key modalities mentioned included, for example, email, social media, websites, posters / flyers / pamphlets, smartphone apps, schools newspapers, mental health campaigns, post-it messages on exams, messaging in high traffic areas, and via formal and informal in-person communication. Of course, on top of being diverse, the participants also agreed that communication strategies needed to be simple, creative, and stand-out in order to be more appealing to the students.

Personal communication strategies were heavily valued by the participants. In many cases, the participants felt that personal communication may leave the greatest impact on students or simply be the most relatable. Margaret spoke to this, stating:

> Multiple overlapping and interdependent methods are required. So we need communication to be reinforced through our people. And I think sometimes we think about communications as brochures, social media and websites, but the greatest impact we have in communication is real time. Human.

An element of interpersonal communication that participants found to be important was the sharing of personal stories. In particular, some participants agreed that creating space for students, faculty, and staff to share their own struggles may not only normalize the experiences of struggling students, but may also encourage help-seeking. Anna spoke about this, noting that informally sharing her own story has been quite helpful for her peers:

> I think it might help if people could hear from others firsthand about their experiences and how it's not so bad. Like I know myself I've started talking to some of my friends about my experiences and tried to encourage others to seek help because I did it and telling them how much better I feel and just everybody says I'm more confident now. So, it's kind of been like look you get in your really low spot and then you get help and it gets better. It's not always going to be a horrible thing.

The participants also agreed that involving students in communication would be of great benefit. The participants felt it was important to make space for student input when it comes to communication as students could provide the greatest insights into what is / what is not tangible for students. Pam talked about how this process of involving students was formalized on her campus via focus groups:

> So we don't know what the best way to communicate is. We don't think what we've done to this point has been stellar, so we're trying different methods and we're always taking students' viewpoints. So Communications works with the students, does focus groups, and finds out what are the ways that they want to be interested about health.

Another essential element of communication was timeliness. Recall that a barrier endorsed by participants was the improper timing of messaging. In response to this, the participants agreed that being more strategic about when communication is offered was essential. As such, some participants suggested

that backing away from incessant messaging at the beginning of a school year and instead offering communication around the mid-point of a semester, for example, might be more valuable. Anna reported that the beginning of the semester was a challenging time to acquire her attention, stating:

> [Using the] first couple of weeks of school to advertise everything really, really, does not help. People are more worried where the beer gardens are. People have different priorities when it first starts. Like it's more mid-semester to after you get mid-terms back and going on exam time when people really start to realize that they have a problem when the first couple weeks back you're still on that summer high.

In addition to this, it was also acknowledged that providing information to students in upper years is important, as much of the information received at that time might feel more relevant than it did in the first year of their university career.

Going hand-in-hand with timely communication was the idea of embedding communication within pre-existing modalities of student-university interaction. In an effort to avoid messaging from being lost in a proverbial "crowd of communication," it was also recommended that the amount of communication be reduced through embedding messaging around mental health into pre-existing communication, namely that coming from residence or departments / faculties to their respective students (e.g., in newsletters, course syllabi, etc.). Not only would this prevent students from being saturated, but it would also give further relevancy to student services, which may otherwise be faceless and easy to ignore. Annette talked about the immense value of this practice, indicating that this approach would also make the messaging more credible:

> Of course, all of the broad based awareness is critical and so that's an area that we've been putting a lot of attention to and probably one of the important directions that we see in the future is really embedding that awareness into the established channels of communication that faculties have for students so they're not just hearing it from Student Services, they're hearing about it through their faculties. 'Cause that's going to be the most significant, credible, relevant for them.

Finally, the participants agreed that communication needed to be both streamlined and consistent. With respect to the former, the participants felt that it was necessary to ensure that communication was organized in such a fashion that most, if not all, units falling under the support services umbrella were communicating with students in the same fashion, portraying the same messaging, in one package. This, of course, was thought to be more efficient than having various units trying to reach students, which would reinvigorate the saturation problem identified previously. Margaret reported that communication was streamlined on her campus via a communication coordinator, who "is responsible for the overall management and strategic design of communication services to students." Next, the participants also agreed that working towards consistent messaging from *all* parties at the university should be an essential goal. In particular, the participants noted that maintaining coherency in the messaging from all support services was very important; however, they also noted that it was important for messaging to be just as consistent from departments / faculties, staff, and of course, faculty members. Crystal recognized that consistency would strengthen messaging, sharing "if a faculty member is saying the same thing that their wellness peer is saying, that I'm saying, then that makes the message so

much stronger," while Wendy noted that such consistency would certainly enhance the credibility of messages, stating:

> I think it's more sincere if it comes from everyone. If you have something you're hearing from your faculty members, and it's something you're hearing from the deans and something that you're hearing from the [health clinic], then it just puts the image out that it is something that people actually believe in, not these crazy people over in the [health clinic] think we should get more sleep, but our profs are also telling us that you need to remember to sleep.

Systemic mechanisms. The systemic mechanisms reported by participants spoke to the factors that were relevant to the university as a whole system and were useful in terms of overcoming the identified barriers and meeting current service demands. These included writing/reworking policy to support mental health and broad, thoughtful, systemic changes; the latter was further broken down into prioritizing mental health, involving everyone in mental health, building a community of caring and acceptance, and increasing value on wellness. Certainly, with respect to policy, there was differentiation between the ideas of the participants as specific policies differ greatly between institutions.

Write / rework policy to support mental health. The participants agreed that university policy failed to support student well-being and in some cases, detracted from student mental health. Stemming from this, many of the participants suggested that changes to policy were needed. First, it was recommended that central administration consider how existing policy may be negatively impacting well-being, even if the effect was inadvertent. Annette endorsed the need for such examination, stating:

> I think some of it has to do with just the fundamental structure of programming and curriculum and policies. All of those pieces have an

> impact, because sometimes those can set up barriers that would cause students to feel very distressed and actually undermine their being able to actualize their potential, which is, you could argue, counterintuitive to what our academic mission is. That's exactly what we should be worried about, is sort of opening up the way for them to actualize their potential. That ought to be what we're in the business of doing. So I would say that all policies and practices that have to do with the academic programming, that have to do with conduct, that have to do with both academic, non-academic conduct, every aspect that impacts on students experience, really, either directly or indirectly is in play. It's all having an impact now. It's just a question - is it neutral, is it negative or is it positive? So we want to be really conscientiously looking at those to, first of all, assess the impact and then look at what are the changes that are needed.

Extending from this, participants identified specific policies that detracted from student well-being. For example, many participants reported that academic concession policies were challenging for students as they often required students to garner proof of significant distress in order to defer academic requirements. Of course, this often prevented students from seeking academic concession, ultimately impacting performance and subsequently detracting from well-being even further. Similarly, Mel reported that she has certainly noticed an impact of grading policies on student well-being that should be reassessed:

> I mean grading policies … here we have a grading curve. So students are graded on a Bell Curve. And mostly on a hundred percent exams. So what's our grading policy? And how much does that affect mental health 'cause it definitely does … It's so stressful!

Meanwhile, Moe acknowledged that that she was negatively affected by financial policies put forth by her own institution:

> So, I missed a week of class in September 2008. Missed the deadline of dropping the classes so that I wouldn't have to pay by two days. And so I came back to the university and I told them three to four weeks later once I was stabilized, and said, 'look, this is my situation. I mean I missed the deadline by two days, I'm extremely financially just strapped, I have NO support… please support me here.' And their policy is, 'you missed it, that's it. Too bad, you pay.'

The general rigidity of policy and policies around student workload were also identified by participants as negative contributors to student mental health and well-being.

Extending from the reconsideration of existing policy, the participants also felt that it was necessary to further consider the systemic values that guided policy development. In particular, while it would be important to see how policy itself detracts from well-being, it was also considered important to recognize the place of mental health within the value set that guided policy to begin with. Mel summarized this process nicely, recognizing that mental health could serve as a guiding value in policy development, which would, in turn, shift policy away from being purely reactionary:

> I think that the cornerstone is first knowing what our values are. And then the policies stemming from that versus creating almost reactionary policies that could also be problematized or problematic. So I don't think it's about staying on the surface of the policies, it's going at the root of those and then having the policies unfold accordingly.

Jackie also spoke to this while again referencing the academic concession policy, noting that the messaging behind the policy reflected a value set that did not support student well-being:

> Students should not have to get a note from their doctor every time they miss something for medical reasons or health reasons. Whether that's physical or mental. And that kind of an approach I think it works counter to what we're trying to [do]... if we're trying to build a supportive environment for students, we're trying to get them to take responsibility for themselves. And yet, why do they need the note? Either because you don't believe them - that's not supportive - or because we think that they need an authority figure and that's not building responsibility. And so I just think, my director would say as employees we're not required to produce a note every time we miss a day of work. And so, why do we expect that of our students? Are we having this culture of not trusting or

> that it's not okay to say that they needed to take a break for whatever reason.

Discussion around broad value shifts within the context of the university as a whole are discussed in the following section. Certainly, however, shifts of this nature may also lead to a value shift that would serve to redefine policy in a more positive and productive light.

Finally, the participants also suggested that consciously generating policy that promotes wellness and contributes positively to psychological well-being would serve as a worthwhile practice. Naturally, this would occur via consideration of mental health in the generation of any policy that impacted students. Margaret encapsulated this idea, stating:

> Well, the policy level – yes, I know what the plans say and I know what policies everyone points to. Policies are in place to compel behavior, so I think we have to be clear what behaviors we're trying to compel and from whom. So student behavior, we want to compel what kinds of things? And when we answer then we can better answer what policies. Same with faculty. And I really think it's about student and faculty behavior, and then staff behavior supports the ends we want to achieve. There's no question there's increasing strain and stress. Every student survey points to that. And you'll have a segment of your faculty that are working to find ways to change what they do to support more space for people. But you'll also find people saying but they can learn to function in an environment that has elements of stress and strain in it, that is important in moving forward. So I think the policy level is broadly about setting out expectations for academic programs to be structured in ways that support student learning that shows a progressive and current understanding of student learning, the attributes of graduates that we're looking for and the real rigorous disciplinary knowledge for students to become experts in whatever their field is. And in doing that, asking each time we create a policy or an academic program will students be able to thrive and do well and what does it take to do that. So I don't know if it's always about changing policies or policy direction, I think it's about this being a criteria on which almost every decision is weighed. Which speaks to a principle foundational way of achieving organizational development, right? How do we take pause and ensure that we're building capacities and conditions for student success.

Broad, thoughtful, systemic changes. Many of the changes identified previously - both structural and policy-related - would certainly occur in tandem with the broad systemic changes that the participants also felt were needed. In particular, the participants reported that in order for students to engage in help-seeking and to deal with service demand challenges, a broad cultural shift across the institution also needed to occur. The specifics of such a shift are subsequently highlighted. However, the participants acknowledged that some of the fundamental aspects of such a change included first recognizing the systemic nature of the university and noticing how any and all elements of the university system could contribute to and/or maintain the current mental health and wellness problems on campus. In addition, the participants agreed that any broad changes needed to be thoughtfully led by persistent leaders, while also maintaining transparency in order to gain traction, support, and longevity. Collectively, the four strategies outlined in the following sections were considered to be important in making the university campus a healthier and more encouraging / productive environment, where help-seeking was not only valued, but a norm.

Prioritize mental health. The participants acknowledged that mental health needed to become a campus-wide priority, rather than being solely shelved within the domain of support services. Certainly, this would require that the university's senior administration recognize and define mental health as a significant priority on campus, which would then ensure that mental health was infused into various domains of the university structure. From this, the participants identified various objectives that would come with prioritizing mental health. First, they suggested

that universities should place greater emphasis on understanding the current state of mental health on their campus. This may occur through encouraging faculty or graduate students to conduct formal academic research and/or via administration conducting campus surveys similar to NCHA, for example, in order to pinpoint particular challenges and preferred solutions. Mel reported that such practices were occurring on her campus and helped to translate to students that administration believed mental health was an important priority:

> And so we have surveys about what are the mental health issues, what are the concerns, what can be done, what do you think of the services so far… so there's like 50 or 60 questions, it was pretty intense but it's engaging in conversation and sending messages that we care.

Garnering a stronger understanding of the current state of mental health on campus has also been accomplished through personal forums that allowed students to share their perspectives directly with administration. Mel discussed how this played out on her campus, when sharing about the national Bell "Let's Talk" event:

> There were live feeds and laptops and things like that where people could tweet about what they think to advance a mentally healthy campus … essentially that was the idea … so that was a five hour fair and then there was a two hour community dialogue, where we had a panel of speakers and the president of [the university] spoke about what they thought [the university] could be doing to advance a mentally healthy campus and then it was a community conversation about ideas around that and ways to move that forward.

Along the same lines, the participants also agreed that transitioning from a very specific perspective on mental health to a more systemic perspective would allow the university to fully appreciate the ways in which mental health is negatively

impacted as a result of systemic variables. Annette acknowledged that this transition was starting to happen, stating:

> I think universities are starting to pay more attention to those broad, systemic pieces, how to create a supportive campus environment, what goes into that. What about the very high level policies, procedures and how do those impact student experience and what's the impact of that on student mental health. So I think universities are starting to look at a more holistic, systemic approach.

Indeed, this would open up the space to re-examine policy, consider institution created barriers, and recognize how the systemic culture contributes to the growth or demise of student well-being.

Another way for the university to prioritize mental health would be through formally defining university-wide objectives for student mental health and well-being and subsequently injecting funding into mental health programs and initiatives. Defining mental health as an important objective might be operationalized via inclusion in strategic plans. At one campus, for example, student well-being was discussed in the student learning section of the strategic plan. Margaret discussed the importance of identifying mental health as a systemic goal and how this not only plays into the work of the university as a whole, but contributes to the values of graduates that come out of the university:

> I think you want to name the goal that you're committed to. At times it will be that clearly named in the strategic plans and at other times it may not be. But as long as the capacity in annual reporting is there to show progress and the way it relates to student outcomes, that's okay. So we're building systems and student outcomes by focusing on mental health and well-being. We're building systems that support our ability to respond to students, to operationalize this priority, to communicate about this priority. We're building all sorts of systems. But we're also, in our focus on health and well-being, building student outcomes, healthier individual students, students who have diagnosed issues, diagnosed medical situations, diagnosed abilities, inabilities to be able to act and enact the world and the

> person they want to be. And we're also creating understandings of student outcomes. So students who graduate from this campus, if they've never, themselves, been to counselling or health or any other unit around mental health, they will have an understanding that mental health is a capacity to be built in all of us. The ability to thrive and flourish is a capacity that's to be built in all of us.

Of course, just as something is identified as an objective, funding is also required to actualize the ability to accomplish tasks related to achieving the objective. Many of the participants reported that increasing funding for mental health initiatives would certainly help to deal with the challenges identified. Indeed, the decision to fund such initiatives would have to come from central administration. Beyond this, it was also recommended that institutions lobby for external funds from government sources as well.

A final element of prioritizing mental health would come via the development of a campus mental health strategy. Staff/administrators from each of the campuses noted that teams of staff from their respective campuses were working together to assess priorities and design and implement strategies in order to encourage wellness, help-seeking, and positive mental health. As expected, these individuals were trying to assess possible solutions beyond the reactionary response of adding more resources and instead were thinking about ways to make the campus a healthier place for students, overall. Joe discussed how this played out on his campus, noting that the team served a liaison between senior administration and the campus at large:

> There's something called a [name of group] that is currently meeting and actually will be reporting to the university executive committee this month on the first phase of their recommendations. And that action committee is really looking at developing a mental health strategy, a campus-wide mental health strategy, to try and deal with some of these issues. And so to

> look at campus-wide education and what we can do on campus to make this a more mentally healthy campus in general 'cause I don't think the answer lies in our centre getting more counsellors; that would be great and we need them but we will never have enough counsellors to realistically deal with all the stuff that's going on with students on our campus.

Involve everyone in mental health. Just as participants acknowledged that administration must prioritize mental health, they also agreed that everyone else on a university campus should be involved in mental health in some capacity. In particular, while the participants agreed that treatment and intervention was often most suited for professionals, they also felt that staff, faculty, students, vendors, teaching assistants, administrators, and so on should be involved in prevention efforts, identifying struggling students, promoting wellness, and/or supporting students both formally – via structured initiatives and programming - or informally – via the development of interpersonal support and care. John encapsulated this nicely, stating how mental health should be a shared responsibility:

> Mental health is a shared responsibility. So it's everybody's responsibility, everybody should look at the person in the desk beside them or the lab beside them, and if they're getting behaviours that are funny, start a conversation. Because it might be the only conversation that person's had.

The participants strongly endorsed the notion that faculty have a significant role to play in the mental health and well-being of students, as the quantity of contact they share with students is greater than most other bodies on campus. In particular, the participants felt that faculty could serve as a body to engage with students and a) act as referral source (i.e., to refer students to appropriate support services), b) promote help-seeking and the use of support services, c) normalize psychological challenges, d) identify students who are

struggling, e) be involved in campus-wide mental health initiatives, f) serve as an approachable, empathetic body, and/or g) promote and facilitate the development of healthy classroom environments. In relaying his own view on the role of faculty, Joe touched upon many of these areas, stating:

> I think faculty have a number of roles to play. One is just how they structure their courses and their curriculum, I mean you can make a course so incredibly stressful. That's not helpful for students. And there are ways to teach that are not like that, that I believe are more valid ways of pedagogy. So I think that's partly it. I'm not expecting that students are necessarily going to open up to faculty members about their mental health issues or their emotional crises, but faculty do need to be alert to signs and symptoms of distress and that's without students necessarily saying anything but if they stop showing up to class or there's something in their writing that they do for a course or their grooming starts to look lousy … those are all issues that if faculty are aware of them they might be able to approach the student or certainly encourage students to seek help if they need it. And, if a student does approach them, be willing to be a listening ear, being willing to be a compassionate human being, they don't have to be a trained counsellor, but they can be a person who cares and demonstrates that caring.

In order for faculty to accomplish such tasks, the participants also felt that additional support and training for faculty (and staff) would absolutely be necessary. Crystal indicated what this might look like:

> In an ideal world, faculty members would do some training or learn a little bit about when to make referrals, knowing about boundaries around, the expectation on them as a professional to intervene or not or in what ways to help, and when to make a referral. And I don't think that's really that difficult, I just feel like that's something quite attainable to be able to give training, especially if people want it. So I am 100% in agreement around getting faculty supportive of the work that we're doing.

Another important population that needed to have involvement in the various aspects of mental health on campus were the students themselves. The participants reported that students should be directly involved in support, promotion of wellness, and prevention via peer-to-peer programing and

investment in related student groups. Beyond that, however, the participants also felt that students could be involved in systemic decision making through sharing feedback based on their own experiences. Moe emphatically captured the need to involve students in decision making, stating "Highlight this piece! Please! Definitely in your overall question of how do you, like help-seeking barriers, ask students and they'll tell you!"

Involving individuals that reside outside the walls of the university was also thought to be particularly important. More specifically, the participants felt that it was important for members of the university to work with people in the broader community for advocacy, to promote social change, and to garner financial support. This might include, for example, partnerships with health boards, governments, external service providers, and/or organizations that support and promote mental health awareness. Jackie discussed the need for the university to get involved in advocacy efforts, stating:

> I think the bigger societal piece is really important and I think that universities have a role to play in bringing that to the forefront and advocating for change. And getting involved in a larger national or local initiatives that are making it okay to ask for help. And okay to tell someone that you've experienced depression at some time in your life. Or that you take medication for anxiety and that it's not going to be a barrier for that person when it comes to other areas in their life. So, I think that still needs to be worked on, and a role to play for universities in that.

A final population acknowledged by participants was staff from both academic and non-academic aspects of the university, as well as vendors. The participants felt that such individuals were often in regular contact with students and served as an important resource in identifying students who were struggling. Snooks recognized how important such people were on her campus, sharing:

> When I was at [another institution] there was a student who spent a lot of time in one of the cafeterias and a custodial worker who wasn't an ed-psych person, didn't have a degree, had English as a Second Language, would always say hello and say a few words to the student. And one evening in conversation with the student became quite concerned about the state of mental health of the student and so made a phone call to the head of student services and said I'm really concerned about this individual. Well, in fact that was a valid concern. The person was at high risk. [So] it's not always going to be the clinician that's there. It's the prof, it's the woman in the student services office, it's the person at [the coffee shop], it's the person in the bookstore.

Stemming from this, the participants agreed that staff would also benefit from additional training on how to support struggling students and how to effectively refer students to appropriate resources.

Although participants agreed that mental health was certainly a shared responsibility, it was also cautioned that mental health should always remain "someone's responsibility" in order to ensure that direction is maintained and tasks are accomplished. More specifically, Pam acknowledged, "'cause sometimes when something's everyone's responsibility it's nobody's responsibility. So we do have to be clear that there are certain people who are the leaders of those."

Build community of caring and acceptance. The participants reported that one of the fundamental aspects of systemic change included building a sense of community that is specifically characterized by interpersonal caring and acceptance of psychological challenges. The participants felt that this shift towards building community – or focusing on building a "healthy campus" - would be a direct change from the tendency to simply respond to the mental health challenges in a reactionary way, or as John stated "I think [we need to be]

thinking out of the box saying like how can we make a healthy campus instead of just fixing a sick campus."

The participants noted that building a caring and accepting community would start through broadly educating all parties on campus about mental health in order to generate normalization, reduce stigma and shame, and build acceptance. Education efforts of this sort would also allow students to recognize when they might be struggling with a mental health problem, allowing yet another barrier to be overcome. Participants suggested that education occur via organized means – including awareness weeks, classroom discussions, extraneous presentations, sharing personal narratives, web communications, posters, and so on – and through informal means, including simply encouraging a sense of openness around mental health generally and opening up space for positive mental health discussions rather than avoiding discussing the topic. Kathryn expressed the need for such openness, stating:

> I think what's most important is creating a culture where we can discuss it openly, because that is more likely to get people actually in the door and seeking help. A culture where we talk about it openly is very important.

Meanwhile, Anna indicated that formal education efforts, like awareness weeks, certainly helped to normalize mental health and eliminate some of the stigma:

> [They] reinforce that it's not something you should be ashamed of … Like go to the doctor when you're sick. Go to psychological services when you have a mental illness. To me, those things should be something that's more socially normal, something that's not, 'oh that guy has depression.'

Beyond education, the participants felt that focusing on the establishment of personal connections was an essential aspect of building a community, or as Kathryn said "people need to be invested in the people around them." If personal

connections are built, resiliency of students would grow as they would feel cared for, accepted, and like they are part of something broader, or as Annette stated, they would no longer feel like "a single individual in a sea of students." The participants indicated that personal connections could occur between anyone on campus and could be formed through organized activities like intramurals, clubs, teams, and so on, or could simply result from showing interest in how one another are doing. Moreover, the participants felt that it was imperative for the university to place value on interpersonal support and relatedness and recognize this as a fundamental aspect of academic and personal success, or as Margaret stated, "it's really important to build priorities of social inclusion." When participants discussed the value of interpersonal connection, they often shared personal anecdotes. For example, Kate recognized how taking an interest in students often opened up space for them to eventually seek help:

> I will get in the elevator, there'll be a student standing there, and I'll go, 'so how's your day going?' 'Oh, good.' 'What faculty are you in?' Engage in conversation. It's just talking to somebody. It's just taking an interest in someone. And by the time we get down, they may have a little smile on their face … I will stand in the Subway line and, 'so how's it going?' And they'll look at me. I said, 'I'm the {states role}. I'm just wondering, how are you doing?' … And nine times out of ten I'll say, lunch is on me today. Big deal, 5 bucks. But if somebody did that for my kid, I'd be really happy. But I've had those students, I'll say, 'if you ever need anything you just come on up [to our] office.' They'll come up and they've sent friends up there to talk to me. So it doesn't have to be the big broadcasting, big screen, whatever. Sometimes just talking and taking an interest in people can really be helpful.

Finally, while staff and faculty all over the university can seek connections with students, the participants also noted that students should be encouraged to care more for one another, or as Kathryn stated "there needs to be more of a

community support. Students need to be more involved, which can be difficult of course, students are busy. But I think students should be more involved in helping each other." In other words, it was suggested universities help students recognize that breaking away from academics and acknowledging and helping rather than competing serves as an invaluable and necessary practice in terms of building a healthy community on campus.

Increase value on wellness. The participants agreed that a global shift within the culture of the university toward valuing wellness was essential in promoting help-seeking and preventing mental health problems. In other words, the participants felt that a broad value shift was needed in order to move away from the "I don't have time for this" (Annette) mentality around caring for one's own health and well-being. Moreover, valuing wellness must be prioritized by all members of the university; in particular, the participants felt that it was not only important for students to see the value in personal wellness, but equally as important for staff and faculty to recognize the immense importance as well. Joe endorsed the necessity of this shift, equating wellness with academic and research success:

> I think that the answer has to be that the university as a whole takes this responsibility as high a priority as the priority they place on academic excellence. So I think there has to be a paradigm shift at our institution that puts mental health and well-being on a par with our concern for academic excellence and research excellence. So that's going to take some doing for people to come to that I think, I hope it will. But I think that's for me the single most important thing 'cause it starts with that.

The participants recognized that one of the central tasks involved in this cultural shift would come through connecting the ideas of wellness and academic

success. In particular, the participants felt it was necessary for universities to translate to their students (and faculty) that academic success is bolstered, and in some cases, made possible, via the investment into personal wellness. At one institution, a large campaign has been established to translate this messaging. Pam discussed the value and success of this campaign, stating:

> I think that one of our most important 'aha moments' was understanding that in order for a student to be able to be successful as a student they need to be well. And to make that link I think that's why students are paying attention. I think that's why faculties are paying attention. It's not just to be kind to these poor old depressed people, but it's also to say why are you here? You're here to get a degree, you're here to get a job, you're here to get an understanding of what you're passionate about. To be able to do that you need to be able to use your brain. Brain health is really important. And I think that's why we've been successful, because we've made that link real.

Moreover, through establishing that academic success hinges on wellness, all student service units would also be provided a common priority to collectively work toward. Margaret spoke to this:

> The first change that I lead was ensuring that people understood that health and well-being was foundational to student success. So I'd probably only identify two issues as foundational, health and well-being and financial stability in that student services is often lead by everyone is important, every issue matters. And it does. But at some point you have to create a model where people can understand themselves in relationship to each other, not be threatened by that, and then become more inspired to build a more collective model of we organize ourselves and how we identify priorities. Student services at universities, it's not the centre - at all! But it's a facilitating and helpful support to student success. The work that we do is about student learning. We spent a year having a conversation about the end isn't mental health, the end isn't physical health, the end isn't intercultural fluidity, the end isn't student leadership. The end is student learning and we are an invaluable support to that end but somewhat invisible. But that's got to be all good 'cause that's who we are! And so I think the change has been in understanding that health and well-being is every director's priority, not just the counselling and health directors' priority. It's foundational, it's preconditions for learning.

Finally, this connection could also be translated to senior administration through identifying the relationship between wellness, academic success, and student retention.

Another aspect of generating this cultural shift might come through embedding mental health into the curriculum. The participants acknowledged that this could occur through various means. For example, faculty members could discuss mental health within their lectures and identify how and why students may seek help or bolster their wellness on campus. Alternately, other participants suggested that designing a for-credit course on help-seeking, support services, and health and well-being that is mandatory for all students may also be beneficial.

Establishing a global sense of importance around the act of help-seeking would also be relevant when generating a cultural shift toward valuing wellness. According to the participants, it would be important to help students understand the process and function of support services, aid them in navigating support services, and normalize the process of seeking help both formally and informally. Kathryn touched on the need for normalization:

> I would say that it is important to normalize seeking help, but seeking help in a healthy way. Treating seeking mental help [as] just something that sometimes we need to do would be a major step forward. As a necessity in our lives, we need somebody to be there for us.

Beyond this, it would be important to establish the notion that help-seeking is safe within any context of the institution. In particular, to establish the importance of help-seeking, the participants felt that it would also be important that asking for help in any environment be deemed acceptable. Mel discussed the need for this in her faculty, stating:

> So I've been speaking to my colleagues about not wanting to be the only person who's considered safe and accessible, I want to be one of many people … so it's not about everyone just referring to a counsellor, it's about how can we have as many accessible, safe supportive people in this environment.

A final aspect of generating a cultural value of wellness could come through investing in and engaging in formal efforts to promote wellness, therefore contributing to and prioritizing prevention. This may occur, for example, through reassessment of policy as identified previously. However, efforts in this direction may also need to be more specific. On one campus, a centre devoted solely to wellness was established to encourage students to be more proactive when it came to caring for themselves. Crystal noted the goals of this centre, stating:

> [The] purpose is instead to be providing more of a preventative health promotion proactive kind of approach. So in other words, a student could come in and learn a little bit more about sleep or nutrition or physical activity or stress management. Although it's reasonable to say that a lot of students are already at the point where maybe they do need to see a professional about some sort of care, which doesn't necessarily mean they can't be proactive about taking care of their health but maybe they're not at that point where they're ready to start thinking about that. In terms of prevention and being proactive.

Summary of Findings

Taken together, the relationship between the barriers to help-seeking and the mechanisms to overcome barriers and meet service demands is portrayed in Figure 3. Naturally, the barriers informed the mechanisms and the mechanisms were designed to inevitably influence the barriers as was repeatedly highlighted throughout the findings. For example, practical issues were identified as a barrier and the implementation of practical changes was identified as a mechanism to overcome barriers and meet service demands. In essence, the relationship was

Figure 3. Summary of Findings

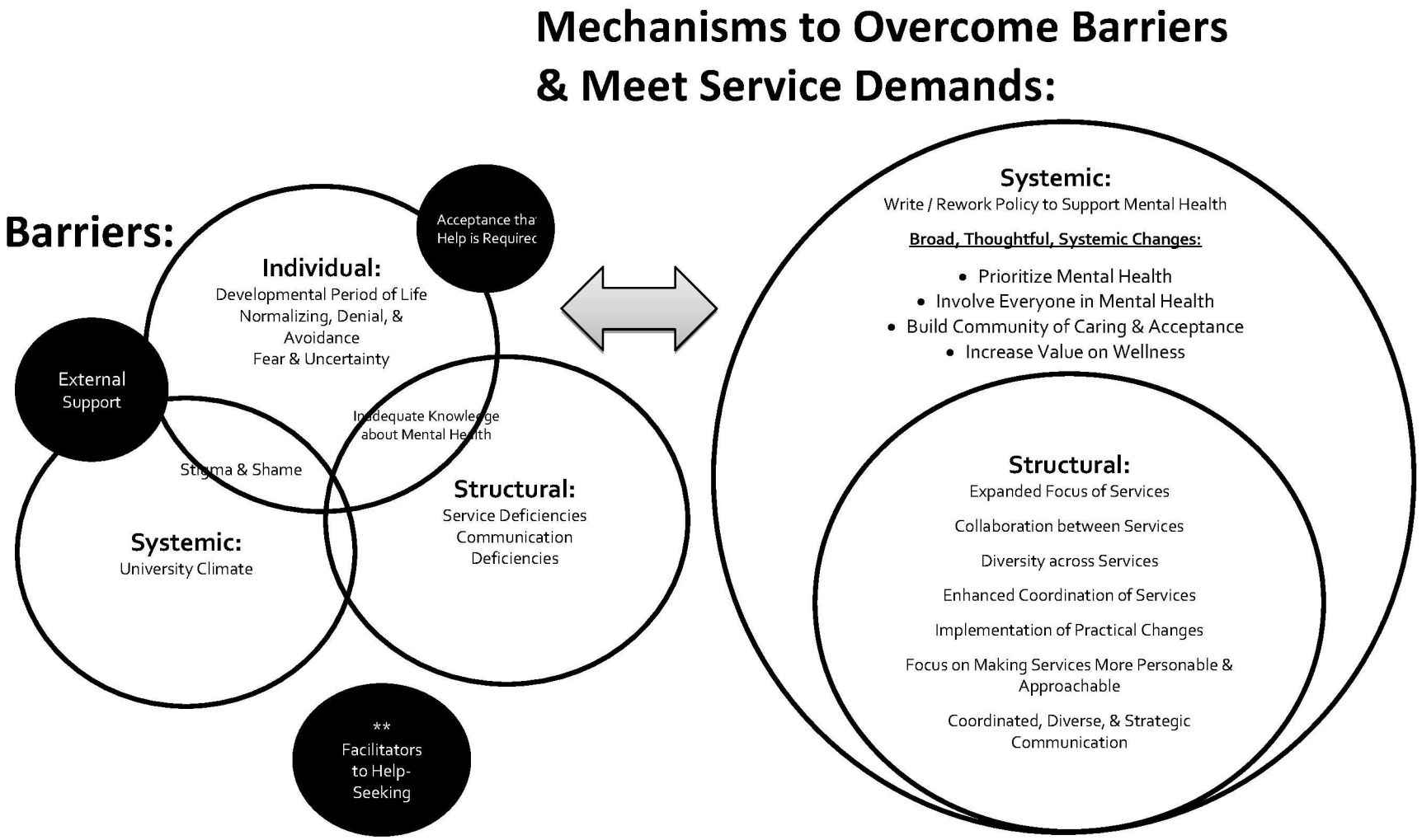

Figure 3. Diagrammatic explanation of relationship between barriers to help-seeking and mechanisms to overcome barriers and meet service demands.

one of continuous influence; thus, this is portrayed with an arrow in the diagrammatic explanation of the relationship (as shown in Figure 3).

Conclusion

Collectively, the findings from the present study highlight a series of related individual, structural and systemic barriers to help-seeking, as well as structural and systemic mechanisms to overcome barriers to help-seeking and meet service demands. The barriers and mechanisms naturally have mutually influential relationship.

Chapter Five

Discussion

The purpose of the present study was to gain a Canadian perspective on the barriers that prevent students from seeking help for psychological issues and further, to better understand how university support services can help overcome these barriers to more effectively serve the growing number of students in need. The present chapter discusses the interpreted findings within the context of current literature. While this triangulation is important in terms of validating the findings, the present chapter also focuses on how the findings can inform practice on Canadian university campuses. The latter, of course, is the central emphasis of the methodological framework that guided the present study (ID; Thorne, 2008).

Barriers to Help-seeking

The barriers to help-seeking were collectively organized into individual, structural, and systemic themes. At the individual level, the developmental period of life, the tendency to normalize, avoid, or engage in denial, and a sense of fear and uncertainty prevented students from seeking help. At the structural level, service and communication deficiencies served as barriers, while at the systemic level, the university climate was considered a central barrier. Finally, although sharing overlap within the broad themes, stigma and shame (overlapping at the individual and systemic levels) and inadequate knowledge about mental health (overlapping at the individual and structural levels) also inhibited help-seeking. These observations certainly showed consistency with the literature garnered from international campuses (e.g., Eisenberg et al., 2011; Eisenberg, Downs, et al.,

2009; Eisenberg, Golberstein, et al., 2007; Furnham et al., 2011;Williams et al., 2008), while also extending beyond pre-existing findings and offering new conceptualizations of barriers.

As previously discussed, some of the seminal literature examining service utilization within the post-secondary population identified stigma, perceived need, time, a preference to deal with things by oneself or informally, inadequate knowledge around mental health, symptom severity, an absence of cultural competence of service providers, normalization of stress, uncertainty around the usefulness of services, lack of knowledge of services, demographic variables (e.g., age, gender, ethnicity, etc.), and cost as common barriers to help-seeking (Eisenberg et al., 2011; Eisenberg, Downs, et al., 2009; Eisenberg, Golberstein, et al., 2007; Eisenberg, Hunt, & Speer, 2012; Furnham et al., 2011; Reavley et al., 2012; Steinfeldt & Steinfeldt, 2012). In the present study, similar barriers were discussed within the context of broader themes. For example, normalization of stress was discussed amongst many other barriers in relation to the university climate and cost was discussed within the context of varying service deficiencies. This expansion on the current literature may be reflective of the fact that the present study was qualitative in nature, whereas the pre-existing work in this area has been predominantly quantitative and has asked participants whether or not they endorsed predetermined barriers. Beyond this, however, the additional information may certainly reflect unique barriers that are predominant within Canadian institutions. Further research is needed in order to discern whether

these differences are reflective of Canadian idiosyncrasies or simply reflective of new ideas that relate to various university contexts across the globe.

Individual barriers. Within the realm of individual barriers, the acknowledgement that the developmental period associated with the undergraduate years serves as a unique barrier extends some of the ideas previously generated among the literature. Namely, in their multi-campus study in the US, Eisenberg and colleagues (2011) highlighted that help-seeking increases with age, with the greatest amount of help-seeking occurring among those 31 years of age and older. As a result of the present study, we see that the undergraduate years are associated with newfound independence and responsibility; this may help to better understand why help-seeking is more prevalent amongst older students. Moreover, other researchers (e.g., Cleary et al., 2011) have also highlighted that the transition from high school to university is one characterized by many stressors, including the novel management of one's own care. In the present study, it was highlighted that the difficulties associated with the transition to university may actually be present throughout the young adulthood developmental period and thus the considerations provided to first year students may actually be relevant to all students falling within this particular developmental demographic.

Normalization, denial, and avoidance were also uncovered as individual barriers. Certainly, previous studies (e.g., Eisenberg et al., 2011; Furnham et al., 2011) have acknowledged the tendency for students to assume that treatment is not needed, that problems will disappear on their own, and that stress is a normal

part of university. Arguably, we can now expand our understanding of this normalization to the normalization of *suffering,* rather than simply the normalization of *stress.* In other words, it is not only the experience of stress that students have come to accept, but it is the prolonged detraction from one's well-being that is sadly being integrated as "part of" the university experience. More and more, students are taking the stance that part of being at university means that they are going to persistently feel terrible and they are required to simply tolerate and accept this, rather than do anything about it. They are defining "normal" as constantly being at a breaking point and having little to no time to invest in their self-care. This, in turn, raises the question as to whether or not the normalization of suffering is a contributing factor to the perceived increase in psychological problems across university campuses observed by some researchers (e.g., Benton et al., 2003; Gallagher, 2010; Hunt & Eisenberg, 2010). In other words, if students are normalizing suffering, does this allow an exacerbation of suffering to the point where psychological issues are ultimately manifested? Again, more research is required to investigate this further.

Uncertainty and fear around help-seeking are certainly not new phenomena (Eisenberg et al., 2012; Eisenberg, Golberstein et al., 2007). Researchers have typically acknowledged the tendency for students to question the severity of their issues and the usefulness of services (e.g., Eisenberg et al., 2012; Eisenberg, Golberstein et al., 2007). However, it is important to recognize that asking for help is both a skill and a task that can invoke anxiety. Some institutions have already recognized the implications of this barrier. For example,

the University of British Columbia has implemented an "Early Alert" system, whereby concerns around students are logged by faculty and staff, allowing students to be offered help by the academy rather than waiting for the student to seek it out on their own volition (Hanlon, 2012). Other institutions across the country are following suit in recognition of the fact that students often do not seek out help for themselves.

Structural barriers. Several structural issues also prevented students from seeking help. Among these issues, an important finding was that services do not meet the diverse needs of the student body. In particular, there was a tendency for services to fail to meet the needs of minority groups, students from diverse cultural groups, international students, and so on. Services were structured in a way that failed to take into account the specific treatment needs of the collective student population and universities failed to realize that one size does not fit all with respect to helping and supporting a diverse student population.

The westernization of support services discussed in the present study certainly helps to explain why previous researchers (e.g., Eisenberg et al., 2011) have found that treatment use declined among minority racial groups including Asians, Blacks, and Hispanics. Moreover, information garnered in the present study also supports the fact that a lack of cultural competence from service providers inhibits help-seeking, as previously identified by Eisenberg and colleagues (2012). These findings provide additional support for the call to universities to consider how their services are incongruent with the needs of the

many cultural groups that comprise the student population, as previously identified by many (e.g., Ruzek et al., 2011; Tung, 2011). Of course, this is particularly important for universities that are focused on increasing international recruitment and enrollment. Certainly, the lucrative nature of international recruitment is appealing for some institutions, yet it is important for universities to recognize that current models of support may not fit for this growing population.

This study helped to highlight the shortcomings of services for both cultural minorities *and* other student groups on campus. For example, it was acknowledged that services do not necessarily meet the needs of commuting students who spend little time at the physical campus. This was not the first time that a difference between commuting and on campus students has been acknowledged; Yorgason and colleagues (2008) noted that living on campus gives students more information about mental health services. Using the present findings, questions are raised around the capability for students to use services when they are simply coming and going to classes and invest minimally into the campus culture. Similarly, a discrepancy seemed to exist between male and female service utilization, with females showing a greater likelihood to access services. While this finding has been commonplace among the research (American College Health Association, 2011; 2013a; Davies, Shen-Miller, & Isacco, 2010; Eisenberg et al., 2011, 2012; Eisenberg, Golberstein, et al., 2007; Yorgason et al., 2008), institutions remain confused around how to close the gap between male and female service utilization particularly when faculties (e.g.,

engineering) are laden with men, yet are not devoid of mental health issues. Some researchers are beginning to hypothesize potential solutions (e.g., Davies et al., 2010), but this research remains in its infancy.

This study also suggested that incompetence among service providers was not only experienced from a cultural perspective, but rather experienced by students more globally at university. While previous researchers have noted that students question the helpfulness of services (e.g., Eisenberg et al., 2011; Eisenberg, Golberstein, et al., 2007; Hunt & Eisenberg, 2010), the findings of the present study suggested that negative experiences with service providers are very real and inhibit future help-seeking. While conflict between students and service providers may be unavoidable, questions remain around how to re-engage students in the help-seeking process when their ambivalence about the process has been validated by negative experiences.

Practical issues such as session limits, hours, cost, waitlists, location and so on were also discussed in the present study and determined to serve as a barriers to accessing services. While some of these practical issues (e.g., cost) have been addressed in previous research (e.g., Eisenberg et al., 2011; Hunt & Eisenberg, 2010), the identification of many of these issues is concerning as they actually speak to attempts institutions are making in order to deal with the service demand issues. For example, researchers such as Kitzrow (2003) note that universities have moved to limit the number of sessions in an effort to deal with the growing demand for services. However, as students gain awareness of this,

they may choose to avoid service utilization all together, assuming their needs cannot be met in this limited time frame.

Similarly, it was illuminated in the findings that the modalities through which some services are offered did not necessarily appeal to the student body as a whole. For example, peer-to-peer and group models of therapy were not always appealing for students who desired more anonymity. Again, Kitzrow (2003) notes that such methods (e.g., group treatment) have been used as a method of dealing with service demands, yet it is clear that students may see this approach as a barrier to help-seeking. Collectively, this suggests that what administrators perceive as solutions may actually be perceived by students as additional barriers.

A final structural barrier highlighted in the present study was the issue of communication deficiencies. In particular, there was an absence of communication around the availability of services and their respective functions. A student having limited knowledge about services on campus is not a new phenomenon. As previously identified by Eisenberg, Golberstein, and colleagues (2007), many students are unaware that their campus offers support services and very few know where or how to access such services. Moreover, Canadian schools including the University of Alberta and Queen's University have acknowledged that students have limited knowledge about available services (Everall, 2013; Queen's University, 2012). Everall (2013) states that "if there is one thing we should change about the current situation, it is the way we communicate with our students" (p. 30), while Queen's University (2012) noted that 1 in 5 students with mental illness-related disability did not know

accommodations could be made for their situation and more than 1 in 10 were unaware that support was offered on campus.

The present study provides insight around why communication efforts may be failing, including potentially defective methods of communication, communication inconsistencies, and untimely communication. More specifically, there seems to be limited variety in the chosen methods of communication and the attempts made to communicate with students are impersonal, complicated to navigate (e.g., websites), and somewhat lackluster, therefore failing to grab the attention of students. Additionally, information is commonly shared at a time when it is not pertinent to students (e.g., orientation week) and is not made readily available when it is of importance (e.g., during midterms or final exams). Moreover, a predominant challenge on university campuses is the lack of consistency between information shared within different student service units and between student services and other university bodies, namely faculties and departments. Naturally, this is increasingly problematic as it generates concern and confusion amongst the student body and leaves students unsure about how to garner the support they need.

Systemic barriers. Various elements of the university climate serve as barriers to help-seeking. Some examples include the competitiveness associated with the university environment, the normalization of stress and busyness, lack of interpersonal connections and community, and a sense that the university is not there to "help" students. In general, the university climate is not one that generates support for student mental health and well-being. Instead there exists a

culture that isolates students and pits them against each other in an effort to "come out on top." Students are encouraged to maintain a persistent state of stress and faculty only further reinforce this message through their own behaviour and expectations, rather than promoting balance and self-care. Instead of seeing the institution as an intricate community that supports the growth and health of students in their pivotal university years, the institution simply becomes a means to an end in the eyes of the students. Students feel they are pushed to the brink rather than encouraged to seek the help needed to succeed.

Interestingly, when examining the literature, little empirical work has been completed to understand how the university climate detracts from help-seeking. Most notably, the Healthy Minds study commonly referenced throughout this document (e.g., Eisenberg et al., 2011) noted a tendency for roughly 50% of students to identify stress as normal, thus preventing them from accessing support services. Similarly, Tinklin and colleagues (2005) acknowledged that normalization of stress and alienation were significant contributors to negative mental health for students. Beyond this, we know very little about the influence of the university climate; Hunt and Eisenberg (2010) aptly acknowledged this, stating, "relatively little is known about how [mental health] varies with respect to factors more specific to the college setting, such as academic workload and competition" (p. 4).

Despite the lack of research, the presence of environmental influences is not entirely invisible. More specifically, some researchers have chosen to simply acknowledge the existence of climate-based stressors in their personal writings

(e.g., Kadison & DiGeronimo, 2004), while others have noted the systemic influence on help-seeking in institutional reports (e.g., Canadian Association of College & University Student Services [CACCUS] and Canadian Mental Health Association [CMHA], 2013; Carlton University, 2009; Everall, 2013; Queen's University, 2012). Thus, while there has been institutional acknowledgement of systemic influence (CACUSS & CMHA, 2013; Carlton University, 2009; Everall, 2013; Queen's University, 2012), little is understood about how the university climate prevents help-seeking in and of itself. As a result of the present study, new questions are raised as to how this phenomenon unfolds, pointing in large measure to a flawed value system and missing sense of community. Further research is needed to better understand the magnitude of these barriers to help-seeking.

Cross-category barriers. In the present study, two multi-categorical barriers were endorsed – inadequate knowledge about mental health and stigma and shame – both of which were highly consistent with current literature.

At the individual and systemic level, it was noted that students had limited knowledge around mental health generally. In particular, students failed to recognize the existence and severity of a mental health problem because they had minimal knowledge of disorders and their respective symptomology. This finding further supports existing research that outlines a tendency for students to be unfamiliar with mental health diagnoses (e.g., Furnham et al., 2011) and supports the notion that students' failed tendency to perceive a need for treatment (as outlined in Zivin et al., 2009) may be influenced by their lack of understanding of

symptom severity as outlined in the introduction. More simply, students may fail to recognize a need for treatment because they do not have the knowledge to recognize both their problem and the severity of the problem.

At the individual and structural level, it was noted that students failed to seek help as a result of stigma and shame. Without a doubt, stigma is one of the most documented and researched barriers to help-seeking on university campuses (e.g., Eisenberg, Downs, et al., 2009; Martin, 2010; Masuda & Boone, 2011; Quinn et al., 2009; Reavley et al., 2012; Reichert, 2012; Storrie et al., 2010; Stuart, 2011; Yakunina et al., 2010). Much of the current research (e.g., Eisenberg, Downs, et al., 2009; Reichert, 2012) examines the difference between perceived/public stigma and personal stigma; this research has found that personal stigma is associated with reduced help-seeking, while perceived/public stigma simply influences personal stigma but does not correlate with reduced help-seeking directly. This phenomenon was validated in the present study, as it was identified that the perceived external stigma was internalized and therefore contributed to a reduction in help-seeking. Finally, the findings of the present study also support existing research stating that stigma is particularly problematic at a university (relative to the greater community) because it is not only associated with a perceived general sense of weakness but redefines (i.e., reduces) one's perceived capabilities both academically and professionally (Martin, 2010; Quinn et al., 2009).

Facilitators of help-seeking. Based on the fact that student services are taxed, we know that many students have the capacity to overcome the identified

barriers and seek help. In the present study, it was determined that external support sources and acceptance that help is required (because they have nowhere else to go, they hold an intrinsic motivation to change, they recognize the seriousness of their challenges and/or they have received help in the past and are comfortable seeking it out again) often motivated help-seeking. These findings directly map on to those currently documented in the literature from researchers such as Downs and Eisenberg (2012), Eisenberg and colleagues (2011) and Eisenberg, Golberstein, and colleagues (2007), further validating the presence of such facilitators in the Canadian context.

Mechanisms to Overcome Barriers and Meet Service Demands

The qualitative nature of the present study helped to better understand how previously and newly identified barriers to help-seeking influence Canadian university students. Certainly, this information also served as a foundation for understanding the mechanisms through which we can overcome barriers and meet service demands. Interestingly, the student participants in the study had some difficulty identifying current mechanisms used by their respective institutions in order to overcome barriers and meet service demands. Moreover, the suggestions for change offered by students were often based on personal ideals; it was challenging for students to identify mechanisms that were feasible at a systemic level (e.g., making tuition free for all). Thus, although the ideas presented by students were generally extensions of the ideas of staff/administrators, it appears that the limited involvement of students in the broader functioning of the

university influenced their ability to recognize appropriate mechanisms for change.

Also of note is the incongruent nature of some of the findings. More specifically, while some participants highlighted potential mechanisms for change, others highlighted the same ideas as barriers to help-seeking. For example, some participants identified that utilizing group counselling is a way to handle service demands, while others acknowledged that the lacking anonymity of group counselling served as a barrier. This provides important information: what some avoid, others find helpful. Thus, balancing the appropriateness of each mechanism with the interests of the students is going to be a challenging but necessary task for administrators moving forward. This is, however, feasible. For example, two campuses in the present study identified that they use "session limits" to control demand issues; for one campus the limit is six sessions, for the other it is sixteen. Thus, mechanisms can be modified to meet the needs of the idiosyncratic population of each institution.

The reported mechanisms were again split into structural and systemic domains. At the structural level, the participants highlighted a need for an expanded focus of services, collaboration between services, diversity across services, enhanced coordination of services, implementation of practical changes, focus on making services more personable and approachable, and coordinated, diverse, and strategic communication. At the systemic level, the participants recognized a need to write/rework policy to support mental health and defined a need for broad, thoughtful, systemic changes.

The findings in this section of the study serve as a clear expansion on the current research in this area. Recall from the introduction that Joyce and Weibelzahl (2011) noted, "the literature is strangely quiet on attempts to overcome … barriers" (p. 287). In fact, much of the formal research in this area has highlighted specific strategies to cope with barriers (e.g., a computerized therapy program; Davis-McCabe & Winthrop, 2010), but has failed to identify more global solutions. Thus, through offering the in-depth qualitative perspective, the present study supplies a foundation from which exploration around overcoming barriers can be undertaken. Moreover, the mechanisms discussed in the present study map on nicely to the needs assessments and mental health strategies published since the original conception of this project by Canadian universities (e.g., Everall, 2013) and organizations (e.g., CACUSS & CAMH, 2013), validating the potential usefulness of these strategies across Canadian institutions.

Structural mechanisms. The structural mechanisms garnered from the present study essentially spoke about ways in which the services themselves can be modified to deal with barriers and help with the service demand challenge. One of the starting places is to expand services to include prevention and early intervention via education, student capacity building (e.g., building resilience and coping strategies), wellness promotion, and early intervention services. The need to focus on prevention and early intervention is not a new concept. Some of the American leaders in campus mental health including Cornell University and The Jed Foundation (TJF) have highlighted prevention and early intervention as

important components of their respective models towards enhancing mental health on campus (Cornell University, 2012; TJF & Educational Development Center, Inc. [EDC], 2011). More recently, Canadian organizations have been calling for the same. On a national level, the Mental Health Commission of Canada (2012) defined prevention of mental illness and promotion of well-being as a central strategic direction towards the betterment of mental health for all Canadians. On a more targeted level, the Ontario Undergraduate Student Alliance (OUSA; 2012) as well as CACUSS and CAMH (2013) have respectively identified early intervention and the promotion of self-management and coping as central priorities. In fact, OUSA (2012) highlighted the fiscal importance of this task, noting "early interventions aimed at post-secondary students can lessen the future need for healthcare, with every $1 spent on early mental health treatment saving $30 in lost productivity and social costs" (p. 10).

Various bodies have provided recommendations on how to proceed with prevention and early intervention. Central to these practices are education (e.g., stress and time management, study skills, coping and life skills, services), focus on building social connections, skill development to enhance emotional well-being (e.g., relationships, physical health, decision-making, and identity development), offering support at different transition periods (e.g., into post-secondary, out of post-secondary, returning to post-secondary), ensuring immediate access to services, and early identification of students whom appear at risk (CACUSS & CAMH, 2013; Cornell University, 2012; Mowbray et al., 2006; OUSA, 2012; Queen's University, 2012; Silverman et al., 2008; TJF, 2013; TJF

& EDC, 2011). Further exploration of these strategies can be found in the practice implications section that follows.

There was also a call for increased diversity across services. Participants spoke about the need for increased diversity in the types of services offered, the types of professionals employed, and the intended recipients of services. Researchers are starting to investigate the efficacy of some alternate forms of service, including online programing (e.g., Davis-McCabe & Winthrop, 2010; Ryan et al., 2010) and formal and informal peer support programming delivered both in person and online (e.g., Horgan, McCarthy, & Sweeny, 2013; Morse & Schulze, 2013). Although much of this research is still in its infancy, initial studies have been promising and have highlighted that students have an interest in online programming and see benefits from this type of programming for their well-being (see Davis-McCabe & Winthrop, 2010; Ryan et al., 2010). Moreover, online peer support programs were shown to be appealing for male students, which has notoriously been a challenging demographic to reach (Horgan et al., 2013). Finally, Morse and Schulze (2013) highlighted that a means of diversifying service providers and programming is to train students in their natural roles (e.g., leadership positions, resident assistants, etc.) on how to offer mental health support to their fellow students. This program has been visibly successful and has contributed to an increase in student referrals for service, helped with service demands, and helped to lessen the stigma associated with mental illness and help-seeking (Morse & Schulze, 2013). Despite these documented successes, there remains a clear need for more diversity in

programming to better meet the needs of the collective student population. The aforementioned studies have but scratched the surface and further efforts are needed to design and evaluate alternate programming strategies as universities move forward in their student service efforts.

The need for diversity amongst service providers and intended recipients of services is also currently being considered by Canadian organizations. For example, OUSA (2012) identified a need for a variety of support workers, including "psychologists, counsellors, mental health nurses … aboriginal counsellors, international student support staff, disability support staff, LGBTQ student supports, and other support workers who may not be classified as mental health workers but who often provide mental health services" (p. 12). Although not included in OUSA (2012), other universities have also recognized the value and need for faith-based support of chaplains and religious leaders (Everall, 2013; Queen's University, 2012). Of course, the important message here is that mental health support often comes from those housed outside of formal psychology. Diversifying who is offering services may therefore hold multiple benefits, including a reduction in staffing costs, an increase in utilization from diverse student groups, and a sharing of the service demand. Further consideration of this strategy is needed, but it has certainly received some preliminary support.

The participants in the present study also called for stronger collaboration and coordination amongst services. In other words, services need to be more purposeful and directed in their functioning at both the intra- and inter- service level in order to increase the general efficiency and directedness of mental health

support. The demand for collaboration and coordination is arguably at the heart of various documents put forth by several universities and public organizations (e.g., CACUSS & CAMH, 2013; Carlton University, 2009; Cornell University, 2012; Everall, 2013; OUSA, 2012; Queen's University, 2012; TJF, 2013; TJF & EDC, 2011; UBC Vancouver, 2012). In each of these documents, there is a demand for various "players" in the university to contribute to the overall betterment of mental health in unique, coordinated and purposeful ways. This suggests that organizations and institutions have started to recognize the enormity of the task at hand and are seeing a need for efficient and organized teamwork in order to promote help-seeking, manage current need for intervention and crisis management, and tackle the service demand challenges. One of the most straightforward examples of this comes from Carlton University (2009), which published a report that highlights various support service offices on campus and explicitly defines their roles in supporting distressed students. Exploration of this document is recommended.

Practical changes were also highlighted as a predominant need in order to overcome barriers and meet service demand challenges. This included rapid access to services, adopting a triage model, expanding service hours, expanding resources, minimizing costs, adopting a brief counselling model, and considering the location of services (e.g., centrally located versus satellite locations). Interestingly, since the conception of this project, many Canadian campuses have put forth and/or adopted recommendations for such changes. For example, Queen's University (2012) has acknowledged a need for faculty-based mental

health service providers, whereas the University of Alberta (Everall, 2013) has implemented such positions over the course of the 2013 calendar year. Similarly, the University of British Columbia (UBC Vancouver, 2012) and the University of Alberta (Everall, 2013) have adopted a systematic triage process, whereas Queen's University (2012) has called for "a revised triage model" (p. 47) that mirrors that of the University of Alberta (via initial consultation from a nurse). The implementation of these and other changes in Canadian institutions are in accordance with best-practice models from the US, including those of Cornell University (2012) and TJF (2013). Given the novel implementation of these strategies and limited formal evaluation and their usefulness, it remains unclear if/how significantly these changes are facilitating help-seeking and aiding with service demands, although preliminary reports are positive.

The approachability of support services was also highlighted as an important mechanism for dealing with help-seeking barriers. In particular, warm, emotionally available, and culturally sensitive service providers and staff who remain housed in inviting offices and work with students from a strength-based rather than a deficit-based model were called for. These suggestions certainly fit with those put forth by CACUSS and CAMH (2013), who, for example, suggested that institutions need "services and programs that are grounded in strengths-based … principles" (p. 17). Moreover, the need for practitioners that fit these criteria is simply a logical extension of what we already know about helpers generally. For example, when outlining the many qualities of effective therapists, Wampold (2011) identified that "a sophisticated set of interpersonal

skills, including … warmth and acceptance" (p. 3) are central to therapeutic success. Similarly, when discussing what makes a good doctor, Hurwitz and Vass (2002) noted that, "readers from 24 countries responding to a *BMJ* [British Medical Journal] debate about what makes a good doctor allude to desirable personal qualities more prominently than proficiency in knowledge and technical skills" (p. 667). The reality is that interpersonal proficiency is necessary for effective helping and thus, it is only logical that this is extended into university health care settings as a means of promoting help-seeking.

The final structural mechanisms that was endorsed related to communication and the specific need for coordinated, diverse, and strategic efforts within this domain. Similar to many of the other structural mechanisms, organizations and universities see a profound need to consider, reconceptualize, and diversify communication strategies (e.g., CACUSS & CAMH, 2013; Cornell University, 2012; Everall, 2013; TJF & EDC, 2011). Moreover, some of the specific suggestions made by participants in the present study map on to the suggestions documented by alternate organizations. For example, in the present study there was a documented need for personal communication and narratives, which also serves as an important function of the "Half of Us" campaign put forth by TJF (TJF & EDC, 2011).

Like much of the work in this area, we are only starting to see research that examines the effectiveness of new communication strategies on campus. For example, the study previously identified by Joyce and Weibelzahl (2011) reported potential success with texting in order to promote help-seeking among students.

Certainly, as post-secondary institutions modify their communication strategies, additional research will be needed to determine effectiveness.

Systemic mechanisms. In large measure, the systemic mechanisms identified in the present study were grounded in the need for a cultural shift across the institution as a whole. Ideally, a shift towards valuing, prioritizing, and promoting mental health would not only reduce barriers and help generate a culture that values help-seeking, but also serves as a foundation for the generation of a mentally healthy campus, which would alleviate the burden being felt by support services nationwide. An important component of this shift is the reconfiguration of university policy via identification of policies that negatively impact well-being, generation of policies that promote well-being, and consideration around the inclusions of mental health among the institutional values that guide policy development. Policy is central to the overall functioning of the academy and policies often reflect the overarching values that are foundational to its existence. More specifically, as CACUSS and CAMH (2013) aptly pointed out:

> … the broader organizational context has an impact on the wellness of those within it. Institutional structure and policies contribute to its culture by reinforcing certain values, beliefs and behaviours; and discouraging others. How a post-secondary institution is structured and its strategic goals, policies, and practices, therefore impact student health, which in turn, impacts student learning (p. 8).

For this reason, CACUSS and CAMH (2013) have identified assessment of policy as an important foundational element towards the generation of a mentally healthy campus. Similarly, in one of the "spokes" of their mental health framework – "foster a healthy educational environment" - Cornell University (2012) endorses

policy initiatives to be of central importance. Collectively, this suggests that reconsideration of policy serves as a way to strategically change the systemic orientation of a university.

Beyond policy change, there was also a highlighted need for broad, thoughtful, systemic changes that span the institution. This begins with prioritizing mental health. It was identified that campuses can prioritize mental health by first acquiring a better understanding of their respective mental health needs and then developing a mental health strategy for their campus. As identified, we have seen the publication of many such surveys and strategies across Canada since the original conception of this project (e.g., Beagrie, Killick, & State, 2012; Everall, 2013; Queen's University, 2012; UBC Vancouver, 2012).

According to the present study, mental health must also be prioritized by the institution via the injection of funding into mental health initiatives. Naturally, funding for mental health projects and initiatives has been acknowledged as a priority by organizations (e.g., OUSA, 2012) and institutions (e.g., Queen's University, 2012) alike. How an institution can move funding towards mental health initiatives, however, is a challenging question. To that end, Hunt, Watkins, and Eisenberg (2012) conducted research that investigated how funding is apportioned to mental health on university campuses. From their work, it was established that funding for mental health initiatives, programming, and services is accrued through four distinct channels: "a) crises related to mental health, b) data, c) activism, and d) upper-level leadership" (p. 852). More specifically, the authors found that the occurrence of mental health-related crises both on campus

and more globally, data profiling the current state of mental health on campus and in the greater community, powerful activism from various bodies on campus, and buy-in from high-level administrators were important when it came to the direction of funding (Hunt et al., 2012). This research helps to clarify how to feasibly prioritize mental health in the funding structure of the academy.

Another central component of systemic change highlighted in the current study was around increasing the value on wellness. Critical to this was the marrying of well-being and academic success; in other words, it was considered imperative for universities to recognize that students can only be academically successful when their mental health is appropriately attended to. Silverman and colleagues (2008) made a similar suggestion, stating:

> The health and well-being of students – from the broadest perspective – contribute to, and indeed, make possible student success. Health creates capacity; students whose health status is positive and flourishing have greater ability and readiness to learn and engage fully in all meaningful educational experiences inside and outside the classroom (p. 7).

This mindset has, of course, been adopted by some campuses (e.g., UBC's "Live Well Learn Well" campaign; UBC Vancouver, 2012) but further adoption of this idea in institutions across the country is needed and evaluation of its influence is of great importance.

Another important component of increasing the value on wellness was embedding mental health into academic curriculum. It was suggested that this be done through various strategies, including formal learning in a classroom context and informal conversation between faculty and students. Others have suggested this strategy, including Mowbray and colleagues (2006). Moreover, research into

the value of curriculum infusion has begun via the aforementioned work of Mitchell and colleagues (2012), who cited positive outcomes, including increased involvement from faculty in mental health matters on campus. While specific strategies for curriculum infusion are highlighted in the practice implications sections, it is important to recognize, based on the data gathered in this study, that this strategy may potentially generate several benefits, including increased awareness around mental health, normalization of help-seeking, and reduction of stigma.

A final component for systemic change comes through engagement among the many individuals that collectively make up the university populace. In particular, there was a reported need to involve virtually everyone on campus in mental health efforts, and to focus on the generation of a caring, accepting community among this population. Certainly, much of the current literature has called for the involvement of the entire campus in mental health initiatives, or as Owen and Rodolfa (2009) suggest, "campus administration and leadership must view college student mental health as a campus issue, not just a counselling center issue. Everyone on campus should be involved in creating a strong safety net for students" (p.30). The present study, however, provided more specification as to what this may look like, sharing that staff, faculty, and students, *as well as* vendors, contracted service providers (e.g., janitors), and members of the surrounding community need to be involved in supporting and promoting mental health and well-being, supporting students directly in formal and informal capacities, contributing to prevention efforts, and identifying struggling students.

Of course, it was also noted that formalized training efforts are needed with the assignment of such a task, a recommendation that has also received support by many others institutions and organizations (e.g., Cornell University, 2012; Mowbray et al., 2006; Queen's University, 2012; TJF, 2013).

With everyone on board towards supporting a mentally healthy campus, another important activity is building a campus of caring and acceptance. Such a community can be generated through education around mental health and well-being and the fostering of community and interpersonal connections in various capacities. The need for social connection is well-founded in the field of psychology; in a review of the research, Weir (2012) highlighted that social rejection is neurologically experienced in much the same way as physical pain, stating "as far as your brain is concerned, a broken heart is not so different from a broken arm" (p. 50). Moreover, social rejection and isolation leads to reduced functioning, including, for example, impaired mood, intellect, and sleep quality (Weir, 2012). Thus, we know that we need to experience social relatedness and, as we have discovered in this study, this need is paramount for the well-being of a university campus. Not surprisingly, other groups have also highlighted the need for connection in this capacity. For example, both Cornell University (2012) and The Jed Foundation (2013) called for the promotion of "social connectedness" as fundamental to an institution's mental health strategy. Finally, Owen and Rodolfa (2009) suggested that generating a "campus climate of care" is essential for prevention efforts, stating:

> On a college or university campus, students interact with various campus units, creating a network of supportive possibilities … The goal of a

> campus community that cares is to develop a place where students feel welcome; where they can reach their potential in a healthy, supportive environment; and where they can come to a greater understanding of who they are, who they want to be with, and where they are headed in life (p. 30).

Thus, through generating a caring climate, we provide students important building blocks that create the foundation for a healthy academic career. Specific strategies for how to undertake this monumental task are discussed in the practice implications; however, it does not go unnoticed that such a task is vast and requires the participation and efforts of various leaders and advocates.

Practice Implications

An important function of the present study is to inform practice at Canadian universities. Over the past decade, conceptualizing mental health needs and strategies on university campuses seems to have taken the visual form of a pyramid (see Figure 4; see CACUSS & CAMH, 2013; Everall, 2013; Queen's University, 2012; TJF & EDC, 2008; UBC Vancouver, 2012). Across the pyramidal structures used by various institutions, the base of the pyramids appear to represent the collective student body and tasks to better the mental health of the campus as a whole are dictated. As one moves up these pyramids, different strategies are highlighted for smaller, yet more concerning sectors of the student population.

Each level of this pyramid in Figure 4 represents important tasks and ideas for administrators to consider with their respective student populations (CACUSS & CAMH, 2013; Everall, 2013; Queen's University, 2012; TJF & EDC, 2008; UBC Vancouver, 2012). More specially, at the base of the pyramid, it appears

Figure 4. Mental Health Framework

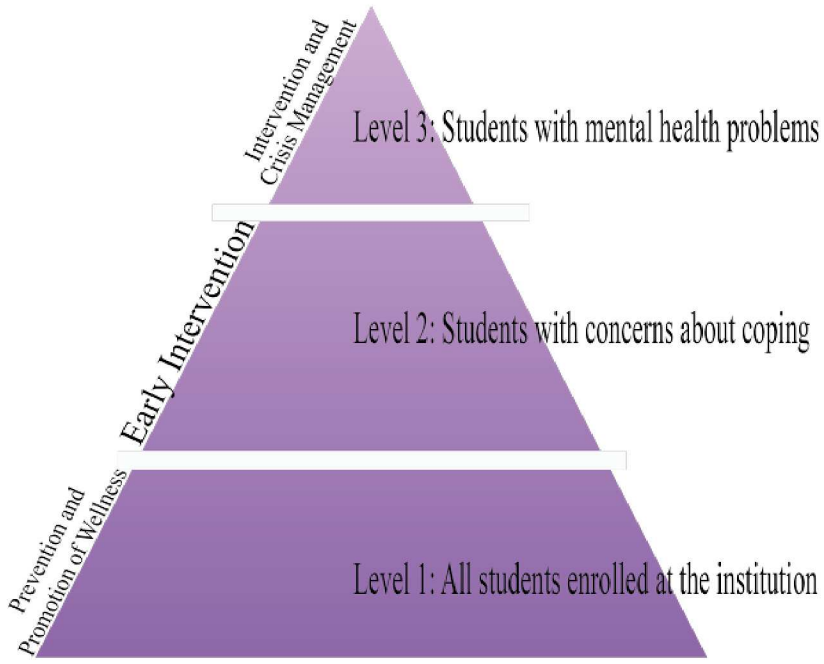

Figure 4. Adapted model from the Canadian Association of College and University Student Services and Canadian Mental Health Association (2013; p. 7), representing the pyramidal mental health framework for Canadian universities.

that many organizations and institutions focus on tasks that contribute to prevention and wellness promotion (CACUSS & CAMH, 2013; Everall, 2013; Queen's University, 2012; TJF & EDC, 2008; UBC Vancouver, 2012). Current models suggest that efforts in this domain may include mental health education, policy review and development, and the fostering of a connected and caring community (CACUSS & CAMH, 2013; Everall, 2013; Queen's University, 2012; TJF & EDC, 2008; UBC Vancouver, 2012). In the middle of the pyramid, organization and institutions seem to focus on tasks that facilitate early intervention efforts (CACUSS & CAMH, 2013; Everall, 2013; Queen's University, 2012; TJF & EDC, 2008; UBC Vancouver, 2012). Efforts in this

domain typically include formalized early identification and early intervention measures, aiding students through transition periods, the promotion of helping from various campus bodies and help-seeking from students, and capacity building (CACUSS & CAMH, 2013; Everall, 2013; Queen's University, 2012; TJF & EDC, 2008; UBC Vancouver, 2012). Finally, at the top of the pyramid, organizations and institutions seem to focus on tasks related to formal intervention and crisis management (CACUSS & CAMH, 2013; Everall, 2013; Queen's University, 2012; TJF & EDC, 2008; UBC Vancouver, 2012). This includes formalized clinical intervention (e.g., counselling and health services) and organized protocols for managing students in crisis (CACUSS & CAMH, 2013; Everall, 2013; Queen's University, 2012; TJF & EDC, 2008; UBC Vancouver, 2012).

Unfortunately, as universities have developed and adapted this pyramidal model to inform their global mental health strategy, they have over-looked the profound influence of help-seeking barriers and service demand issues. In other words, universities have focused on how best to help and serve students, but have ignored that barriers must be shattered and service demand issues must be resolved before students will access the help and services put forth by the institution. Thus, I argue that the model presented in Figure 3 serves as an important precursor to the well-used pyramid model outlined in Figure 4. In essence, the model generated through this study can be offered as a consideration during the establishment of a campus mental health strategy as it provides an important starting place for long-term planning.

In Table 2, I provide a series of suggestions related to each of the structural and systemic mechanisms identified in the present study. In large measure, these suggestions come directly from the ideas put forth by the participants but also relate back to current research and the aforementioned strategies put forth by Canadian institutions and organizations (e.g., CACUSS & CAMH, 2013; Everall, 2013; Queen's University, 2012; TJF & EDC, 2008; UBC Vancouver, 2012). Naturally, when engaging in a process of overcoming barriers and dealing with service demand issues, the well-being of a campus is going to be enhanced. As such, there will certainly be overlap between recommendations offered by the present study and those related to the existing pyramidal model.

Table 2

Practical Suggestions Based on Findings of the Present Study and Current Mental Health Framework Models

Structural Mechanisms
Expanded Focus of Services: • Implement a wellness-oriented service unit that heads efforts around mental-health education, student capacity building, and wellness promotion. On some campuses, this is referred to as a "Wellness Team" or a "Wellness Center." This may include individuals trained in public health promotion and include direct involvement from students. • Potential initiatives from a wellness-based unit may include a wellness peer-to-peer program; information and formal education around study skills, time management, coping, and general life skills; online forum discussions; the development of wellness awareness campaigns, etc. • Education efforts around wellness are needed for staff, faculty, and students. This ensures that messaging around wellness is consistent across the campus. • As a means of focusing services on early intervention, it is important to incorporate an "Early Alert" system similar to that of UBC Vancouver in order to proactively identify students that are struggling. This helps to move services away from being purely reactionary.

- Cornell University and the Jed Foundation offer unique models for how to consider approaching mental health beyond the provision of clinical services and can be used as a guiding document when considering the expansion of services and the need for a broader focus.
- References: CACUSS & CAMH, 2013; Cornell University, 2012; Everall, 2013; Queen's University; TJF, 2013; UBC Vancouver, 2012

Collaboration between Services:

- Support services need to exist under one collective umbrella to allow for consistent direction. There needs to be a close relationship between this umbrella of services and other student-oriented services (e.g., advising, Registrar's Office) to ensure that students are served efficiently and with consistency.
- Senior leadership for support services need to identify mental health as a priority for all service units and subsequently, define specific goals related to mental health. Each support service unit needs to have a clear understanding of how they can contribute to the defined mental health goals.
- Unit directors need to meet on a regular basis to discuss happenings in their respective units; unit directors need to bring this information back to their teams via regular team meetings.
- Staff in each support service unit needs to be educated on the functioning and capacities of fellow service units as part of training and orientation to their positions. This is imperative to ensure that appropriate referrals are made between services.
- Where appropriate, partnerships between units can be fostered to support mental health needs. For example, one campus in the present study identified the need for wellness staff and staff associated with the campus' exchange program to collaborate in order to educate students around the mental health challenges that come with completing an exchange. Partnerships such as these should be routinely considered by unit directors and leadership teams.
- References: CACUSS & CAMH, 2013; Carlton University, 2009; Everall, 2013; Queen's University, 2012

Diversity across Services:

- Consideration around diversifying programming with the help of the student body is needed. Implementation of various peer-to-peer programs needs to be considered. UBC Vancouver offers a plethora of peer-to-peer

options to model after, including peer programs that support academic functioning, social functioning, and wellness.

- Consider the implementation of online programming to support student mental health. This may include online courses to teach students about mental health and/or coping strategies; this may also include online support programming (e.g., communication with wellness staff).
- Consultation between support services and members of various minority groups need to occur to better understand how to effectively offer services to these groups and the ways in which current services are deterring various minority groups. Lobbying for funding based on these suggestions will then need to be considered.
- Consideration around the types of professionals that provide services is needed in order to both maximize financial resources and provide students a plethora of options. For example, hiring social workers may require fewer financial resources than hiring additional psychologists / physicians and students might find such individuals less threatening to approach for help. Considering the use of interns and practicum students in various support domains (e.g., social work, nutrition, physical education) may also have similar implications.
- References: CACUSS & CAMH, 2013; Everall, 2013; Queen's University, 2012; UBC Vancouver, 2012

Enhanced Coordination of Services:

- Case managers are needed for students that require more complex and coordinated care (e.g., students who require mental health, medical, and academic support). Case managers are also important for students who are in crisis and require long-term care in the community, withdrawal/re-entrance privileges to the academy, or the support of various on campus services.
- The referral process that exists between support services needs to be streamlined such that it is clear where a student is coming from, why they are being referred, and what services have already been offered. Follow-up between referring and receiving bodies is also an important part of this process. This will require consultation with privacy officers on individual campuses to determine legalities around the sharing of information.
- In order to determine the extent of students' mental health challenges, all professionals involved in assessment and treatment decisions should use consistent measurement tools to ensure diagnosis and treatment planning are consistent across campus.

- In order to maximize the benefit of group services, group therapy and workshop programming should target only the most prevalent issues on campus (e.g., depression, anxiety, stress, relationship issues, etc.).
- Students need to be provided timely access to care; an important component of this is making care easily accessible. Providing mental health services in faculties / departments might encourage more immediate use by students. This may take the form of satellite psychologists, mental health and wellness coordinators, or advisors, for example.
- Crisis management needs to be coordinated and streamlined and include a designated interdisciplinary team.
- References: CACUSS & CAMH, 2013; Carlton University, 2009; Cornell University, 2012; Everall, 2013; Queen's University, 2012; TJF, 2013; UBC Vancouver, 2012

Implementation of Practical Changes:

- Counselling service offices need to implement a triage system whereby intake staff (e.g., nurse) direct students to appropriate services.
- Support service offices need to be open during hours that are conducive to student schedules. This includes varying evening hours and potentially weekend hours.
- It is important that students have access to 24/7 support and that awareness of this support is expanded across the campus. This type of support may be in the form of a distress line or all-hours walk-in clinic. Partnering with existing community resources may allow for a reduction of the financial burden associated with such resources.
- Partnerships with community resources need to be strengthened such that cost for community-based services can be subsidized to minimize the financial burden felt by students who require services. Current coverage in student insurance plans may need to be renegotiated to support community-based care.
- A rapid access (i.e., walk-in) model for mental health care needs to be implemented in on campus counselling clinics such that students can be seen by mental health service providers at any time with a minimal wait.
- Counselling centres need to adopt a brief counselling model in order to serve the greatest number of students using the allocated resources. In the present study, "brief" models were defined by some institutions as six session and by other as sixteen sessions. Consideration needs to be provided to available resources, demand, and quality of care when deciding on session limits in order to prevent the generation of additional barriers.

- The location of support services needs to be accessible to students, while still providing a sense of confidentiality. While some argued that "hiding" support services contributes to the sense of stigma, the privacy of students needs to be respected. It is recommended that the student body as a whole be consulted on their preference for the location of support services.
- Students need to be provided easy methods of appointment booking and communicating with service providers. Use of online booking programs and secure online communication channels may be an asset.
- Of course, there needs to be ongoing efforts to lobby for funding in order to support the continual growth of staff in support service units.
- Counselling centres can be encouraged to utilize group programming where feasible. Group programming should never replace individual interventions as some students require anonymity and moreover, certain presenting issues call for one-on-one treatment.
- References: CACUSS & CAMH, 2013; Everall, 2013; Queen's University, 2012; UBC Vancouver, 2012

Focus on Making Services More Personable and Approachable:

- Support service personnel need training on how to orient language, goals, and services towards a strength-based rather than deficit-based perspective.
- Conscious efforts need to be made around staffing choices for support services, such that warm, sensitive, judgement-free staff being hired where possible. This includes service providers and administrative staff.
- The names of support service offices need to be considered such that they are inviting to students (e.g., "The Health & Wellness Centre" rather than "Counselling & Disability Services").
- The physical space of support offices needs to be inviting and comfortable for students. This includes, for example, warm décor, comfortable furniture, appropriate lighting, etc.
- References: CACUSS & CAMH, 2013; Everall, 2013; TJF, 2013

Coordinated, Diverse, and Strategic Communication:

- Consistent and similar messaging must be sent to students via a plethora of methods, including email, social media, websites, posters, flyers, smartphone apps, pamphlets, text messages, newspapers, mental health campaigns, post-its on exams, in-person communications, and messaging in high-traffic areas (e.g., bathrooms).
- Communication strategies that involve personal components need to be implemented. This may include for example, video vignettes or posters

that portray stories of help-seeking from students, staff, or faculty who have faced mental health or psychological challenges.

- It is recommended that support services assign a communications coordinator for all units to ensure communication strategies are consistent. This individual would also work with communication representatives from each of the faculties to embed communication from support services into existing faculty / department communication with students (e.g., department newsletters; course outlines).
- Communications coordinators need to gather student feedback around communication strategies; this may be completed via focus groups, online surveys, informal conversation, etc.
- Websites need to be simple and straightforward. They need to provide students with information on available services, as well as information about how to access services, the function of services, and what help-seeking may look like. An example of this may be a website entitled "ineedhelp.institutionname.com" which takes users through a series of options, ultimately leading to a roadmap of what help-seeking may look like.
- Institutions need to be strategic around the timing of broad communication efforts (e.g., awareness campaigns). It was repeatedly acknowledged that inundating students during the first weeks of the semester is ineffective. Moreover, it is important to consider when mental health information is more pertinent to students based on semester stressors (e.g., November; March) and offer communication at this time.
- Regular and on-going communication between faculty and support services is essential in order to ensure consistency of messaging. This may occur best through staff such as satellite psychologists, mental health and wellness coordinators, or advisors, as mentioned previously.
- References: Cornell University, 2012; Everall, 2013; Queen's University, 2013

Systemic Mechanisms

Write/Rework Policy to Support Mental Health:

- Support services and faculty need to examine current policy to determine the scope of influence on mental health and recognize where policy detracts from well-being. Consideration around academic concession, accommodation, and evaluation may be particularly important to consider. Related to this are policies around financial reimbursement for students who need to withdraw from one or all classes due to mental health issues.

- Support services and faculty need to consider the implementation of policy that promotes mental health and well-being. This may include implementing policy around the structure of course programming (e.g., workload and time demands), evaluation (e.g., exam weights), program requirements (e.g., required courses), and course scheduling (e.g., cumulative difficulty of each semester).
- Leaders in support services need to work with senior administration to provide education around mental health in order to promote future policy development that supports rather than detracts from mental health and well-being. This will need to include information around the current state of mental health respective to the campus and systemic goals for mental health.
- References: CACUSS & CAMH, 2013; Cornell University, 2012; Everall, 2013; Queen's University, 2012; UBC Vancouver, 2012

Broad, Thoughtful Systemic Changes: Prioritize Mental Health:

- Efforts to better understand the current state of mental health on campus are needed. Given the research orientation of universities, it is feasible for these efforts to be led by faculty with related research interests. Gathering such information needs to occur through various facets in order to ensure much of the campus has the opportunity to be heard. Forums, online surveys, focus groups, informal conversations, and in-class surveys are some potential strategies to begin with.
- Using information garnered from the campus population, it is also important that a task force be identified in order to develop a campus mental health strategy much like the ones discussed in this project. These individuals need to be responsible for identifying reasonable strategies for their respective campus in order to better the mental health of everyone. Strategies for the three tiers of students identified in Figure 4 are an important component to consider in the development of such a document. It is important to use leaders in the field (e.g., Cornell University) to help guide this process.
- Using information generated from the aforementioned tasks, it is important that senior university administration (e.g., president, provost) be made aware of the importance of mental health and well-being on campus and define the betterment of campus mental health as a strategic priority. In turn, it is imperative that central administration use this awareness to increase funding for mental health initiatives on campus.

- Senior administration from support services and central administration will need to continually investigate alternate sources of funding for mental health initiatives from local, provincial, and federal bodies.
- References: CACUSS & CAMH, 2013; Cornell University, 2012; Everall, 2013; Queen's University, 2012

Broad, Thoughtful, Systemic Changes: Involve Everyone in Mental Health:

- Stemming from the messages and established priorities of senior administrators, it is important for all members of the university community to recognize their role in supporting student mental health and well-being. This includes staff, faculty, students, vendors, TAs, administrators, contracted professionals, and so on. Some of the ways in which this responsibility can be delineated include: identifying struggling students, becoming involved in prevention efforts put forth by students and support services, promoting wellness formally and informally, and serving as an informal source of support.
- Deans and department chairs (via the direction of senior administration) need to highlight the roles and responsibilities of faculty in relation to mental health. Existing faculty need to be provided optional training and new faculty need to be provided mandatory training around supporting student mental health. This may include information about support services on campus, how to refer students to services, how to identify students that are struggling, and how to get involved in broad campus efforts.
- Faculty needs to be encouraged to consider how they are contributing to student well-being. Faculty are encouraged to normalize psychological challenges, serve as an approachable resource for students, and develop healthy classroom environments via the structure and design of their courses and evaluations methods.
- Similar training to that offered to faculty is also recommended for staff. Staff can also serve as important facilitators to help-seeking. It is important that staff understand how to identify and respond to students who are struggling with mental health issues.
- The student body needs to be central in the promotion of campus mental health. This may include the implementation of peer-to-peer programming, supporting the development of related student groups, or involving students in decision making around mental health initiatives and programming.
- It is important that support services develop partnerships with outside community services. The purpose of these relationships may be to support

the mental health of the campus through the provision of financial resources and/or services; in addition, the relationships can help to ensure that campus and broad community objectives correlate.
- It is imperative that mental health efforts be regularly directed by student service administration such that the process is strategic and clear.
- References: CACUSS & CAMH, 2013; Carlton University, 2009; Cornell University, 2012; Everall, 2013; Mowbray et al., 2006; Queen's University, 2012; TJF, 2013

Broad, Thoughtful, Systemic Changes: Build Community of Caring and Acceptance:

- Normalization of mental health challenges needs to become an institutional priority. Indeed, this is going to come through education efforts similar to those described throughout this table, including for example, awareness weeks, websites, formal and informal dialogues, and classroom learning. Normalization will also occur at the hands of staff and faculty who create space in their learning environments or offices for positive mental health discussion.
- Building a sense of community on campus also needs to become an institutional priority. It is important to first capitalize on pre-existing opportunities for social inclusion, including those that exist in residence, athletics, student groups and clubs, and small classes. In addition, it is important that new opportunities to create connection be generated through campus events, the creation of opportunities for involvement, involving the campus body in collective goals, and the generation of physical spaces that promote connection.
- Building a community of caring may also occur through a "How are you?" campaign where student are encouraged to reach out to their fellow peers and show interest in the well-being of one another rather than exist purely in competition.
- References: CACUSS & CAMH, 2013; Cornell University, 2012; Owen & Radolfa, 2009; Queen's University; TJF, 2013; UBC Vancouver, 2012

Broad, Thoughtful, Systemic Changes: Increase Value on Wellness:

- Students need to be taught through formal messaging, modeling from staff and faculty, and campus-wide messaging that self-care, wellness, and help-seeking are important and valuable skills.
- Messaging on campus needs to reflect the idea that health and well-being and academic success are connected. UBC's "Live Well Learn Well" campaign is a strong example of how this may occur. At the level of

senior administration, it is important that attention be paid to the connection between health and well-being, academic success, and student retention.

- Mental health efforts need to be embedded into the academic sphere of the university, given that this is the primary focus for much of the student body. Formal means of this task may include the implementation of a for-credit, mandatory course that introduces students to information around mental health, coping, self-care, and help-seeking. Alternately, the inclusion of such information into pre-existing courses or course syllabi may also be important avenues to explore. More informal methods, including conversation around these topics in lectures, labs, and seminars may also be valuable.
- It is important that the university as a whole adopt an "open door policy" such that help-seeking is considered safe at any access point (e.g., from a professor, from a staff member, from a support service unit, and so on).
- Identifying wellness as a priority may also come through the creation of a dedicated Wellness Centre as identified previously. This could serve as the hub for wellness promotion efforts and contribute to the education efforts described throughout.
- References: CACUSS & CAMH, 2013; Cornell University, 2012; Everall, 2013; Mowbray et al., 2006; Queen's University, 2012; Silverman et al., 2008; UBC Vancouver, 2012

Study Considerations and Future Research

It is important to bring attention to specific study considerations. First, in the present study, data was collected from three Canadian institutions. Although these institutions do reflect the broader post-secondary climate in Canada, it is impossible for the present study to fully highlight the individual climates and structures that come with the various models of post-secondary education that exist in our nation (e.g., college versus university, religious versus not religious schools, private versus public, etc.). Thus, readers are encouraged to consider the transferability of the findings relative to the unique characteristics of their respective institution. As this study was completed with large institutions, future

research can be conducted to better understand barriers and mechanisms specific to smaller institutions including, for example, rural universities or colleges, primarily undergraduate institutions, and so on.

Secondly, it is also important to recognize that the present study was exploratory in nature. As such, the study certainly generates a multitude of future research questions to explore from a qualitative as well as a quantitative capacity. To enhance the validity of the present study, it is recommended that both qualitative and quantitative investigations at both the local and national level be completed going forward.

Lastly, the sample in the present study was female-dominant. Although this was unavoidable given the nature of the sampling strategies, it is important to recognize that the findings may be skewed away from male perspectives. While this may not be overly problematic with respect to the staff population (as support services are largely female-dominant), it certainly presents some potential discrepancy within the student population. Going forward, it is important that quantitative research involves large, random samples in order to effectively understand the perspectives of the population.

Researcher Reflections and Conclusion

The present project answered important questions related to Canadian post-secondary student mental health. In particular, in response to the aforementioned research questions, this study provided a conceptual model of the individual, systemic, and structural barriers to access faced by students and the structural and systemic mechanisms needed to overcome these barriers and meet

current services demands. Thus, it is clear that the reasons students fail to seek help are multi-faceted and span many layers of the university system. Subsequently, it comes as no surprise that the mechanisms to overcome barriers and meet service demands are just as broad.

The present project was both rewarding and challenging. As a long-term student myself, I have been personally exposed to many of the shortcomings that exist around student services. On the other side of that, however, I have seen how deeply students can be impacted when the right group of people work together and rally for the betterment of student well-being. Thus, even though I see the findings of this project as somewhat daunting and overwhelming, I find comfort in knowing that it does not take much to impact a single student and thus, every step forward, no matter how big or small, has meaning and value.

Going forward, universities have their work cut out for them. The current state of affairs on campuses is startling, but we can hold hope in the fact that changes are being made and progress is being observed. Underlying a successful future for university students is the need for a broad cultural shift towards the true valuing of mental health and wellness. I appreciate that this task is currently aspirational and more importantly, is monstrous in nature; it is one that will involve time, the efforts of strong leaders, endless hard work from staff and faculty, the lobbying for money in tough financial times, the buy-in of a community, challenging reflection on current practices, and a complete reorganization of a university culture. However, it is through this shift that we will generate a healthier student body; from there, we set students up to thrive.

Arguably a university is responsible for educating the citizens of the future; I challenge universities to consider what they want our citizens of tomorrow to look like and consider that when defining the priorities of the institution.

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Appendix A

Are you a FULL-TIME STUDENT?

Are you interested in PARTICIPATING IN A RESEARCH STUDY about help seeking & campus support services?

We are looking to conduct **1:1 interviews** to determine what **prevents students from seeking help on campus** and how **support services can be modified** to better meet the needs of students.

Interviews will be 1-2 hours in length. The interviews will be **confidential** and can be completed on campus, over the phone, or via Skype.

For more information or if you are interested in participating, please contact Erica Lauridsen at lauridse@ualberta.ca or 780.850.0561.

This study has been approved by the Research Ethics Board.

Erica Lauridsen (Research Study) lauridse@ualberta.ca
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Appendix B

Sample Facebook or Online Classified Advertisement:

WE NEED **YOUR** HELP!

Are you a FULL-TIME STUDENT studying at the University of Alberta[1]? Are you interested in PARTICIPATING IN A RESEARCH STUDY about help-seeking & campus support services?

We are looking to conduct **1:1 interviews** to determine what **prevents students from seeking help on campus** and how **support services can be modified** to better meet the needs of students.

Interviews will be 1-2 hours in length. The interviews will be **confidential** and can be completed on campus, over the phone, or via Skype.

For more information or if you are interested in participating, please contact Erica Lauridsen at lauridse@ualberta.ca **or 780.850.0561.**

This study has been approved by the Research Ethics Board

1. **Name changed depending on the particular school.**

Appendix C

Information Form

Study Title: Overcoming Help-Seeking Barriers and Service Demands on Canadian University Campuses & the Role of Campus Support Services

Principal Researcher:
Erica Lauridsen, M.Ed.
Department of Educational Psychology
University of Alberta
(780) 850-0561
lauridse@ualberta.ca

Supervising Researcher:
Dr. Robin Everall, Ph.D
Professor
University of Alberta
(780) 492-1163
robin.everall@ualberta.ca

You are invited to participate in a research study being conducted by Erica Lauridsen in order to fulfil the dissertation requirement for the Doctor of Philosophy degree in Counselling Psychology. The purpose of this study is to answer three key questions – a) What are the barriers identified by administrators and students that prevent Canadian students from seeking help for psychological issues on university campuses?, b) What mechanisms are currently being used by universities to address the help-seeking barriers and service demands on their campuses?, and c) What policy and practice changes are still needed in order to address help-seeking barriers and service demands? This topic is being explored through the lens of both students and university staff and administrators. This study will ultimately be able to inform practice at Canadian universities through providing a series of service provision strategies that address the needs and help-seeking preferences of today's students.

Data will be collected through the completion of confidential interviews that will be approximately one to two hours in length. Interviews will be based upon a guided list of questions that will be emailed to you prior to participation. Additional conversation and exploration of responses will occur in order to fully understand your perceptions. Interviews will be completed in private, during in-person, telephone, or Skype meetings and will be audio-recorded for future transcription by a hired transcriptionist.

Once data analysis for the present study is complete, you will be contacted again by the principal investigator (via email or phone) to assess the accuracy of the data analysis. Any input given at this time is completely voluntary and not a requirement of participation.

Your information, and any information you share, will be private, anonymous, and confidential. The only people who will have access to the data you provide are the researchers identified above, the transcriptionist, and the Research Ethics Committee. You will be given a pseudonym that will be attached to all of your data and thus your legal name will *not* appear in any notes, transcriptions, reports,

publications, or presentations resulting from this study. Further, the transcriptionist will sign a confidentiality agreement to ensure that your information is held in strict confidence. In addition, all electronic data will be encrypted. All data will be kept for a period of 5 years after the study is completed and will be securely stored in a locked office, to which only authorized researchers have access. After this period, the data will be destroyed; all electronic data will be deleted and all hard data will be shredded.

Data will be disseminated through professional conferences and through publication in scholarly journals. Because all identifying information will be removed from the data and pseudonyms will be used, your anonymity will be ensured when dissemination occurs. Should you wish to receive any publications related to the present study or if you wish to comment about the research, please contact Erica Lauridsen at lauridse@ualberta.ca or 780.850.0561.

Your participation in this study will help to inform future practices on Canadian university campuses. There are no anticipated costs to you and no foreseeable risks associated with participation. However, should any unforeseeable issues arise, you are encouraged to contact either the principle investigator or the supervising professor, either of whom can refer you to appropriate services.

Participation in this study is entirely voluntary. Should you have any questions or concerns about your participation at any time throughout the course of this study, please contact Erica Lauridsen or Dr. Robin Everall using the contact information above. Please be aware that you have the right to not participate and/or you may withdraw from the study at any point without penalty. If you choose to withdraw from the study, your data will not be included in any way. All data collected will be deleted from any electronic databases and all hard data will be shredded.

If you have concerns about this study, you may contact the Research Ethics Office at 780.492.2615. This office has no direct involvement with this project.

Thank you for your consideration.

_____

Erica Lauridsen, B.A., M.Ed.
Doctoral Student
Department of Education Psychology
University of Alberta
Edmonton, Alberta, Canada

Appendix D

Demographic Information

Study Title: Overcoming Help-Seeking Barriers and Service Demands on Canadian University Campuses & the Role of Campus Support Services

Pseudonym: _____

Current Age: _____

Occupation (e.g., "student" or position title):_____

Number of years in current occupation: _____

Years involved at current university: _____

For Students Only:

What other universities have you attended: _____

Highest level of education: _____

For Staff Only:

How long have you been involved in university administration: _____

How many other universities have you worked for: _____

Is student services an important part of your portfolio:

Yes No

Highest level of education: _____

Do you have any other professional designations (e.g., registered psychologist?

_____

_____

Appendix E

Consent Form

Study Title: Overcoming Help-Seeking Barriers and Service Demands on Canadian University Campuses & the Role of Campus Support Services

Principal Researcher:
Erica Lauridsen, M.Ed.
Department of Educational Psychology
University of Alberta
(780) 850-0561
lauridse@ualberta.ca

Supervising Researcher:
Dr. Robin Everall, Ph.D
Professor
University of Alberta
(780) 492-1163
robin.everall@ualberta.ca

You are invited to participate in a research study being conducted by Erica Lauridsen in order to fulfil the dissertation requirement for the Doctor of Philosophy degree in Counselling Psychology. The purpose of this study is to answer three key questions a) What are the barriers identified by administrators and students that prevent Canadian students from seeking help for psychological issues on university campuses?, b) What mechanisms are currently being used by universities to address the help-seeking barriers and service demands on their campuses?, and c) What policy and practice changes are still needed in order to address help-seeking barriers and service demands? This topic is being explored through the lens of both students and university staff and administrators. This study will ultimately be able to inform practice at Canadian universities through providing a series of service provision strategies that address the needs and help-seeking preferences of today's students.

Data will be collected through the completion of confidential interviews that will be approximately one to two hours in length. Interviews will be based upon a guided list of questions that was emailed to you prior to participation. Additional conversation and exploration of responses will occur in order to fully understand your perceptions. Interviews will be completed in private during in-person, telephone, or Skype meetings and will be audio-recorded for future transcription by a hired transcriptionist.

Once data analysis for the present study is complete, you will be contacted again by the principal investigator (via email or phone) to assess the accuracy of the data analysis. Any input given at this time is completely voluntary and not a requirement of participation.

Your information, and any information you share, will be private, anonymous, and confidential. The only people who will have access to the data you provide are the researchers identified above, the transcriptionist, and the Research Ethics Committee. You will be given a pseudonym that will be attached to all of your data and thus your legal name will *not* appear in any notes, transcriptions, reports, publications, or presentations resulting from this study. Further, the transcriptionist will sign a confidentiality agreement to ensure that your information is held in strict confidence. In addition, all electronic data will be encrypted. All data will be kept for a period of 5 years after the study is completed and will be securely stored in a locked office, to which only authorized researchers have access. After this period, the data will be destroyed; all electronic data will be deleted and all hard data will be shredded.

Data will be disseminated through professional conferences and through publication in scholarly journals. Because all identifying information will be removed from the data and pseudonyms will be used, your anonymity will be ensured when dissemination occurs. Should you wish to receive any publications related to the present study or if you wish to comment about the research, please contact Erica Lauridsen at lauridse@ualberta.ca or 780.850.0561.

Your participation in this study will help to inform future practices on Canadian university campuses. There are no anticipated costs to you and no foreseeable risks associated with participation. However, should any unforeseeable issues arise, you are encouraged to contact either the principle investigator or the supervising professor, either of whom can refer you to appropriate services.

Participation in this study is entirely voluntary. Should you have any questions or concerns about your participation at any time throughout the course of this study, please contact Erica Lauridsen or Dr. Robin Everall using the contact information above. Please be aware that you have the right to not participate and/or you may withdraw from the study at any point without penalty. If you choose to withdraw from the study, your data will not be included in the present study in any way. All data collected will be deleted from any electronic databases and all hard data will be shredded.

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Research Ethics Board (REB 1) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Coordinator of the REB 1 at (780) 492-2615.

I agree to participate in the study "Overcoming Help-Seeking Barriers and Service Demands on Canadian University Campuses & the Role of Campus Support Services" conducted by Erica Lauridsen and Dr. Robin Everall of the University of Alberta. I have come to this decision based on the information provided above and I have been given the opportunity to ask any questions that I may have regarding the study. I understand that I am able to withdraw this consent at any time and through doing so I will not receive any penalty. I also understand that all information will be audio-recorded in the present study in order to ensure the integrity of the data.

I understand that this study has been reviewed for its adherence to ethical guidelines and approved by the Research Ethics Board (REB 1) at the University of Alberta. I also understand that I may contact this office if I have any comments or concerns resulting from my participation in this study.

Name: _____

Signature: _____

Date: _____

Witness Signature: _____

NB: One copy is to be kept by you, and the other is to be returned to the researcher.

Appendix F

Interview Guide – Students

Study Title: Overcoming Help-Seeking Barriers and Service Demands on Canadian University Campuses & the Role of Campus Support Services

Thank you for taking the time to meet with me today. To start off, I just wanted to provide you with some information about the nature of this study. The purpose of this study is to answer three key questions – a) What are the barriers identified by administrators and students that prevent Canadian students from seeking help for psychological issues on university campuses?, b) What mechanisms are currently being used by universities to address the help-seeking barriers and service demands on their campuses?, and c) What policy and practice changes are still needed in order to address help-seeking barriers and service demands To start off, do you have any initial thoughts related to these questions or anything that initially comes up?

The following questions will also be asked during the duration of the interview:

- What, if any, interactions have you had with campus support services?
- Have you ever felt like you were in need of support services, like counselling, career guidance, health care, etc. for psychological issues? In no, what about a close friend?
    - Did you / they seek these services?
        - If yes, did you / they seek services on or off campus and why?
        - If no, why did you / they choose not to seek services?
- Research shows that up to 90% of students do not seek help for mental health and psychological issues. What are your thoughts on this?
- Do you have any thoughts around what prevents students, in general, from seeking help on campus for psychological problems?
    - What would you say are the major barriers to help-seeking faced by university students?
- Universities are well-aware of the fact that many students fail to see help on campus; however, universities are also struggling to keep up with the current demand of students seeking help. What do you think universities are doing to change this?
    - Have you noticed any changes on your campus with respect to support services, promotion of use of support services?
    - With respect to support services, what is working on campus? What do you think is really helping students to seek help?
- With respect to support services on campus, what do you think needs to change in order to better meet the needs of students?
    - How do you think support services should be structured?
    - What support services should be involved in preventing and treating mental health problems on campus?
    - How do you think information about support services should be communicated to students?
    - What would make support services more user-friendly or accessible for students?
- Do you have any additional comments that you'd like to share?

Appendix G

Interview Guide – Staff/Administrators

Study Title: Overcoming Help-Seeking Barriers and Service Demands on Canadian University Campuses & the Role of Campus Support Services

Thank you for taking the time to meet with me today. To start off, I just wanted to provide you with some information about the nature of this study. The purpose of this study is to answer three key questions – a) What are the barriers identified by administrators and students that prevent Canadian students from seeking help for psychological issues on university campuses?, b) What mechanisms are currently being used by universities to address the help-seeking barriers and service demands on their campuses?, and c) What policy and practice changes are still needed in order to address help-seeking barriers and service demands? To start off, do you have any initial thoughts related to these questions or anything that initially comes up?

The following questions will also be asked during the duration of the interview:

- Can you tell me about your role and how you interact with the various support services on your campus?
- Research shows that up to 90% of students do not seek help for mental health and psychological issues. What are your thoughts on this?
- Do you have any thoughts around what prevents students, in general, from seeking help on campus for psychological issues?
    - What would you say are the major barriers to help-seeking faced by university students?
- As you are probably well-aware, university counselling and health services are being taxed despite the fact that many students fail to seek help for their psychological problems. What mechanisms are being used by your campus to address both of these problems (i.e., the barriers to help-seeking and the burden felt by certain campus services)?
    - What or whom was the driving force behind these approaches? How were these decision made?
    - Who has been involved in driving these mechanisms?
    - How are students and staff responding to these approaches?
- With respect to support services, what is working on campus? What do you think is really helping students to come forward and seek help? What is helping tackle the demand issues?
- With respect to support services on campus, what do you think needs to change both at a policy and a practice level in order to better meet the needs of students?
    - Ideally, how do you think support services should be structured?
    - What services should be involved in the prevention and treatment of psychological problems on university campuses?
    - Are there other universities that have support structures that you think are desirable? Why do you think their model is successful? How can this model be adapted by other universities?
    - How do you think information about support services should be communicated to students?
    - What would make support services more user-friendly or accessible for students?
    - What are the perspectives of both students and other staff with respect to this issue?
- Do you have any additional comments that you'd like to share?

Appendix H

Confidentiality Agreement

Study Title: Overcoming Help-Seeking Barriers and Service Demands on Canadian University Campuses & the Role of Campus Support Services

I, _____, the transcriber, have been hired to transcribe the data provided within the interviews.

I agree to -

1. Keep all the research information confidential by not discussing or sharing it in any form or format (e.g., audio files, transcripts) with anyone other than Erica Lauridsen and Dr. Robin Everall.

2. Keep all research information in any form or format (e.g., audio files, transcripts) secure while it is in my possession. I will save data only on the provided USB and encrypt all transcripts so it is only accessible by me and the research team.

3. Return all research information in any form or format (e.g., audio files, transcripts) to Erica Lauridsen or Dr. Robin Everall when I have completed the research tasks.

4. After consulting with Erica Lauridsen and/or Dr. Robin Everall, erase or destroy all research information in any form or format regarding this research project that is not returnable to Erica Lauridsen and Dr. Robin Everall.

_____	_____	_____
(Print Name)	(Signature)	(Date)

Primary Investigator:

_____	_____	_____
(Print Name)	(Signature)	(Date)