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TMU/CSDC

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Creating a culture of collaborative program development informed by data

Why collect data?

- Telling our story
- Informing our care

What information is needed in order to plan programming and make changes?

- Student population
- Team
- Guiding principles
- Data (qualitative and quantitative)

How to make these changes in a collaborative way

How to assess these changes?

What

Context

What changes make sense in your context? Background variables matter a lot

Staff skills, areas of expertise, and interests

Therapy modalities

Areas of clinical expertise (e.g., eating disorder, sexual violence)

Areas of clinical interest (supporting neurodiverse students, brief/single session, longer-term trauma work, etc.)

Student Needs

Presenting issues

Resources

Social location

Local resources and supports available

Building bridges to higher level care

Resource database of low-cost therapy covered by school insurance

Available free programming for specific areas of need

Staffing ratios

Counsellors/students enrolled

Many centres above the 1:1000 to 1:1500 ratio

What

Guiding Principles

We collaboratively came up with the following guiding principles

Keep the front door open

Meet each student where they're at and tailor care to their needs

Get everyone the care that meets their needs in the most timely way

We value flexibility, responsiveness, and equity for our students and ourselves

Take care of each other so that we can take care of the students

What

Data

This will help you identify gaps, bottlenecks, and areas of need

Quantitative data

Volume: appointments requested, booked, billed (tracked by front desk staff in Excel + EMR data)
Wait for first appointment (from EMR)
Wait for ongoing counselling: capacity utilization of appointments, percent on wait list, number of session/student, staffing ratio (calculated from EMR + wait list data in Excel)
Presenting issues (coded by clinicians in the EMR)
Priority students (coded by clinicians in the EMR)
Progress monitoring and outcome data: group outcomes (group cohesion, BDI, BAI, and a group-specific measures such as DERS), individual session-to-session measures (CORE 10)

Qualitative data

Client satisfaction (sent out once per semester via anonymous survey in Qualtrics)
Student focus groups and feedback questionnaires (structured focus group)
Feedback from campus partners (usually more informal)
Staff wellbeing (anonymous surveys and individual check ins)

How do you make decisions as a team?

Top down

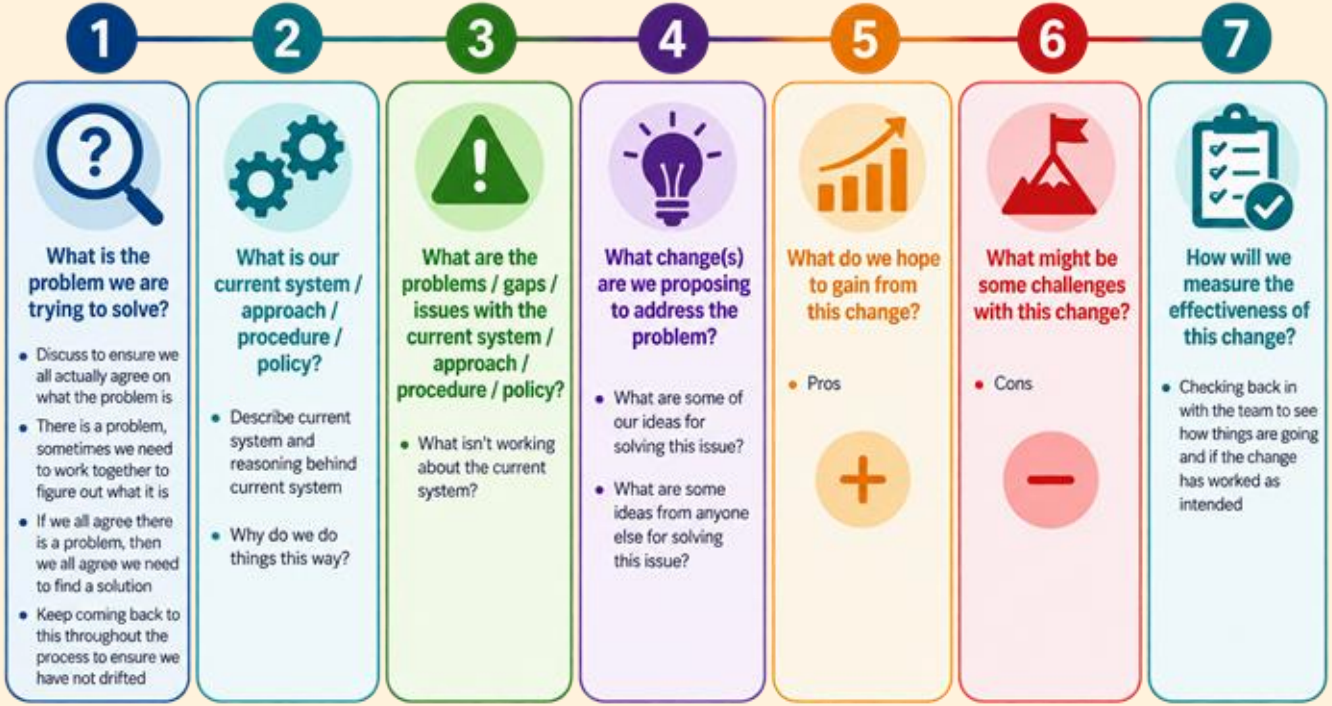
Bottom up

Somewhere in between?

Leadership structure matters, but so does philosophy

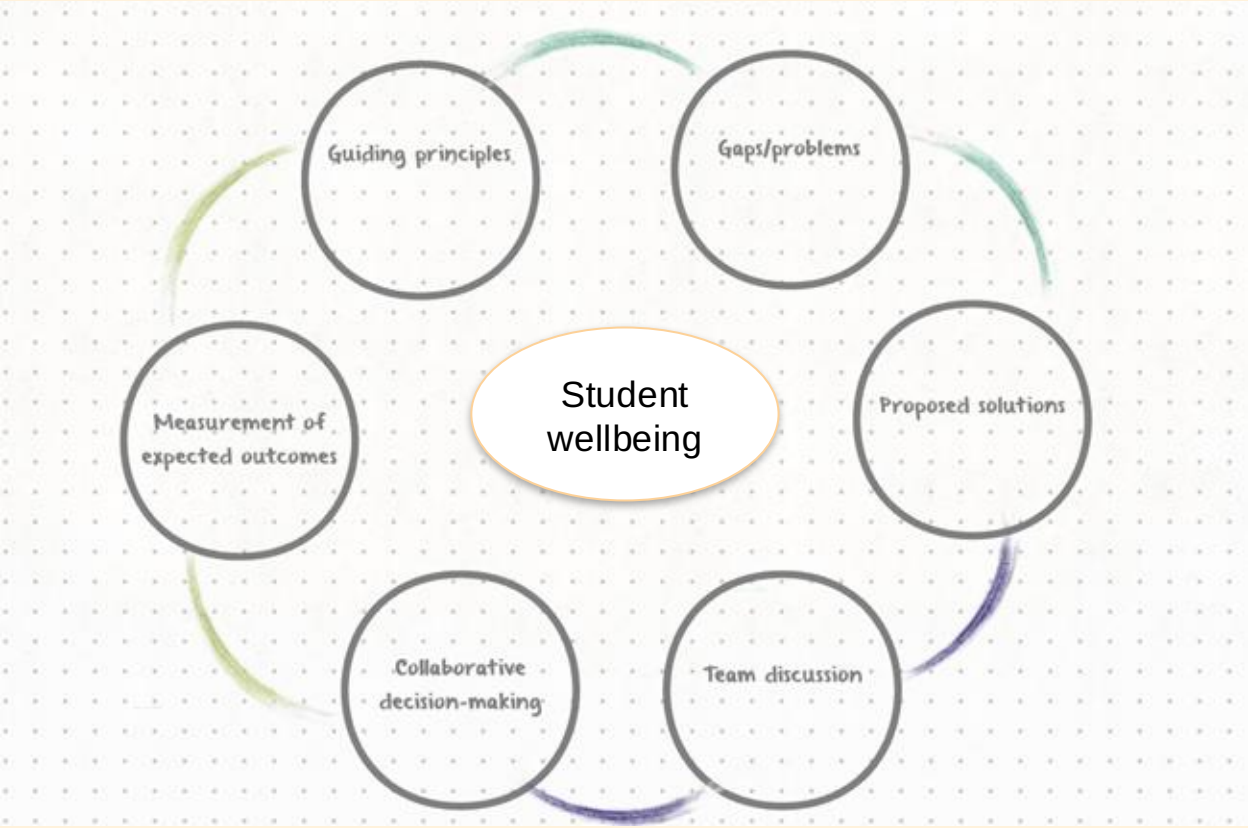
How

Team discussion and collaborative decision-making



How

Cycle of change and feedback



Specific example: Development of our Equitable Care Model

What is the problem we are trying to solve?
How to meet the needs of students with chronic complex mental health needs and few resources within our current staffing ratios; many students without parents' insurance or capacity to pay for care; many first gen and equity-deserving students

If students who are less likely to access mental health care in general have an experience of being disappointed when they do come to counselling, it will reduce the likelihood that they'll access this again or seek help when they need it

Having the option to offer robust and longer-term therapy at a pivotal time in students' lives is critical to students, and allows staff to do meaningful work

AND

We do not have capacity to see all students for individual therapy in house and do meaningful or longer-term work with everyone

Development of our Equitable Care Model

What are the gaps?

Long wait 1 and wait 2 times
Not able to see students in a timely manner, not able to triage risk up front
Most students seen for ongoing counseling only for a short course of therapy due to high volume
Staff burnout high, didn't feel like they could meaningfully help students with complex needs

Possible solutions

Strict session caps
Single session only and come back as needed
Space out sessions (e.g., every 4-6 weeks)
Run a wait list
Traditional stepped care

Team discussion

Presented the problem , the data, and three proposed service-delivery models with varying pros and cons as solutions to the problem.

Collaborative discussion on aspects of these models that match our underlying values as a team and our students' needs

Development of our Equitable Care Model

Collaborative team solution

Ensure that first appointments are accessible so we can make sure students are safe and have a plan that meets their needs

No rigid steps to access care; focus on collaborative decision-making with student considering their presenting issues, resources, and social location; stream to a care pathway (single-session, brief, ongoing, or group therapy, referral to TMU or community resources) that best meets needs in a timely way

Preserve in house resources to support students with complex needs and few resources and help students with good access to resources to connect externally; use school insurance to refer students with mild/moderate presenting issues who want individual therapy to community therapists

No hard session caps but staff need to keep flow in and take new clients monthly, and are responsible for clinical decision making to ensure flow

Development of equitable care pathways (e.g., Black, Indigenous, Trans students) and shared care teams to support students with complex presenting issues (e.g., eating disorders)

Gather group outcomes, and pilot progress monitoring for individual therapy, with the goal of ensuring that students are benefitting from care, that their outcomes are good



Questions?

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Thank you!