2022

Mental Health in America: The Case of UVM and Collegiate Mental Health Services

Elias Anders Colberg
University of Vermont Undergraduate

The Case of UVM and Collegiate Mental Health Services

MENTAL HEALTH IN AMERICA

Elias Colberg

University of Vermont

Mental Health in America: The Case of UVM and Collegiate Mental Health Services

Author: Elias A. Colberg

University of Vermont, Undergraduate, Spring 2022

Primary Advisors: Prof. Sayamwong (Jom) Hammack and Prof. Dale Jaffe (ret.)
Readers: Profs. Mary Burke and Jay Silveira

College of Arts and Sciences
Department of Sociology: Individually Designed Major Thesis
The University of Vermont Honors College Thesis

Table of Contents

Abstract:

Introduction:

The Centre for Mental Health (CMH) cites evidence that "60% of disability experienced by those aged 15-34 years is caused by mental illness; as such, it represents a major burden of disease for this age group and should be a public health improvement priority (Khan, 2016)." This thesis aspires to provide an overview of the current mental healthcare systems, and their known weaknesses, within the United States and its colleges and universities before delving into the specific mental healthcare systems and issues at the University of Vermont (UVM). I then aim to offer potential improvements for UVM's mental healthcare system through concrete and affordable recommendations to increase the resiliency and decrease the vulnerability of the university's students.

Methods:

I utilized publicly accessible sources of information about the mental healthcare system; several electronic databases were scoured for reliable information regarding mental health, mental ill-health, and the mental healthcare systems of the U.S. and its institutions of higher learning. Next, I subjected this information to qualitative analysis via a case study of UVM. Existing programs at other universities were then used to provide recommendations for improvements at UVM.

Conclusion:

The mental healthcare services at UVM appear to strive towards a goal of excellence, which places them above the general U.S. mental healthcare system. The current system of providers, locations, and patients provides an established framework for a potentially effective system. However, there remain avenues for university officials to obtain an increased understanding of the efficacy and impact of the mental ill-health situation, care models, and communications on campus. Hopefully, especially with continued student efforts to push our university towards excellence, we will witness the continued improvement of student resiliency and quality of life in the coming years at UVM.

Methodology:

Selection of Studies:

I independently searched publicly accessible electronic databases, including Google Scholar, CATQuest, PubMed, ScienceDirect, U.S. National Library of Medicine, and Google, for scholarly articles focusing on information and studies from peer-reviewed journals, reliable news sources, or first-hand accounts from students. Reference lists of retrieved papers, sites, and sources were also examined for relevant articles—inclusion of sources determined by relevancy to topics discussed. Due to the inherent biases of first-hand accounts, I attempted to corroborate all first-hand accounts with academic sources. A complete list of search terms was not maintained but included: The University of Vermont, Stepped-Care Model, Healthcare Systems in America, Mental Healthcare Systems in America, Mental-Ill Health, Mental Health Research, University Mental Health, Effectiveness of Psychological Therapies, UVM Suicide, UVM CAPS, COVID-19 Mental Health, Impacts of COVID-19 Healthcare, Mental Health Stigmatization, and Improvements College Mental Health.

Selection of University Webpages:

I utilized links from UVM websites to obtain additional relevant pages/information sources. I independently searched the University of Vermont Webpage utilizing the search terms: Mental Health, CAPS, Anxiety, Depression, Stress, and Access. All found pages on mental health, substance abuse, and sexual assault were entered into the Excel table.

Excel Table of the University of Vermont's Services:

See Excel document. Document available upon request to the author.

Interview Method:

To obtain a further understanding of university policies, procedures, and general statistics surrounding mental health, an interview with John Paul Grogan, the Interim and Outreach Director at Counseling and Psychiatry Services, was obtained. A qualitative, semi-structured, approximately one-hour-long interview was conducted with the main topics of the University of Vermont's mental health services, UVM's integration within Vermont's mental health services, challenges faced by UVM mental health services, and ongoing improvements to mental health services at UVM. This semi-structured, qualitative interview method was selected due to its ability to be open-ended and provide previously unseen information (Harvard University, 2012). Permission for recording was obtained from John Paul Grogan and is available upon request to the author. No patient information nor specific patient data was discussed. Considerations of an interview were discussed and approved by Prof. Dale Jaffe and Prof. Jom Hammack. Due to John Paul Grogan's position as a University Official and the topic of discussion being mental healthcare systems, rather than his (or any specific student's) personal mental health, an IRB review was not required.

Analysis:

This report only focuses on the services available to UVM students, i.e., services that UVM directly provides, primarily regarding mental health, substance abuse, and sexual assault.

These areas were selected due to their significant proclivity for drastically affecting the mental health of individuals. Data from University Webpages was put into an Excel Table under the categories of services provided/description, mental health-specific, modalities of care, hours of operation, contact, licensure level of providers, number of providers, Vermont service, National service, and UVM service. Selected services, data obtained from publicly accessible journals, news sources, first-hand accounts, and data obtained from the interview were subjected to further qualitative review and analysis via the case-study method. The utilization of a case study is justified since "the case study method is an extremely useful technique for researching relationships, behaviors, attitudes, motivations, and stressors in organizational settings (Bruce L. Berg, 2012)."

All information is accurate to the best of the author's knowledge as of April 28, 2022.

Introduction:

On September 12, 2015, Harvard second-year Luke Tang died by suicide during Harvard's Fall semester (Kella, 2021). He was an impressive violinist and excellent mathematician who demonstrated significant academic prowess within the physics department. However, this exhaustive combination of academics and expectations forced him to attempt to take his life in his first year at university before passing away in his second year. His death motivated Harvard to re-address the mental health needs of their students to prevent suicide. Likewise, mental health and its delivery systems within the United States and at the University of Vermont have recently received a renewed focus.

Historical Context of Mental Health:

Historically, the definition of mental ill-health varies depending on the era and location of an individual. As Ingrid G. Farreras wrote, "Whether a behavior is considered normal or abnormal depends on the context surrounding the behavior and thus changes as a function of a particular time and culture. In the past, uncommon behavior or behavior that deviated from the sociocultural norms and expectations of a specific culture and period has been used as a way to silence or control certain individuals or groups. (Farreras, 2019)"

One of the earliest examples of mental illnesses existed within cave dwellers when they utilized a technique known as "trephination, in which a stone instrument known as a trephine was used to remove part of the skull, creating an opening…from as early as 6500 BC. (Lumen Learning, 2019)" Researchers infer that these cave dwellers believed the surgical drilling of these holes would allow for the treatment of head injuries, epilepsy, and to allow for "evil spirits" trapped within the skull to be released.

In Ancient Greece, an era when mental illness was difficult to conceptualize, the gods often caused mental illness (Beck, 2014). The tale of Orestes details an epic where, according to Homer, Orestes avenges his father's, King Agamemnon of Mycenae, death by killing his mother, Clytemnestra (The Editors of Encyclopaedia Britannica, 2022). Following Orestes' matricide, he was tormented by the Furies, female chthonic goddesses of vengeance (The Editors of Encyclopaedia Britannica, 2022).

Similarly, ancient texts detailing fits of "manic forgetfulness, flying into rages, and wild activity, among other symptoms" were hardly limited to Western society's experiences (McLeod, 2017). Chinese scholars have long recorded episodes of mental illness; however, it was not until the Tang Dynasty that the first officially documented management of the mentally ill was recorded in China (Liu, et al., 2011). Between 618 and 907 AD, the mentally ill were cared for by monks at the Bei Tian Fang.

The first modern, western-style, dedicated mental health facility in America was the Pennsylvania Hospital for the Insane, which "opened in 1856 and remained open under different names until 1998. (U.S. National Library of Medicine, 2015)" Furthermore, in the decades following World War II, global efforts to deinstitutionalize mental healthcare and promote psychiatric reforms took broad effect and mental healthcare shifted from in-patient asylums to active "treatment and support 'in' the community (Novella, 2010)."

Modern Issues:

Unfortunately, even the global reforms post-World War II have failed to adequately resolve the U.S. mental health crisis: 21.0% of all U.S. adults suffered from mental ill-health in the past year (National Institute of Mental Health, 2022). In 2016, the United States Centers for

Disease Control and Prevention released a study that warned that mental illnesses and suicides were not decreasing but growing (Curtin, Warner, & Hedegaard, 2016). In 2019, this warning was further proven when the American Psychological Association (APA) published a report on the adolescent-young adult rate of mental illness (Twenge, 2019). Twenge and her co-authors analyzed data from the National Survey on Drug Use and Health, a nationally representative survey that has tracked drug and alcohol use, mental health, and other health-related issues in individuals aged 12 and over in the United States since 1971. They determined that the rate of mental illness increased by 63 percent in young adults from 2009 to 2017 (8.1-13.2 percent), with similar increases in severe episodes and suicidal thoughts/outcomes. One may attribute these drastic increases in mental illnesses to several notable societal changes that have occurred within the past decade: the social-economic crises following the 2008 recession, the increasing prevalence and effects of social media on youth, and, most recently, the more recent social damage caused by the global coronavirus pandemic. Nevertheless, it has also been hypothesized that the United States Healthcare system, much less the United States Mental Healthcare system—composed of three core areas: the providers of the healthcare system, the insurance companies, and the patients—is in a poor state to contend with significant adverse events or even the most basic functions of a modern healthcare system.

Effective Structures within the Modern United States Healthcare System:

The modern United States Healthcare system contains four main types of providers often operating within three primary settings: highly trained providers, generalists, social service providers, and informal volunteers working within hospitals, outpatient clinics, and informal venues (Sundararaman, 2009).

Highly trained providers include psychiatrists, psychologists, and psychiatric nurse practitioners. These providers usually have a doctoral level of education and professional training and are licensed by licensure boards in each state (National Alliance on Mental Illness, 2020). Psychologists utilize clinical interviews, psychological evaluations, and testing to make diagnoses and may offer individual and group therapies. Psychiatrists are licensed medical doctors who have completed professional psychiatric training that allows them to diagnose mental health conditions, prescribe and monitor medications and provide therapies. Psychiatrists are also licensed to practice by state organizations and may additionally be board-certified psychiatrists by the Board of Neurology and Psychiatry. Psychiatric or Mental Health Nurse Practitioners can provide assessments, diagnose and offer therapy for mental health conditions or substance use disorders, and, with additional training and qualifications, prescribe and monitor medications. They are licensed nurses within the state they are practicing and may additionally undergo National Council Licensure Examination (NCLEX) or Board Certification in psychiatric nursing through the American Academy of Nurses Credentialing Center. Highly trained providers generally operate out of hospitals and outpatient clinics.

Generalists include family practitioners, pediatricians, and nurse practitioners. Often licensed to the same degrees as psychiatrists and psychiatric nurse practitioners, generalist providers may be able to monitor and prescribe some medications but likely do not have the same requite specialization in mental health training as the highly trained providers. Often generalist providers may refer patients to more specialized providers if the patient demonstrates and need for more acute or specific mental health treatments. Family care or primary care physicians (PCP) will be licensed as a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) within the states that they are practicing. Family Nurse Practitioners (FNP) are

often required to have a Master of Science (M.S.) or Doctor of Philosophy (Ph.D.) in nursing within the states where they are practicing. FNPs may also obtain NCLEX or Family Nurse Practitioner Board Certified credentialing (FNP-BC). Generalist providers primarily operate out of hospitals or outpatient clinics.

The third classification of providers is those trained to provide social services, such as advocacy and community organizing, aiding the aging members of our population, providing services regarding child welfare services, and assisting individuals with developmental disabilities. Social workers in healthcare also often focus on research, the development of programs, and other administrative/community-focused tasks (National Association of Social Workers, 2022). In the mental healthcare setting, social workers may be able to provide case management, group and individual therapy, family counseling, advocacy for jobs and housing needs, and education and policymaking. Providers within the social worker category may not be associated with a medical accreditation body and generally deliver care within non-medical institutions, such as universities, prisons, patient personal residences, and additional informal venues. Social workers often work in conjunction with additional therapies provided by higher levels of providers.

Informal volunteers compile the final category of providers within the United States Mental and Physical Healthcare systems. Due to shortages in the supply of trained mental health professionals, the U.S. Healthcare system, especially in more rural areas, is increasingly forced to rely upon providers lacking any formal training or licensures to provide mental health services. Additionally, these providers may not be required to regularly attend mental health training or obtain any continuing education on mental health. Many mental health hotlines,

support groups, peer counseling services, and other informal venues rely upon volunteer providers to aid their communities.

While these four main categories of providers and the three primary mental healthcare settings may have the potential to care for and treat patients effectively, patients must be able to afford the services of these providers; and one of the most considerable barriers to Americans in affording and receiving mental healthcare is the structure of the American Health Insurance systems.

Lack of Structure within the U.S. Healthcare Systems:

An article in the American Medical Association Journal of Ethics by George B. Moseley III, JD, MBA extensively details the formation of America's Healthcare System from independent physicians treating patients in their homes, to the onset of prepaid service plans in 1929 at Baylor University Hospital, to the Blue Cross and Blue Shield "cost plus" plans, to the Health Maintenance Organizations, and their "managed care," of today (Moseley III, 2008).

Nowadays, modern healthcare plans aim to promote a "perfect market," where "all consumers, including those under employer-based health plans, will assume greater responsibility for making decisions about many aspects of their health care: how much of their own money to spend on it, the type of insurance protection to buy, which providers (physicians and hospitals) to use, and what specific clinical procedures to receive." Unfortunately, while theoretically, a perfect market is a phenomenal goal, a significant portion of the population remains uninsured, "the uninsured rate, 8.5 percent of the population, is down from 16 percent in 2010, the year that the landmark Affordable Care Act became law. (The Commonwealth Fund, 2020)" Additionally, "the U.S. continues to spend 50 percent more on health care as measured by

its share of the GDP (gross domestic product), than any other developed country…[and] at the same time, life expectancies are lower and infant mortality rates higher in the U.S. than in most of those other developed countries."

The concept of a disjointed U.S. Healthcare system has only grown since Moseley's article; in 2021, an article in the Harvard Medical Journal emphasized that not only does the U.S. Healthcare system maintain "high cost, [but] not the highest quality…and a high financial burden," the system additionally has significant healthcare disparities and has "a cruel tendency to delay or deny high-quality care to those who are most in need of it but can least afford its high cost…contributing to avoidable healthcare disparities for people of color and other disadvantaged groups. (Shmerling, 2021)" And even within non-disadvantaged groups, health insurers may discourage care deemed appropriate by a physician, an example illustrated by individuals who may be denied coverage for an effective medication if a cheaper prescription is prescribed (even if the cheaper medication may not work and has been trialed by the patient).

The U.S. Healthcare and Healthcare Insurance systems also appear to focus primarily on the cure-all, one-time treatments that leave a client with complete resolution of symptoms. If that sounds too perfect to be true, it is because it likely often is. That emphasis on technology and specialty care over more uncomplicated but equally effective preventative care may result in doctors prescribing a cortisone injection for tendinitis of the ankle when the shoe insert that may be equivalently successful is not covered by insurance. Additionally, the innovation of telehealth, which has flourished in recent years due to necessity, was previously "stifled…in part due to a lack of insurance companies willing to cover it."

Another critical hallmark of the disjointed American healthcare approach is its fragmentation of continued care. A fragmented healthcare system may result in "duplication of

care, poor coordination of services, and higher costs for patients. (Shmerling, 2021)" Often occurring either due to the fragmentation of primary care or specialty care services, "among Medicare beneficiaries the median individual is seen by 8 distinct providers each year, and 10% are seen by over 21 providers. (Agha, Frandsen, & Rebitzer, 2017)" Additional research has also demonstrated that fragmented healthcare systems may affect the quality-of-care patients receive due to primary care fragmentation leading to significant increases in hospitalizations.

Merriam-Webster defines a *system* as "a regularly interacting or interdependent group of items forming a unified whole." In contrast, although the American Healthcare systems may achieve the first half of that definition, they fall grossly short of achieving a "unified (and effective) whole" due to the systems' inadequacies and inefficiencies regarding insurance policies, costs to patients, and quality of care amongst all patients.

Challenges within the U.S. Mental Healthcare System and Further Effects of the U.S. Mental Healthcare System on Patients:

Unfortunately, the issues within the U.S.'s Healthcare systems affect specific populations to a significantly greater extent than others (American Psychiatric Association, 2017). People of color, members of the LGBTQ+ community, and many other minority groups are unduly affected by historical issues and governmental policies, suffering worse patient outcomes than non-marginalized populations. Historical issues, such as the Tuskegee study—where for 40-years a Syphilis experiment run by the Public Health Service debilitated participants and ruined their family's lives--have grossly damaged the public trust in the American Health System; resultingly, "black patients consistently express less trust in their physicians and the medical

system than white patients, and are much less likely to have common, positive experiences in health-care settings. (Newkirk II, 2016)"

Similar to the U.S.'s physical healthcare system, the U.S.'s mental healthcare system contains a variety of providers and insurance systems that result in deep inequalities across socioeconomic lines, unfair compensation from insurers, and a significant burden on the U.S.'s GDP (Yeo, 2021). Moreover, a 2015 study estimated these costs and burden at approximately $210.5 billion annually, attributable to direct costs, suicide-related costs, and decreased workplace productivity (Greenburg, Fournier, Sisitsky, Pike, & Kessler, 2015). However, unlike most of the features within physical healthcare, the U.S. mental healthcare system's third core area—the patients—often experience significantly increased hardships surrounding accessibility, desirability, quality, and affordability of mental healthcare.

In 2008, the U.S. Congress passed the Mental Health Parity and Addiction Equity Act in hopes of eliminating the disparities in health insurance between mental health and general medical benefits. Furthermore, in the past decade, there have also been significant efforts to protect individuals of the LGBTQ+ community. For example, the passage of the Affordable Care Act (ACA) in 2010 placed three imperative provisions to aid in protecting LGBTQ+ individuals with behavioral health conditions: "it provided more health coverage options…prohibited healthcare discrimination based on sexual orientation and gender identity…and required most plans, including Medicaid plans, to provide behavioral health services in parity with medical and surgical benefits. (Coursolle & Holtzman, 2019) Nevertheless, despite the passage of these crucial and long-overdue pieces of legislation, Americans continue to experience difficulties accessing mental health providers. When they manage to, they are often forced to go out of network and pay out of pocket (National Alliance on Mental Illness, 2016).

Respondents to the National Alliance on Mental Illness's (NAMI) study on the unfulfilled promise of parity stated that, as respondents, they remained eighty and seventy percent more likely to have trouble finding a therapist or prescriber, respectively, for mental illnesses that would accept their insurance in comparison to a respective medical specialist. Unfortunately, this lack of accessible providers, high costs, and insufficient insurance coverage, along with long wait times, results in "one in four Americans having to choose between getting mental health treatment and paying for daily necessities…one in five Americans having to choose between getting treatment for a physical health condition or a mental health condition due to their insurance policy…and nearly half of Americans, or 46%, having had to or known someone who has had to drive more than an hour roundtrip to seek [mental health] treatment. (National Council for Mental Wellbeing, 2018)"

Additionally, due to a distrust of the U.S. Healthcare system, "people of racial/ethnic minority groups [are] less likely to receive mental health care…[and] among adults with any mental illness, 48% of whites received mental health services, compared with 31% of black and Hispanic, and 22% of Asians. (American Psychiatric Association, 2017)" And according to Mongelli, Georgakopoulos, and Pato, there is "growing evidence that the mental health services available to LGBTQ+ individuals are often scarce and may offer inadequate and stigmatizing treatments. (Mongelli, Georgakopoulos, & Pato, 2020)" These inequalities may stem from antigay prejudice or, more commonly, are caused by a lack of knowledge about sexual minority groups and negative and stigmatizing attitudes toward LGBTQ+ clients, indicating a need for further training about sexual and gender identity, as well as increasing the cultural competency of mental health service providers.

Just as members of marginalized communities are significantly more likely to attempt suicide than their non-LGBTQ+ peers, marginalized communities often experience worse clinical mental health outcomes than non-marginalized populations. “As of 2018, life expectancy among Black people was four years lower than White people, with the lowest expectancy among Black men…[and] low-income people report worse health status than higher-income individuals and LGBT individuals experience certain health challenges at increased rates. (Ndugga & Artiga, 2021)” Worse health outcomes that emphasize the importance of recognizing and understanding that social determinants can greatly impact one’s life, livelihood, and mental health.

There is also a continued need to protect and expand governmental policies regarding social equality for LGBTQ+ individuals. Recent efforts by the Trump administration removed questions about sexual orientation and gender identity from nationwide Health and Human Services studies, resulting in a diminished understanding of how prevalent a variety of health-related behaviors, health status indicators, and measures of healthcare service utilization and access vary across a representative sample of the civilian, non-institutionalize U.S. adult population (Ruth & Santacruz, 2017). Information that, in the past, has revealed that “lesbian, gay men, and bisexual individuals of all ages are more than twice as likely to have attempted suicide than their non-LGB peers. (Coursolle & Holtzman, 2019)” In the coming years, it will be essential to continue to protect the critical provisions already established in defense of at-risk individuals and expand them further as needed to achieve equal and maintained parity between all medical services and groups within the U.S.

COVID-19:

Inequalities within mental healthcare are also grossly prevalent within the ongoing global pandemic. Two studies have shown that non-binary individuals had higher levels of depression and anxiety following the COVID-19 pandemic (Alonzi, Torre, & Silverstein, 2020) and that people who identified as transgender were more likely to report higher levels of PTSD symptoms than cis-gendered individuals (Liu, Zhang, Wong, Hyun, & Hahm, 2020). Nevertheless, while the COVID-19 pandemic has unduly affected marginalized and at-risk populations, the pandemic has drastically and dramatically changed the entire mental healthcare landscape.

The American Psychological Association (APA) recently sounded the alarm that COVID-19 and stressors resulting from the pandemic were causing a national mental health crisis (Bethune, 2020). Correspondingly, a systematic review of current evidence performed by the Copenhagen Research Centre for Mental Health determined that patients with pre-existing psychiatric disorders reported worsening psychiatric symptoms; and a general decrease in psychological well-being was observed within the general public (Vindegaard & Benros, 2020). General anxiety and fear surrounding the disease, impacts of physical and social distancing at home and within the community, concerns surrounding employment and unemployment, alongside additional increased economic burdens and concerns, and an inability to meet with mental health clinicians have all been purported to provide some explanations to a cause for individual's worsening mental health (Czeisler, et al., 2020).

On a larger healthcare system level, patients appear to be visiting mental health providers and group workshops at a reduced rate than prior to the pandemic (Ornell, et al., 2021). Notably, there has been an uptick in the number of mental health patients requiring emergency assistance since the onset of the COVID-19 pandemic. Therefore, it is not believed that this decrease is due

to a decreased demand or need for mental health providers; instead, in line with a recent World Health Organization assessment, COVID-19 has incurred significant disruption to the mental healthcare system (World Health Organization, 2020). Significantly, 93% of countries have halted mental health services, and one-third have entirely or partially disrupted at least 75% of their mental health services. 30% of countries reported disruptions to medications for people with mental, neurological, and substance use services, while another 35% of countries noted disruption to life-saving emergency management for MNS services; and essential laboratory services for severe mental health conditions noted disruptions in 40% of countries.

Similarly, 24% of suicide prevention programs noted a complete disruption of their services, with critical harm reduction services for substance use being completely disrupted in 30% of countries and partially disrupted in 35% of countries. Of note, prevention and promotion of mental health services and programs were the most severely affected, with approximately three-quarters of school mental health or workplace mental health services wholly or partially disrupted. Therefore, at a time when they are highly needed, mental health services for the most vulnerable were reported to be disrupted, as less than 30% of countries noted no disruption to adolescent mental healthcare and nearly 60% of all psychotherapy and counseling services were partially disrupted. To a complete and partial extent, the sum of these disruptions was unheard of prior to this pandemic; we will likely continue to witness the effects of the COVID-19 pandemic on the mental healthcare system for the coming days, months, years, and even decades.

Mental Health at Universities and Colleges:

Sadly, one segment of the population that has been further disproportionally affected by the disruption of the mental healthcare system and the societal-wide effects of the pandemic is

college students. According to the Centers for Disease Control (CDC), the global COVID pandemic placed the most considerable mental health burden on 18-24 years old (Alkhouri, 2021). The CDC discovered several shocking statistics, including that 63% of these young adults reported symptoms of anxiety and depression, with 25% reporting substance use to contend with those symptoms, and 25% of those individuals seriously considering death by suicide. The Healthy Minds Network further reported that 80 percent of college students stated that COVID-19 had negatively impacted their mental health (The Healthy Minds Network, 2020). Moreover, 50 percent of college students believe that people think less of someone who has received mental health treatment (American Council on Education, 2019)—exemplifying that the extensive deterioration of college-age students' mental health due to COVID-19 only exacerbates the fact that young adults were already one of the most susceptible populations to increased suffering from mental illnesses (National Institute of Mental Health, 2019).

College students, who already had to contend with transitioning into and out of universities, shifting their support and social networks, and increased academic concerns (Cage, Jones, Ryan, Hughes, & Spanner, 2021), are increasingly at risk due to the abrupt shift off-campus during the pandemic, a subsequent loss of a social network, and potential long-term impacts on job prospects (Kleiman, Yeager, Grove, Kellerman, & Kim, 2020). A policy brief to the U.S. Department of Health and Human Services reported that "in the past decade, the number of students who visited campus counseling centers grew by 30 percent, while the average enrollment at U.S. colleges only increased by a mere 5 percent. This 25-percentage-point difference reveals why the nation has reached what could be called a 'campus mental health crisis. (Long, 2019)"

Damage to this population additionally stands to pose a significantly extensive burden on future work performance and education (Alkhouri, 2021). Economic losses associated with mental illness are expected to increase six-fold over the next 30 years (Doran & Kinchin, 2017). In the U.S., the NAMI estimates show that serious mental illnesses (SMI) alone cause an estimated $193.2 billion in lost earnings annually and that global economic losses exceed $1 trillion each year (The National Alliance on Mental Illness, 2022). Poor mental health that may also hinder students' academic successes, resulting in lower GPAs, discontinuous enrollment, and lapses in enrollment (American Council on Education, 2019).

Despite these challenges, college students are an element of the population that may hold significant potential for improvement. Research by the National Alliance on Mental Illness reveals that 75% of all lifetime mental illnesses develop by the age of 24 (The National Alliance on Mental Illness, 2022). NAMI also reported that almost "73% of students living with a mental health condition experienced a mental health crisis on campus. Nevertheless, 34.2 percent also reported that their college did not know about their crisis. (Chadron State College, 2022)" Data surrounding students who are no longer attending college within the past five years also reveals that 64% of college students who dropped out reported no longer attending due to a mental health-related reason, with 45% of those students reporting failing to receive appropriate accommodations and another 50% of never accessing mental health services (Gruttadaro & Crudo, 2021). Together, these statistics demonstrate a common trend that college students and college counseling services stand at a unique crossroads within mental health, a crossroads that provides a unique opportunity to impact these students, our societies, and our futures significantly—especially since the earlier treatment is received, the better lifetime outcomes for individuals experiencing mental ill-health (American Council on Education, 2019).

Therefore, due to young adults' baseline vulnerability—which has only been increased during the ongoing global pandemic—and their potential for improvement, significant resources, treatments, and research should be directed towards the college student population. This dedication of resources should also prove beneficial to colleges and universities. In addition to improving students' academic performance, improving mental health services at college is a good investment of resources for colleges due to its ability to increase a university's retention of students (and graduation rates are a vital component of college rankings).

Case Study:

The College Experience:

"These will be the best four years of your life. (Stauffer, 2021)" This prominent slogan has accompanied the past several generations of college students as they begin what they hope will be a bright start to their future. It is a societal expectation for a future full of newfound independence that embodies the belief, and the American dream, that "if you wanted a good job, if you wanted to be stable, you got a college degree." However, while some students may experience a perfect set of college years, the best four years of one's life are hardly the experience all college students undergo; and while the percentage of individuals under twenty-five years old attending college within the United States has consistently increased over the past years—a remarkable 11 percent from 2007-2017—a shocking 40 percent of all students will drop out before completing their degree, often due to unhealthy work-school-life balances compounded by emotional and societal events and mental health issues (Strauss, 2019).

College students are increasingly required to withstand an arduous work-school-life balancing act, and as of 2015, "according to a Georgetown University Center on Education and the Workforce, 70 percent of full-time college students were working while in school." A work-life-student balance that is increasingly resulting in college experiences similar to those of Jessica Tietz, a second-year University of Oregon student, who reported working "40 hours a week at Home Depot, Monday through Thursday, 8 p.m. to 6 a.m. 'I sleep in between classes, or Tuesdays and Thursdays I'm done at 10 a.m. so I just sleep after class…I don't have time to think about my mental health (Pierotti, 2021)." While another student reported, "my mental health kind of goes on the backburner."

Students attending Goshen College also described similar stories and upon asking students how they were, "the most common responses were variations of 'eh, tired,' 'stressed,' or 'hanging in there," with a common concern that stress for college students is far more normalized than it should be (Schmauss, 2021). Additionally, Schmauss noted that, due to the pandemic, in addition to stress from exams or homework, students have had to worry increasingly about their personal health, the health of families and loved ones, and the global struggles with COVID-19. Undoubtedly, partly due to the struggles surrounding a healthy work-life-student balance, college students increasingly feel that their mental health is diminished, delayed, or disregarded while obtaining their degree.

In 2019, a global storytelling movement known as The UNTOLD Project began mining the unknown tales of humanity; in 2020, this project was expanded to include a segment called Campus Diaries in an attempt to improve mental health awareness within campus communities and connect with students' suffering (The UNTOLD Project, 2022). One article, titled "Overwhelmed," noted that while taking only 12 hours of academic work, the student never had this much outside work and, while working 30+ hours a week, that every free moment of theirs was filled with homework…nevertheless, they still felt unable to catch up on their work. Another article, titled "Mental Health as a Nursing Student," recounted one nursing student's struggles with online lectures, the unknown of her future, and academic troubles. Her struggles altogether caused the student to feel as if her mental health was deteriorating and increased her difficulty in coping with her stress. A final article, titled "Off Balance," detailed another student's burdens with school through the global pandemic. Here, the student noted feeling mentally drained due to the complex balancing of the pandemic, work, election season, and racial tensions. Although

other students indeed also reported great joy during their college careers, there remain significant feelings of helplessness, despair, and an inability to balance one's life appropriately.

These emotions and struggles, particularly since the onset of COVID-19, are not limited solely to outside of the University of Vermont. An article in the Vermont Cynic by Liz Chadwick described some of the recent mental health challenges facing students at UVM (Chadwick, 2021). From students and professors feeling an inability to connect, to students experiencing "very acute and very specific experiences of grief and loss, both of loved one and aspects of previous life," Chadwick found that within these past two years, there has been a substantial negative impact on overall health and wellbeing at UVM.

These subjective reports are further supported by the ongoing student emotional health and wellness study at the University of Vermont, which revealed persistent (negative) impacts on first-year students' mood and wellness behaviors due to COVID-19 (Copeland, et al., 2021). These adverse effects were comparable to students who experienced natural disasters overall, with increased levels of internalizing symptoms. Interestingly, this study found no significant change in students' stress levels post-COVID-19. Researchers proposed that stress levels may have been reduced due to students' return to home, additional academic accommodations, and decreased class instruction time. However, COVID-19 still appears to have negatively impacted students' mental health at the University of Vermont.

Furthermore, mental ill-health within the student populations at the University of Vermont is hardly limited to undergraduate students. In 2017, a study of mental health services used by UVM medical students determined that, even though UVM medical students utilized mental health services at a higher rate in comparison to the general population and students at other medical schools, substantial barriers to care remain (Rodriguez, Corse, & Rosen, 2017).

Their research revealed that UVM medical students continued to experience issues regarding logistical factors regarding obtaining care and fears of stigma surrounding obtaining mental health services. Likewise, other graduate students at the University of Vermont experience slightly differing issues from undergraduate students (Wyatt & Oswalt, 2013). Notably, graduate students often demonstrate higher rates of stress due to increased detachment from campuses and often report that this detachment negatively affects their mental health and stress levels. Therefore, in addition to the issues surrounding undergraduate collegiate experiences, particular attention to varying needs should also be directed at students beyond their undergraduate careers.

The University of Vermont's Mental Health Services:

The University of Vermont, directly and indirectly, provides a variety of on-campus mental health services for students (discussed below). UVM also provides several links to health services provided by nationwide and Vermont-wide services***. If in need of mental health services, please see the University of Vermont's CAPS Webpage for additional resources***. The University of Vermont's Center for Health & Wellbeing reports obtaining and maintaining accreditation through the Accreditation Association for Ambulatory Healthcare (The University of Vermont, 2022).

Descriptions of Mental Health Services directly provided by the University of Vermont:

IN AN EMERGENCY, OR IF THERE IS A POTENTIAL FOR DANGER TO SELF OR OTHERS, PLEASE CALL CAMPUS POLICE AT (802-656-3473), IF ON CAMPUS, OR (911) SHOULD BE CALLED IMMEDIATELY.

COUNSELING & PSYCHIATRIC SERVICES (CAPS):

Counseling and Psychiatric Services, or CAPS for short, is a segment of the Center for Health & Wellbeing at the University of Vermont designed to be a meaningful collaborator in the health and development of all UVM Students, staff, and faculty. It aims to promote an inclusive, caring community while respecting and valuing diverse cultures, ideas, and beliefs in the hopes of fostering personal, social, and academic development, thereby contributing to the realization of individual and community potential (The University of Vermont, 2022). CAPS offers a variety of clinical, consultive, and preventative services described below:

Phone Triage:

Phone triage is available 24/7 via phone (at 802-656-3340), online scheduling, or the UVM Health & Wellbeing Portal. The phone number will connect you with a licensed counselor and is solely provided by the University of Vermont without an outside referral, connection, insurance, or payment required and is referred to as the "front door" for CAPS services.

Individual Counseling:

Individual counseling is available after scheduling an appointment via the phone triage line or the UVM Health and Wellbeing Portal (The University of Vermont, 2022). The primary focus is a short-term therapy model that emphasizes helping one cope with one's individual

personal and academic life. Individual counseling offers a confidential, supportive setting to explore emotions, challenges, or other concerns at UVM. Short-term therapy is provided directly by licensed counselors on CAPS staff. Longer-term therapy needs will be eventually referred to outside services in the greater-Burlington community via Shrink Space or a list of local referrals. CAPS will offer longer-term therapy on an as-needed basis, especially for marginalized populations, which may encounter more significant barriers to accessing off-campus treatments. Counseling is available to all UVM students at no additional cost and is encompassed within the UVM Health Fee.

Group Counseling:

UVM directly provides both short-term and semester-long group counseling sessions that explore a wide range of topics, including grief and loss, body positivity, anxiety management, and graduate student support groups to share experiences and struggles, obtain feedback from peers, and try out new coping skills (The University of Vermont, 2022). Group Counseling at UVM is primarily formatted into sessions lasting eight to twelve weeks; however, some are shorter, with the reasoning provided being to allow group members to become more comfortable and build trust between members. Groups are typically composed of ten students and two group leaders. Group leaders are CAPS counselors who guide self-exploration, give feedback, and encourage group cohesion. The nine current group leaders maintain various certifications, including LICSW, LADC, LCMHC, NP, MA, LADC, and CS. Available on a by-appointment basis, without requiring an additional fee, students are advised to call (802)-656-3340 to schedule an appointment with the group facilitator.

Psychiatry:

Psychiatric evaluations and ongoing medication management are directly provided by CAPS staff at the Jacobs House (145 S. Williams St.) and Redstone Campus, inside Wright Hall (436 S. Prospect St.) (The University of Vermont, 2022). Following a screening appointment, students match with a psychiatric provider to determine the student's treatment plan, including medication, individual and group therapy, other support services on-campus, or off-campus referrals for more specialized treatment. Of note, psychiatry services are not encapsulated by the UVM student health fee; instead, a student's insurance coverage determines out-of-pocket costs; but students facing barriers to care related to institutionalized oppressive structures or socially unjust conditions may be eligible for a fee waiver. Additionally, appointments must be canceled at least 24 hours prior to one's appointment, as missed appointments are still billed to one's UVM account, including for students with fee waivers.

Case Management and Referral:

CAPS aims to connect students to mental health and addiction support at the University of Vermont or within the greater Burlington community (The University of Vermont, 2022). Importantly, case management is not an ongoing therapeutic counseling service but rather intended to help students obtain longer-term services. Students first connect with one's case manager via phone, in-person, virtually, or through secure messenger. Case managers will then inquire about what the student hopes to obtain in a counselor, what one wants to work on during

counseling, past counseling experiences, one's transportation options, insurance, and schedule. Within two business days, a case manager will provide the student with a list of clinicians and resources. If needed, case managers will continue to work with the student to find them a resource until one settles into a routine with a clinician or service that the student enjoys. Students are reminded that they can continue to utilize Counseling and Psychiatry services, groups, and workshops while obtaining off-campus mental aid.

Let's Talk Drop-In Consultations:

First come, first serve, drop-in appointments, available in-person and virtually. Resources are available to students through three groups: all students can access services at Living Well or Wage, students of color through the Mosaic Center, and LGBTQAI+ students through the Prism Center (The University of Vermont, 2022). Virtual appointments may be scheduled via MyWellbeing or by calling (802)-656-3340.

LET'S TALK AT LIVING WELL: Drop-in hours: Tuesdays from 1:30-4:00 pm with Mary H., Wednesdays from 1:30-4:00 pm with Sarah L, and Fridays from 1:30 - 4:00 pm with Jenny.

LET'S TALK AT WAGE: Drop-in hours: Thursdays from 2:30-4:30 pm with Laurie, Followed by Survivor Space drop-in sessions from 5:00-6:30.

MOSAIC CENTER FOR STUDENTS OF COLOR: Drop-in hours: Mondays from 1:00-3:00 pm with Keiba, Tuesdays from 1:00-3:00 pm with Keith, Wednesdays from 1:00-3:00 pm

with Keiba, Thursdays from 1:00-3:00 pm with Mary, Fridays from 10:00-12:00 pm with Andrea.

UVM PRISM CENTER: FOR STUDENTS IDENTIFYING AS QUEER, TRANS, OR IDENTIFYING AS LGBTQAI+: Drop-in hours: Wednesdays from 1:00 - 3:00 pm with Stefan (in person) (Please note that on the last Wednesday of every month Let's Talk Hours at Prism will not begin until 2:30 pm), Thursdays from 2:30-4:00 pm with Walter (virtual).

Mental Health Workshops:

Designed to help individuals build coping skills, resiliency, and radical self-care practices through examining different mental health and identity elements. No current workshops are available as of 03/26/2022 (The University of Vermont, 2022).

Of note, Campus Connect, CARE Team Roadshow, and Mental Health First Aid for Higher Education appear to remain available upon request (The University of Vermont, 2022).

Campus Connect is a 3-hour suicide prevention gatekeeper training that covers knowledge of warning signs and resources to support people in crisis, increased listening and communication skills for conversations surrounding suicide, and increased self-awareness around potential emotional reactions one may have while interacting with someone in crisis. Training is available for UVM faculty, staff, and students.

CARE Team Roadshow is a 60-90-minute-long presentation for faculty and staff that focuses on current collegiate mental/behavioral health trends and challenges facing the student population. It aims to identify best practices for faculty/staff in identifying, supporting, and referring distressed students. Additionally, the presentation will address relevant ethical and legal considerations.

Mental Health First Aid for Higher Education is an 8-hour course designed to teach faculty, staff, and students to identify, understand, and respond to signs of mental health problems and substance abuse disorders. Details a five-step action plan to help people in crisis connect with appropriate professional help and outlines methods to assess one's own views and feelings surrounding mental health problems and disorders.

CARE FORM:

Concerning and/or Risky Event Forms are designed to be an anonymous report that allows students and staff to express concern about a UVM community member or a specific event (The University of Vermont, 2022). If willing to be on the record, individuals are asked to contact the Dean of Students Office at (802)-656-3380. Additionally, the page provides a link to resources with recommendations on how to/how not to properly deal with situations that, unfortunately, may arise during one's time at UVM. Topics covered are abusive dating relationships, anxiety, bias incidents & hate crimes, demanding behavior, depression, eating disorders, grief and loss, poor contact with reality, self-injurious behavior, sexual harassment & misconduct, hazing, students with disabilities, substance abuse, and suicide.

HEALTH AND WELLBEING EDUCATION AND OUTREACH @ LIVING WELL:

The goal of Health and Wellbeing is to provide students with the tools and resources to thrive at the University of Vermont and in the future (The University of Vermont, 2022). Supports access to medical and mental health services, promotes radical self-care, and aims to co-create a safe, supported, and seen environment for the entire UVM community. Resource lists include links to support surrounding alcohol, cannabis, and other drugs; community health; radical self-care; sexual violence support and advocacy; and further training.

MENTAL HEALTH SCREENING TOOL:

An anonymous, confidential, brief, and immediate questionnaire regarding a student's behavioral health—encompassing mental health, substance use, overall well-being, and more—in the hopes of providing information and next steps as warranted (MindWise Innovations, 2022). Designed to quickly determine whether a student or someone a student cares about should connect with a behavioral health professional.

Shrink Space:

A private, encrypted, HIPAA, and VPAT-compliant online messaging platform and referral system partnered with UVM's counseling center to connect private therapists with

students for continued care (The Shrink Space, 2022). Hopes to save time and employ a variety of filters to aid in students finding the perfect counselor for their specific needs.

Descriptions of Substance Abuse Services directly provided by the University of Vermont:

CATAMOUNT RECOVERY PROGRAM:

The Catamount Recovery Program (CRP) aims to provide an affirming and supportive community for students in recovery from substance use, considering recovery, or taking a break (The University of Vermont, 2022). Provides opportunities for community-building, housing, learning, and advising through a 24/7 community gathering space. CRP also provides academic support and liaising, referrals to recovery-specific counseling and psychiatry resources, education, and recovery support. Regularly holds monthly programming on-and-off campus, on-campus recovery housing (available to students with a minimum of six months of active recovery), CRP class, therapeutic recovery group, and community game night on Friday nights. CRP's approach maintains five foundation elements: recovery, community, academics, self-care, and advocacy to support students in recovery. The program contains at least one counselor trained as an MSS.

T-BREAK GUIDE (TOLERANCE BREAK GUIDE):

Tom Fontana established the T-Break Guide, LCMHC, LADC as part of the Alcohol, Cannabis, and Other Drugs Initiatives Manager for the University of Vermont (Fontana, 2022). It

was created to assist students in completing a tolerance break from cannabis. The guide consists of daily practices which fall under a different theme each week of the guide. Week one is physical, week two is emotional, and week three is spiritual/existential, with a total guide length of twenty-one days. The guide covers various topics, including but not limited to staying busy, sleep, food, cravings, routine, withdrawal, irritability, anxiety, boredom, loneliness, creativity, connections, and what to do after twenty-one days.

CENTER FOR HEALTH AND WELLBEING SUBSTANCE USE TEAM:

The Substance Use Team provides resources for students or students supporting friends trying to cut back or quit nicotine, tobacco, alcohol, and other drugs. Additionally, the Team provides confidential one-on-one office hours to offer guidance and support on skills to assist students in changing their habits and reducing their intake of nicotine, tobacco, or cannabis.

BASICS:

Balancing Alcohol and Substances to Improve College Success (BASICS) is a program designed to help students explore their alcohol and drug use in a supportive and non-shaming environment (The University of Vermont, 2022). BASICS sessions are offered in both individual and group sessions. Importantly, BASICS is not an abstinence-only program, meaning students will not automatically be told to stop using substances. Topics covered within BASICS sessions are personalized blood alcohol content (BAC) information, brain functioning, sleep, nutrition, and social norms and patterns. Individual BASICS sessions begin with an online survey about

one's substance use and then a 60-minute session with a BASICS provider. Group BASICS sessions, mandated for varsity athletes, fraternity, and sorority members, consist of an online survey followed by a 90-minute group session with the BASICS coordinators. Any UVM student is invited to participate in a BASICS session at no cost, and everything said during the session or reported on the survey one takes is entirely confidential.

Descriptions of Sexual Assault Services directly provided by the University of Vermont:

SURVIVOR SUPPORT SPACE:

A student-generated drop-in space supported by CAPS that welcomes all genders, sexualities, and identities (The University of Vermont, 2022). Allows students to meet, connect, and share (if desired) with survivors about the process of healing after sexual violence. The Survivors Support Space aims to cultivate a safe and supportive environment while building community, sharing in experience, celebrating human resilience, and reclaiming aspects of life that may feel compromised. Available at the Women & Gender Equity Center (WAGE), 34 S. Williams St., on Thursdays between 5:00-6:30 pm. As a licensed LICSW and staff counselor at CAPS, Laurie Brown leads it.

CAMPUS ADVOCACY:

Confidential advocacy and support for members of the UVM community who are victims or bystanders of sexual assault or rape, violent or potentially violent relationships, gender-based

stalking, sexual harassment, physical or emotional or mental assault, bias-related incidents, hazing, sexual exploitation, and other related types of victimization (The University of Vermont, 2022). In addition to Campus Victim's advocacy services provided by the Center for Health and Wellbeing, advocacy support is also provided by HOPEWorks through a formal agreement with UVM. Services are available to all UVM students, faculty, and staff regardless of gender, sexual orientation, or other identities. Services provided by Campus Advocacy include free and confidential support in person, virtually, or by the phone, both on and off-campus; counselors specially trained in addressing trauma related to sexual violence, relationship violence, or stalking; connecting students to appropriate medical care, including sexual assault nurse examinations; aid with securing appropriate safety measures, such as relief from abuse orders/restraining orders and personal safety planning; information and referrals about support systems and processes; academic or housing relocation needs; and support for family and friends. Centrally located on-campus office hours for Spring 2022 at the Living/Learning Annex (34 University Heights) Room 215 are: Mondays 11-2 pm, Wednesdays 12-3 pm, Thursdays 12-3 pm (first and third Thursday of the month) or 4:15-7:15 pm (second and fourth Thursday of the month), Fridays 12-3 pm, and Saturdays 12-3 pm. Students are advised to contact beth@hopeworksvt.org if they would like to schedule a time to meet. Support is also available to the friends and family of survivors, particularly information about how to help, available resources on campus and in the Burlington community, and how to provide emotional support for individuals as one processes the impact of sexual violence.

Descriptions of Outside Mental Health, Substance Abuse, and Sexual Assault Services:

In addition to the above services directly provided by the University of Vermont, a significant number of sources, within a variety of modalities of care, are available to UVM students. Many crisis hotlines, meeting groups, support housing, and other resources provided by volunteers and licensed counselors are available to UVM students via state and national mental health, substance abuse, and sexual assault services. Of note, most of these services are without additional cost to UVM students; however, as often with licensed psychiatric care, some services do require insurance or additional out-of-pocket costs.

Opportunities from other Universities/Institutions:

Seeking to improve collegiate mental health is hardly a new concept. Several other universities around the nation have developed innovative and exciting programs, systems, and training for their students, faculty, and staff. Therefore, looking to see what has already been implemented at other institutions is undoubtedly a necessary step toward examining, comparing, and improving UVM's mental health facilities. Throughout the changes that numerous universities across the nation have implemented, five recurring areas of change are mental health counseling and services; campus meditation services, along with other stress-reducing activities; campus spas, acupuncture, and massage therapies; wellness weeks; and peer support groups (Hoffman, 2020).

Just as colleges often educate first-year students about alcohol, drugs, and sexual assault, mental health awareness for first-year students is more and more commonly found on the first-year student orientation list. One exciting program designed to improve mental health awareness

among high-school and college students is Kognito (Ascend Learning, 2020). This health simulation combines learning, conversation, and game technology to allow students to try different approaches, receive feedback, and better contend with difficult conversations in real life. Significantly, Kognito is an evidence-based health simulation listed in the National Registry of Evidence-based Programs and Practices that has resulted in measurable changes in students' social, emotional, and physical health. For a college of about 3,000 students, one Kognito module costs $3,250; and the price increases based on additional enrollment.

Another exciting program is the Bridge to Campus College Readiness Consultations from McLean Hospital, a Harvard Medical School Affiliate (McLean Hospital, 2022). They were designed to assist college students with ongoing mental illnesses and adjustment issues and ensure the greatest probability of academic and personal success. These consultations consist of one to two initial, one-on-one, 50-minute meetings with the student to obtain a background patient history, assess primary mental health concerns, prior school experiences, and the student's goals. The student and their parents then undergo another 50-minute meeting with a counselor to explore family concerns and perspectives, obtain an increased understanding of prior interactions with providers/key support people, and discuss a student's need for medications/therapy support. A thorough review of the student's academic and mental health records is completed, and a comprehensive report is then written detailing recommendations regarding the student's support team, their roles, and suggestions for a seamless transition. The student and parents undergo one final 50-minute session in which an ultimate plan is summarized, the plan's goals clarified, and step-by-step instructions provided for everyone

involved. Often, these plans include methods of minimizing academic setbacks due to mental health conditions, how to appropriately utilize leaves of absence, recommendations for on and off-campus resource utilization, education on how to effectively advocate for accommodations and additional resources, suggestions for discussing one's mental health with friends and professors, and advice on whether colleges will have the necessary resources and services to help a student maintain stability throughout their college career. However, unfortunately, McLean Hospital's Bridge to Campus service cost is $2000, with additional individual 50-minute meetings costing $200.

During the 2013-14 academic year, while mourning the deaths of three of their undergraduates, two of whom died by suicide, and the general student population—including upper-class students—repeatedly stating that they did not know about the campus counseling center, Northwestern University, with student input and urging, added a mental health session to new-student orientation (Brown S. , 2016). Currently, the session has developed into a series of narratives about students' mental health problems, written by anonymous Northwestern students and read by Northwestern student actors. The director of their counseling and psychological services then discusses the various resources available to students on campus, followed by small group discussions by the students. A key message of the orientation session is that counseling services are not only for students suffering from severe mental health problems but all students.

University of California Los Angeles and Seattle University provide yet another approach to increasing mindfulness and wellness among the student population (Eva, 2019). Both universities opted to incorporate mental health into their curriculum. UCLA's Mindful

Awareness Research Center developed a five-minute mindful breathing exercise to play at the start of lectures, and a few professors at Seattle University initiated 'mindful moments' at the beginning of class, where students work on anchoring their minds and breath while simultaneously obtaining a more relaxed posture. Seattle University found that within a few months, across their teacher education program, students were asking for a 'mindful moment' in all their classes.

The University of Wisconsin-Superior and Thiel College in Pennsylvania took a more comprehensive approach to incorporating mental health into their curriculum through the creation of a social-emotional learning project, "SuccEssfuL (SEL) in Stats (Eva, 2019)." The program features fifteen short weekly activities for students to complete outside of class (apart from an initial first day in-class activity). In easy-to-follow sections, the guide includes a " Self-Compassionate Letter (to practice encouraging and being kind to yourself), Use Your Strengths (to draw on your skills in creative ways), Finding Silver Linings (to change your perspective on a negative event), and Best Possible Self (to foster optimism as you imagine your future)." A pilot study of the SuccEssfuL program at two universities found that students "reported a decrease in math anxiety" and that by the end of the course, students also described a "change in the way they perceived their stress—more as a challenge rather than a threat to their wellbeing."

During the COVID-19 pandemic, the University of Florida also began "recharge days (Brown N. , 2021)." After noticing that their students were tired, the university embraced the sunshine and Florida weather to provide painting, clay pot making, a tie-dye T-shirt station, and

different food stations. The university hoped that doing so would provide students with a much-needed break and allow them to relax and rejuvenate. UF additionally is increasingly providing more and more diverse options for group therapies at the University (Lee, 2016). Currently, they offer group therapies around a variety of categories: first-generation students, graduate students, international student support (offered in different languages), for students of color, sexual orientation groups, different themed groups around medical challenges, anger management, sexual assault survivors, and even three different anxiety management group workshops.

Closer to Burlington, Norwich University also engages in 'Wellness Days' to allow students to relax and recharge (Crowley, 2021). The university's various colleges all selected activities pertaining to their school. They offered students board games, movies, yoga, table tennis, tie-dying, a hot cocoa bar, waffles and popcorn, and many more athletic events across the day and campus.

In April 2020, Cornell completed a Mental Health Review of their campus that assessed the current state of mental health and wellness and offered a significant and substantial variety of recommendations for improvements (Cornell University, 2020). These recommendations fell under four key areas:

- Fostering a healthy campus environment

Key recommendations included reviewing the actual costs for an equitable Cornell experience (as well as financial aid and student loan information and policies), ensuring adequate

funding for equitable access to central Cornell experiences, and improving ease of access to information and campus resources.

- Promoting social connectedness and resilience:

Critical areas for improvement noted were reviewing the orientation and programming for new students to foster improved understanding of university resources, increasing social connections between students and between students and advisors, and managing student expectations regarding the transition into college. They also advised expanding access and quantity of free physical fitness opportunities, revamping university services to more adequately meet students' needs and align with students' schedules, providing a weekly slate of robust student activities, and expanding campus spaces for social interaction.

- Increasing help-seeking behavior and identifying people in need of care:

The report also recommended ensuring that all new students receive information about how to recognize symptoms of mental illness, where to obtain resources and support, how to talk to struggling friends, and how to provide appropriate support to those friends. The report also noted including mental health services planning as a segment of the new student checklists and within recruitment materials. The report also advised creating a social media platform for faculty, staff, and students to model help-seeking behaviors by sharing stories of students asking for help, seeking professional assistance, and experiencing challenges and disappointment. They

also recommended ensuring that mental health and related staffing needs reflect best practices for an institution of Cornell's size.

- And improving medical and mental health services:

Lastly, Cornell aims to develop a framework for student/patient access and continuity of care. Considering consultation with the International Accreditation of Counseling services to benchmark against other collegiate mental health services, particularly regarding cutting-edge practices such as the same day appointments and integrated healthcare. Cornell also plans to conduct ongoing assessments of outcomes and experiences related to CAPS and implement annual professional development training expectations for all clinical staff on crucial topics in collegiate mental health.

The National Association of Student Personnel Administrators (NASPA) Research and Policy Institute recently promoted several strategies for federal and postsecondary education centers to address an increasing need for mental health support on college campuses (Wesley, 2019). One of their key recommendations was for institutions to "remain true to the 'no-wrong-door' adage." For example, the University of North Texas (UNT) developed a flow chart on how their CARE team operates and how connecting individuals with on-and-off campus resources functions. It also guides readers to an appropriate action step in response to concerns about a student's behavior, which aims to simplify complex or ambiguous processes for individuals unsure about how to aid a student who is a threat to themselves or others, thereby promoting the

idea that any student can visit any official location on campus and receive helpful and accurate direction to mental health services if needed.

They also advocated for increasing Telemental Health Services. Telemental Health Services may offer increased access to mental healthcare by allowing students to access care on their own time and for students who may be reluctant to receive face-to-face counseling. Due to TMH's only recent rise to everyday use, there is a lack of research surrounding TMH, which may place universities at a higher risk of malpractice claims. Nevertheless, recent research has also demonstrated that Digital Mental Health Interventions may be effective (42, 47%) or partially effective (30, 34%) in producing beneficial changes in the main psychological outcome variables (Lattie, et al., 2019). Importantly, NAPSA noted that "there is no one best model of care; the design of an institution's mental health support efforts will depend on the specific campus context and realities faced by its students and campus practitioners (Wesley, 2019)."

NASPA also constructed a memo for improving student access and utilization of campus mental health resources (Lee, 2016). This memo promoted the creation of online referral systems to notify campus response teams about student issues and concerns, creative marketing, and outreach for items that students may actually keep (beyond a brochure), efforts to improve the diversity of options available to students, more peer-to-peer programs, and continued constant assessment of services.

A noteworthy example of increased diversity of options for students exists at the University of Denver. For two hours every day, students may walk into counseling and be

connected with a trained professional without undergoing any intake forms, providing any personal information, and may choose to remain completely anonymous.

The University of Minnesota devised a creative method to improve outreach from their wellness staff. University of Minnesota staff offers a welcome week and challenges students to balance a “feather” on their fingertips. “This feather serves as a metaphor for the balancing that students will be facing in college, the activity attracts students to the table, and the students then get to keep the feather which has all of the health information related to resources around health and wellness; that the campus offers.”

Comparably, the Worcester Polytechnic Institute is leading the way in peer-to-peer programs. The Student Support Network at the University offers a 6-week training program that students can take for credit that helps them prepare to offer support to students on campus. Sessions last 50-minutes and are taught by Worcester Polytechnic Institute counseling center staff.

Finally, the United States Air Force Suicide Prevention Program has seen effective results (United States Department of the Air Force, 2022). This program contains eleven key initiatives including active involvement from senior leadership to motivate full engagement with suicide prevention efforts; suicide prevention education in all formal trainings; all commanders receiving training on how and when to use mental health services, and one’s role in encouraging early help-seeking behaviors; effective tracking and encouragement of prevention activities; annual suicide prevention training for all members; following any period of high-risk for suicide,

individuals must be assessed by a supervisor and a mental health providers obtained if any question about the possibility of suicide exists; trauma stress response teams help personnel deal with emotions following serious accidents or suicides; an Integrated Delivery System and Community Action Information Board provides a forum for cross-organizational review and resolution of individual, family, installation, and community issues that may impact the quality of life for air force members; Mental Health providers offer increased confidentiality; creation of the IDS Consultation Assessment Tool (originally the Behavioral Health Survey) to allow supervisors to design interventions to support the health and wealth fare of their personnel; and a central database that all active-duty suicides and suicide attempts are entered into to facilitate the analysis of potential risk factors for suicide in air force personnel. Notably, studies have demonstrated that, through the air force's program, "it is possible to reduce the rate of suicide across a period of years using a multifaceted, overlapping, community-based approach, and reductions in suicide rates cannot be simply maintained by virtue of a program's inherent momentum (Knox, et al., 2010)."

Discussion on Present Services:

The University of Vermont:

The Mental Healthcare System at the University of Vermont shares many similarities to the broader United States Mental and Physical Healthcare systems. UVM's mental healthcare system, like that of the U.S, consists of high-level providers, generalists, social workers, and volunteers within the three main settings of hospitals, outpatient clinics, and other informal venues. However, there are some critical differences between the two models. Unlike within the rest of the United States, all University of Vermont students are required to have health insurance while in attendance at the University (The University of Vermont, 2022). Additionally, the University of Vermont offers a variety of services unique to the university. Together, these extra aids, along with other recent improvement efforts, help cement UVM's place above the basic mental healthcare system in the United States.

The University of Vermont directly employs three higher-level providers, one doctor of medicine and two psychologists, to provide mental healthcare services (The University of Vermont, 2022). The Doctor of Medicine is board-certified in psychiatry, while the two psychologists have both obtained clinical psychology degrees (PsyD); all are licensed to practice in Vermont. UVM additionally retains a generalist-level provider, another Doctor of Medicine, who has yet to obtain a degree in psychiatry but has worked within CAPS since 2005.

The University also maintains thirteen providers at the social worker level. Licensure for these providers ranges from providers with master's degrees to licensed mental health counselors, licensed independent clinical social workers, and alcohol and drug counselors. UVM's licensed providers are all verified by the state of Vermont, and several also hold national

certifications. Furthermore, while the University of Vermont does offer peer-counseling services and support groups, any services directly provided by the University will contain at least one provider at the social worker level or above (The University of Vermont, 2022). For example, the group/peer counseling services will be run by one or two providers with social work degrees and classes on mental health issues will be overseen by an individual with a clinical psychology degree. Therefore, no services directly provided by the University of Vermont will be solely offered by informal volunteers.

Of note, the ratio of providers to students recommended by the International Accreditation of Counseling Services is 1 provider to 1,600 students and the University does achieve this goal (as the number of students at the University of Vermont is 11,898 students and the University directly supplies 20 providers, a 1:600 ratio) (International Accreditation of Counseling Services, 2019). However, a more recent report from the Hopeful Futures campaign updated those recommendations to 1 psychologist per 1,500 students, 1 social worker for 1,250 students, and 1 counselor for 1,250 students (Barton, 2022). UVM achieves the latter two goals but nowhere near the first. Most providers at the University of Vermont practice at the generalist/social worker level. Therefore, one may wonder if hiring more higher-level providers with additional specialized training in mental health may provide increased benefits for students. One study analyzing the effectiveness and issues surrounding a master's level education in counseling psychology found that there are some concerns about the master's level education's ability to integrate training within the full spectrum of psychology and that "master's trained individuals differ from those with a doctorate in both the foundational competency domain and the functional competency domain (Jackson & Scheel, 2013)."

Mental health services directly provided by UVM predominantly occur within the outpatient and more informal settings. Outpatient services are mostly provided within the CAPS Offices in Wright Hall (436 S. Prospect St) on the Redstone Campus and within the Jacobs House (146 S. Williams St.). As stated in a 2018 Cynic Staff editorial, these offices, due to their locations on Redstone Campus (almost a mile from Central Campus), "are not accessible locations for many students…[since,] when students are feeling discouraged, any roadblock on the path to getting mental health services can turn people away completely. (Vermont Cynic Staff, 2018)" Likewise, consideration of moving or, during further developments, constructing mental health facilities in more accessible locations on campus may demonstrate an active effort to increase awareness, accessibility, and normalization of mental illness and obtaining treatment when needed.

The University of Vermont has also recently initiated some efforts to improve the accessibility of counseling services for UVM students. As of this current semester (Spring 2022), through leftover grant funds, the UVM Care Team has hired one counselor and is actively looking to hire another to live in the dorms, offering more rapid access to counseling services for UVM Students (Grogan, 2022). The hiring of these resident counselors was, in conjunction with renewed efforts to switch to a short-term counseling model (stepped-care) and additional actions to decrease waitlist times, precipitated by the death by suicide of two UVM students in 2018. The University of Vermont's healthcare team's transition to the stepped-care model prioritizes less-intensive treatments (self-help guides and group therapy) prior to more-intensive treatments (individual therapy provided by specialists and possibly subsequent psychopharmacological treatments) (Ho, Yeung, Ng, & Chan, 2016). This transition aligns with current best practices and is considered one of the best possible solutions to reducing the existing (mental) healthcare

burden. When appropriately implemented, the stepped-care model is one of the most self-correcting and least-restrictive models of care, being more clinically effective in treating anxiety and depression while also more cost-effective in treating bulimia in comparison to care as usual and traditional cognitive behavioral therapy. Patients still requiring frequent and intensive therapies are referred out to providers in the community (Grogan, 2022).

Sadly, these students often find themselves contending with the massive shortage of mental healthcare professionals in Burlington, Vermont—and nationwide (Grogan, 2022). Vermont Public Radio recently reported this shortage was potentially reaching a "point of no return. (Hirschfeld, 2021)" Often waitlists include hundreds of people leading to wait times of eight to ten weeks, or more, for individual therapy appointments, and, while people in need of immediate care are often seen within 48 hours, these patients face serious hindrances to reaching definitive, continued, and consistent mental healthcare (Viglienzoni, 2021). These extended waitlists within the greater-Burlington area force students to travel further and further to obtain their mental healthcare needs (Grogan, 2022). Unfortunately, there is little data to demonstrate how extensive or often these "transportation barriers lead to rescheduled or missed appointments, delayed care, and missed or delayed medication usage, with consequences possibly leading to poorer management of chronic illnesses and thus poorer health outcomes (Syed, Gerber, & Sharp, 2014)." One measure that supports a greater need for improving the transportation available to patients seeking mental healthcare is the drastic increase in overdose deaths within Vermont in recent years (Vermont Care Partners, 2022). Primarily in reaction to this increase, the Howard Center, a Burlington-based nonprofit offering professional crisis and counseling services for those struggling with mental health and substance abuse disorders, has decided to invest in a clinical vehicle to provide mobile outreach to patients in need.

In the years since 2018, one thing that has not changed about the University's response to deaths by suicide on campus is the announcement of these events to students at the University. UVM continues to refer to student deaths by suicide as "an untimely death." Per Dr. Alan Berman, the executive director of the American Association of Suicidology, this may be due to the University "acceding to family wishes…or false beliefs…and University concerns over litigation, and if they call it what it looks like, that increases the chances that there will be a lawsuit. (Picard, 2010)" However, it also stifles openly discussing and normalizing mental illness by encouraging the continued stigmatization of one of its most tragic outcomes.

A review of published literature has demonstrated that "acknowledging and talking about suicide may in fact reduce, rather than increase, suicidal ideation, and may lead to improvements in mental health in treatment-seeking populations (Dazzi, Gribble, Wessely, & Fear, 2014)." Likewise, in 2008, Scotland embraced a new national strategy called 'Choose Life' (the initial program began in 2002) and a poster, press, and radio-advertising campaign called 'Don't hide it. Talk about it (Briggs, 2010).' Since its onset, Scotland has recorded at least an eighteen percent decrease in deaths by suicide (British Broadcasting Corporation, 2013), suggesting that increasing discussion surrounding mental health across the entire campus population may be worth further consideration.

UVM students, who are required to have insurance, do not suffer the same nationwide cost barriers to mental healthcare as the broader population. However, as a population, students continue to experience considerable financial burdens that impact their mental health(care). For example, the Urban Institute reports that "thirty to forty percent of all undergraduate students take federal student loans; and seventy percent of students who receive a bachelor's degree have education debt by the time that they graduate. (Urban Institute, 2017)" With students already

paying $10,000 or more each year to attend college, thousands of dollars in medical bills, even if only the result of coinsurance payments, adds substantial stress and impedes a student's ability to obtain mental healthcare and a good quality of life (Rau, 2021). Unfortunately, as of 2021, "just 56% of psychiatrists accept commercial insurance compared to 90% of other, non-mental health physicians. (Leonhardt, 2021)" Often due to insurance companies continued paying of mental health professionals at lower negotiated rates for their services compared to physicians with similar backgrounds and experience levels, patients and students are forced to obtain out-of-network care, traditionally ranging from $65-$250 for each hour-long session.

Notably, the University of Vermont Student Health Insurance Plan (UVM SHIP) covers "many services at 100% that are not covered by the Student Health Fee. This includes lab costs and orthopedic supplies. UVM SHIP covers psychiatry at Counseling and Psychiatry Services at 100% for the initial visit and 80% for additional visits. The remaining 20% is charged to the student or the student's account. (The University of Vermont, 2022)" This discrepancy adds to the observation that the physical and mental healthcare systems are not administered equally. Out-of-network, coinsurance, and medication costs can also result in a patient with major depression spending an "average of $10,836 a year" on related health costs (Leonhardt, 2021). However, students at the University of Vermont are not the only ones facing or managing high financial costs. Due to the COVID spending freeze enacted by the University of Vermont, the mental health services (and a substantial portion of the university) have been unable to adjust or increase the allocation of their funds within the past several years (Grogan, 2022).

Despite lacking funds, the University of Vermont Mental Healthcare team attempts to manage their finite resources, to the best of their abilities, with the large number of students at UVM who experience mental health issues during their collegiate experience; this author

believes that they have made productive progress with their department-wide transition and renewed efforts toward a successful stepped-care model. This assessment is based on the fact that the stepped-care model aligns with nationwide and global best care practices for mental health treatment within universities (Ho, Yeung, Ng, & Chan, 2016). The stepped care model has also reduced wait times for students to reach their initial visits and provided a better allocation of providers to students (Grogan, 2022). The University of Vermont Mental Healthcare services also provides significantly increased accessibility to mental health services than are generally available to many segments of the U.S. population. The group counseling sessions, drop-in counseling hours, substance use and abuse teams, sexual assault survivor resources, and active measures to account for the issues faced by minority groups all support the reality of constructive advancement by UVM's mental health services beyond the status quo. Nonetheless, there remain substantial areas for future study and advancement within the UVM Mental Healthcare systems.

Considerations for the Future:

One of the most significant areas for further research within the University of Vermont Mental Healthcare system is the frequency at which students, who are experiencing mental health difficulties, approach advisors and other gatekeepers within the university and how effective the responses are from those advisors and gatekeepers. It also remains unclear how well certain aspects, such as academics, financial aid, athletics, and other departments within the University of Vermont, interact with the more clinically-focused mental health services on campus. How well is the university remaining true to the 'no-wrong-door adage," where any student can visit any university official and be directed appropriately toward helpful and effective mental health services?

Another area for further study is how students feel about the quality and quantity of mental health services at the University of Vermont. While cognitive-behavioral therapy, psychodynamic therapy, and humanistic therapy all produce roughly equivalent results within the general public, the University of Vermont should strive to make sure that all three are offered by mental health providers at the University of Vermont, as some of those modalities are more effective in the treatment of certain problems (Michigan School of Psychology, 2014). Currently, it is unclear, on the UVM mental healthcare websites, whether different therapy methods beyond Cognitive Behavioral Therapy are available to students. In addition to maintaining the three primary effective modalities of psychotherapy, by implementing further effective programs with student input, the University of Vermont could reduce the stress and anxiety of students on campus and hopefully result in lower rates of other general mental illnesses (depression, substance abuse, social isolation, problems functioning at school or work, poor quality of life, and suicide) on campus (Mayo Clinic, 2018).

The University should obtain and publish more concrete and specific data on student use and satisfaction with the mental health services at the University of Vermont. Two methods for obtaining this data could be: implementing exit surveys after every CAPS appointment and performing more thorough needs-based assessments of the current student population—or both. If the latter were the method utilized, individual student interviews should be included, as well as a general population survey. Student interviews might allow the development of more candid conversation on the matters and enable the researcher and University to hopefully discover new and innovative avenues for improving the mental health services at the University of Vermont.

Just as continued upkeep of available mental health services is essential to the University of Vermont maintaining and improving their students' mental health services, the University

should continue to strive to improve the awareness of mental ill-health and advocate for the de-stigmatization of mental ill-health. To promote speaking out about mental health and mental ill-health, in addition to openly discussing the topic of suicide, the University of Vermont could pursue a similar approach as Northwestern University and add a significant mental health awareness session to new-student orientation. The university could also consider adding a comprehensive mental health screening to all new students attending UVM to identify varying levels of at-risk students. While the University of Vermont already offers a mental health screening tool, the screening is voluntary, and a more comprehensive approach, especially earlier on, could offer improved patient outcomes. For example, students perceived as significantly at-risk could be referred to a program similar to McLean Hospital's Bridge to Campus College Readiness Consultations. Additionally, all students may benefit from utilizing a mental health awareness simulation like Kognito prior to attending UVM. Hopefully, through these programs, the University could witness increased student awareness of the available mental health tools, programs, and resources on campus; reduced stigmatization of mental-ill health; and continued spreading of the message that "mental healthcare services are for all students."

The University of Vermont could also consider increasing the accessibility of wellness programs throughout the semester. For example, one thing that deterred this author from utilizing some of the gym classes/services (yoga, meditation, recreational sports, and more) were the associated costs. Similarly, the costs associated with psychiatric care at UVM may deter students from pursuing treatment. On the topic of accessibility, the University should follow in the steps of the University of Denver and provide more anonymous drop-in hours with high-level counselors. Crucially, these hours should be varied daily to best accommodate most university students' already intense but incredibly unique schedules. Likewise, dedicating a week, or

several extra days, each semester, to the awareness of the mental health resources, could aid in reducing students' stress levels. Ideas on how to fill that week could be drawn from the University of Minnesota's Mental Health staff's "Welcome Week," the University of Florida's recharge days, and Norwich University's "Wellness Days." Furthermore, short mental health programs could be added to the curriculum of UVM required classes. Implementing even simple five-minute mindful breathing exercises and social-emotional learning projects may allow students to say, "I can do this."

However, perhaps most importantly, as has been similarly requested by students regarding sexual assaults on campus, the University of Vermont must continue to become more transparent and open about data regarding and proposed changes pertaining to mental health on campus. It needs to increase the amount of student data/input collected in order to continue improving the status quo. Bottomline, the University of Vermont should aspire to remain at the forefront of advancements surrounding student mental health. Doing so is an essential component of fulfilling the *health and public service* aspects highlighted in its vision, "To be among the nation's premier research universities with a comprehensive commitment to a liberal arts education, environment, *health*, and *public service*. (The University of Vermont, 2022)"

Implementation Issues:

Future progress will certainly encounter hurdles. Two predicted problems will be the affordability of new programs and overcoming concerns from administrators related to an increasingly open approach to mental health research.

Currently, CAPS and the University of Vermont feel that their budget is tightly confined (Grogan, 2022). However, there may be some avenues to expand those budgets. One model to increase the income of the mental health services at the University of Vermont would be to follow the billing model of the University of Vermont Rescue. In a best attempt to avoid any undue hardship to students, staff, and faculty of the University of Vermont, UVM Rescue will bill every transported student's insurance; however, UVM Rescue will avoid billing past the amount that a student's insurance company pays out. Therefore, all students can afford the costs associated with emergency medical care at UVM. CAPS and other mental health services (possibly including wellness services) may be able to enact a similar billing platform—no longer offering any free services—but instead allowing students to always be able to obtain any needed mental health care. Additionally, UVM should continue to scour the available state and federal grants related to mental healthcare to provide more funding for desperately needed services, if not already doing so.

Secondly, given historic trends surrounding mental health research among students at UVM, it is likely that the University of Vermont's Institutional Review Board (IRB) may have significant hesitancy with substantial mental health research being performed on students, especially among students actively undergoing clinical treatment and those at risk of suicidality.

However, research suggests that adverse mental health reactions are unlikely and occur only slightly more than within the general population, “less than 10% of persons with psychiatric disorders who participated in interview-based research experienced more than minimal anxiety and that even fewer reported this anxiety reached severe levels. Comparable rates of reports by participants of greater than minimal anxiety have been found in behavioral studies of psychiatric symptoms in populations without psychiatric disorders. Studies of psychiatrists have found that they regard questionnaire-based studies as the least risky category of research for people with psychiatric disorders and that they consider these studies to involve less risk than persons in this population would encounter in daily life. (Yanos, Stanely, & Greene, 2009)” In addition to this research potentially saving lives, relieving significant distress, improving quality of life, reducing levels and stigmatization of mental ill-health, and generating social and economic benefits within our communities, it would stand to contribute meaningfully to a severely underfunded and underprioritized area of medicine (Alliance of Mental Health Research Funders, 2015). Research on student satisfaction with mental health services at the University of Vermont could also provide influential quality assurance and quality improvement data for the various mental health programs at UVM. An example of potential gains could be understanding whether students can easily, and when needed, reach an available mental health counselor during the at-present available drop-in hours. Moreover, as evidenced by the United States Air Force Suicide Prevention Program, continued research, implementation, and upkeep of mental health programs are required for organizations and individuals to continue receiving meaningful benefits (Knox, et al., 2010).

Conclusions:

The mental healthcare services at the University of Vermont appear to strive towards a goal of excellence, which places them above the general U.S. mental healthcare system. The system of providers, locations, and patients provides an established framework for a potentially effective system. However, there remain avenues for university officials to obtain an increased understanding of the efficacy and impact of the mental ill-health situation, care models, and communications on campus. Therefore, within continued improvement efforts, based on other universities' effective programs, the University of Vermont should continue investing in students' mental health and improving the social, education, and economic wellbeing of their students, campuses, and broader society. Inspired by guidelines proposed by the American Council on Education, UVM should aim to:

- make active, evidence-based efforts to discuss mental ill-health more openly and transparently, even at the risk of slight liability concerns.
- strive to invest further in its mental healthcare services by continued hiring of diverse providers at the doctoral level and with a variety of therapeutic techniques and styles.
- integrate mental health and mental ill-health awareness, training, and destigmatization efforts within the academic curriculum to increase help-seeking behavior, promote social connectedness, and foster a healthier campus environment.
- prioritize listening to, incorporating, and responding to students' needs and desires via increased research and understanding surrounding UVM's baseline mental health levels.

Hopefully, especially with continued student efforts to push our university towards excellence, we will witness the continued improvement of student resiliency and quality of life in the coming years, and decades, at the University of Vermont.

Limitations:

The author of this report denies any known conflicts of interest or sources of funding. However, I do note some potential biases within my research. This report reflects my interests, questions, and concerns. The report also predominantly utilizes qualitative research techniques, losing some of its replicability and strict scientific methodologies; instead, it focuses on potential avenues for further research and discovery relating to this information. I also experienced significant time constraints during this project; given additional time, I would endeavor to interview more individuals within the University of Vermont's mental healthcare system and provide further review and synthesis of these materials. This report additionally notes limitations regarding its ability to adequately assess or determine the effectiveness and frequency of communication between the various mental health services at the University of Vermont. This weakness is primarily due to a lack of publicly accessible data (number of student visits to each service, lengths of visits, frequency of use by individual students, referrals to other university and outside services, frequency of follow-up discussions with students, and more). I also recognize that this thesis has strayed from the biopsychosocial approach and become more sociologically focused. This transition was intentional due to a lack of ability to obtain and appropriately evaluate the psychological effects and impacts of specific clinical therapies on students, much less their relation to students' underlying neurobiological conditions, within the time frame and resources available to a single undergraduate student. I recommend that further research within sociological, psychological, and bio-neurological fields amongst students at the University of Vermont, and the general complement of colleges and universities in the United States, be completed. However, I would also advocate the incorporation of psychologists, psychiatrists, neurobiologists, and additional doctoral-level researchers to provide a more

compelling clinical and professional understanding of the topics and resources necessary to complete such research successfully.

Acknowledgments:

I want to acknowledge several outstanding professors who have helped me complete my thesis. Thank you to retired Professor Dale Jaffe for starting this extensive project with me (and aiding me in designing my undergraduate major) and comprehensively coaching and introducing me to the processes surrounding healthcare research, especially the part about making sure that I would attempt a thesis that I could successfully manage within my senior undergraduate year. I would also like to thank Professor Jom Hammack for stepping in halfway through my thesis and always answering any questions; the help has been truly appreciated. Thank you to Professors Jay Silveira and Mary Burke for taking the time out of their demanding schedules to review my thesis and participate in my thesis defense; I could not complete this work without you both. To John Paul Grogan, thank you for allowing me to interview you; the discussion was illuminating and certainly provided information and perspective that I would not have had before. To my friends and family, thank you for putting up with the long hours and inattention by me as I focused on mental health research for the past two and a half years.

Lastly, I would like to acknowledge that my thesis would not exist without the immense suffering of thousands of individuals each minute, hour, day, and year within colleges and universities around our nation. Therefore, I would like to take a moment to acknowledge that we have not been able to save or help everyone…and I am sorry that we, as a society, have not yet been able to understand the experiences and troubles that people with mental ill-health constantly face. I hope that we can do better and together make the world a brighter place in the future.

Glossary of Terms:

Mental Ill-health:

"A mental illness is a disorder diagnosed by a medical professional that significantly interferes with an individual's cognitive, emotional or social abilities. There are different types of mental illness and they occur with varying degrees of severity. Examples include mood disorders (such as depression, anxiety and bipolar disorder), psychotic disorders (such as schizophrenia), eating disorders and personality disorders. Mental Health problems will also be encapsulated within this definition and are defined as, "A mental health problem also interferes with a person's cognitive, emotional or social abilities, but may not meet the criteria for a diagnosed mental illness. Mental health problems often occur as a result of life stressors, and are usually less severe and of shorter duration than mental illnesses. These often resolve with time or when the individual's situation changes. However, if mental health problems persist or increase in severity, they may develop into a mental illness. (Everymind, 2022)"

Mental Health:

"A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. With respect to children, an emphasis is placed on the developmental aspects, for instance, having a positive sense of identity, the ability to manage thoughts, emotions, and to build social relationships, as well as the aptitude to learn and acquire an education, ultimately enabling their full active participation in society. (World Health Organization, 2013)"

Mental Healthcare:

"Services devoted to the treatment of mental illnesses and the improvement of mental health in people with mental disorders or problems. (Collins Dictionary, 2020)"

United States Healthcare System:

"The U.S. health system is a mix of public and private, for-profit and nonprofit insurers and health care providers. The federal government provides funding for the national Medicare program for adults aged 65 and older and some people with disabilities as well as for various programs for veterans and low-income people, including Medicaid and the Children's Health Insurance Program. States manage and pay for aspects of local coverage and the safety net. Private insurance, the dominant form of coverage, is provided primarily by employers. Public and private insurers set their own benefit packages and cost-sharing structures, within federal and state regulations. (The Commonwealth Fund, 2020)"

—This report opted to include the aspect of patients into consideration surrounding the American and University of Vermont Healthcare systems due to the significant issues regarding stigmatization, accessibility, affordability, and a "patient's willingness" to obtain physical and mental health services within the United States of America.

Health Maintenance Organizations

"A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for

coverage. HMOs often provide integrated care and focus on prevention and wellness. (HealthCare.gov, 2022)"

Gatekeeper:

"A gatekeeper is someone in a natural position to see warning signs of [mental ill-health] in others. Gatekeepers interact frequently with students and can guide someone to the appropriate professional care or resources. Examples of gatekeepers might be Residence Life staff, academic advisors or student leaders. (Washington State University, 2016)"

Biopsychosocial Model of Mental Health:

"Most medical professionals now consider mental health to be affected by three main areas that are encapsulated in the biopsychosocial model:

- Biological (e.g. genetics, brain chemistry and brain damage)
- Social (e.g. life traumas and stresses, early life experiences and family relationships)
- Psychological (e.g. how we interpret events as signifying something negative about ourselves)

These factors interact with each other in complex ways to produce the final result that is a person's overall mental health…According to the biopsychosocial model, mental health is the result of many forces occurring at different which have a cumulative effect on the individual. These forces can be positive or negative. If the negatives outweigh the positives then a person could develop a mental illness…It's unlikely to be one specific thing that causes mental ill-health, but rather a mixture of negative circumstances that have built up. There might be one

thing that pushes a person too far, but it's unlikely to be this alone that caused a disorder. (Delphis, 2019)"

Marginalized Populations:

"Marginalized populations are groups and communities that experience discrimination and exclusion (social, political and economic) because of unequal power relationships across economic, political, social and cultural dimensions. (National Collaborating Centre for Determinants of Health, 2022)"

LGBTQAI+; GSM; DSG:

"*Abbreviation*: Shorthand or umbrella terms for all folks who have a non-normative (or queer) gender or sexuality. Many different initialisms are preferred. *LGBTQIA* is Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, and Asexual/Agender/Aromantic (sometimes with a + at the end in an effort to be more inclusive); *GSM* is Gender and Sexual Minorities; *DSG* is Diverse Sexualities and Genders. Other options include the initialism GLBT, LGBT or LGBTQ and the acronym QUILTBAG (Queer/Questioning Undecided Intersex Lesbian Trans Bisexual Asexual/Allied and Gay/Genderqueer). (National Athletic Trainers Association, 2021)"

Parity:

"Parity means that health plans cover services for mental health and substance use and services for medical and surgical problems comparably:

- Benefits. If a plan offers mental health and substance use benefits, they must be provided in every classification in which medical and surgical benefits are offered. For example, a plan can't cover in-network inpatient stays for patients recovering from surgery but exclude in-network inpatient treatment for mental health.
- Limits on treatment. Treatment limitations applied to mental health and substance use benefits generally can't be more restrictive than those applied to "substantially all" physical health benefits. For example, mental health and substance use benefits generally can't have lower limits on treatment frequency. Requirements related to prior authorization of treatment and medical necessity determinations must also be comparable and no more stringently applied to mental health and substance use coverage than physical health coverage.
- Cost-sharing. Copayments, coinsurance, deductibles, and out-of-pocket costs for mental health and substance use benefits are subject to a formula that—in simplified terms—means that copayments, for example, cannot be higher for mental health and substance use services than the copayments for two-thirds of all physical health benefits in the same classification. (American Psychological Association, 2021)."

Disparity:

"The definition employed by the Institute of Medicine (IOM) in its *Unequal Treatment* report: a disparity is a difference in health care quality not due to differences in health care needs or preferences of the patient. As such, disparities can be rooted in inequalities in access to good providers, differences in insurance coverage, or discrimination by health professionals in the clinical encounter. (McGuire & Miranda, 2008)"

Copay:

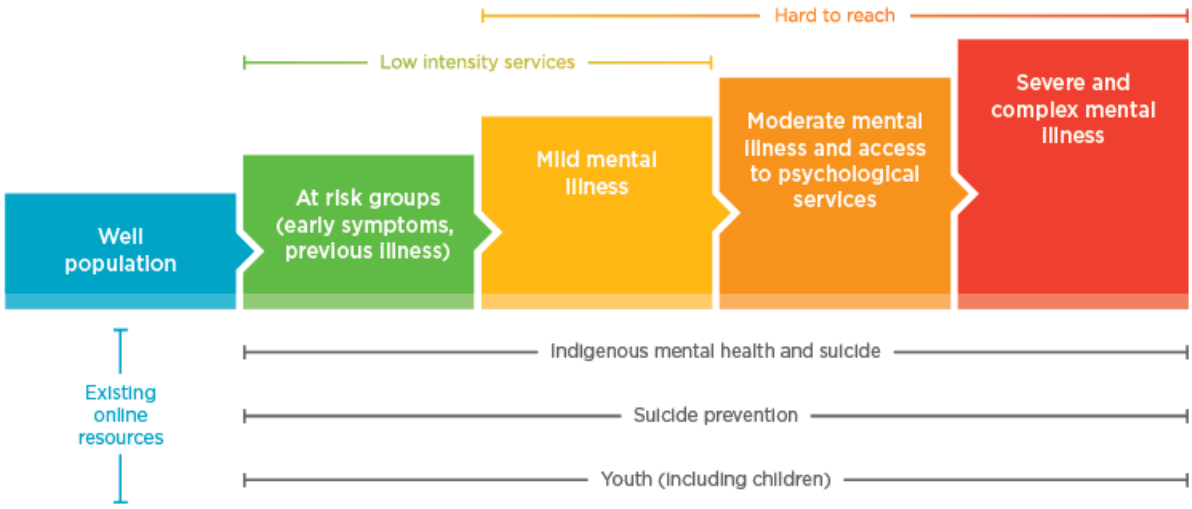
"A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service. (Centers for Medicare & Medicaid Services, 2020)"

Coinsurance:

"Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.) (Centers for Medicare & Medicaid Services, 2020)"

Stepped-Care Model:

Stepped care is an evidence-based, staged approach to the delivery of mental health services, comprising a hierarchy of interventions—from the least to the most intensive—matched to the individual's needs. It is about ensuring that people can access the most appropriate services for their mental health needs at any given time— including the ability to step up and step down to different levels of care as they move along their recovery journey. (Connect to Wellbeing, 2022)"



Cognitive Behavioral Therapy (CBT):

"Cognitive behavioral therapy (CBT) is a form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorders, and severe mental illness… CBT is based on several core principles, including:

- Psychological problems are based, in part, on faulty or unhelpful ways of thinking.
- Psychological problems are based, in part, on learned patterns of unhelpful behavior.
- People suffering from psychological problems can learn better ways of coping with them, thereby relieving their symptoms and becoming more effective in their lives.

CBT treatment usually involves efforts to change thinking patterns…treatment also usually involves efforts to change behavioral patterns…CBT places an emphasis on helping individuals learn to be their own therapists. Through exercises in the session as well as "homework"

exercises outside of sessions, patients/clients are helped to develop coping skills, whereby they can learn to change their own thinking, problematic emotions, and behavior.

CBT therapists emphasize what is going on in the person's current life, rather than what has led up to their difficulties. A certain amount of information about one's history is needed, but the focus is primarily on moving forward in time to develop more effective ways of coping with life. (American Psychological Association, 2017)"

Psychodynamic Therapy:

"Psychodynamic therapy is an approach that involves facilitation a deeper understanding of one's emotions and other mental processes. It works to help people gain greater insight into how they feel and think.

By improving this understanding, people can then make better choices about their lives. They can also work on improving their relationships with other people and work toward achieving the goals that will bring them greater happiness and satisfaction.

Psychodynamic therapy is rooted in psychoanalytic theory but is often a less intensive and lengthy process than traditional psychoanalysis. While psychoanalysis tends to focus a great deal on the patient and therapist relationship, psychodynamic therapy also places a great deal of emphasis on a patient's relationships with other people in the outside world.

Psychodynamic therapy is a form of talk therapy. It is based on the idea that talking to a professional about problems people are facing can help them find relief and reach solutions.

Through working with a psychodynamic therapist, people are able to better understand the thoughts, feelings, and conflicts that contribute to their behaviors. This approach to therapy also works to help people better understand some of the unconscious motivations that sometimes influence how people think, feel, and act.

This approach to psychotherapy can be helpful for dealing with mental or emotional distress. It can help promote self-reflection, insight, and emotional growth.

By better understanding your emotional patterns and their roots, you are better equipped to manage your problems and develop coping techniques that will help you both now and in the future. (Cherry, 2021)"

Humanistic Therapy:

"Also known as humanism, humanistic therapy is a positive approach to psychotherapy that focuses on a person's individual nature, rather than categorizing groups of people with similar characteristics as having the same problems. Humanistic therapy looks at the whole person, not only from the therapist's view but from the viewpoint of individuals observing their own behavior. The emphasis is on a person's positive traits and behaviors, and the ability to use their personal instincts to find wisdom, growth, healing, and fulfillment within themselves.

Humanistic therapy is used to treat depression, anxiety, panic disorders, personality disorders, schizophrenia, addiction, and relationship issues, including family relationships. People with low self-esteem, who are having trouble finding their purpose or reaching their true potential, who lack feelings of "wholeness," who are searching for personal meaning, or who are not comfortable with themselves as they are, may also benefit from humanistic therapy.

Humanistic therapists believe people are inherently motivated to fulfill their internal needs and their individual potential to become self-actualized. Self-actualization can take many forms, including creative endeavors, spiritual enlightenment, a pursuit of wisdom, or altruism. (Psychology Today, 2022)”

Bibliography

Agha, L., Frandsen, B., & Rebitzer, J. B. (2017, April). *CAUSES AND CONSEQUENCES OF FRAGMENTED CARE DELIVERY: THEORY, EVIDENCE, AND PUBLIC POLICY.* Retrieved April 2022, from NBER Working Paper Series: https://www.nber.org/system/files/working_papers/w23078/revisions/w23078.rev1.pdf?sy=078

Alkhouri, D. (2021, February 21). *Pandemic's mental health burden heaviest among young adults*. Retrieved from ABC News: https://abcnews.go.com/Health/pandemics-mental-health-burden-heaviest-young-adults/story?id=75811308

Alliance of Mental Health Research Funders. (2015). *Prioritising Mental Health Research.* Manifesto, Alliance of Mental Health Research Funders, United Kingdom.

Alonzi, S., Torre, A. L., & Silverstein, M. W. (2020). The Psychological Impact of Preexisting Mental and Physical Health Conditions During the COVID-19 Pandemic. *APA PsychNet, 12*(1), 236-238.

American Council on Education. (2019). *Investing in Student Mental Health.* American Council on Education, Washington, DC.

American Psychiatric Association. (2017, December 19). *Mental Health Disparities: Diverse Populations.* Retrieved March 2022, from American Psychiatric Association: https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts

American Psychological Association. (2017, July). *What is Cognitive Behavioral Therapy?* Retrieved April 2022, from PTSD Guidline: https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-

behavioral#:~:text=Cognitive%20behavioral%20therapy%20(CBT)%20is,disorders%2C%20and%20severe%20mental%20illness.

American Psychological Association. (2021, May 05). *What do employers need to know about parity?* Retrieved April 2022, from Managed Care Insurance: https://www.apa.org/topics/managed-care-insurance/parity-employers#:~:text=What%20does%20parity%20mean%3F,Benefits.

Ascend Learning. (2020). *Kognito*. (Blackstone Private Equity and The Canadian Pension Plan Investment Board) Retrieved April 2022, from Kognito: https://kognito.com/about/

Barton, A. (2022, March 3). *Where could Vermont's student mental health policies be stronger? Report card shows*. Retrieved April 2022, from Burlington Free Press: https://www.burlingtonfreepress.com/story/news/2022/03/03/vt-school-mental-health-report-card/9356838002/

Beck, J. (2014, January 23). *Diagnosing Mental Illness in Ancient Greece and Rome.* Retrieved February 2022, from The Atlantic: https://www.theatlantic.com/health/archive/2014/01/diagnosing-mental-illness-in-ancient-greece-and-rome/282856/

Bethune, S. (2020, October 20). *Stress in America 2020 Survey Signals a Growing National Mental Health Crisis*. Retrieved March 2022, from American Psychological Association: https://www.apa.org/news/press/releases/2020/10/stress-mental-health-crisis

Briggs, S. (2010). Suicide prevention: The contribution of psychoanalysis. In *Off the couch: Contemporary psychoanalytic applications* (pp. 44-66). London, United Kingdom: Taylor & Francis.

British Broadcasting Corporation. (2013, December 03). *Suicide prevention plan set out by Scottish government*. Retrieved April 2022, from BBC News: https://www.bbc.com/news/uk-scotland-25201480

Brown, N. (2021, October 19). *Innovative solutions at UF are supporting students' mental health well-being*. Retrieved 2022 April, from University of Florida News: https://news.ufl.edu/2021/10/from-florida-episode-5/

Brown, S. (2016, September 19). *Colleges Add Mental-Health Awareness to Crowded Orientation Lineup*. Retrieved April 2022, from The Chronicle of Higher Education: https://www.chronicle.com/article/colleges-add-mental-health-awareness-to-crowded-orientation-lineup/

Bruce L. Berg, H. L. (2012). *Qualitative Research Methods for the Social Sciences.* New Jersey: Pearson Education.

Cage, E., Jones, E., Ryan, G., Hughes, G., & Spanner, L. (2021, February 10). Student mental health and transitions into, through and out of university: student and staff perspectives. *Journal of Further and Higher Education, 45*(8), 1076-1089.

Centers for Medicare & Medicaid Services. (2020, January). *Glossary of Health Coverage and Medical Terms.* Retrieved April 2022, from Resources and Forms: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Uniform-Glossary-01-2020.pdf

Chadron State College. (2022). *CARE Team* . Retrieved from Chadron State College: https://www.csc.edu/care/resources/index.csc

Chadwick, L. (2021, February 11). *Students on campus face mental health challenges*. Retrieved April 2022, from The Vermont Cynic: https://vtcynic.com/features/students-on-campus-face-mental-health-struggles/

Cherry, K. (2021, January 28). *What Is Psychodynamic Therapy?* (S. Gans, Ed.) Retrieved April 2022, from Psychotherapy: https://www.verywellmind.com/psychodynamic-therapy-definition-uses-effectiveness-5094933#:~:text=Psychodynamic%20therapy%20is%20an%20approach,better%20choices%20about%20their%20lives.

Collins Dictionary. (2020, February 13). *Mental health care*. Retrieved from English Dictionary: https://www.collinsdictionary.com/us/dictionary/english/mental-health-care

Connect to Wellbeing. (2022). *Stepped Care support.* Retrieved April 2022, from Connect to Wellbeing: https://www.connecttowellbeing.org.au/stepped-care

Copeland, W. E., McGinnis, E., Bai, Y., Adams, Z., Nardone, H., Devadanam, V., . . . Hudziak, J. J. (2021, January). Impact of COVID-19 Pandemic on College Student Mental Health and Wellness. *Journal of the American Academy of Child & Adolescent Psychiatry, 60*(1), 134-141.

Cornell University. (2020). *Mental Health Review.* Cornell University, Cornell Health, Ithaca, New York.

Coursolle, A., & Holtzman, R. (2019, June 4). *Protections for LGBTQ People with Behavioral Health Needs.* Retrieved March 2022, from National Health Law Program: https://healthlaw.org/wp-content/uploads/2019/06/LGBTQ-Behavioral-Health-IB-final-6.4.2019.pdf

Crowley, M. (2021, November 10). *On Wellness Days, myriad ways to relax and recharge*. Retrieved April 2022, from Norwich University Newsroom: https://www.norwich.edu/news/3446-on-wellness-days-myriad-ways-to-relax-and-recharge

Curtin, S. C., Warner, M., & Hedegaard, H. (2016, April). *Increase in Suicide in the United States, 1999-2014.* Retrieved February 2022, from National Center for Health Statistics: https://www.cdc.gov/nchs/products/databriefs/db241.htm

Czeisler, M. É., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., . . . Rajaratnam, S. M. (2020). *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020.* Centers For Disease Control and Prevention. U.S. Government.

Dazzi, T., Gribble, R., Wessely, S., & Fear, N. T. (2014, July 07). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? *Psychological Medicine, 44*(16), 3361-3363.

Delphis. (2019, August 27). *The Biopsychosocial Model of Mental Health*. Retrieved April 2022, from Mental Health: https://delphis.org.uk/mental-health/the-biopsychosocial-model-of-mental-health/

Doran, C. M., & Kinchin, I. (2017, Novemeber 13). A review of the economic impact of mental illness. *Australian Health Review, 43*(1), 43-48.

Eva, A. L. (2019, January 11). *How Colleges Today Are Supporting Student Mental Health*. (University of California Berkeley) Retrieved April 2022, from Greater Good Magazine: https://greatergood.berkeley.edu/article/%C3%ADtem/how_colleges_today_are_supporting_student_mental_health

Everymind. (2022). *Understanding mental ill-health*. Retrieved April 2022, from Mental Health: https://everymind.org.au/mental-health/understanding-mental-health/what-is-mental-illness#:~:text=A%20mental%20illness%20is%20a,cognitive%2C%20emotional%20or%20social%20abilities.

Farreras, I. G. (2019). General Psychology: General Psychology: Required Reading Required Reading. In B. Poteet, & L. Brewer, *General Psychology: Required Reading* (pp. 1-324). Campaign, IL, USA: Diener Education Fund Publishers.

Fontana, T. (2022). *T-Break: Take a Cannabis Tolerance Break*. Retrieved March 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/t-break-take-cannabis-tolerance-break

Greenburg, P. E., Fournier, A.-A., Sisitsky, T., Pike, C. T., & Kessler, R. C. (2015, Feb). The economic burden of adults with major depressive disorder in the United States (2005 and 2010). *Journal of Clinical Psychology, 76*(2), 155-62.

Grogan, J. P. (2022, February 28). Discussion on CAPS Services. (E. A. Colberg, Interviewer)

Gruttadaro, D., & Crudo, D. (2021). *College Students Speak: A Survey Report on Mental Health.* National Alliance on Mental Illness.

Harvard University. (2012, May 10). *Some Strategies for Developing Interview Guides.* Retrieved February 2022, from https://sociology.fas.harvard.edu/files/sociology/files/interview_strategies.pdf

HealthCare.gov. (2022). *Health Maintenance Organization (HMO)*. (D. o. Services, Producer, & U.S. Centers for Medicare & Medicaid Services) Retrieved April 2022, from HealthCare.gov: https://www.healthcare.gov/glossary/health-maintenance-organization-hmo/

Hirschfeld, P. (2021, December 06). *Vermont's mental health agencies worry staffing shortages are reaching 'point of no return'*. Retrieved April 2022, from Vermont Public Radio: https://www.vpr.org/vpr-news/2021-12-06/vermonts-mental-health-agencies-worry-staffing-shortages-are-reaching-point-of-no-return

Ho, F. Y.-Y., Yeung, W.-F., Ng, T. H.-Y., & Chan, C. S. (2016, July 05). The Efficacy and Cost-Effectiveness of Stepped Care Prevention and Treatment for Depressive and/or Anxiety Disorders: A Systematic Review and Meta-Analysis. *Scientific Reports, 6*.

Hoffman, M. (2020, September 22). *25 Colleges Prioritizing Health & Wellness*. Retrieved April 2022, from EDUMED: med.org/resources/top-25-colleges-for-health-and-wellness/

International Accreditation of Counseling Services. (2019). *Staff to Student Ratios*. Retrieved April 2022, from iacs: https://iacsinc.org/staff-to-student-ratios/

Jackson, M. A., & Scheel, M. J. (2013, July 1). Quality of Master's Education: A Concern for Counseling Psychology? *The Counseling Psychologist, 41*, 669-699. Retrieved April 2022, from APA.org: https://www.apa.org/education-career/ce/masters-education.pdf

Kella, S. (2021, August 10). *The Imperfect Storm: College Students and Suicide.* Retrieved April 2022, from Harvard Political Review: https://harvardpolitics.com/the-imperfect-storm/

Khan, L. (2016). *16-25 years: Missed opportunities: children and young people's mental health.* Retrieved September 2021, from Centre for Mental Health : https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/CentreforMentalHealth_MissedOpportunities_16-25years.pdf

Kleiman, E. M., Yeager, A. L., Grove, J. L., Kellerman, J. K., & Kim, J. S. (2020, December). Real-time Mental Health Impact of the COVID-19 Pandemic on College Students: Ecological Momentary Assessment Study. *JMIR Mental Health, 7*(12).

Knox, K. L., Pflanz, S., Talcott, G. W., Campise, R. L., Lavigne, J. E., Bajorska, A., . . . Caine, E. D. (2010, December). The US Air Force Suicide Prevention Program: Implications for Public Health Policy. *American Journal of Public Health, 100*(12), 2457-2463.

Lattie, E. G., Adkins, E. C., Winquist, N., Stiles-Shields, C., Wafford, Q. E., & Graham, A. K. (2019, July). Digital Mental Health Interventions for Depression, Anxiety, and Enhancement of Psychological Well-Being Among College Students: Systematic Review. (G. Eysenback, Ed.) *Journal of Medical Internet Research, 21*(7).

Lee, C. (2016). *IMPROVING STUDENT ACCESS & UTILIZATION OF CAMPUS MENTAL HEALTH RESOURCES.* NASPA.org.

Leonhardt, M. (2021, May 10). *What you need to know about the cost and accessibility of mental health care in America.* Retrieved 2022 April, from CNBC.com: https://www.cnbc.com/2021/05/10/cost-and-accessibility-of-mental-health-care-in-america.html

Liu, C. H., Zhang, E., Wong, G. T., Hyun, S., & Hahm, H. ". (2020). Factors associated with depression, anxiety, and PTSD symptomatology during the COVID-19 pandemic: Clinical implications for U.S. young adult mental health. *Psychiatry Research, 290*.

Liu, J., Ma, H., He, Y.-L., Xie, B., Xu, Y.-F., Tang, H.-Y., . . . Yu, X. (2011, October). Mental health system in China: history, recent service reform and future challenges. *World Psychiatry, 10*(3), 210-216.

Long, M. A. (2019). *Policy Brief on Mental Health on U.S. College Campuses.* RhetTech.

Lumen Learning. (2019). *History of Mental Illness from the Stone Age to the 20th century*. Retrieved from Abnormal Psychology: https://courses.lumenlearning.com/hvcc-

abnormalpsychology/chapter/1-5-prominent-themes-in-abnormal-psychology-throughout-history/

Mayo Clinic. (2018, May 04). *Anxiety Disorders*. Retrieved April 2022, from Diseases and Conditions: https://www.mayoclinic.org/diseases-conditions/anxiety/symptoms-causes/syc-20350961#:~:text=Having%20an%20anxiety%20disorder%20does,or%20other%20mental%20health%20disorders

McGuire, T. G., & Miranda, J. (2008, March/April). New Evidence Regarding Racial And Ethnic Disparities In Mental Health: Policy Implications. *Health Affairs, 27*(2).

McLean Hospital. (2022). *College Mental Health Program*. Retrieved April 2022, from McLean: https://www.mcleanhospital.org/treatment/cmhp

McLeod, A. (2017). *Chinese philosophy has long known that mental health is communal.* (S. Dresser, Ed.) Retrieved February 2022, from Psyche: https://psyche.co/ideas/chinese-philosophy-has-long-known-that-mental-health-is-communal

Merriam-Webster Dictionary. (2022, April 6). *System*. Retrieved April 2022, from Merriam-Webster: https://www.merriam-webster.com/dictionary/system

Michigan School of Psychology. (2014, August 20). *Effective Therapy*. Retrieved April 2022, from MSP: https://msp.edu/effective-therapy/#:~:text=Thus%2C%20the%20best%20available%20research,the%20treatment%20of%20some%20problems.

MindWise Innovations. (2022). *How are you feeling?* Retrieved March 2022, from The University of Vermont: https://screening.mentalhealthscreening.org/uvm

Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and Opportunities to Meet the Mental Health Needs of Underserved and Disenfranchised Populations in the United States. *Focus.psychiatryonline.org, 18*(1).

Moseley III, G. B. (2008). The U.S. Health Care Non-System, 1908-2008. *American Medical Association Journal of Ethics, 10*(5).

National Alliance on Mental Illness. (2016). *The Doctor is Out*. Retrieved from National Alliance on Mental Health: https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out

National Alliance on Mental Illness. (2020, April). *Types of Mental Health Professionals*. Retrieved April 2022, from National Alliance on Mental Illness: https://www.nami.org/About-Mental-Illness/Treatments/Types-of-Mental-Health-Professionals

National Association of Social Workers. (2022). *https://www.socialworkers.org/News/Facts/Types-of-Social-Work*. Retrieved April 2022, from National Association of Social Workers: https://www.socialworkers.org/News/Facts/Types-of-Social-Work

National Athletic Trainers Association. (2021, April). *LGBTQIA+ Terminology 101*. Retrieved April 2022, from National Athletic Trainers Association: https://www.nata.org/practice-patient-care/health-issues/cultural-competence/lgbtq-terminology#:~:text=LGBTQIA%20is%20Lesbian%2C%20Gay%2C%20Bisexual,is%20Diverse%20Sexualities%20and%20Genders.

National Collaborating Centre for Determinants of Health. (2022). *Marginalized populations*. (S. F. University, Producer) Retrieved April 2022, from Glossary of Essential Health Equity

Terms: https://nccdh.ca/glossary/entry/marginalized-populations#:~:text=Marginalized%20populations%20are%20groups%20and,political%2C%20social%20and%20cultural%20dimensions.

National Council for Mental Wellbeing. (2018, October 10). *New Study Reveals Lack of Access as Root Cause for Mental Health Crisis in America.* Retrieved February 2022, from National Council for Mental Wellbeing: https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america/

National Institute of Mental Health. (2019). *Mental Illness*. Retrieved from National Institute of Mental Health: https://www.nimh.nih.gov/health/statistics/mental-illness

National Institute of Mental Health. (2022, January). *Mental Illness*. Retrieved February 2022, from National Institute of Mental Health: https://www.nimh.nih.gov/health/statistics/mental-illness

Ndugga, N., & Artiga, S. (2021, May 11). *Disparities in Health and Health Care: 5 Key Questions and Answers*. Retrieved March 2022, from Kaiser Family Foundation: https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

Newkirk II, V. R. (2016, June 17). *A Generation of Bad Blood.* Retrieved March 2020, from The Atlantic: https://www.theatlantic.com/politics/archive/2016/06/tuskegee-study-medical-distrust-research/487439/

Novella, E. J. (2010, January 10). Mental Health Care in the Aftermath of Deinstitutionalization: A Retrospective and Prospective View. *Health Care Anaylsis, 18*, 222-238.

Ornell, F., Borelli, W. V., Benzano, D., Schuch, J. B., Moura, H. F., & Sordi, A. O. (2021, December 01). The next pandemic: impact of COVID-19 in mental healthcare assistance in a nationwide epidemiological study. *The Lancet: Regional Health, 4*(100061).

Picard, K. (2010, November 03). *UVM Acknowledges Two Recent Student Deaths But Won't Use the S-Word*. Retrieved April 2022, from Seven Days: https://www.sevendaysvt.com/vermont/uvm-acknowledges-two-recent-student-deaths-but-wont-use-the-s-word/Content?oid=2141813

Pierotti, S. (2021, October 27). *A juggling act: Working students talk about balancing their job, school and mental health*. (E. M. Group, Producer, & University of Oregon) Retrieved March 2022, from Daily Emerald: https://www.dailyemerald.com/arts-culture/a-juggling-act-working-students-talk-about-balancing-their-job-school-and-mental-health/article_2b2854fe-36d5-11ec-89b0-6b261ecdb4fd.html

Psychology Today. (2022). *Humanistic Therapy.* Retrieved April 2022, from Types of Therapy: https://www.psychologytoday.com/us/therapy-types/humanistic-therapy

Rau, J. (2021, February 26). *College Tuition Sparked A Mental Health Crisis. Then The Hefty Hospital Bill Arrived.* Retrieved April 2022, from National Public Radio: https://www.npr.org/sections/health-shots/2021/02/26/969494206/college-tuition-sparked-a-mental-health-crisis-then-the-hefty-hospital-bill-arri

Rodriguez, M. L., Corse, A. K., & Rosen, L. D. (2017, February 28). ental Health Services Use Among Medical Students: Perceived Stigma and Barriers to Care. *Medical Science Educator, 27*, 267-272.

Ruth, R., & Santacruz, E. (2017). *LGBT Psychology and Mental Health: Emerging Research and Advances.* ABC-CLIO, 2017.

Schmauss, M. (2021, October 14). *College will be the best four years of your life...right?* Retrieved March 2022, from The Record: https://record.goshen.edu/opinion/college-will-be-the-best-four-years-of-your-life-right

Shmerling, R. H. (2021, July 13). Is our healthcare system broken? *Harvard Medical School: Harvard Health Publishing*.

Stauffer, R. (2021, July 27). *The best four years of your life?* Retrieved March 2022, from Vox.com: https://www.vox.com/the-highlight/22573842/the-best-four-years-of-your-life

Strauss, V. (2019, September 10). *'A dereliction of duty': The college dropout scandal — and how to fix it.* Retrieved April 2022, from The Washington Post: https://www.washingtonpost.com/education/2019/09/10/a-dereliction-duty-college-dropout-scandal-how-fix-it/

Sundararaman, R. (2009). *The U.S. Mental Health Delivery System Infrastructure: A Primer.* Conressional Research Service, Congress.

Syed, S. T., Gerber, B. S., & Sharp, L. K. (2014, October). Traveling Towards Disease: Transportation Barriers to Health Care Access. *Journal of Community Health, 38*(5), 976-993.

The Commonwealth Fund. (2020, June 05). *International Health Care System Profiles*. Retrieved April 2022, from The Commonwealth Fund: https://www.commonwealthfund.org/international-health-policy-center/countries/united-states

The Editors of Encyclopaedia Britannica. (2022, February 07). *Furies: Greek Mythology*. Retrieved February 2022, from Philosophy and Religion: Ancient Religion and Mythology: https://www.britannica.com/topic/Furies/additional-info#history

The Editors of Encyclopaedia Britannica. (2022, January 18). *Orestes: Greek Mythology*. (E. Britannica, Editor) Retrieved February 2022, from Britannica: Philospophy & Religion: Ancient Religions & Mythology: https://www.britannica.com/topic/Orestes-Greek-mythology

The Healthy Minds Network. (2020). *THE IMPACT OF COVID-19 ON COLLEGE STUDENT WELL-BEING.* American College Health Association.

The National Alliance on Mental Illness. (2022, February). *Mental Health By the Numbers*. Retrieved March 2022, from National Alliance on Mental Illness: https://www.nami.org/mhstats

The Shrink Space. (2022). *https://uvm.theshrinkspace.com/*. Retrieved March 2022, from The University of Vermont: https://uvm.theshrinkspace.com/

The University of Vermont. (2022). *BASICS: Balancing Alcohol and Substances to Improve College Success*. Retrieved March 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/BASICS

The University of Vermont. (2022). *Billing Information*. Retrieved April 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/billing-information

The University of Vermont. (2022). *CARE Team*. Retrieved March 2022, from Vice Provost and Dean of Students Office: https://www.uvm.edu/deanofstudents/student_advocacy/care_form

The University of Vermont. (2022). *Case Management*. Retrieved March 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/case-management

The University of Vermont. (2022). *Catamount Recovery Program*. Retrieved March 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/CRP

The University of Vermont. (2022). *Counseling and Psychiatry Staff*. Retrieved April 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/counseling-and-psychiatry-staff

The University of Vermont. (2022). *COVID-19 Mental Health Resources*. Retrieved February 2022, from The University of Vermont: https://www.uvm.edu/health/covid-19-mental-health-resources

The University of Vermont. (2022). *Emergency*. Retrieved February 2022, from The Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/emergency

The University of Vermont. (2022). *Group Counseling*. Retrieved March 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/group-counseling

The University of Vermont. (2022). *Healthcare at UVM*. Retrieved April 2022, from Office of International Education: https://www.uvm.edu/oie/healthcare

The University of Vermont. (2022). *Individual Counseling*. Retrieved March 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/individual-counseling

The University of Vermont. (2022). *Let's Talk: Drop-in Conversations with Counselors*. Retrieved March 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/letstalk

The University of Vermont. (2022). *Mental Health Care at Counseling and Psychiatry Services*. Retrieved March 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/CAPS

The University of Vermont. (2022). *Mental Health Trainings and Workshops*. Retrieved March 2022, from Center for Health & Wellbeing: https://www.uvm.edu/health/mental-health-trainings-and-workshops

The University of Vermont. (2022). *Mental Health Workshops*. Retrieved March 2022, from Center for Health & Wellbeing: https://www.uvm.edu/health/mentalhealthworkshops

The University of Vermont. (2022). *Mission and Vision*. Retrieved April 2022, from The University of Vermont: https://www.uvm.edu/mission-and-vision

The University of Vermont. (2022). *Promoting Wellbeing*. Retrieved March 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/healthpromotion

The University of Vermont. (2022). *Psychiatry Services*. Retrieved March 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/psychiatry-services

The University of Vermont. (2022). *Sexual Violence Support and Advocacy*. Retrieved March 2022, from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/sexual-violence-support-and-advocacy

The University of Vermont. (2022). *Students of Concern*. Retrieved February 2022, from The University of Vermont: https://www.uvm.edu/deanofstudents/students_concern

The University of Vermont. (2022). *Survivor Support Space*. Retrieved from Center for Health & Wellbeing at UVM: https://www.uvm.edu/health/survivor-support-space

The University of Vermont. (2022). *The Center for Health & Wellbeing at UVM*. Retrieved February 2022, from The University of Vermont: https://www.uvm.edu/health/about

The UNTOLD Project. (2022, February). *Campus Diaries*. (UNTOLD Originals, LLC) Retrieved March 2022, from UNTOLD.: https://untoldproject.org/category/campus-diaries/

Twenge, J. M. (2019). Age, period, and cohort trends in mood disorder indicators and suicide-related outcomes in a nationally representative dataset, 2005–2017. *Journal of Abnormal Psychology, 123*(3), 185-199.

U.S. National Library of Medicine. (2015, March 24). *Early Psychiatric Hospitals and Asylums.* Retrieved February 05, 2022, from History of Medicine: https://www.nlm.nih.gov/hmd/diseases/early.html

United States Department of the Air Force. (2022). *Suicide Prevention Program*. Retrieved April 2022, from Department of the Air Force Resilience: https://www.resilience.af.mil/Suicide-Prevention-Program/

Urban Institute. (2017, April). *Borrowing*. Retrieved April 2022, from Understanding College Affordability: http://collegeaffordability.urban.org/covering-expenses/borrowing/#/

Vermont Care Partners. (2022, February 24). *Going Mobile to Better Reach People Misusing Substances*. Retrieved April 2022, from Vermont Care Partners: https://vermontcarepartners.org/going-mobile-to-better-reach-people-misusing-substances/

Vermont Cynic Staff. (2018, February 14). *Mental Health on Campus.* Retrieved April 2022, from VT Cynic: https://vtcynic.com/opinion/mental-health-on-campus/

Viglienzoni, C. (2021, February 24). *Demand for mental health care surges*. Retrieved April 2022, from WCAX.com: https://www.wcax.com/2021/02/24/demand-for-mental-health-care-surges/

Vindegaard, N., & Benros, M. E. (2020, October 9). COVID-19 pandemic and mental health consequences: Systematic review of the current eviden. *Brain, Behavior, and Immunity, 89*, 531-542.

Washington State University. (2016, September 06). *What is a gatekeeper?* Retrieved April 2022, from News & Resources: https://cougarhealth.wsu.edu/2016/09/06/what-is-a-

gatekeeper/#:~:text=A%20gatekeeper%20is%20someone%20in,academic%20advisors%20or%20student%20leaders.

Wesley, A. (2019, May). *NASPA Policy and Practice Series: Strategies for Addressing Mental Health Support on Campus.* Retrieved April 2022, from NASPA Research and Policy Institute: https://www.naspa.org/images/uploads/main/NASPA_Policy_and_Practice_Issue_4_Mental_Health_DOWNLOAD.pdf

World Health Organization. (2013, May 27). *Comprehensive mental health action plan 2013-2020.* Retrieved February 2022, from https://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf?ua=1

World Health Organization. (2020). *The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment.* Geneva: WHO.

Wyatt, T., & Oswalt, S. B. (2013, March 12). Comparing Mental Health Issues Among Undergraduate and Graduate Students. *American Journal of Health Education, 44*(2), 96-107.

Yanos, P. T., Stanely, B. S., & Greene, C. S. (2009). Research Risk for Persons With Psychiatric Disorders: A Decisional Framework to Meet the Ethical Challenge. *Psychiatr Serv, 60*(3), 374-383.

Yeo, P. K. (2021, June 30). *The US spends at least $225 billion on mental illness each year in a broken system with no clear-cut solutions.* Retrieved February 2022, from Buisness Insider: https://www.businessinsider.com/cost-of-inequity-americas-225-billion-broken-mental-healthcare-system-2021-4