

**The Third Place Model of Mental Health for Emerging Adults**

by

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### Abstract

This capstone project addresses the escalating mental health crisis among emerging adults (EAs) in Canada, a demographic uniquely vulnerable to loneliness (Buecker et al., 2021), trauma (Grasso et al., 2012), anxiety, and depression (Kessler et al., 2007; Mental Health Research Canada [MHRC], 2024; Paul, 2024). Despite the high need for mental health support, 58.3% of EAs remain underserved (MHRC, 2024) due to systemic barriers, including cost (Statistics Canada [StatCan], 2023), stigma (Jack.org, 2024), and the transition out of youth care (Doucet, 2020). This research proposes the Third Place Model of Mental Health, a novel framework grounded in Ray Oldenburg's sociological concept of "third places," which are informal community environments outside of home and work (1989). By integrating a literature review of community care models with the neurobiology of social connection and relational clinical theories, this study shifts the primary therapeutic mechanism from individual clinical intervention to the social environment itself. The project identifies seven core tenets for implementation: community-focused, accessible, casual, de-stigmatized, youth-driven, safe, and sustainable. Furthermore, it establishes the policies, practices and guardrails required in order to design and run the model within a Canadian context, including how the framework can leverage current initiatives like the Youth Mental Health Fund (Government of Canada, 2024) to provide a proactive, cost-effective, and scalable paradigm shift in the mental health care of EAs. Ultimately, this project offers a practical roadmap for policymakers, clinicians, and organizations to foster long-term resilience among the 1.25 million Canadian EAs currently in need of support (MHRC, 2024).

*Keywords: emerging adulthood, third places, community-based care, social connection, mental health*

### **Dedication**

To the EAs at my practicum site, I dedicate this work to you. You didn't know you were teaching me, but you were. You showed me what courage actually looks like, in that it is not the absence of struggle, but the willingness to show up anyway. You reminded me that healing doesn't come from the outside in; it rises from within, waiting to be witnessed. For that, I am changed. Thank you.

### **Acknowledgements**

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### **Territorial Acknowledgement**

I acknowledge that I live, work, and play on the traditional, ancestral, and unceded territories of the Sk̓w̓x̓wú7mesh Úxwumixw (Squamish Nation), the sə́lilwətał (Tsleil-Waututh Nation), and the xʷməθkʷəy̓əm (Musqueam Nation). Unceded means there is no record of the Sk̓w̓x̓wú7mesh, sə́lilwətał, or xʷməθkʷəy̓əm people ever signing a treaty or agreement to hand over their territory to the British Crown or the Canadian government. Legally, their "Aboriginal Title" has never been extinguished. Because the land was never legally surrendered, its occupation by settlers happened without the consent of the original owners.

As I explore community-based mental health models and the shift away from Western individualistic paradigms, I recognize that I am a guest on stolen land. The community-driven healing I am learning about is not a new discovery; it is a way of being that has been practiced, protected, and passed down by the Coast Salish peoples since time immemorial. I am deeply grateful to be learning from the Indigenous knowledge keepers who hold the cultural wisdom of this land, wisdom that understands well-being as something inherently tied to the health of the collective, the ancestors, and the earth itself. I commit to ensuring my work does not just "study" these concepts, but actively honours the sovereignty of the people who have always known that healing happens in relationship. Ultimately, I recognize that true wellness is inseparable from justice, and I stand in solidarity with the communities who continue to fight for the legal recognition and return of the land that sustains this healing.

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## **Chapter 1: Introduction**

Emerging adulthood, a developmental phase spanning ages 18 to 29 as defined by Arnett (2000), is marked by heightened mental health risks (Kessler et al., 2007; MHRC, 2024; Paul, 2024). Systemic barriers to supportive resources further compound these challenges, leaving this population vulnerable and with significant unmet needs (Clarke, 2024; Doucet, 2020; Doucet et al., 2022; MHRC, 2024). This capstone will propose a potential model for accessible mental health care inspired by "third places," which are community-centred environments outside of home or work that are inclusive, low-barrier, and designed to foster social connection and support (Oldenburg, 1989). In the following chapters, this study will assess its suitability for emerging adults (EAs), explore the benefits and potential limitations of this model, and examine its feasibility within the Canadian context.

### **Overview of the Topic**

#### ***Emerging Adults***

Emerging adulthood is a distinct stage characterized by a transitional "in-between" feeling where individuals do not fully identify as adolescents or adults (Arnett, 2000). This stage has gained recognition for its unique challenges and developmental needs, given that traditional milestones like stable careers and marriage are often reached later than in previous generations, especially in developed countries and increasingly in developing ones. This phenomenon also often varies across national, cultural, and socioeconomic contexts. During this developmental period, EAs often face numerous changes and transitions, leading to instability in relationships, careers, and finances as they navigate this stage without established support systems. High distress levels are often reported following these life transitions, posing risks to subjective well-being (Lane et al., 2014). This is also a period of identity exploration and formation, with

shifting belief systems and roles in education, work, and living. Economic factors, such as the high cost of living (StatCan, 2023) and Canada's housing crisis (Choi & Ramaj, 2024; Revington & August, 2020), further intensify these challenges, disproportionately impacting EAs and exacerbating their need for accessible and affordable support systems.

Unfortunately, these many stressors often coincide with the average onset of significant mental health challenges, including loneliness (Buecker et al., 2021), trauma (Grasso et al., 2012), depression, and anxiety (Kessler et al., 2007; MHRC, 2024; Paul, 2024). In fact, EAs consistently report the highest levels of anxiety across age groups, and suicide is the second leading cause of death for those aged 15-34 years in Canada (StatCan, 2022). Marginalized individuals in society, particularly black and Indigenous EAs, newcomers, students, 2SLGBTQI+ communities and those with disabilities, all face heightened mental health risks, especially those with intersecting identities (MacLeod & Brownlie, 2014; MHRC, 2024).

The vulnerability of this population is compounded by systemic barriers to accessing mental health resources. In British Columbia, many young adults in the foster system "age out" by 19, often without the necessary resources, healthcare benefits, or financial stability to seek independent care (Doucet, 2020). Existing independent living programs in Canada often lack sustained emotional support and mentorship, focusing on immediate independence (Doucet et al., 2022). Access to government support that does exist is hindered by complex application processes, eligibility rules, and approval requirements (Doucet, 2020). In fact, 58.3% of EAs (ages 16-24) who require mental health support are not receiving it, and 34% of EAs who do have access to services report unmet needs (MHRC, 2024). EAs in school can access institutional resources, such as university counselling services, but these are underfunded, understaffed, and face low engagement rates, limiting their accessibility to many in need (Clarke,

2024). As an example, a study found that 56% of students are aware of available campus mental health services, but only 39% feel comfortable accessing them due to ongoing stigma (Jack.org, 2024), with newcomers (MHRC, 2023) and young males (McKenzie et al., 2022, Kids Help Phone, 2024) particularly vulnerable. In fact, Canada's mental health funding has historically been below the average of many peer countries (Organization for Economic Cooperation and Development, 2021). This lack of funding essentially turns the transition to adulthood into a "cliff-edge," where the system effectively walks away just when these EAs need support the most, leaving them to navigate these challenges entirely on their own.

EAs worldwide also experience some of the highest levels of loneliness, a trend documented across numerous studies (Buecker et al., 2021). The COVID-19 pandemic has intensified these mental health challenges, amplifying feelings of social isolation among this age group (Patulny & Bower, 2022) and reducing mental health outcomes (MHRC, 2024). Socially and financially disadvantaged EAs, in particular, are at an even greater risk for isolation and loneliness (Simone et al., 2023).

### ***Third Places For Mental Health***

Research shows that community and social support can ease mental health challenges, providing relief from anxiety, depression, and loneliness (Alvarez et al., 2024; Clarke, 2024). Perceived community support is a key protective factor for EAs (Benson & Whitson, 2022; Zadavec Šedivy et al., 2017), and many fields of research emphasize that community-based environments can promote subjective well-being. For example, therapeutic taskscapes (Bell et al., 2018; Parr, 2006; Smith et al., 2021), community hub models (Settipani et al., 2019), and social prescribing (Morse et al., 2022) all show that being in a meaningful community can have therapeutic value. While this capstone introduces the concept of third places as a novel way to

approach mental health, it also acknowledges older, more established community-based traditions, such as Indigenous craft and healing circles (France, 2020). These practices have historically contributed to healing and subjective well-being (France, 2020; Bond et al., 2017), while also serving as vital acts of decolonization and cultural revitalization (France, 2020).

To address this need for community-based care for this underserved population, the government launched the Mental Health Promotion Innovation Fund (MHP-IF), allocating \$5 million annually for community-based youth mental health programs (Government of Canada, 2023) as well as a \$500 million investment in the Youth Mental Health Fund (YMHF; Government of Canada, 2024), aiming to expand mental health support resources for EAs across Canada. In this context, fostering purposeful third places as community-driven environments distinct from home or work for EAs presents a fresh approach to mental health that resonates with the fund's objectives.

Sociologist Ray Oldenburg (1989) initially conceptualized "third places" as inclusive, accessible, and informal spaces that foster community and a sense of belonging (Jeffres et al., 2009). Throughout history, third places have evolved from ancient Greek public squares, Chinese teahouses, and cafes frequented by writers and philosophers (Rittner & Haine, 2016) to modern examples like coffee shops, libraries, parks, and community organizations (Jeffres et al., 2009), and more recently, virtual spaces such as social media (McArthur & Farley White, 2016) and online gaming environments (Steinkuehler & Williams, 2006). Third places have been shown to alleviate loneliness (Buecker et al., 2021) and support mental health recovery through social engagement and connection beyond conventional systems (Doroud et al., 2018; Duff, 2012). However, research shows that engagement with existing services is often low for this population (Clarke, 2024). The casual nature of third places may help improve engagement by providing an

accessible entry point for EAs to access mental health care services, such as counselling. Third places allow for the organic building of trust within a community, which may improve engagement with mental health resources. Additionally, third places that foster supportive community networks could enhance long-term resilience within the population by encouraging individuals to continue supporting one another, even if they are no longer directly engaging with services within the third place.

Nonetheless, real barriers currently hinder access to third places, especially for marginalized groups. The decline of third places due to urban development and commercialization (Finlay et al., 2019), along with their uneven distribution in rural and economically disadvantaged areas (Rhubart et al., 2022), limits the availability of these spaces where community support is most needed. Additionally, instances of racism, exclusionary behaviours, and social norms within existing third places often create unwelcoming environments, further alienating marginalized individuals (Littman, 2022; Zhuang & Lok, 2023). These barriers emphasize the need for a third place model for mental health that adheres to Oldenburg's original principles while intentionally incorporating inclusivity and accessibility.

This third place model could support EAs by providing low-cost, low-barrier environments that promote social engagement and de-stigmatization in ways that traditional mental health services may not achieve. By intentionally creating welcoming and inclusive third places, this model could overcome current issues EAs face and offer a novel approach to address the unique mental health needs of EAs.

**Purpose Statement*****Research Question***

This capstone investigates the potential of an intentional third place model to support mental health and subjective well-being among EAs through three primary questions: (1) What issues are EAs facing in Canada? (2) How can the third place model of mental health solve this? (3) How can we implement this model in Canada? By answering these questions, this study aims to address critical gaps in mental health support for an underserved, high-needs group.

***Audience***

This capstone's primary audience includes clinicians, allied health professionals, and policymakers interested in innovative, low-cost, and accessible approaches to mental health care for EAs. This research introduces the third place model as an innovative, alternative framework, offering practical recommendations for creating and managing these spaces to ensure their therapeutic benefits. By comparing this model with other community-based care approaches, the capstone will also equip professionals with knowledge about the unique ways third places can help serve this vulnerable population.

***Relevance***

EAs face elevated risks of loneliness, mental health challenges, and subjective well-being concerns, especially within marginalized groups (MHRC, 2024). Nearly 60% of EAs aged 16-24 who need support are currently underserved (MHRC, 2024), underlining the need for accessible mental health solutions. This new application of third places for mental health may help address this critical need. Additionally, Canadian mental health funding initiatives, such as the YMHF (Government of Canada, 2024) and the MHP-IF (Government of Canada, 2023), are prioritizing innovative community support models for EAs, making this new approach an ideal fit.

**Contribution to the Field**

This capstone addresses notable gaps in mental health literature by challenging the prevailing Western individualistic approach to mental health, which often prioritizes individual, 1:1 solutions and overlooks or undervalues the role of community-based, shared spaces in fostering well-being (Benning, 2013). Existing studies predominantly focus on centralized, formal support systems and structured therapeutic settings, with limited research examining informal, community-driven models for mental health support, particularly for EAs. This capstone will fill this gap by synthesizing the currently available literature on community-care models, including community hubs, therapeutic taskscapes, and social prescribing, and will also craft a new community-care model, the “third place model for mental health.”

Research on third places is limited and typically focused on specific environments, tasks or populations (Bell et al., 2018; Parr, 2006; Smith et al., 2021). Although there is extensive research on the needs of EAs, few studies address the therapeutic potential of third places for this group. Canadian integrated community-based mental health hubs, such as Foundry BC (n.d), Youth Wellness Hubs Ontario (n.d.) and ACCESS Open Minds Sites (n.d.), offer centralized support but differ from third places, which foster organic social interactions within informal, community-driven settings. While nonprofits like Hard Feelings (n.d.) and charities such as Third Space Charity (n.d.) are loosely based on third place ideologies, little effort has been made to investigate which aspects of the framework offer therapeutic value, or how to replicate this model for EAs. This capstone aims to build a foundation for implementing and replicating third place environments for emerging adult mental health, providing actionable guidelines for Canadian contexts and highlighting areas for further research to solidify the model's therapeutic value.

### **Theoretical Framework**

In this literature review, I approach the research through an integrative and community-centred lens, grounded in the belief that mental health support is most effective when it addresses multiple facets of subjective well-being and fosters collective engagement. This research is informed by a holistic view of health, understanding mental subjective well-being as deeply connected to social, emotional, and environmental factors that extend beyond traditional, individual-focused clinical settings. This multimodal, integrative approach aligns with the perspective that diverse therapeutic methodologies can be beneficial, particularly when tailored to an individual's unique needs. Furthermore, this research is inspired by the principles of social prescribing, which emphasize the role of community resources as essential supports for mental health healing, and by collectivist cultural values that challenge the assumption that healing occurs in isolation. Scott et al. (2004) emphasize that even in highly individualistic contexts, prioritizing self-reliance and individual healing can have significant social and psychological drawbacks, such as diminished social support networks, heightened hopelessness, and decreased willingness to seek help. This highlights the relational nature of healing, even in cultures that value self-reliance. Similarly, Martino et al. (2017) assert that humans are fundamentally "wired to connect", a concept supported by self-determination theory, which identifies "relatedness" (feeling socially connected to others) as one of three basic needs for achieving optimal well-being. This perspective provides further evidence for the inherently relational aspect of healing. Together, these perspectives form the foundation for this research on the third place model of mental health, emphasizing the role of community spaces in fostering relational healing and providing collective support.

**Reflectivity and Positionality Statement**

This research holds deep professional and personal significance for me. As a white settler in Canada, I have been on my own journey of cultural humility, striving to understand the profound impact of colonialism in this country and how Indigenous knowledge holders have been historically overlooked and under-credited in research, public discourse, and beyond. Western research often imposes an individualistic, capitalist framework on mental health, prioritizing solitary healing and self-reliance over the collective wellness that is central to many cultures (Benning, 2013; Gamby et al., 2021). In contrast, as I complete my capstone project, I intend to honour the historic knowledge holders in Indigenous and other collectivist cultures who have long practiced community-based healing. I hope that the third place model can challenge Canada's prevailing colonial and capitalist approach to mental health, particularly for those marginalized by current systems, and, in doing so, contribute to the decolonization of Canada's mental health services.

My commitment to community-based care is ancestral, not just academic. My grandparents fled Slovenia during World War II, arriving in Canada as refugees who survived by building informal, culturally affirming social networks. Long before I had the academic language for it, they lived the third place model, finding sanctuary at kitchen tables, in local churches, and on the cultural farms where they gathered to belong. Writing this capstone while simultaneously reconnecting to the Slovenian community moved my research from the theoretical to the experiential. I witnessed firsthand how intergenerational spaces serve as sites for relational repair. This experience has illuminated how grassroots, non-clinical environments act as a fabric for resilience, providing a vital blueprint for communal wellness across diverse cultural contexts.

My clinical perspective is further informed by my current role at a post-secondary practicum site, where I work directly with EAs navigating the complexities of this life stage. In this academic setting, I witness that students often express that their distress is rooted in isolation and yet they lack non-clinical spaces to exist and seek support. Observing the stark contrast between the heavy demand for formal counselling and the scarcity of informal, communal support has solidified my belief that mental health interventions must extend beyond the therapist's office to be truly effective. This practicum experience has allowed me to see the daily barriers EAs face, reinforcing the urgency of developing third place models that prioritize social connection as a primary tool for wellness.

Also, my belief in accessible, low-cost, community-based mental health support is grounded in my own personal experiences with the transformative power of community spaces to foster belonging and mutual support. When I was an emerging adult myself, navigating career changes and mental health challenges, I became aware of the gaps in accessible support for this population. Community-driven activities, like neighbourhood craft and fitness classes or local volunteering, often offered therapeutic connections that felt more approachable than formal settings. While my experiences highlight the positive impact of such spaces, I recognize that studies show third places can be exclusionary or inaccessible, especially for visible minorities, marginalized groups and those with intersecting identities (Littman, 2022; Zhuang & Lok, 2023), challenging their perceived inclusivity. Acknowledging my own privilege in feeling welcomed in community activities and accessing financially gated spaces motivates me to find ways to make these resources accessible to everyone. Therefore, I am committed to exploring intentional design strategies that reduce barriers and more effectively support all EAs. Also, my goal to implement this model post-graduation drives me to investigate this topic, which may influence

me toward positive findings; however, I am dedicated to rigorously evaluating both the strengths and limitations of third places for mental health.

## **Definition of Terms**

### ***Ageing Out***

The transition from government-supported care to independence, typically around the age of 18 or 19, often creates resource and support gaps (Doucet, 2020).

### ***Care Cliff***

The sudden and disruptive transition out of youth mental health services at age 18 or 19 creates a critical gap in support for EAs during a high-risk developmental window.

### ***Collectivistic***

A cultural orientation that prioritizes the group over the individual, emphasizing community subjective well-being, cooperation, shared goals, and mutual support.

### ***Community***

A group of people with shared interests, goals, or geographic location who support each other through social connections and a sense of collective identity.

### ***Community-Based Mental Health Care***

An approach centred on providing support within a community setting rather than clinical or institutional environments. This model leverages social connections and connects individuals with in-situ resources to enhance mental health.

### ***Community Hub***

A centralized space in the community that offers resources and services, such as social services, career guidance and mental health support.

### ***Emerging Adults***

A developmental phase where individuals transition from adolescents to adults, typically spanning ages 18 to 29 (Arnett, 2000). This "in-between" phase is often characterized by exploration, change, and economic instability, which can exacerbate stress and mental health challenges.

### ***Financially-Gated Places***

Places where financial means restrict access, often due to entry fees or purchase requirements. This structure creates accessibility barriers, particularly for low-income individuals, impacting their ability to participate in the benefits of these venues.

### ***Identity Formation***

The ongoing process through which individuals explore and integrate their values, beliefs, and self-perceptions to develop a cohesive and authentic sense of self within society.

### ***Individualistic***

A cultural orientation that prioritizes the individual over the group. Individualistic values focus on personal autonomy, independence, and self-achievement, which may sometimes conflict with collectivistic values.

### ***Intersectionality***

The overlapping of social categories, such as race, socioeconomic status, gender, and sexual orientation, compounds vulnerabilities and creates unique challenges and benefits (Cooper, 2016).

### ***Loneliness***

A subjective experience of feeling alone, which may stem from a lack of social connections or an absence of meaningful connections, even if surrounded by others.

### ***Social Prescribing***

Social prescribing is an innovative healthcare approach that addresses health needs by referring patients to community-based activities and resources rather than solely depending on individual clinical treatments (Morse et al., 2022).

### ***Stewards***

Non-directive facilitators of a third place who replace traditional adult clinical roles to act as "hosts," levelling power dynamics and curating a neutral, inclusive environment where organic social interaction can thrive.

### ***Subjective Well-Being***

An individual's perception of their quality of life, happiness, and overall satisfaction (Magyar & Keyes, 2019).

### ***Therapeutic***

Any scenarios, environments, interventions and interactions that promote improved mental health and subjective well-being.

### ***Therapeutic Landscape***

A geographic concept suggesting that everyday environments become sites of healing through the social relationships, sense of belonging, and feelings of calm and safety they facilitate

### ***Therapeutic Taskcape***

A concept referring to the interconnected, routine activities that occur within a place or landscape that help improve mental health and wellness. These may involve everyday social interactions and shared tasks, such as conversations, crafting, or group games, that create a sense of community and belonging.

### ***Third Place***

A social environment distinct from home (the "first place") and work (the "second place") where individuals can gather, connect, relax, and build community. Third places are accessible, inclusive spaces designed to facilitate casual connections and to foster community and belonging (Oldenburg, 1989).

### ***Trauma-Informed Practice***

A framework that prioritizes the physiological and psychological safety of participants by recognizing "difficult" behaviours as self-protective adaptations and emphasizing choice, collaboration, and strengths-based healing (BC Provincial Mental Health and Substance Use Planning Council [BCMHSUS], 2013).

### **Outline of the Capstone Project Chapters**

Chapter two explores the intersection of EA mental health and the therapeutic potential of third places. The first section examines specific risk factors and socioeconomic challenges, including the recent impact of COVID-19 and technology, to identify critical service gaps, particularly for marginalized subpopulations. The second section evaluates the theoretical frameworks of third places, distinguishing them from traditional community-based models to assess their unique benefits and limitations. By analyzing Canadian policy, funding landscapes, and various organizational structures like nonprofits and charities, this chapter culminates in the creation of seven core tenets designed to meet the specific needs of EAs.

The goal of Chapter Three is to provide a comprehensive, actionable roadmap for implementing "The Third Place Model of Mental Health for Emerging Adults" within Canada. Translating the theoretical insights from the previous chapter into practice, this section will introduce the seven tenets as a foundational blueprint for the model. It establishes specific guidelines for creating, maintaining, and scaling these informal, community-centred spaces to

ensure they effectively address the diverse mental health requirements of Canada's EA population.

## **Chapter 2: Literature Review**

As established in Chapter One, EAs face significant mental health challenges compounded by barriers to traditional care. This chapter will review the literature to address the central research questions by examining two primary themes. The first theme, "Emerging Adults' Mental Health and Access to Care," will synthesize research on the specific stressors, systemic barriers, and societal context that define this population's mental health landscape. The second theme, "Can Third Places Be Therapeutic?," explores the theoretical and empirical evidence supporting the third place model as a viable approach to meeting EAs' needs, drawing on the wisdom of collectivist cultures, the neurobiology of social connection, lessons from clinical practice, and an in-depth analysis of Ray Oldenburg's third place concept (1989) to establish the seven core tenets of the proposed model and the evidence-based rationale for each.

### **Review of Research Literature**

#### ***Emerging Adults' Mental Health and Access to Care***

Emerging adulthood is a period of heightened vulnerability, as it coincides with the typical onset of most psychiatric conditions. Statistically, roughly half of all lifetime mental disorders begin by the mid-teens, and this prevalence escalates to three-quarters by the mid-20s (Kessler et al., 2007). This developmental stage is when the majority of mental health disorders, including depression, anxiety, and substance use disorders, first appear (Macleod & Brownlie, 2014). This time frame is distinct, representing a new developmental stage between adolescence and young adulthood, primarily characterized by identity exploration, diversity in life paths, and a subjective feeling of not being fully adult (Arnett, 2000). Although most pronounced in developed nations, this phenomenon is increasingly observed in developing countries, and its manifestation is shaped by diverse cultural and socioeconomic factors.

This time frame is particularly challenging for post-secondary students (ages 16–25), who face a confluence of significant life changes, new pressures and rapid neurodevelopment, leading to significant stress (Paul, 2024). Specific stressors common during this period include moving away from family, managing finances, and balancing new academic and personal demands. Financial stress is widespread, with nearly half (45%) of those in the lowest income bracket reporting high stress (StatCan, 2023). EAs are disproportionately represented in this bottom 20% of earners, including 15.7% of youth aged 15 to 24 and 13.8% of those aged 25 to 34 (StatCan, 2023). Moreover, approximately 1 in 5 Canadian households (all ages) say their housing is unaffordable, spending 30% or more of their pre-tax income on housing as of 2021 (Choi & Ramaj, 2024). This problem is exacerbated by financial speculation that prioritizes investor profits over affordability for students (Revington & August, 2019). Consequently, 68.9% of Canadian post-secondary students reported overwhelming anxiety, and 51.6% felt so depressed that it was difficult to function (Jack.org, 2024). Furthermore, suicide is the second leading cause of death for young people in Canada (ages 15–34), with young men dying by suicide at three times the rate of young women (Government of Canada, 2023). Specifically, research in Canada identified five priority groups with higher mental health needs and specific barriers to care: 2SLGBTQI+ EAs, young women, newcomers, Black EAs, and Indigenous EAs (MHRC, 2024). High-risk groups also include those with developmental challenges (e.g., fetal alcohol spectrum disorders, autism spectrum disorders, and other developmental delays), as their developmental needs often do not match typical timelines (Mental Health Commission of Canada [MHCC], 2017), as well as those speaking non-dominant languages (Patulny et al., 2013).

**Access to Care.**

Despite the widespread need for support, a massive unmet need for care persists across countries (OECD, 2021). In Canada, the mental health crisis among EAs is severe, with an estimated 1.25 million of the country's 4.6 million EAs requiring support (MHRC, 2024). Systemic issues create significant fragmentation, as roughly 70% of mental health services occur outside of provincial health systems, necessitating private insurance or out-of-pocket payments (MHRC, 2024). These challenges are particularly acute in semi-urban and rural regions, where geographic isolation and a lack of specialized EA psychiatric care further delay the identification of mental health issues (Reaume-Zimmer et al., 2019). The primary barriers to care include cost, long wait times, or distance barriers, which led to 63.7% of working-age people who desired care being unable to access it (OECD, 2021). For example, in the rural community of Chatham-Kent, Ontario, demand for youth mental health services increased by approximately 25% in a single year, despite the same number of limited local resources available (Reaume-Zimmer et al., 2019)

This access problem is compounded by the structural decline of informal, low-barrier third places, which can provide community peer-based support (Finlay et al., 2019; Rhubart et al., 2022). Additionally, research shows a clear bias in where third places are located: there are far fewer third places in low-income neighbourhoods or communities with many Black or Hispanic residents (Rhubart et al., 2022; Bell et al., 2018). Even when these third places are physically there, marginalized EAs are often pushed out by social policing, which includes things like heavy security cameras, laws against hanging out (anti-loitering), and defensive architecture like benches designed to be uncomfortable (Littman, 2022). Because of this, third places cannot just be a physical space; they must also be a space where EAs actually feel safe and included.

Similar to youth in foster care, the current age limit on mental health services at age 18-19 artificially forces a transition from youth to adult services, creating a critical gap in care (MHCC, 2017). This disruption is particularly poorly timed, as roughly 75% of mental health issues emerge during this window (Carver et al., 2015), even though biological brain development continues well into the mid-twenties (Leschied, 2017). Consequently, approximately 720,000 EAs in Canada require mental health support but are not receiving it, a figure that includes both 300,000 currently accessing services with unmet needs and 420,000 needing but not accessing any services (MHRC, 2024). This multifaceted access crisis in Canada, accelerated by failures in the formal healthcare system and the erosion of informal community infrastructure, highlights the urgent need for low-barrier settings like third places, which serve as central, community-driven spaces that require no formal referral or clinical diagnosis, and can offer both preventative and reactive mental health support.

### ***Foster Care.***

The systemic failure to provide care during the transition out of foster care represents the most glaring gap in support for EAs. This lack of care specifically impacts the approximately 6,700 EAs, roughly 10% of the Canadian foster care population, who age out of the system annually (Doucet et al., 2018). Programs designed to assist this population are largely ineffective, showing limited to no positive impact on transition outcomes like housing and employment, with some even yielding negative effects (Doucet et al., 2022). Consequently, former foster youth face mental health challenges that are 2–5 times higher than the general population, alongside much higher rates of homelessness, substance abuse, and justice system involvement (Leschied, 2017). This population is often disconnected from meaningful supportive relationships, with nearly half of youth transitioning out of care lacking enduring connections with supportive adults (Doucet,

2020). In addition, approximately 16% of EAs (ages 18–25) experience social isolation, with higher risks observed for those who are male, have marginalized racial and ethnic identities, lower socioeconomic status, and are unemployed (Simone et al., 2023). For this uniquely vulnerable population, third places may serve as a direct antidote to the aging-out gap, offering the infrastructure for building the stable, informal, and supportive community connections they are missing.

### **Crisis-Driven Care.**

Livingston (2020) argues that structural stigma within the health-care system frequently traps individuals with mental health issues in a cycle of crisis-driven care, systematically denying them proactive interventions. Due to chronic underfunding, diagnostic overshadowing, and an overreliance on coercive practices, patients often only receive short-term, emergency services when their conditions reach critical levels, leaving many EAs untreated. Anticipating stigmatizing interactions, many individuals further delay seeking help until a mental health crisis makes it unavoidable. To dismantle these barriers, Livingston (2020) suggests that care must fundamentally shift away from crisis-only models toward proactive, recovery-oriented care, which requires prioritizing early intervention and fully integrating mental health services with other healthcare systems to ensure patients receive holistic, coordinated support rather than fragmented treatment.

### **Individualism.**

The influence of individualistic cultural values presents a significant challenge to positive mental health. For example, a strong individualistic orientation is linked to smaller social support networks and less developed emotional skills (Scott et al., 2004). While feelings of hopelessness and suicidal thoughts appear more frequently in individualistic cultures, this connection is driven

by the fact that individuals in these societies often have fewer or less satisfying social relationships. Understanding this mechanism is vital because positive social functioning is a foundational component of well-being, which is theorized to serve as a primary buffer against suicide risk (Magyar & Keys, 2019). These cultural challenges, particularly the erosion of social support networks, are magnified when specific populations face additional systemic barriers; for example, male and racialized post-secondary students access on-campus mental health services at lower rates, indicating that supports are likely not sufficient to close persistent equity gaps (Jack.org, 2024). In this context, third places can function as a necessary counterbalance to these individualistic norms; by offering accessible, community-based settings for informal social support, they can mitigate the effects of isolation and circumvent the systemic barriers that prevent vulnerable populations from engaging with more formalized systems of care.

### **COVID-19 Pandemic.**

While loneliness has been gradually increasing for decades (Buecker et al., 2021), the COVID-19 pandemic acted as a significant accelerant, triggering a global rise in mental health challenges (OECD, 2021). The associated social changes included a forced shift to digital interactions that often felt hollow compared to in-person contact, disproportionately affecting individuals who were single, disabled, low-income, or lacked strong social ties pre-pandemic (Patulny & Bower, 2022). This problem was exacerbated by the widespread closure of third places, such as public parks and libraries (civic) or coffee shops and bookstores (commercial), that provide crucial opportunities for connection, especially for EAs who were navigating the most transitional period of their lives with fewer established social ties.

According to Borowski and Stathopoulos (2023), the loss of third places intensified social barriers for young adults in the U.S., leading to a significant decline in mental health. This

study is highly applicable to a Canadian context as both nations feature nearly identical urban social infrastructures and mirrored declines in youth mental health during the pandemic. Their research found that while the closure of physical spaces was detrimental, an aversion to virtual socializing was an even stronger predictor of increased loneliness and poorer mental health, particularly for women and nonbinary individuals. Furthermore, this loss of access was not equitable, reflecting shared systemic inequities: Asian, other non-white, and 2SLGBTQI+ young adults reported a greater loss of civic places, while low-income women, nonbinary people, and Black individuals lost more access to commercial venues. Ultimately, these findings highlight that the pandemic's impact on social infrastructure created universal barriers to well-being for marginalized EAs across North America.

### **Technology.**

The proliferation of technology and digital media has introduced a significant paradox into the lives of EAs. While promising greater connection, technological engagement often fosters the opposite, leading to increased isolation, confusion, and emotional overwhelm (Tao, 2014). For individuals in this developmental stage (ages 18-29), who are already navigating major life transitions and identity formation, technology adds layers of complexity. It creates a tension between presenting an authentic versus a curated self, can foster a dependence on external validation through likes and comments, and makes life events more public, which can lead to shame and regret. Furthermore, large online networks may create an illusion of social support that lacks the real intimacy necessary for well-being, ultimately contributing to feelings of loneliness.

Research from Twenge and Campbell (2019) demonstrates a link between high levels of digital media use and adverse mental health outcomes, though the nature of this use is a critical

factor. They found that there is a strong correlation between time spent on digital media and lower psychological well-being. For instance, adolescents who use digital media for five or more hours daily are 48-71% more likely to be unhappy and twice as likely to attempt suicide compared to light users.

While the link between social media and mental health is often correlational, Taylor et al. (2024) suggest the nature of engagement determines the outcome, in that passive scrolling is uniquely detrimental. Unlike active non-social use, which actually correlates with decreased stress, passive consumption fosters a subjective feeling of isolation. This mediation through loneliness is particularly impactful for EAs, who report the highest loneliness rates of any age group, subsequently escalating symptoms of anxiety and depression. A meta-analysis by Shannon et al. (2022) confirmed a moderate but significant link between what is defined as "problematic" social media use and higher rates of depression, anxiety, and stress among adolescents and young adults, highlighting that the pattern of use, rather than use itself, is a key determinant of its mental health impact. This research underscores a need for physical third places, perhaps serving as a direct antidote to the isolated and curated nature of online life, and providing the authentic, face-to-face connection essential for psychological well-being.

### **Summary.**

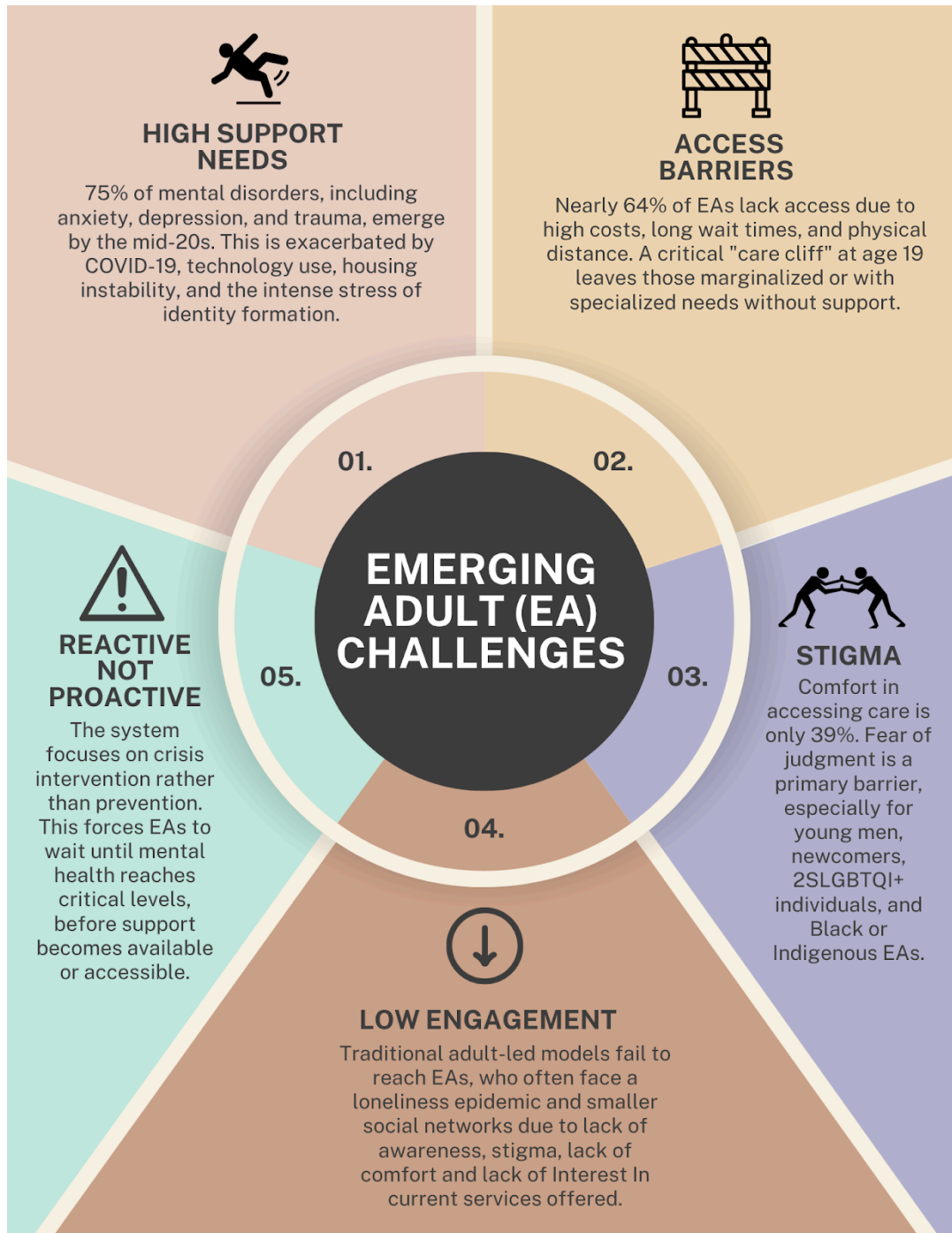
This review of the literature on the first theme, "Emerging Adults' Mental Health and Access to Care," synthesized research demonstrating that the unique developmental period of EA is marked by a heightened vulnerability to mental health challenges such as anxiety, loneliness, depression, and suicide. These issues have been made worse by isolation often tied to technology and a widespread loneliness epidemic that was accelerated by the COVID-19 pandemic. This life stage is defined by significant instability and stress caused by managing finances, securing

housing, aging out of foster care, academic and career pressure, social and identity exploration, and navigating frequent change. Furthermore, specific groups face even higher risks due to systemic barriers, including 2SLGBTQI+ individuals, Indigenous and Black EAs, and those with developmental disabilities or neurodivergence.

Although many EAs need mental health support, they often do not receive the care they require for their mental health needs. According to the literature review so far, the problem is caused by several main factors, summarized in Figure 1, including (a) population with high support needs, (b) access barriers, (c) the stigma surrounding mental health, (d) low engagement in programs and (e) reactive, not proactive approaches.

**Figure 1**

*Emerging Adult Challenges to Accessing Care*



*Note.* This figure summarizes the main challenges that EAs have in accessing mental health care in a Canadian context.

### ***Can Third Places Be Therapeutic?***

The systemic failures, cultural influences, and access gaps to care detailed above necessitate an exploration of alternative therapeutic paradigms for EAs. The following sections will shift from defining the problem to examining the evidence for a solution rooted in community and social connection, including the specific feasibility of a third place model of mental health care for EAs in Canada.

#### **The Therapeutic Value of Place.**

Community-based settings support mental health recovery through several interconnected mechanisms that emphasize the role of “place” in fostering healing, specifically through the geography concept of “therapeutic landscapes.” This framework posits that everyday spaces become healing not just because of their physical attributes, but through the social relationships, interactions, and sense of belonging they enable (Bell et al., 2018). Within these landscapes, research identifies four key functions that facilitate recovery: providing a place for “being,” which offers safety, privacy, and stability; enabling “doing,” by supporting daily routines and meaningful activities; fostering “becoming,” through environments that inspire hope and personal growth; and creating “belonging,” by facilitating social connections and community participation (Doroud et al., 2018). Ultimately, these healing-oriented “places” offer a suite of resources that extend beyond the clinical, including social opportunities for connection and affective resources, such as feelings of calm and hope (Duff, 2012).

#### **The Therapeutic Value of Activity.**

Various community care models are set up to actively support mental health and recovery through the role of “activity.” The “therapeutic taskscape” is a concept that emphasizes how collaborative, task-oriented settings, such as woodworking workshops or community arts

projects, become inherently healing through the act of doing (Smith, 2019). Unlike traditional service delivery models, these spaces utilize non-hierarchical structures and peer mentorship to foster psychological stability and social connection (Parr, 2006). By shifting the focus from a "patient-provider" dynamic to a "side-by-side" collaborative effort, these environments help dismantle social barriers and reduce the stigma often associated with mental health interventions (Smith, 2019). Participants benefit from the rhythmic, grounding nature of physical tasks, which creates a sense of agency and belonging. Ultimately, these taskscapes function as active landscapes where the social and the material intersect, allowing individuals to build organic support networks and a refuge from daily stressors through the shared experience of doing the activity together (Parr, 2006; Smith, 2019).

For example, in Vancouver, BC, several community-led initiatives have successfully operationalized these geographic and social theories by creating low-barrier third places that prioritize collective well-being through activity. We Should Be Friends (n.d.) facilitates this by hosting arts-based social gatherings that reduce the friction of urban isolation, allowing participants to engage in creative tasks that serve as a bridge to meaningful peer connection. Similarly, Flock Events (n.d.) curates "creative wellness" workshops, ranging from floral design to painting, where the therapeutic value is derived from the shared rhythm of the activity rather than the artistic output itself. Furthermore, the Thumb's Dinner Club (Johnson, 2025) applies the concept of the "therapeutic taskscape" to the communal table, utilizing the act of shared dining to foster a sense of radical belonging and support. By embedding mental health concepts within these wellness-oriented activities, these groups move recovery out of clinical settings and into the everyday fabric of the city, showing that "healing landscapes" can be built through activity in the community (Bell et al., 2018).

**Well-Being and Third Places.**

The concept of third places, which are informal gathering spots outside the primary realms of home (the first place) and work (the second place), is foundational to building community and promoting subjective well-being (Oldenburg, 1989). These spaces can be categorized as either commercial or civic. Commercial third places are venues where a purchase is typically required, such as cafés, bookstores, or malls. In contrast, civic third places are free and publicly accessible, including libraries, recreation centers, religious centers, and parks. Regardless of their type, these spaces are defined by several key characteristics: they are neutral ground, act as social "levellers" where status is less important, and have an informal connection as their central activity. This environment fosters a sense of belonging, social vitality, and civic engagement. Research demonstrates a direct link between the availability of these spaces and individual satisfaction, showing that perceived access to third places is significantly correlated with higher perceived quality of life at both the community and neighbourhood levels (Jeffres, 2009).

Despite these benefits, third places are disappearing. While they support mental health through social connection and therapeutic environments that promote calm, safety, and improved mood (Duff, 2022), these vital community assets are in decline, with U.S. food and beverage stores decreasing by 23% and religious organizations by 17% between 2008 and 2015 (Finlay et al., 2019). This decline contributes to rising social isolation and stress, with a disproportionate impact on vulnerable groups who rely on these spaces for daily support, protection, and connection.

In response to this physical decline, digital environments, such as online games and social media communication, can also function as third places if they fulfill most of Oldenburg's

criteria, including fostering conversation and establishing communities with regular participants (Steinkuehler & Williams, 2006; McArthur & White, 2016). This suggests that digital environments could serve as a low-risk gateway to expanding physical third places, as they can help to build up a group of regulars, as well as provide the essential efficacy data to justify the high costs of developing and maintaining physical infrastructure.

### **Historic Societal and Cultural Wisdom.**

While individualistic norms often result in smaller support networks and increased hopelessness (Scott et al., 2004), community-based approaches offer a significant departure from conventional Western therapeutic paradigms (Ingle, 2021) by grounding healing in collective resilience (Gamby et al., 2021). This shift challenges mainstream models that overemphasize individual responsibility and personal agency, which can inadvertently create barriers for marginalized communities who rely on shared support systems to navigate systemic obstacles. For decades, psychological research was dominated by theories derived from WEIRD (Western, Educated, Industrialized, Rich, and Democratic) societies, which often imposed a narrow, individualistic "self-help" model to all of humanity that, while useful in some contexts, often misses the profound healing potential found in collective identity (Krys et al., 2025). Shifting toward community-oriented values that prioritize helping others creates a sense of "mutual mattering," which has been shown to be significantly protective against suicide (Zadravec Šedivy et al., 2017).

Many principles of community-based approaches are rooted in longstanding, informal and culturally specific practices that have always existed to promote healing outside of formal systems (Bond et al., 2017). For example, various traditional and Indigenous healing practices are rooted in a collectivist worldview where the self is not seen as an isolated entity but as

inherently connected to community, land, and ancestors (Benning et al., 2013). This perspective shapes how mental distress is understood and treated, moving the focus from individual pathology to communal well-being. For instance, Indigenous approaches frequently use creative arts, such as music, storytelling, and woodcarving, and practices like Healing Circles, as integrated, holistic methods supporting well-being. These are not isolated therapies but are designed to foster collective healing, reinforce cultural identity, and strengthen the bonds within the community (France, 2020). This principle is not unique to North American Indigenous contexts but is echoed in collectivist societies worldwide. For example, the Southern African philosophy of Ubuntu, often translated as "I am because we are," frames identity and well-being as fundamentally relational and interdependent (Mugumbate & Chereni, 2020). Similarly, Filipino psychology centers on the concept of Kapwa, or shared identity, reframing self-actualization not as individual achievement but as *Kaginhawaan*, which is defined as a state of collective comfort and well-being (Cervantes, 2025). Likewise, many East Asian cultures emphasize social harmony, viewing an individual's mental state as inextricably linked to the health of their family and broader community (Kramer et al., 2002). The global prevalence of such community-centric paradigms underscores that the Western individualistic model of mental health is a cultural outlier rather than a universal human standard.

### **Clinical Evidence.**

The therapeutic value of third places is rooted in well-established psychological principles that identify secure relational connections as the core mechanism for healing. Research across attachment theory, psychodynamic therapy, neuroscience, and evolutionary biology all converge on this idea. From an evolutionary perspective, the human "social brain" developed because group cohesion was as vital for survival as hunting or gathering; to be alone

was, quite literally, to be at risk (Bowlby, 1969). Attachment theory further asserts that those wounded in relationships must be repaired through new, secure bonds (Johnson, 2004), mirroring the ancestral drive to seek safety within a tribe. Similarly, Accelerated Experiential Dynamic Psychotherapy emphasizes “undoing aloneness” as a pathway to emotional transformation (Fosha, 2000), while neuroscience highlights the role of affective co-regulation, through “right-brain to right-brain” attunement, in fostering psychological well-being (Schoore, 2001). Consistent with these frameworks, Lambert’s (2013) common factors model attributes roughly 30% of psychotherapy outcomes to the quality of the therapeutic relationship itself. Moreover, Yalom and Leszcz (2020) describe universality, which is the recognition that one is not alone in suffering, as a central therapeutic factor in group therapy. Viewed through this clinical lens, third places can be understood as community-based extensions of these relational healing processes. They enact the same principles of secure connection, attunement, and shared humanity that underlie effective therapy, only in informal, accessible, and naturally occurring social spaces. By fostering consistent, authentic, and validating interactions, third places decentralize healing from the therapy room into the community, transforming everyday environments into sources of relational repair and growth for EAs.

Beyond these foundational clinical theories, the clinical evidence supporting relational and community-based approaches is substantial and growing. A major meta-analysis confirmed a significant inverse relationship between social support and suicidal behaviours, underscoring the protective power of connection (Darvishi et al., 2024). In addition, research has shown that joining just one community group can reduce the risk of a depression relapse by 24%, with this protective effect rising to 63% for individuals who are part of three groups (Martino et al., 2017). Even structured social connection programs have been shown to produce small but meaningful

improvements (effect size of  $d = -0.19$ ) in depression symptoms among young adults (Alvarez et al., 2024). However, it is crucial to acknowledge the limitations of the existing evidence base. The majority of these studies have been conducted with college students in wealthy nations, which highlights a critical need for more research to understand the effectiveness of these interventions across more diverse populations and contexts.

### *Neuroscience and Evolutionary Biology.*

As mentioned earlier, community-based and social-connection-focused approaches to mental health are supported by neuroscience and evolutionary biology, which show that humans are fundamentally social beings. Bowlby's (1969) attachment theory identifies the formation and maintenance of close social ties as an evolutionarily adaptive drive essential for survival and emotional regulation. Neurobiological research supports this, revealing that oxytocin and vasopressin facilitate bonding, trust, and social recognition (Donaldson & Young, 2008), while Porges' (1995) Polyvagal Theory demonstrates how social cues regulate the autonomic nervous system, shifting individuals between states of safety and defence. Similarly, Self-Determination Theory (Deci & Ryan, 1985; Martino et al., 2017) emphasizes that social connection is a basic human need critical for well-being, growth, and optimal functioning. Brooks (2011) reinforces this view, showing that unconscious emotional processes and social interactions profoundly shape human behaviour, decision-making, and success. Together, these findings position social connection not as a preference but as a biological necessity for mental health and human well-being.

Given that social connection is a biological imperative, research has shown that its absence is physiologically damaging, making the promotion of strong social bonds a public health priority. The World Health Organization Commission on Social Connection (WHO, 2025)

identified loneliness as a global crisis, affecting one in six people and contributing to an estimated 871,000 premature deaths annually (World Health Organization, 2025). Chronic loneliness activates the stress response, triggering harmful neuroendocrine changes including elevated cortisol and increased inflammation, that impair cognition, disrupt sleep, and compromise overall health (Cacioppo et al., 2015; Hawkey & Cacioppo, 2010). Recent research further confirms that loneliness induces measurable blood protein changes directly detrimental to physical health (Shen et al., 2025). Conversely, robust social relationships are strongly protective: individuals with stronger social ties have a 50% higher likelihood of survival, with social integration identified as the most powerful predictor of mental and physical health outcomes (Holt-Lunstad et al., 2010; Holt-Lunstad, 2024). Moreover, the relationship between social connection and physiological health appears to be a self-reinforcing cycle; greater autonomic flexibility allows individuals to build stronger social connections, and those positive social experiences reciprocally enhance physiological resilience (Kok & Fredrickson, 2013). Together, these findings make a compelling case that community-based, connection-focused interventions are not merely beneficial but are essential for safeguarding both the mental and physical health of EAs.

### **Current Examples of Community Care.**

These community-based healing benefits are already reflected in various currently established care models. For example, “social prescribing” is a growing global practice that connects individuals to non-medical, community-based services, such as art classes, volunteer opportunities, or exercise groups, to improve well-being (Morse et al., 2022). In Canada, integrated youth service hubs like Foundry BC and Youth Wellness Hubs Ontario co-locate mental health, primary care, and social services in a single, youth-friendly setting to provide

rapid and accessible care (Settipani et al., 2019; Foundry BC, n.d.; Youth Wellness Hubs Ontario, n.d.). Beyond large networks, smaller-scale models also exemplify the third place approach. Organizations like Hard Feelings (n.d.) in Toronto and Third Space Charity (n.d.) in Kelowna, BC, operate as single-location hubs that blend low-cost clinical counselling with the informal atmosphere of a retail shop or café. Another approach is the pop-up model, exemplified by the Community Living Room (Ebb & Flow Connections Cooperative, n.d.) in Wisconsin, which creates temporary peer-led listening spaces to address social isolation through connection-focused peer support.

Despite a noted lack of shared implementation guides for replication of these smaller models of community care, a review of existing integrated youth service hubs reveals a set of common principles that underpin their general design. The core tenets of these community-based models include rapid access to care and a focus on early intervention, meaningful EA and family engagement in service design, creating emerging adult-friendly settings and approaches, a commitment to using evidence-informed practices, and building strong cross-sector partnerships with health, education, and social services (Settipani et al., 2019).

### ***How Third Places Compare.***

While these community-based models share a common foundation in leveraging connection for well-being, the proposed third place model is distinguished by its primary therapeutic mechanism. Unlike community hubs, where structured services and programs are the central attraction, this model prioritizes the intentional crafting of the environment itself to foster belonging and low-barrier, organic social connection. In this framework, the sense of place is not a secondary benefit of service delivery but the principal agent of change. Any shared activities, peer-support services, or resources offered are supplementary, designed to enrich an inherently

supportive atmosphere, rather than being the primary reason for engagement. The third place model's focus on the environment itself also distinguishes it from therapeutic taskscapes, which are defined by a shared activity. In this way, third places can serve as an ideal destination for social prescribing, as they are deliberately designed to be easy to access and to facilitate belonging, community connection, and enhanced mental health.

### **Summary.**

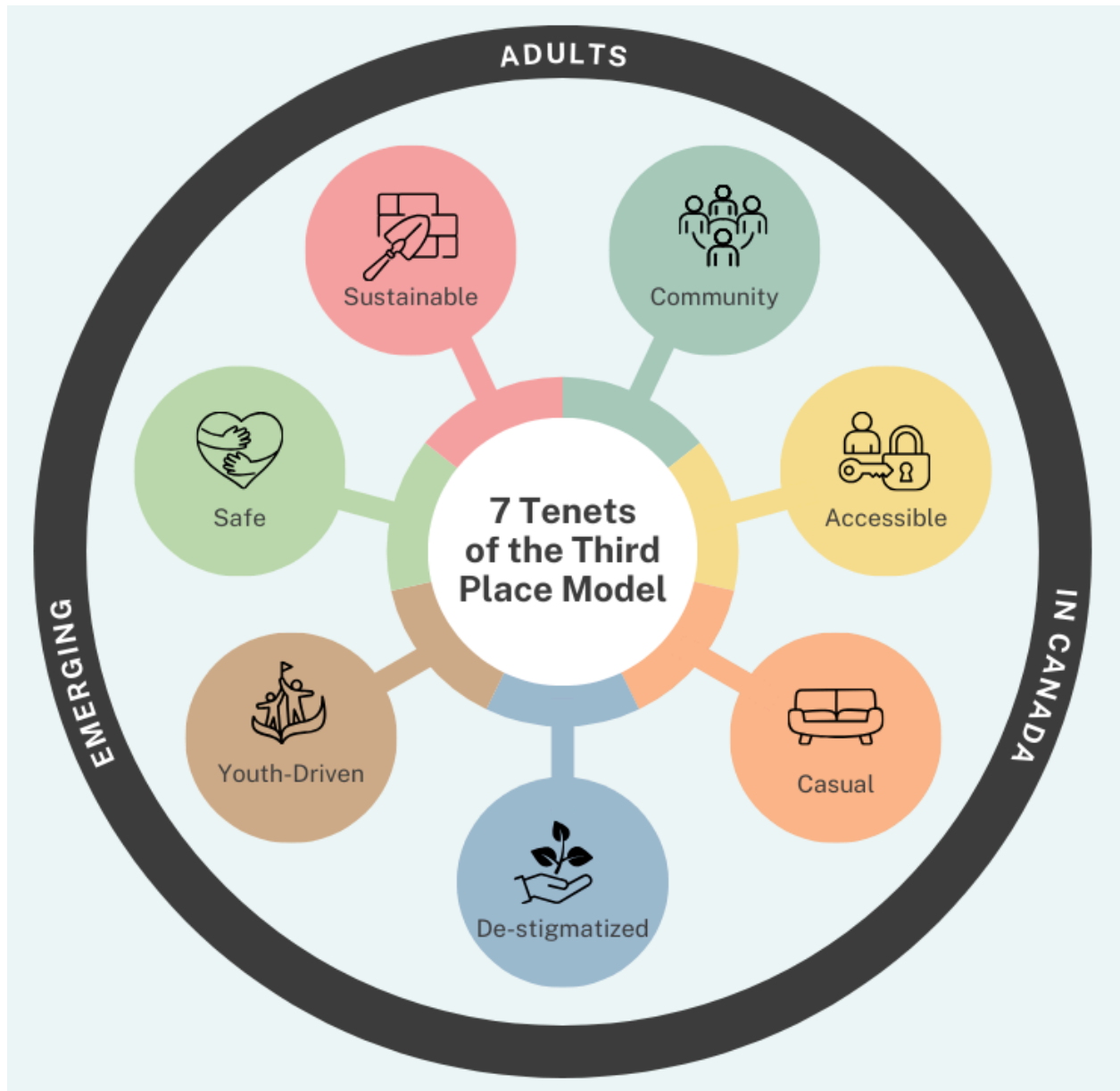
EAs face multiple challenges in accessing and engaging in needed mental health support. In response to these challenges, the literature review on the second theme, "Can Third Places Be Therapeutic?," confirms Ray Oldenburg's (1989) third place concept as a promising theoretical framework to viably address the critical need for accessible mental health support in Canada for EAs by prioritizing environment as the primary therapeutic mechanism, based on theories of therapeutic landscapes and taskscapes, the alignment with collectivist cultural wisdom, and the clinical evidence that positions social connection as a biological imperative for mental health. However, translating this model into a functional Canadian landscape requires a specific set of operational standards. To explicitly bridge the gap between theoretical concepts and the practical needs of EAs, the following section outlines the core requirements for a successful application of the model.

### **Third Place Model Tenets**

Based on the research, the third place model can be operationalized using seven tenets, as seen in Figure 2, which are (a) community-focused (b) accessible (c) casual (d) de-stigmatized (e) youth-driven (f) safe and (g) sustainable, which are designed to address the current factors leading to EAs lack of mental health support in Canada.

**Figure 2**

*Seven Tenets of the Third Place Model*



*Note.* This figure summarizes the seven tenets of the third place model of mental health for EAs in Canada.

### ***Community-Focused***

Reflecting the systemic gaps highlighted in Figure 1, EAs often face high support needs that go unmet due to a reactive system, creating an urgent need for third places to be community-oriented, providing a preventative, peer-based safety net. While EAs experience the highest rates of loneliness, current clinical models often rely on an individualism that leads to smaller social networks and poorer health outcomes. By shifting away from these isolating structures, community-oriented values serve as a vital protective factor (Zadravec Sedivy et al., 2017), especially for marginalized communities (Gamby et al., 2021).

Oldenburg (1989) posits that a third place serves as a vital space to gather, relax, and build community. This concept is supported by cross-disciplinary evidence suggesting that community environments are inherently therapeutic; in these settings, formal services act as a support system rather than the primary draw for attendance. By providing a "sense of belonging" and the "chance to participate in the life of the community," these spaces foster deep psychological comfort (Oldenburg, 1989, p. 39).

Specifically, community-based healing has societal and cultural roots known for millennia (Benning et al., 2013; France, 2020; Kramer et al., 2002; Mugumbate & Chereni, 2020). Furthermore, humans are biologically wired to connect (Donaldson & Young, 2008), helping with our evolutionary survival (Bowlby, 1969), essential needs (Deci & Ryan, 1985; Martino et al., 2017), and regulation of our nervous system (Porges, 1995). Such connections also reduce depression (Alvarez et al., 2024; Martino et al., 2017), reduce suicide risk (Darvishi et al., 2024), and increase life expectancy (Holt-Lunstad et al., 2010, 2024). Research shows that community, social engagement and connection can reduce mental health challenges (Doroud et al., 2018; Duff, 2012), providing relief from anxiety, depression, and loneliness (Alvarez et al.,

2024; Buecker et al., 2021; Clarke, 2024), especially as an antidote to any isolating effects of online social interactions (Taylor et al., 2023). Perceived community support is a key protective factor for EAs (Benson & Whitson, 2022; Zadavec Šedivy et al., 2017), meaning third places could be a proactive service instead of a reactive one. This is reinforced by foundational clinical theories, from universality (Yalom and Leszcz, 2020) to relational repair (Johnson, 2004) to coregulation (Schore, 2001), which identify secure relational connection as the core mechanism for therapeutic change, positioning third places as real-world environments for healing.

Additionally, Oldenburg (1989) reminds us that these third places offer a sense of belonging and a chance to be part of a community. This is important because that support does not stop at the front door. Once these bonds are formed between participants, EAs continue to look out for one another on their own, creating a peer safety net that stays in place even after they have moved on from the third place itself. For example, we know that social connections can increase physiological resilience, and this in turn can create an "upward spiral" (Kok & Fredrickson, 2013), meaning that EAs may be more likely to create even more connections, reinforcing a positive cycle of engagement.

### *Accessible*

In light of the significant access barriers mapped in Figure 1, such as high costs and the age-19 'care cliff', third places must be intentionally designed as low-barrier environments that prioritize ease of entry. These systemic hurdles leave a majority of EAs without the support they desire, a risk that is even more pronounced for marginalized groups, those with housing instability, or youth transitioning out of provincial care.

To address these systemic failures, we can leverage the accessibility of third places, aligning with the ethical principle to promote equitable access to care (BC Association of

Clinical Counsellors [BCACC], 2023, Principle V). Ray Oldenburg defines these essential social environments as being "easy to get to and easy to leave," noting that a third place "must be a place where one can drop in at any time and find someone to talk to, without the need for an appointment or a formal invitation... the primary 'cost' is simply the time and effort it takes to be there and engage with others" (1989, p. 34). Intentional third places can bridge gaps in service by providing low-barrier, community-integrated support. For example, by embodying Oldenburg's criteria, third places can remove systemic obstacles by being low-cost, nearby, and fast to access without the need for referrals or insurance. Crucially, these spaces do not require "intake" forms at the door or clinical diagnoses; instead, entry is based on participation. This "no-referral" approach is a core strategy of the ACCESS Open Minds model, which facilitates rapid access by removing the clinical gatekeeping that often discourages EAs from seeking help (Reaume-Zimmer et al., 2019). This is vital as Figure 1 illustrates that financial concerns are a primary barrier to access for EAs, where the high costs of traditional clinical care often make professional support unreachable. By offering a low-cost or free alternative, third places can increase the number of EAs able to be served, and reduce the overall operating costs by exploiting the group format and peer-to-peer support available in the model.

However, previous research indicates that traditional third places and community hubs often can perpetuate exclusionary behaviours that alienate marginalized individuals in society (Littman, 2022; Zhuang & Lok, 2023). Access to these healing and supportive spaces is often a privilege rather than a right, which is a reality that any new model must actively counteract. Consequently, developing truly inclusive third places requires a commitment to lowering barriers for marginalized folks, including but not limited to Indigenous, 2SLGBTQI+, racialized, and neurodivergent communities. This must be achieved through targeted outreach, implementation

plans for rural versus urban settings, culturally responsive design, and the employment of staff who mirror the lived experiences of these populations (Wang et al., 2020). Creating culturally appropriate services, such as the culturally specific programming in youth hubs seen in Henderson et al. (2022), is essential for supporting Indigenous EAs and other marginalized groups. And because EAs are consistently online, third places should incorporate digital engagement to meet them where they are (Pawluczuk et al., 2019), especially in rural communities where distance can make travelling to the third place harder (Reaume-Zimmer et al., 2019).

### *Casual*

The casual nature that underpins the effectiveness of the third place model for EAs is facilitated by the removal of bureaucracy and the clinical nature of the setting, which typically creates access barriers and stigma. While integrated service hubs can be effective at providing centralized support for EAs, they often prioritize clinical delivery over informal social connection (Settipani et al., 2019). In contrast, the activity within third places is "largely unplanned, unscheduled, unorganized, and unstructured" (Oldenburg, 1989, p. 33), offering a lack of formality that allows an EA to enter the space for a low-stakes reason, such as a coffee or a craft, while staying for the community support that naturally emerges. These casual, relaxed, non-hierarchical environments can replace the potentially intimidating atmosphere of a clinical waiting room. This casual framing is also central to the concept of therapeutic taskscapes, where healing is a byproduct of a shared, low-pressure task like woodworking or art (Smith, 2019). Through these everyday interactions and a genuine sense of belonging, third places transform from simple social hubs into "therapeutic landscapes" that build long-term resilience and psychological stability before a crisis occurs (Bell et al., 2018; Parr, 2006).

### ***De-stigmatized***

While Figure 1 illustrates that service awareness is high, the persistent social judgment shown in the data explains why actual comfort in accessing care remains low. Therefore, third places need to be de-stigmatized, neutral grounds that level the social playing field. This fear of perceived rejection or judgment acts as a primary barrier to seeking support, a challenge that is especially pronounced among young men and newcomers. Third places address this by providing a neutral ground that levels the social playing field for all participants (Oldenburg, 1989), which is essential for reducing the stigma and power imbalances often felt by EAs in clinical settings (MHRC, 2024). For example, fear of judgment or social rejection often prevents EAs from interacting with peers, especially if they perceive a high social cost or a lack of common ground (Martínez-Hidalgo et al., 2018). According to Martínez-Hidalgo et al. (2018), by engaging in cooperative, unstructured activities in a supportive community environment, alongside peers with and without diagnoses, EAs can significantly reduce their self-stigma and boost their sense of personal worth and social inclusion. Furthermore, using facilitators who are not mental health professionals but have personal experience with mental health can further reduce the power imbalance and anticipated stigma (Martínez-Hidalgo et al., 2018). We also know that representation matters, meaning that staff who identify as part of a marginalized community (e.g. 2SLGBTQI+, neurodiverse, Indigenous, BIPOC, etc) are more likely to engage marginalized EAs (Wang et al., 2020).

### ***Youth-Driven***

The failure of traditional adult-led models to reach EAs, as evidenced by the trends in Figure 1, underscores the necessity for third places to be youth-driven and self-directed. This lack of engagement is driven largely by the fact that many services do not offer the informal,

peer-based support that EAs actually prefer. To counter this, Oldenburg (1989) argues that EAs require self-directed third places that prioritize EA agency over adult-imposed schedules. By centring the EAs' autonomy (BCACC, 2023, Principle I), these environments naturally foster mental well-being:

When kids were free to wander around their neighbourhoods, to follow their own interests, to be creative in their own fashion, and to match activities to their own moods rather than to adult-imposed schedules, the antidotes to depression may well have been built into the structure of the childhood years. (Oldenburg, 1989, p. 253)

To summarize, EAs often know best what they need and want. Youth-led programs can act as a leveller to reduce power dynamics (Oldenburg, 1989) often inherent in conventional adult-driven programming that characterizes many EAs services (MHRC, 2024). Including EAs with lived mental health experiences further dissolves these power dynamics and reduces anticipated stigma (Martinez-Hidalgo et al., 2018), which can significantly boost engagement through a higher degree of ownership and empowerment (Larson et al., 2005). Also, if EAs are involved in designing and running activities, these activities are more likely to appeal to EAs (Abdel-baki et al., 2019). Because representation is a critical factor in sustained engagement (Wang et al., 2020), involving diverse EAs, with a range of lived experiences, at every level, ensures the service reflects the community it intends to serve (BCACC, 2023, Principle II). Ultimately, meaningful EA engagement is "integral to the planning, operations, evaluation and promotion of services" (Reaume-Zimmer et al., 2019). This participatory approach is not just a secondary benefit but a core requirement for the long-term success and efficacy of engaging EAs (Henderson et al., 2019).

To move from theory into practice, these third places could benefit from setting up a clear way for young people to lead, where they are treated as real partners in paid, decision-making roles instead of just being asked for occasional input (MHCC, 2017). One way to make this happen is by forming EA advisory committees (Hetrick et al., 2017; Settapani et al., 2019) that can help decide where a center should be located (Reaume-Zimmer et al., 2019) and what kinds of activities should happen inside (Abdel-baki et al., 2019). It might also be helpful to include EAs in the hiring process for new staff to make sure the team truly shares EA values, as well as to have them lead the way in gathering feedback to keep improving the service (Reaume-Zimmer et al., 2019). Finally, encouraging young people (especially those who have navigated mental health concerns themselves) to act as ambassadors can help make talking about mental health feel more normal, less stigmatized and keep the service connected to the community it is meant to support (Reaume-Zimmer et al., 2019).

### *Safe*

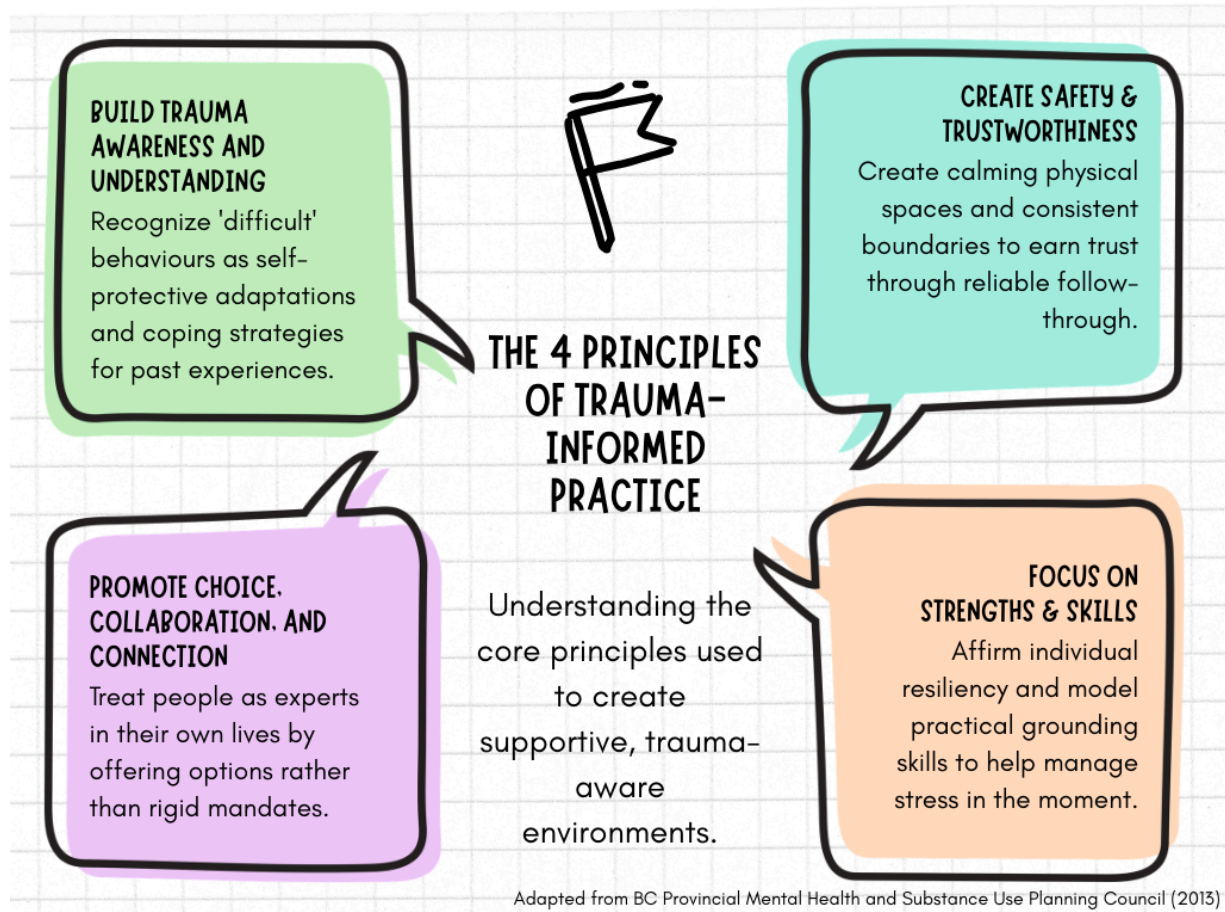
Because EAs are navigating the intersection of high support needs and systemic barriers to care (as seen in Figure 1), third place design must prioritize safety for those at elevated risk (BCACC, 2023, Principle III). While the majority of mental health disorders emerge during this developmental window, the current system is often reactive and exclusionary, leaving many EAs without the care they require. This ethical duty highlights how the informal nature of third places creates unique clinical risks that cannot be ignored. However, this professional commitment to safety is not merely a regulatory requirement, but also a biological prerequisite for healing. In fact, the literature indicates we can only achieve the neurological benefits of community, such as “undoing aloneness” by Fosha (2000) and relational repair (Johnson, 2004), if the environment is perceived as safe and there is a felt sense of safety. And based on Porges’ (1995) research, the

body must feel safe before social connection is biologically possible, in that humans can only utilize their ability to connect with others when the autonomic nervous system is not occupied by defensive strategies (Porges, 1995). Therefore, in order to leverage the benefits of third places for healing through fostering genuine connection, the environment must be designed to help the body feel physiologically safe. In fact, the literature suggests that the environment itself must be reimagined as the tool for healing (Bell et al., 2018).

Integrating Oldenburg's (1989) Third Place model with the principles of Trauma-Informed Practice (TIP) provides a framework that inherently supports the psychological and physiological safety of EAs within this new model (BCMHSUS, 2013) and upholds the ethical duty of responsible caring (BCACC, 2023, Principle III). Trauma-informed practice centers on (a) trauma awareness, (b) creating safety and trustworthiness, (c) promoting choice, collaboration, and connection, and (d) building on people's strengths and skills to support healing, as seen in Figure 3.

**Figure 3**

*The Four Principles Of Trauma-Informed Practice*



*Note.* This figure summarizes the four principles of trauma-informed practice adopted from the BCMHSUS (2013) TIP, to be used in the third place model of mental health for EAs in Canada.

And, because third places are designed as neutral ground (Oldenberg, 1989), this means that the typical power structures that can exacerbate trauma (Isobel & Edwards, 2017) should not be as present. This neutrality promotes agency and choice by allowing EAs to make decisions free from these power dynamics. Especially when these spaces are youth-led, this can facilitate a collaborative environment that shifts the focus from typical institutional hierarchies to peer-based connection (BCMHSUS, 2013). This egalitarian nature also ensures the environment remains strengths-based rather than deficit-based. Because everyone is equal, the focus shifts from a person's symptoms to their unique character and contribution to the community. Healing is supported by valuing what each person brings to the group rather than focusing on what they lack.

In practice, to honour EAs' autonomy (BCACC, 2023, Principle I) while ensuring responsible care (BCACC, 2023, Principle III), the model must integrate transparent safety guardrails (BCACC, 2023, Principle IV) that protect the "casual" nature of the space without compromising physiological and cultural safety (BCACC, 2023, Principle II). In order to reimagine the environment itself as the tool for healing, the following design features must be built into the framework from the start. Features like trauma-awareness training, clear group agreements, transparent crisis protocols and de-escalation procedures need to be clearly set up to ensure the container is set up for safety. Given that 55% to 72% of EAs in integrated hub models report suicidal ideation (Hilferty et al., 2015), these crisis protocols must be designed to have warm handoffs to minimize harm. This could also involve integrating sensory-friendly quiet zones for regulation (Ames & Loebach, 2023) or adopting parallel play models to facilitate co-regulation without the demands of direct face-to-face social interaction (Wass et al., 2024).

Establishing this trauma-informed environment is a mandatory requirement for practice (Leschied, 2015), yet we must also critically acknowledge what the model cannot do: it is not a replacement for acute psychiatric care. Defined clearly, the scope of this model is an intervention for mild-to-moderate distress, loneliness, and prevention; and individuals with severe mental illness, such as active psychosis or severe suicidality, would require prompt and warm handoff to more intensive clinical services (BCACC, 2023, Principle IV). One potential strategy to maintain this balance is to create a private space, such as a peer support lounge, distinct from the main area to preserve both functions. So, if someone becomes overwhelmed or needs a warm handoff (Hilferty et al., 2015), they can move to the private lounge. The benefits of this are two-fold: it allows the person in crisis a calm, private environment for regulation, while ensuring the felt sense of safety is maintained for the rest of the community. By containing acute distress, we prevent the defensive strategies (Porges, 1995) of other regulars from being triggered, thereby preserving the third place as a viable site for relational repair and connection (BCACC, 2023, Principle III).

Adults can help support these protocols in a safety capacity rather than a power-over sense, helping to maintain a secure and predictable environment for the group (BCMHSUS, 2013). By replacing traditional adult clinical roles with "stewards," the environment remains youth-led while maintaining responsible care (BCACC, 2023, Principle III). The concept of stewards mirrors Oldenburg's (1989) concept of the host, whose role is not to direct the community but to curate a levelling environment where social barriers are removed, and organic interaction can thrive. Such a shift is particularly vital for 2SLGBTQI+ and racialized EAs, for whom safety is inextricably linked to representation, active inclusion and the presence of culturally specific programming (Henderson et al., 2022).

Additionally, the third place model is designed to foster a consistent core of "regulars" who can provide a predictable social rhythm (Oldenberg, 1989). The predictable presence of regulars may help foster long-term safety and trustworthiness through consistency. This consistency is essential for creating the "felt sense of safety" necessary for social interaction. In summary, by grounding the informal nature of the third place in a robust trauma-informed framework, we ensure that the environment remains a sanctuary where EAs can safely shift from self-protection to social healing.

### ***Sustainable***

Ultimately, this model cannot serve the EAs it is designed to support unless it is sustainable, a requirement that is as much therapeutic as it is logistical. A third place only facilitates genuine healing when it remains a constant fixture, because the sense of safety EAs need can only be cultivated over time through consistent, reliable connection (Porges, 1995). Oldenburg (1989) posits that third places require a consistent core of "regulars" to facilitate this steady environment. If the space closes, that safety ruptures, and for EAs who have already experienced instability, the model inadvertently replicates the very harm it was intended to heal (BCACC, 2023, Principle III). We also know that in order for the "upward spiral" effect (Kok & Fredrickson, 2013) to work, the space needs to persist long enough to allow this to happen naturally. In fact, according to Figure 1, we know EAs face stigma and low engagement with services, so it may take time to build up enough trust and safety to engage. To reiterate, EA co-ownership is a core requirement of this model, but it is also crucial for the long-term sustainability, ensuring that the third place remains culturally relevant and adaptive to the population it serves over time (BCACC, 2023, Principle II). Without this, the space risks becoming an adult-led service that merely "hosts" EAs, rather than a third place owned by them.

This includes cultural safety that is defined by the EAs themselves, as well as diverse representation across all levels of leadership. We know that representation is a critical factor in sustained engagement (Wang et al., 2020), as well as an ethical obligation (BCACC, 2023, Principle II), but it also ensures that the container remains safe and accessible for all EAs by functioning as a social leveller (Oldenburg, 1989).

To protect this therapeutic container, the model requires an affordable, accessible, and welcoming location that remains high-quality without sacrificing the environment's "home away from home" feel (Oldenburg, 1989). This will require robust and diverse funding streams, with a rotating budget dedicated to maintaining the physical space, funding activities, and providing honorariums or salaries for EA volunteers to honour their labour and co-ownership. Luckily, the Canadian political landscape is shifting to prioritize non-clinical, community-based spaces for EAs. Key opportunities include the YMHF, which provides \$500 million through 2029 to expand care options (Government of Canada, 2024), and the MHP-IF (Government of Canada, 2023). The latter allocates \$5 million annually over ten years to test and scale programs with a specific focus on health equity and reducing systemic barriers for Indigenous, 2SLGBTQI+, and newcomer EAs (Government of Canada, 2023, 2024). Given their emphasis on innovative approaches for youth (including vulnerable EAs), these funds are a strong fit for developing the third place model. Successful government-funded nonprofits like Foundry BC (n.d.) and Youth Wellness Hubs Ontario (n.d.) have already proven the viability of these revenue streams. However, if political priorities shift, the third place model remains vulnerable to funding disruptions. Another option is to adopt a hybrid financial approach, much like Third Space Charity (n.d.) or Hard Feelings (n.d.), by blending government grants, donations, and social enterprise activities (e.g., retail storefronts or sliding-scale fees), which can help reduce

dependency on a single source. In fact, this type of model has been shown to improve access and reduce stigma through visible storefronts and low-cost services, while its non-clinical atmosphere engages those who usually avoid traditional care (Turpin et al., 2021).

To keep a program running, you have to prove to the people providing the money that it is making a real difference. This starts with a solid operational design, which is essentially a blueprint for how the program works and how you will measure success (Reaume-Zimmer et al., 2019). To secure funding renewals, programs must build "proof of impact" into their design from the very beginning by using a mix of numbers and personal experiences. This means tracking quantitative data, such as who uses the service, how many people use the service, and whether their mental health scores (like loneliness scales) improve over time. However, numbers do not tell the whole story, so it is equally important to collect qualitative data through interviews and focus groups. These conversations help explain how participants feel, specifically focusing on the problems EAs are facing (see Figure 1) and tenets of the third place model (see Figure 2), providing the "human" evidence that the program is truly helping people.

Although the safety protocols and warm handoff procedures outlined above are designed primarily to protect the therapeutic integrity of the space, they also serve a critical operational function. Unlike hub models such as Foundry BC or Youth Wellness Hubs Ontario, which deliver services directly under one roof, the third place model functions more like a community connector, offering EAs a visible menu of external resources and actively supporting them in accessing whatever they choose. For most EAs, this process remains entirely self-directed, in that they can choose what they need, when they need it, and on their own terms (BCACC, 2023, Principle I). However, when an EAs' safety is at risk, the model cannot rely on choice alone (BCACC, 2023, Principle III). It is specifically in these moments that transparent, formal referral

pathways and written scope-of-practice agreements between partner organizations become essential, ensuring clear, gap-free handoffs so that no EA in crisis falls through the cracks between services (BCACC, 2023, Principle IV). Additionally, shared electronic records and data systems must track key metrics such as attendance, engagement, and well-being outcomes to generate the proof of impact that funders like the MHP-IF require, but it is essential that this is done lightly and intentionally so the space never starts to feel clinical. By borrowing the tools of clinical infrastructure without replicating its culture, the operational framework does not contradict the third place identity of the model but protects it, demonstrating to stakeholders that a community-owned, non-clinical space can be both therapeutically meaningful and organizationally sustainable.

### **Summary**

This chapter reviewed the literature across two central themes. The first established that EAs face a significant and underserved mental health crisis, shaped by developmental vulnerability, systemic access barriers, stigma, and the compounding effects of individualism, technology, and the COVID-19 pandemic, with marginalized groups facing disproportionate risks. The second examined the theoretical and empirical case for community-based care, drawing on neuroscience, clinical theory, evolutionary biology, and cross-cultural wisdom to position social connection and belonging as foundational mechanisms for healing. Together, this evidence supports Ray Oldenburg's third place concept as a viable and necessary framework for EA mental health in Canada, operationalized through seven tenets as seen in Figure 2. The following chapter moves from this conceptual foundation to a formal analysis of the model's strengths and limitations, followed by practical implementation guidelines and outcome measures essential for its sustainable application in practice.

### **Chapter 3: Discussion and Application**

The preceding literature review has established that EAs in Canada are experiencing a profound mental health crisis, further exacerbated by systemic barriers to traditional psychiatric care. Building upon the evidence that community-based third places offer neurobiologically protective social environments for healing, this chapter translates these conceptual foundations into a formalized framework for implementation. Specifically, it delineates evidence-based guidelines for clinicians adopting the Third Place Model of Mental Health, while providing an honest analysis of its operational viability. This analysis includes an evaluation of the model's inherent strengths, limitations, and the outcome measures necessary for its sustainable application in clinical practice.

#### **Analysis**

##### ***Strengths***

###### **A Paradigm Shift in Canadian Care.**

The Third Place Model for mental health offers a transformative approach to the Canadian mental health landscape, specifically targeting EAs who currently have unmet mental health needs. By prioritizing the environment as the primary therapeutic mechanism, this model catalyzes a major change in how we think about care, moving away from a reactive, crisis-driven medical model (Livingston, 2020) toward a proactive, preventative approach. This shift corrects a long-standing oversight in Western healthcare in recognizing that physical surroundings (Smith, 2019) and community connection are essential to healing (Doroud et al., 2018; Duff, 2012). Rather than viewing the setting as just a backdrop for individual, clinical interventions, this model recognizes that the "place" itself possesses inherent therapeutic properties capable of regulating the nervous system and fostering belonging (Bell et al., 2018; Parr, 2006). The model

also addresses common mental health issues before they escalate into clinical crises that require potentially expensive and reactive interventions (Livingston, 2020). By focusing on these proactive strategies, the model could act as a guide for the whole country, helping remove the current barriers to services for this population and taking the heavy weight off emergency systems for mental health care.

### **De-stigmatizing Support through Social Connection.**

This youth-led and neutral ground third place can effectively reduce the stigma and power imbalances often felt by EAs in traditional clinical settings (Jack.org, 2024; Larson et al., 2005). By embedding mental health support in a casual, normalized social setting, help-seeking becomes a natural extension of community life rather than an intimidating medical experience, one that persists even outside of the third place through peer support and enduring bonds. This works because the third place model is built on being accessible and nearby, which removes the physical and financial barriers that can keep EAs from care (BCACC, 2023, Principle V). Its casual and de-stigmatized nature makes it feel less clinical and more like a normal part of life, which helps keep EAs coming back, ensuring continuity of care (BCACC, 2023, Principle III).

### **Strategic Financial Impact.**

From a systemic standpoint, the model is financially strategic, in that more EAs can be helped for less cost, given its proactive approach to mental health care, its group format and the opportunity for peer-to-peer support. Proactive care can be significantly more cost-effective than reactive crisis management, which often involves emergency room visits or intensive inpatient care (Livingston, 2020). By utilizing peer support and group-based formats, the model achieves a much lower "per-head" cost than traditional one-on-one clinical therapy. This financial efficiency

allows for a broader reach within the same budget, maximizing the number of EAs able to be served (BCACC, 2023, Principle V).

### **Biological Necessity and Historic Wisdom.**

Furthermore, the model is grounded in the biological necessity of connection, leveraging principles of attachment theory (Bowlby, 1969; Johnson, 2004) and co-regulation (Schoore, 2001). It creates a peer safety net, where healing occurs through organic social interaction and the recognition of universality, meaning the comfort of knowing one is not alone in their suffering (Yalom and Leszcz, 2020). This approach honours a way of healing that has worked since time immemorial in many cultures around the world (BCACC, 2023, Principle II). While many modern systems focus on the person alone (Ingle, 2021), this model returns to the historic wisdom found in non-Western cultures (Benning et al., 2013; Cervantes, 2025; France, 2020; Kramer et al., 2002; Mugumbate & Chereni, 2020). By looking at mental health through a community lens, we recognize that people are not meant to heal in isolation, which is a view that has built resilience for centuries. In the big picture, this model stops treating wellness as a private burden for EAs to carry alone, and instead integrates it into the natural fabric of how we live and look out for one another in our own neighbourhoods.

### **Empowerment and Long-term Resilience.**

This model is particularly targeted to provide support to marginalized groups (BCACC, 2023, Principle V), such as those aging out of foster care or 2SLGBTQI+ EAs, who frequently face many systemic barriers (Reaume-Zimmer et al., 2019; MHRC, 2024) or stigma (Martínez-Hidalgo et al., 2018) in traditional care. Because the model is youth-driven and prioritizes diverse representation at every level, it is designed to adapt and remain relevant over time, fostering deep empowerment by ensuring those with lived experience lead the way

(BCACC, 2023, Principle I). This leadership allows the program to actively identify specific barriers for these populations and ensure they are removed in a timely manner, preventing drop-off often caused by negative encounters. Trauma-informed practices ensure the space remains a reliable environment to find safety (BCMHSUS, 2013), especially for EAs who have historically felt unsafe in mental healthcare spaces. And, because healing through connection takes time and sustained relationships, the sustainability tenet of the model is what allows that healing to actually take root, giving the time for healing to happen, and ensuring the program evolves to meet the shifting needs of both funders and participants, such that it sticks around.

### ***Limitations***

#### **Clinical Scope and Boundaries.**

A critical limitation of the third place model is its clinical scope; it is specifically designed as an intervention for mild-to-moderate distress and prevention, meaning it cannot accommodate acute psychiatric conditions. Individuals experiencing active psychosis, severe suicidality, or complex trauma will still require timely warm handoffs to more intensive clinical services. Acknowledging these boundaries is essential, as the model functions best as a complementary layer to the healthcare system rather than a standalone substitute for specialized medical treatment. By defining the boundaries of care clearly (BCACC, 2023, Principle IV), the model ensures that participants receive the appropriate level of care (BCACC, 2023, Principle III) while maintaining the safety and integrity of the community space.

#### **Challenges of Organic Discovery.**

Unlike hub-integrated models, a standalone third place lacks an internal referral stream. Consequently, a reliance on organic discovery may fail to reach the most isolated EAs who are not already connected to social, academic, or clinical networks. Without an intentional outreach

strategy, such as peer-led street teams or integration into non-health sectors like employment centers or transit hubs, the model risks becoming yet another space only accessible to EAs who are already socially mobile and face the fewest obstacles to care (BCACC, 2023, Principle V). While this autonomy (BCACC, 2023, Principle I) protects the space from becoming clinical, it places the full burden of outreach on the model itself, requiring significant investment in non-clinical community presence to reach those most in need.

### **Physical and Geographic Barriers.**

Implementing this model faces significant physical and geographic barriers. In urban centers, the decline of affordable space makes it difficult to establish a consistent, low-cost third place for this model to operate from (Finlay et al., 2019; Rhubart et al., 2022). In rural areas, geographic distance makes a single physical location impractical for the population it needs to serve, a problem compounded by limited or unaffordable transportation options that can make even a nearby space effectively unreachable for low-income EAs (Reaume-Zimmer et al., 2019). In the remote north of Canada, this tension becomes acute, in that a sustainable, in-person third place is often not feasible for the reasons outlined above, yet according to Tao (2014), an online-only version of this model can have the opposite effect, creating a false illusion of social support that actually feeds loneliness. One can imagine that weather may further compound these challenges in Northern contexts, where harsh seasonal conditions may make travel to any physical space unsafe or impossible during these periods.

The physical space itself may present additional barriers for marginalized populations that this model is designed to serve, without careful consideration. EAs with mobility limitations, chronic pain, or physical disabilities may find attendance difficult if the space is not purposefully designed for accessibility. Similarly, neurodivergent EAs may find certain physical environments

overwhelming if sensory considerations are not built into the design. Also, EAs experiencing housing instability may face a different barrier, as a lack of safety or privacy in their living situation can make consistent social engagement difficult even when the space itself is accessible. Additionally, in small towns, a single space associated with mental health support may increase stigma, as higher community visibility means entering it can publicly signal that a young person is struggling, working directly against the de-stigmatized tenet this model depends on.

For these reasons, implementation of this model in these specific contexts must be flexible in order to ensure equal access (BCACC, 2023, Principle V). For example, hybrid approaches, such as a distributed pop-up style design, may reduce stigma in small towns by distributing gathering places across multiple, less obviously identifiable spaces. In fact, land-based approaches (particularly in Northern and Indigenous communities) would potentially be a more suitable third place for Indigenous EAs, where connection to the land already functions as a natural gathering space, one that is cost-effective, culturally relevant, and free of the stigma attached to a designated support space.

### **Research and Metric Misalignment.**

There is a notable gap in empirical research regarding third places used in direct clinical practice. While sociological literature on third places is robust, there is limited longitudinal data or randomized controlled trials specifically evaluating the third place model as a mental health intervention for EAs. Without that evidence base, the model cannot yet make the same credibility claims as established interventions, making it harder to convince risk-averse funders, healthcare systems, or institutional partners to adopt it. It also means that practitioners implementing the

model are doing so without an evidence-tested blueprint, which increases the likelihood of inconsistent implementation across sites.

This gap is compounded by the fact that the model's primary therapeutic mechanism, a felt sense of belonging and community connection, is notoriously difficult to capture using conventional clinical metrics. Funders and health authorities typically require quantifiable outcomes such as a reduction in emergency room visits, improved scores on standardized mental health measures, or documented diagnostic changes. Because the model's core output does not map neatly onto these measures, it risks being evaluated as ineffective by systems that are simply not designed to measure what it does.

#### **Systemic and Inter-Provincial Friction.**

This potential credibility gap has direct funding consequences. Without a recognized evidence base or quantifiable, measurable clinical outputs, securing stable, long-term funding is more challenging, and thus threatening the sustainability tenet of the model. This funding challenge may be further compounded by inter-provincial differences in healthcare governance. Because healthcare in Canada is managed by individual provinces rather than a single national authority, a model successfully piloted under British Columbia's health authority, for example, may face significant resistance when moving to Ontario or Quebec, simply because their systems are built differently. Without a standardized national framework, scaling the model across provinces would require navigating varying laws, standards, and protocols, which may stall momentum before the model has had a chance to demonstrate impact.

#### **Colonial Defaults and Western Centricity.**

Although I have researched cultural and historic sources of wisdom, it is fair to say that as a white settler in Canada, this model has not yet achieved the diverse representation (including

EAs, especially those with marginalized lived experiences and various cultural perspectives) that it claims is a vital tenet of its success. In its current form, there is a risk that this is simply another Western, WEIRD framework created by adults who hold power over the design process for EAs. For this to truly work, we must be open to fundamentally changing the tenets of the model through genuine collaboration with diverse voices (BCACC, 2023, Principle II).

For example, because this framework was developed within a Western settler context, there is a genuine risk that it defaults to Western assumptions about what healing looks like. To illustrate, Indigenous EAs often view a third place not as a building or a designated space, but as the land itself, where healing is communal and relational rather than individual. Without diverse representation in governance, including the making of the model as outlined so far, this model risks replicating the same colonial pattern of imposing external frameworks onto communities that already have their own ways of supporting collective well-being.

Beyond Indigenous contexts, there is also a practical risk that even a well-intentioned third place can become exclusionary over time. Without ongoing trauma-informed training and diverse representation among those who run and steward the space, marginalized EAs may gradually feel unwelcome, not through any single act, but through the accumulation of small moments that signal the space was not truly designed for them, or is not safe for them. Genuine success will require that the communities this model seeks to serve are not just consulted, but are actively governing the space from the beginning, including in shaping the model itself.

### **Competition with Integrated Youth Services.**

A significant hurdle is the competition with established Integrated Youth Services like Foundry BC (n.d.) and Youth Wellness Hubs Ontario (n.d.), which creates compounding challenges across three fronts. First, established hubs already have proven track records and

government relationships, making it harder for a newer, less clinically measurable model to compete for the same funding. Second, because hubs are already the recognized solution for EA mental health in Canada, the third place model risks being dismissed as redundant by the very systems it needs to work alongside, rather than recognized as a distinct and complementary approach. Third, hubs have built-in referral streams and institutional partnerships that a standalone third place must build entirely from scratch, requiring significant time and community investment before the model can reach the population it is designed to serve. Together, these three barriers mean the model enters a landscape where funding, legitimacy, and referral infrastructure are already concentrated elsewhere, making the case for its distinct value more difficult to establish.

One potential solution is to work with existing infrastructure rather than alongside it. Provinces could add third place initiatives onto existing hub locations, transforming them into low-pressure entry points to care that de-stigmatize help-seeking before a young person ever accesses clinical services. However, successful integration must actively guard against the risk that the casual, unprogrammed nature of the third place becomes gradually overridden by the more clinical culture of the hubs they are added to. To be effective, the informal autonomy of this front-facing community space must be protected, ensuring it remains a genuine community destination rather than simply a rebranded waiting room. This approach would also benefit from a refreshed aesthetic and conceptual identity, signalling that the space is a general-purpose community resource where entry is a normal part of a social routine, rather than a potential indicator of their need for support.

### **Implementation Guidelines for Clinicians**

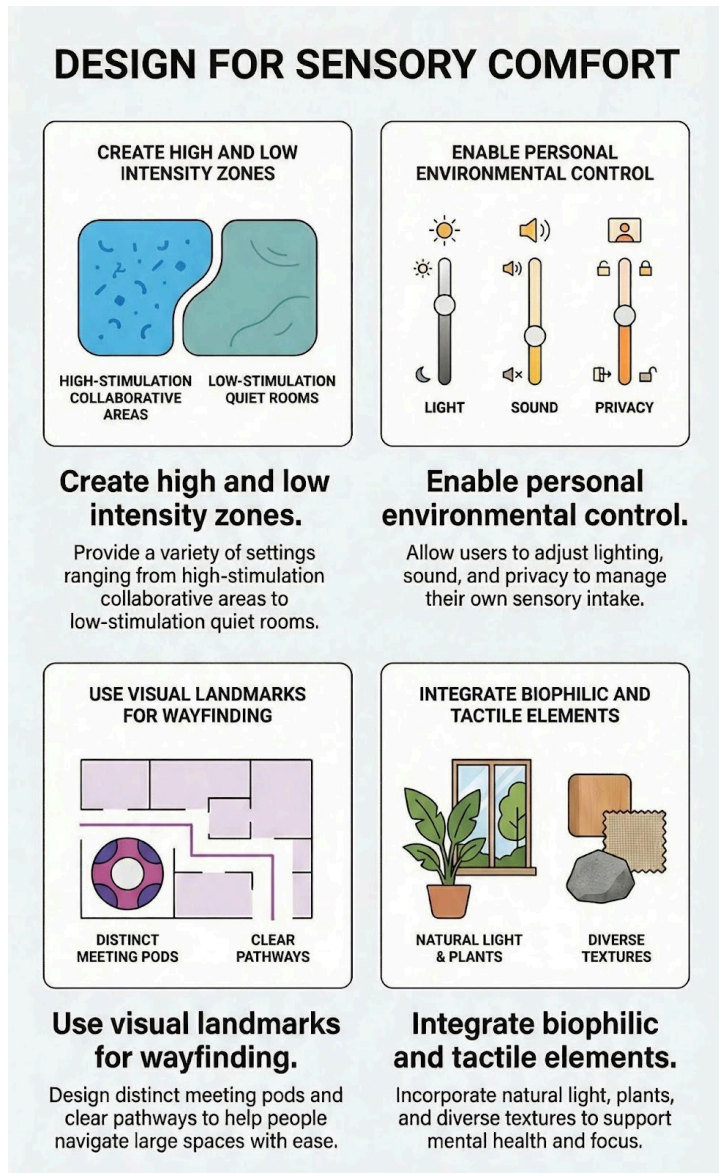
The Appendix contains a comprehensive infographic that details the necessity of the third place model for EAs, integrating theoretical frameworks, cultural wisdom, and scientific research regarding the efficacy of these spaces for healing. By highlighting real-world examples of community care within the Canadian context and outlining various financial streams, this resource serves as a foundational tool for clinicians and policymakers, providing a succinct synthesis of benefits essential for stakeholder engagement and the procurement of project funding.

### ***Therapeutic Environment***

The therapeutic environment is more than a backdrop; it is a tool for healing in its own right. To be effective, the physical space must be designed to promote the qualities of a third place, in that it facilitates gathering, relaxing, building community, and restoration. Central to this is the use of universal design (Mace, 1985), meaning creating a space that is inherently accessible and usable by all EAs by default, regardless of their needs. This type of design promotes customization and encourages agency. For example, intentional sensory design can ensure the environment is neither overwhelming nor exclusionary, providing a regulated foundation for all neurological and physical needs of all EAs using the space (see Figure 4).

**Figure 4**

*Designing For Sensory Comfort*



*Note.* This figure summarizes four considerations for sensory design, adapted from Hames Sharley (n.d.), using NotebookLM (Google, 2026) to generate an infographic.

Because the space must specifically appeal to EAs to engage them, it is crucial to involve them directly in the design, implementation, and maintenance of the environment, to ensure they can shape the way the space feels and is used. This sense of belonging is further supported by removing the formal, bureaucratic elements, such as intake forms or rigid appointment structures, that often make clinical environments feel forced. By allowing for drop-in access and offering flexible "pop-up" or online options for those facing geographical barriers, the environment becomes a truly accessible and natural extension of the community.

### ***Participation***

To cultivate meaningful engagement, the third place must focus on inviting connection through scaffolding, skills, and activities that provide a predictable social fabric for connection, in a way that is relevant to those participating. This is best achieved by empowering EA ambassadors to invite their peers in a low-pressure way, ensuring that diverse voices are present to shape the activities to be both culturally responsive and neurodivergent-affirming. Participation has to be flexible, though, balancing the individual's choice to engage with structured support, such as designated zones for active socializing, quiet reflection, or parallel play through joint low-pressure tasks. Even in unplanned social areas, the environment should provide icebreakers or conversation starters to ease the transition into connection, with the ultimate goal of helping EAs form bonds that persist beyond the space to create a self-sustaining support system. To ensure these interactions lead to relational repair rather than rupture, the program should offer optional training on trauma co-regulation and social skills while tasking stewards with modelling these healthy dynamics during daily participation.

***Governance***

To ensure the third place remains a secure and enduring environment, governance must prioritize safety, transparency, and long-term sustainability through its daily operations. This involves embedding TIP that fosters physical and relational safety while promoting participant agency, allowing young people to engage with the space on their own terms. While essential infrastructure like transparent crisis protocols and warm handoffs to clinical services must exist to hold EAs safely, these elements should remain unobtrusive to preserve the casual, non-clinical essence of a true third place. This sense of security is further reinforced by co-creating visible community agreements and advertising clear policies regarding confidentiality and de-escalation, all of which are upheld by trained stewards. Financially, the space maintains itself best through spending on diverse funding streams (such as government grants, donations, and social enterprise models), making sure a budget is specifically allocated for compensating EAs for their work and maintaining a therapeutic physical environment. To satisfy funding requirements without making the space feel monitored, success metrics should be gathered through unobtrusive methods that balance qualitative and quantitative data, ensuring the focus remains on the community rather than clinical tracking.

***Leadership.***

In order for the third place to thrive, leadership within the space must shift toward an inclusive, co-ownership model where young adults hold paid decision-making power and staff mirror the community's lived experiences to foster genuine trust and engagement. To truly cultivate a representative environment, leadership must be rooted in inclusivity and the active empowerment of EAs through defined, paid roles that treat them as genuine partners and co-owners of the space. Rather than settling for occasional input, this model integrates young

people into all levels of governance, from forming EA advisory committees that decide on center locations and outreach strategies to involving them directly in the hiring process to ensure a youth-centric culture. To maintain a safe and welcoming environment, traditional "power-over" clinical roles should be replaced by trained stewards who participate as equals, levelling power dynamics through a non-directive, transparent, and collaborative approach that prioritizes the shared stewardship of the community.

### ***Proof of Impact***

To secure long-term funding, "proof of impact" must be integrated into the operational blueprint of the program from its inception. This requires a dual approach that utilizes both statistical and experiential evidence to demonstrate efficacy. The proposed plan outlines a data collection strategy for the third place model, integrating automated entry tracking, QR-coded exit surveys, usage statistics, and youth-facilitated feedback sessions. This framework ensures the space remains responsive to its community while gathering the necessary metrics for funding and operational improvements.

### **Access & Entry Protocol.**

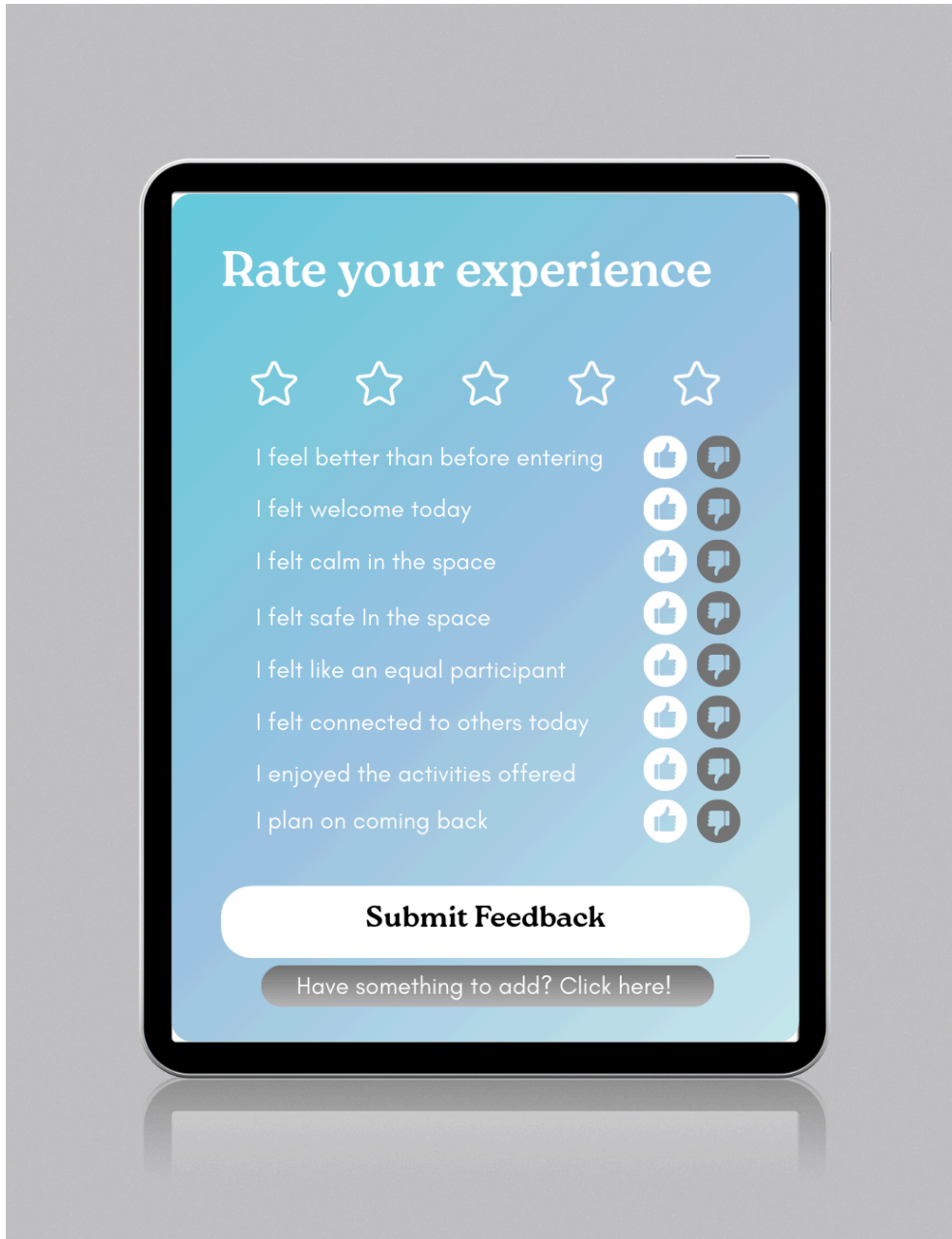
To automate quantitative tracking, the space should utilize a two-tier entry system designed for efficiency and data integrity. EAs entering the third place will utilize a tap card system upon entry, which automatically logs attendance, frequency of visits, and distinguishes repeat users from new users. First-time users scan a QR code at the entrance to register via a digital intake form. This form collects essential information, including name, contact information, and emergency contact details for safety. Optional demographic data, such as age, ethnicity, and gender identity, is also collected to track diversity and ensure equitable access.

**Quantitative Metrics.**

The health and reach of the community being built should be measured through specific, trackable data points that provide a clear picture of program engagement. Leadership representation is assessed by tracking the number of EAs in leadership roles, compared against the overall demographic diversity of the participant population. Usage volume is monitored through total daily and monthly visitors, alongside the ratio of new members to repeat attendees. Additionally, the system tracks service integration through the number of "warm handoffs," or direct referrals, made to external partner services. General participant satisfaction is captured through results from the "Rate Your Experience" digital exit survey.

***The Exit Survey.***

To prompt EAs to fill out the exit survey, a QR code should be prominently displayed at the exit to facilitate immediate feedback from participants. To encourage participation, a call-to-action reminds users that filling out the survey helps keep the space running and tailored to them, emphasizing that because it is their space, they should have their say. The survey utilizes a 1–5 star scale for overall ratings and incorporates a binary sentiment system, such as a thumbs up or down, to ensure the process is as easy and accessible as possible. All fields remain optional to respect user privacy, as illustrated in the example form shown in Figure 5.

**Figure 5***Example of Exit Survey*

*Note.* This figure shows a mockup of a tablet view of a digital exit survey, which can be used to quickly facilitate the collection of quantitative participant satisfaction data. The survey also includes a link to give anonymous qualitative feedback.

### **Qualitative Impact and Testimonials.**

To capture the qualitative aspects of the space, the framework should implement youth-facilitated feedback sessions and long-form digital questions. This qualitative data is vital for outreach and grant applications, providing the necessary context for the numerical data collected elsewhere. Specific inquiries are used to prompt these narratives, such as a “vibe check” where participants are asked if they could change one thing about the vibe of the space today, what would it be. To identify "Connection Points," users are asked what activity or area made it easiest for them to connect today and what they would like to see added. Finally, to document "Impact Moments," participants are asked to describe a moment today where they felt truly seen or heard by the community. These inquiries allow participants to provide nuanced feedback that ensures the space remains defined by its users.

### **Conclusion**

In conclusion, the evidence and framework presented in this capstone articulate a clear path forward for the Third Place Model of Mental Health. The analysis confirms that this model is not only theoretically viable but also a biological and social necessity to address the current, profound unmet mental health needs of EAs in Canada. By shifting the primary therapeutic mechanism from individual clinical intervention to the social environment itself, the model addresses the root causes of the current crisis, specifically a population with high support needs facing systemic access barriers, pervasive stigma, and a healthcare system that remains reactive rather than proactive.

The efficacy of this model is rooted in its seven core tenets: community-focused, accessible, casual, de-stigmatized, youth-driven, safe, and sustainable. By prioritizing the environment itself as the agent of change, the model leverages the neurobiology of social

connection and historic collectivist wisdom to foster an upward spiral of resilience. For EAs, this provides a low-barrier sanctuary where healing is an organic byproduct of belonging rather than a medical problem to solve. It effectively dismantles the safety-casualness paradox by integrating trauma-informed design with youth-led governance, ensuring that the space remains a predictable source of relational repair for those EAs who need it most.

However, the potential of the Third Place Model can only be realized through an intentional implementation process that acknowledges its inherent limitations. As an intervention for EAs with mild-to-moderate distress, not crises, it is designed to work alongside professional care, never instead of it. This requires scope-of-practice agreements for stewards, formal referral pathways to clinical care, and warm handoffs so no one gets dropped between supports. For the model to work safely, stewards need de-escalation training, spaces need sensory-friendly quiet zones, and crisis protocols must be clear to everyone involved. Furthermore, the model must address the "discovery" gap by using proactive outreach to reach isolated EAs who may not find the space organically. Open questions remain about how the model scales through land-based or hybrid adaptations in rural and Northern communities, and how to measure success when the goal is belonging rather than clinical outcomes. Future research should track how Third Place Models affect EA wellbeing over time, including the effectiveness of youth-led governance and whether access to these spaces reduces reliance on reactive supports like crisis services.

Ultimately, by adhering to these principles and centring the autonomy of the 1.25 million Canadian EAs in need, the Third Place Model moves from a promising concept to a tangible, impactful, and scalable solution. It challenges the prevailing Western individualistic approach to wellness, offering instead a collectivist paradigm that honours the biological necessity of connection, setting the stage for a new era of community-based mental health care, one where

mental health is not a private burden to be fixed in isolation, but a shared responsibility nurtured within the neighbourhoods and third places where EAs truly live.

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## Appendix

### Quick Guide to the Third Place Model



## Emerging Adults in Canada

### ! Population and Need

**1.25 Million**

**CANADIAN EMERGING ADULTS**

*Emerging adults aged 16-24 estimated to be in need of mental health support.*

**58.3%**

**UNDERSERVED**

*Percentage of emerging adults who require support but are not receiving it.*

**720,000**

**ACCESS GAP**

*Subset of emerging adults identified as needing support but lacking access.*

**75%**

**ONSET RATE**

*Statistic that three-quarters of all lifetime mental disorders begin by the mid-20s.*

**16%**

**ISOLATED EMERGING ADULTS**

*Emerging adults aged 18-25 who experience significant social isolation.*

**10%**

**AGING OUT GAP**

*Approximately 6,700 emerging adults who age out of the foster care system annually.\**

\* Populations including \*\*those with trauma, racialized individuals, newcomers, low-SES individuals, young males, Indigenous emerging adults, LGBTQIA2S+ communities, neurodivergent emerging adults, and emerging adults aging out of care\*\* face significant societal barriers, including access to care, stigma, discrimination, previous bad experiences, long wait times, and a lack of representative leadership, flagging them as disproportionately impacted in terms of access to care.

## The Essence of Third Places

**Third places** are defined by several core characteristics that distinguish them from home (first place) and work/school (second place):

1. **Neutral Ground:** Individuals are free to enter or leave without obligation, fostering an open and welcoming atmosphere.
2. **The Levelled State:** Social status is minimized, allowing individuals to interact as equals.
3. **Conversation First:** Spontaneous social interaction is the primary focus.
4. **Low-Barrier Access:** These places require low cost, no appointments, and no formal referrals.

### Third Places vs. Clinical Settings

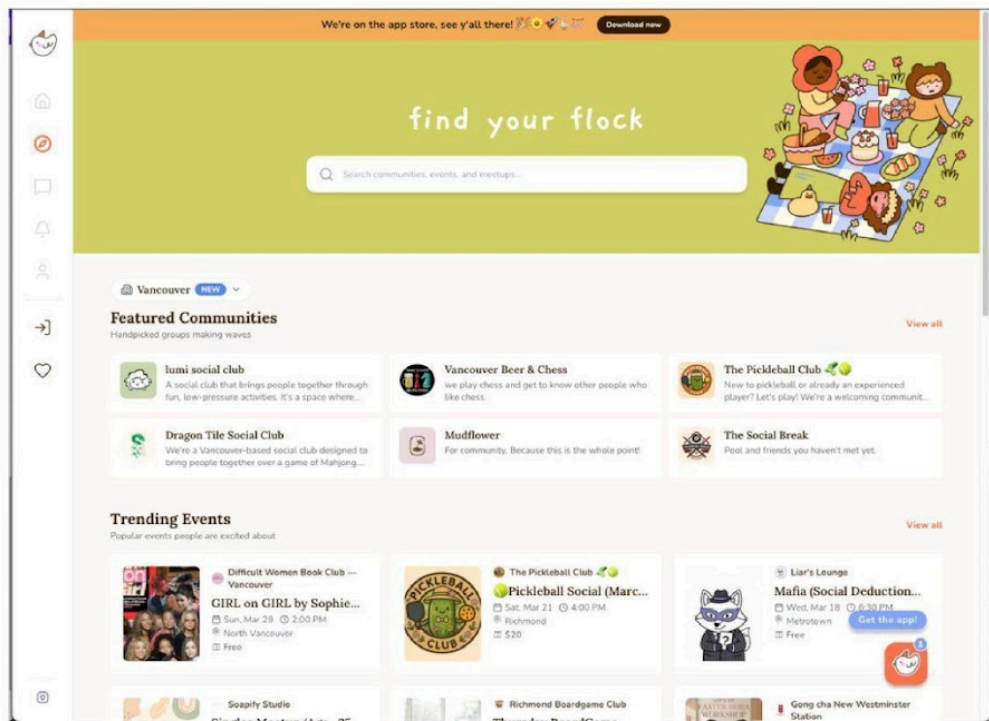
Feature	Third Place Model	Traditional Model
Approach	Proactive, Preventative	Reactive, Crisis-driven
Environment	Casual, Home-like	Clinical, Institutional
Power Structure	Emerging Adult-led, Collaborative	Expert-led, Power-over
Access	Low-barrier, "Drop-in"	Requires Intake or Diagnosis
Cost	Low per-head (Group/Peer)	High per-head (One-on-one)
Primary Goal	Relational repair & Belonging	Symptom reduction

### Local Vancouver Initiatives

**We Should Be Friends:** Arts-based connection.



**Flock Events:** Creative wellness.



**Thumn's Dinner Club:** Promoting radical belonging.



## Pre-Existing Community Care Models / Initiatives

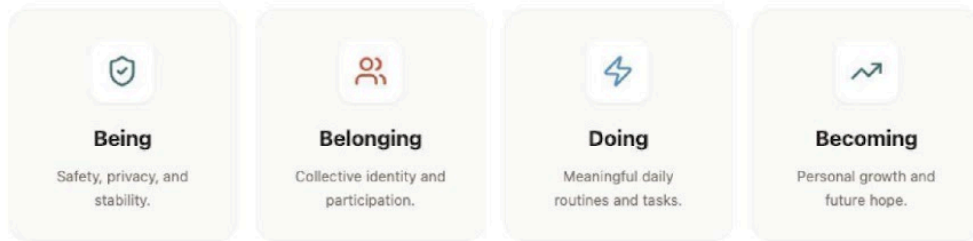
### Examples of Community-Based Care Models

1. **Social Prescribing:** Connecting individuals to non-clinical support.
2. **Emerging Adult Service Hubs:** Integrated services for emerging adults.
3. **Therapeutic Landscapes:** Healing through environmental design.
4. **Therapeutic Taskscapes:** Healing through shared activities.

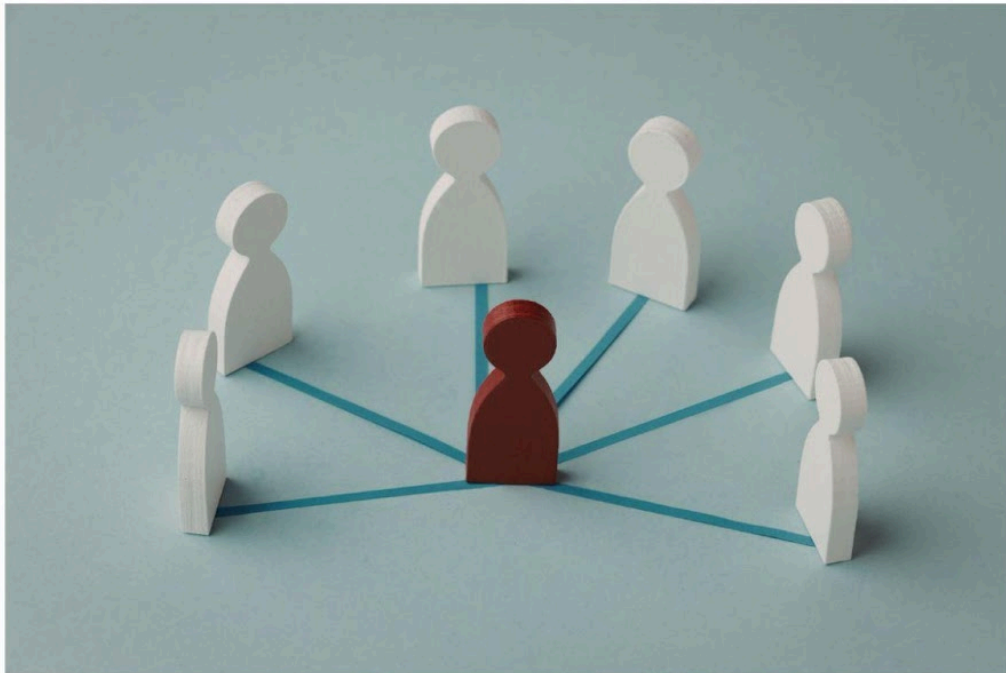
5. **Single-Location Third Places:** Counseling services within casual settings.

## Why Are Third Places Therapeutic?

### The 4 Therapeutic Pillars



### Scientific Mechanisms of Connection



1. **Relational Healing (Attachment Theory):** Healing wounds created in relationships through consistent, healthy connections.
2. **Power of Connection (Common Factors Model):** 30% of therapy success is attributed to the quality of the relationship, beyond technique.
3. **Undoing Isolation (AEDP):** Transitioning from isolation to shared emotional experiences is crucial for recovery.
4. **Biological Regulation (Polyvagal Theory):** Social cues physically regulate the nervous system, shifting from defense to safety.
5. **Universal Experience (Group Therapy):** Recognizing shared struggles alleviates individual burdens.
6. **Innate Human Needs (Self-Determination Theory):** Social relatedness is essential for human flourishing.

### Therapeutic Landscapes & Taskscapes

**Healing occurs through both the environment and shared activity:**

**Therapeutic Landscapes:** The environment itself can promote healing through feelings of safety, calm, or community.



**Therapeutic Taskscapes:** Shared activities with others build a sense of belonging and mastery.



**Biological Imperative and Historical Wisdom**



## Funding Options

### Financial Approach



Sustainable models integrate multiple sources of funding:

- **Grants:** Scaling models through federal investments.
  - **Youth Mental Health Fund (YMHF):** \$500M dedicated to community-based care through 2029.
  - **MHP-Innovation Fund:** \$5M annually focusing on health equity and systemic barrier reduction.
- **Donations:** Local philanthropic support and individual contributions.
- **Enterprise:** Sliding-scale fees, retail storefronts, and service revenue.

*Note.* This resource is a comprehensive infographic advocating for the third place model to support the mental health and healing of emerging adults in Canada, designed to help clinicians and policymakers to quickly understand, gain buy-in and secure funding.