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Developing a minimum data standard for student mental health services in the UK: A qualitative study with staff from university support services

Jennifer O'Donnell¹  | Emma Broglia²  | Afra Turner³ | Mark Fudge⁴ | Louise Knowles⁵ | Michael Barkham⁶  | on behalf of the SCORE Consortium

¹British Association for Counselling and Psychotherapy, Lutterworth, UK

²Department of Psychology, University of Sheffield, Sheffield, UK

³Student Support and Wellbeing Service, Kings College, London, UK

⁴The Charlie Waller Trust, Newbury, UK

⁵University of Sheffield Counselling Service, and Research and Clinical Placements Unit (RCPU), University of Sheffield, Sheffield, UK

⁶Clinical and Applied Psychology Unit, Department of Psychology, University of Sheffield, Sheffield, UK

Correspondence

Jennifer O'Donnell, British Association for Counselling and Psychotherapy, 15 St John's Business Park, Leicestershire, Lutterworth LE17 4HB, UK.
Email: jennifer.odonnell@bacp.co.uk

Abstract

Objective: This study is part of the Student Counselling Outcomes Research and Evaluation (SCORE) initiative that is pooling university counselling service data to improve datasets and evidence for counselling in this sector. This study aimed to explore university counselling staff views about which data should be included in a national minimum data standard (MDS) to provide evidence for counselling in the sector.

Method: Semi-structured focus groups were conducted with university counselling staff including counsellors, service leaders and mental health advisors. They explored data to include in an MDS, current data collection practices, service and sector level data collection barriers. Two researchers performed content analysis involving identifying fields for inclusion. Thematic analysis was used to identify contextual issues surrounding data collection. Ten focus groups were conducted with 41 participants across 26 university counselling services.

Results: Content analysis identified fields of information for the MDS within the categories of student characteristics, demographics, clinical assessment and service evaluation. Thematic analysis explored context and culture surrounding data collection, barriers and facilitators, institutional influence and ideal data collection practices. This highlights the need for service support and training around data collection, clear processes, and adequate IT infrastructure and staff resources.

Discussion: These findings will inform the development of an MDS as part of the SCORE study. The next stage will involve further development of the MDS and piloting in services. The longer term aim is to implement an MDS across university counselling services, enabling the growth of evidence for the sector which may allow increased funding and service provision.

KEYWORDS

qualitative methods, service, students, university

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1 | INTRODUCTION

Minimum data standards (MDS) have been successfully implemented in various sectors, such as England's National Health Service (NHS) Talking Therapies for anxiety and depression programme (formerly known as Improving Access to Psychological Therapies, IAPT), which pools all service data (NHS Digital, 2021). In the Higher Education (HE) counselling sector, MDS are used internationally by the US Centre for Collegiate Mental Health (CCMH) and Psychological Counsellors in Higher Education in Ireland (PCHEI; Center for Collegiate Mental Health, 2022a, 2022b; Trinity College Dublin, 2021). There is currently no MDS in the UK HE counselling sector and consensus by researchers in the sector is that an MDS would be beneficial (Barkham et al., 2019; Broglio et al., 2018; Broglio, Bewick & Barkham, 2021; Broglio, Millings & Barkham, 2021; Broglio, Ryan et al., 2021). However, challenges persist surrounding pooling data across multiple services due to inconsistencies across services in which demographic fields are being recorded, routine outcome measures use and data collection practices (Barkham et al., 2019; Broglio et al., 2018; Broglio, Bewick & Barkham, 2021; Broglio, Millings & Barkham, 2021; Broglio, Ryan et al., 2021). Consistency in the fields being collected and data collection practices are crucial for pooling data.

There is therefore a need to consult with practitioners in the sector for their requirements on which fields should be included in an MDS. Coproduction research with practitioners is essential to devise specific fields and to ensure that the MDS meets their needs. As demonstrated in existing MDS, these datasets are useful for benchmarking and reporting statistics such as service utilisation, treatment outcomes and demographics (Center for Collegiate Mental Health, 2022a, 2022b; NHS Digital, 2021). A large dataset also enables the sector to identify potentially under-represented groups through assessing service access according to demographic characteristics (Universities, UK, 2020). Further evidence also suggests there may be differences in disclosure and experiences of mental health according to student demographics and course type (Broglio, Bewick & Barkham, 2021; Broglio, Millings & Barkham, 2021; Broglio, Ryan et al., 2021; Heard-Laureote et al., 2021; Lipson et al., 2016; McKerrow et al., 2020; NHS Mental Health of Children and Young People, 2017; Office for Students, 2019; Singh et al., 2020; Skead & Rogers, 2015). A large dataset may therefore inform service development and funding bids to help individual services address these inequalities (McKenzie et al., 2015). It may also aid more targeted service provision and assist with the planning of services.

The first aim of this paper was to inform the first phase of identifying suitable data fields to form part of a MDS for the university counselling sector. The second aim was to explore barriers and facilitators for data collection in the sector which may affect the longer term use of a MDS in the sector.

Implications for practice and policy

- This research highlights the need for a minimum data standard (MDS) for the sector and provides some consensus about which fields should be included in this data standard, which will be developed further and piloted in services.
- To successfully implement an MDS in services, culture change surrounding data collection and use within services is essential to ensure it is an integral part of routine service operations. Investment in adequate infrastructure, IT platforms and support is also crucial.
- Implementation of an MDS for university counselling services will help to develop an evidence base for the sector, which may inform policy and funding decisions.

2 | METHOD

2.1 | Study background

This study is part of the research being conducted by the Student Counselling Outcomes Research and Evaluation (SCORE, 2022) initiative. This research-practice consortium started in October 2018 and aims to pool routinely collected data across university counselling services to improve the sector evidence base. The SCORE consortium includes MB and EB, who are research experts in student counselling research. It also includes practitioner members (including AT, MF and LK), who are accredited practitioners working in HE counselling services. The first author, JO, is a research member of the consortium and employed by the British Association for Counselling and Psychotherapy (BACP), a professional body for counsellors and psychotherapists in the UK. For further information, please see <https://score-consortium.sites.sheffield.ac.uk/>.

2.2 | Participants

Professional staff in counselling and/or mental health services embedded in HE in the UK were eligible to take part in the focus groups if their role met either one of the following criteria, according to their self-report job titles: a client-facing counsellor or mental health advisor role, or a counselling service leader role.

Participants were recruited through two channels:

- An online survey for SCORE which captured data fields services currently collected and recommended for inclusion in an MDS. Respondents could express an interest in focus group participation; however, these survey findings are not presented in the current paper.

- Snowball recruitment was implemented by inviting heads of service through a professional mailing list and contacting staff through the university mental health advisory network.

All eligible respondents who expressed an interest were invited to take part in a focus group.

Our final sample included 41 participants (15 counsellors, 4 mental health advisors and 22 service leaders across 26 institutions). This included institutions of various sizes: seven small, nine medium and 10 large universities. The types of universities included the following categories: seven Russell Group, two ancient, three red brick, five plate glass and nine polytechnic/metropolitan. Our sample therefore represents approximately 16% of the 166 HE institutions in the UK (Times Higher Education, 2023).

2.3 | Procedure

Online semi-structured focus groups were conducted using Microsoft Teams videoconferencing between October 2020 and April 2021. The questions were devised through consultations with practitioners and the SCORE consortium. The focus groups explored participant views on which data fields were most important to collect from students related to the data categories of student characteristics, demographics, outcomes and presenting issues. These key areas for the coding framework had been developed by the SCORE consortium based on the key areas that are routinely collected in services that might be used to inform decisions. Reasons and barriers for obtaining this data in their service, across the sector and strategies for addressing barriers were also discussed. Participants also discussed general sector and service data collection issues. Table S1 shows the full focus group guide. Six facilitators led the focus groups (three researchers and three practitioners) and either one or two facilitators led each focus group. Some participants and facilitators had met in a professional capacity prior to the focus groups; however, it was ensured that practitioner focus group facilitators were not currently employed by the same institution as their focus group participants. Focus groups were video-recorded, anonymised during transcription and a member of the BACP administrative team was present at all focus groups to manage this process. Participants provided informed consent for their data to be used in the development of the MDS.

2.4 | Ethics approval and informed consent

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. All procedures involving human patients were approved by the University of Sheffield's Ethics Review Procedure, as administered by the Psychology

Department (reference number: 036289). Informed written consent was obtained electronically using the Questback software from all participants before focus group participation.

2.5 | Data analysis

Two researchers, JO and EB, were involved in the data analysis. At the time of conducting the analyses, JO was a Research Fellow and non-practitioner, female, educated to Masters level with extensive research experience. EB was a Research Manager and non-practitioner, female, educated to PhD level and the project manager and study lead for SCORE.

The study used two types of analysis to examine patterns in the data.

Quantitative content analysis followed the approach of Erlingsson and Brysiewicz (2017), which involved labelling parts of the text according to their meaning to formulate codes and grouping codes into categories. JO was the lead coder of all interview data using the QDA Miner Lite qualitative analysis software to identify data fields for inclusion in the MDS. EB was the second coder and analysed a sub sample of this data. Related words and terms were counted to form codes (e.g., ethnic group and gender identity) and frequency determined their importance for inclusion in the MDS. Prior to coding, EB developed the initial coding categories using a deductive approach based on previous knowledge from the SCORE consortium on areas already collected in student counselling services. These categories were student characteristics, demographic information, service evaluation, clinical assessment and outcomes. Codes were labelled according to whether the participant was a counsellor, mental health advisor or service leader. The results of the content analysis are presented in Table 1. We sought advice from stakeholders, including members of BACP's equality, diversity and inclusion (EDI) Task and Finish Group on the wording of the variables and examples to ensure they were in line with the latest EDI guidance. The results have been presented according to this advice; however, in some instances, there were disagreements over the wording of variables. For example, where we have named the variable 'ethnic group', some members thought this should have been named 'race'.

Qualitative thematic analysis using a deductive approach was also used to explore barriers and reasons for using service and outcome data (Braun & Clarke, 2006, 2021). EB used a deductive approach to devise initial themes and JO checked these themes. Analyses followed these six steps: data familiarisation, generating initial codes, searching for themes, reviewing and refining themes, defining and naming themes, producing the report.

3 | RESULTS

Ten focus groups were conducted with 41 participants across 26 universities. Each focus group included between three and seven participants (15 counsellors, 4 mental health advisors and 22 service

TABLE 1 Fields reported most frequently by participants for inclusion in the minimum data standard (MDS) combined with the latest equality, diversity and inclusion (EDI) evidence.

Category	Field	Examples mentioned during focus groups combined with the latest evidence
Demographic information	Sex or gender identity	Male, female, non-binary, (include gender reassignment)
	Ethnic group	White; Asian or Asian British; Black, Black British, Caribbean or African; Mixed or multiple ethnic groups; Other ethnic group
	Sexual orientation	LGBTQ+, heterosexual
	Disabled	Physical disability, learning difficulty
	Nationality	International or UK students
Student characteristics	Degree/faculty/department	Engineering, languages
	Level of study	Undergraduate, postgraduate, foundation level
	Year of study	First year, second year
	Student preference for therapist	Sex/gender, sexual orientation, ethnic group, religion and belief
	Referral route	Self-referral, GP, family member
Clinical assessment and outcomes	Presenting issue/s	From therapist perspective or an agreed therapist/client perspective for example anxiety, low mood
	Self-harm/suicide and risk	Self-harm, suicidal ideation, suicide attempts
	Alcohol/substance use	Frequency/amount of use
	Valid clinical measure (sessional)	The CORE* was the most frequently mentioned measure of psychological distress alongside CCAPS*, GAD-7* and PHQ-9*
	Academic outcomes	The CIAO* was mentioned to assess academic outcomes
Service evaluation	University dropout	Has the person dropped out of university
	Student feedback	Rating scale or written feedback
	Waiting times	Waiting time for the first appointment
	Therapy dropout	Has the person dropped out of therapy
	Numbers accessing service	Numbers accessing the whole service over a time period, for example annually, during examination period

Abbreviations: *CCAPS, Counselling Center Assessment of Psychological Symptoms; *CIAO, Counselling Impact on Academic Outcomes; *CORE, Clinical Outcomes in Routine Evaluation; *GAD-7, General Anxiety Disorder 7; *PHQ9, Patient Health Questionnaire 9.

leaders) within universities. Demographic information was not collected from participants. Group sizes were kept small because the focus groups were conducted online, and it was anticipated that more time would be required to ensure the discussion was engaging, included contributions from all participants and time to manage potential technical issues.

First, we report the results from the quantitative content analysis showing the frequency fields were mentioned by respondents for inclusion in the MDS, highlighting their importance. Secondly, we present the results from the thematic analysis which explores the key issues, barriers and context surrounding collecting this data.

4 | QUANTITATIVE CONTENT ANALYSIS RESULTS

This section identifies the fields participants perceived as most important for inclusion in the MDS within the categories of demographic information, student characteristics, clinical assessment and outcomes, and service evaluation. [Table 1](#) shows the fields most frequently reported by participants for inclusion in the MDS which

are described in the text. The third column shows response option examples mentioned by participants in the focus groups combined with the latest EDI terminology. These examples do not reflect the final response options for these data fields, which are currently under development. All potential fields discussed by participants and their relative importance are found in [Supplementary Table 2](#).

4.1 | Data categories

[Table 1](#) shows that the *demographic fields* participants mentioned most frequently were sex or gender identity, ethnic group, sexual orientation, disabled clients and nationality. It was important to monitor service access according to these characteristics to assess the extent to which minority groups are represented. The *student characteristics* described as most important were degree/faculty/department, level of study and year of study to monitor trends and assess whether the service was reaching all areas of the university. Student preference for therapist was important to ensure the suitable allocation of therapists where possible and referral route was important to measure service access through different routes. Participants explained the importance

of identifying the key presenting issue/s from a therapist perspective or an agreed therapist/client perspective.

5 | QUALITATIVE FINDINGS

Four key themes were identified through thematic analysis, including (1) fostering a positive culture for using measures and service data, (2) improving data collection and use to understand the student population, (3) promoting regular service evaluation to respond to fast-changing needs and (4) adopting a whole sector approach to share best practice.

5.1 | Theme 1: Fostering a positive culture for using measures and service data

Encouraging a culture to promote the use of outcome measures and service data was viewed as important.

5.1.1 | Addressing the mixed culture for using measures

Outcome measure use varied across services and depended on a combination of factors including time, resources and perceived usefulness.

'I come from a team where we have been using routine outcome measures into a team where there has been no culture of doing that at all, so that's a whole different problem in a way really about how to make the case really and to do it so that it feels ok'

(ID: Head of Service).

Some believed measures did not capture therapeutic change, and this process took longer for clients and clinical outcomes were only one aspect of the therapeutic journey. To encourage their use, addressing this mixed culture was particularly important.

5.1.2 | Demystifying misconceptions about measures

Some believed that services held concerns about measures being used to judge services based on client recovery, and this could be used to compare service success nationally.

'It's how the data's used, once it's out there it's, I'm playing devil's advocate a bit because I'm not that overly paranoid, but I think once you start to record and publish information it is out of your hands and people will do with it what they want'

(ID: Head of Service).

It was important to reassure services the data would not be used for this purpose.

5.1.3 | Using measures at every session to capture outcomes for all clients

Most who used measures did not collect these sessionally due to staff time and resources. These barriers, alongside mixed views on measure use across the sector, meant implementing sessional data collection would be challenging. However, interviewees acknowledged promoting a culture of sessional measure collection was important for progress monitoring, client discussion and a more complete dataset if unplanned endings occurred.

'We use it so consistently on a session by session basis because if a practitioner, whatever their role is in the team goes, this student is getting worse with their scores, or they're not moving, maybe this is the time to try something different'

(ID: Head of Service).

5.1.4 | Training in measure and general data use

Training and guidance in measure and data use were believed to help foster a data-driven culture. Some lacked experience in outcome measures, so there was a training need for their use and benefits. There was also a training need for using the MDS, different systems, data collection processes and effectively utilising the data as concerns were expressed about data being used meaningfully.

'We're going to have on these dates sort of Q&A, explain why we're doing this, the benefits of it what we can do with this data'

(ID: Head of Service).

5.2 | Theme 2: Improving data collection and use to understand the student population

Formal data collection procedures to improve efficiency and reduce duplication of work were highlighted as important. This encompassed technical support, IT system infrastructure, formalised definitions of presenting issues and electronic data collection methods. Demographic data could be used to examine patterns in access and presenting issues.

5.2.1 | Using computer systems to save time

Staff time and resources were barriers to collecting data, so electronic systems and strategies were recommended to save time. For

example, students completing measures before sessions would improve efficiency and maximise consultation time.

'I think if there's a general problem that people have told me about that would be it. The time factor, they spend too much time in every session trying to catch up on where the client is. If it's done outside, we're fortunate to have this done outside the room and then that's absolutely fine.'

(ID: Counsellor).

It was important to ensure electronic systems included all outcome measures typically offered across institutions.

5.2.2 | Using demographic data to understand service use and clinical presentation

Linking data was important to understand service access and presenting issues according to EDI characteristics and by course.

'Its relevant to ensuring that we're accessible and if we're not accessible what are we doing, if you have a university with a range of demographics and we're not serving some of that then it might be a question to explore so I think it's very relevant from that point of view. I think maybe if that isn't the case it might be how do we let people know that we're here, how do we access, what are we not doing to make our service accessible.'

(ID: Counsellor).

5.2.3 | Making use of existing university data

Some data were collected by other university departments, for example course information and demographics during registration. With student consent, using some existing university data would reduce data collection duplication and improve efficiency. However, the relevance of sharing information should be considered from an ethical and clinical point of view.

'It is interesting I think because the University holds a lot of information about students and actually we have access to some of the central university held records, that we don't routinely use, but it's there should we want to find out, which holds quite a lot of information we're talking about, and more, about them so actually we do have access to that whether it's something that we feel is ethical or clinically relevant to the service is something else.'

(ID: Counsellor).

5.2.4 | Addressing challenges to access relevant data

It was more challenging to obtain measures and data after therapy had ended and formal data collection procedures would reduce this risk. It was important to ensure confidentiality and student consent procedures were followed, particularly if intake information provided during university registration was shared. Clients should be reassured counselling service information would not be shared with other parties, for example other university departments or NHS services.

'This idea about downloading information from the central database sounds reasonable and we could get consent from the students, but students are really worried about what data we might share outside the service, so if it's coming one way they might think well maybe it's going the other way as well and I think there's something really valuable about making it clear that our data collection is discreet and it's not shared outside of the service.'

(ID: Mental Health Advisor).

5.2.5 | Having sufficient technical support and infrastructure

Technical support and infrastructure were essential for continued data collection efficiency in the future. This required financial and staff resources at institutions.

'And also I said technology from the point of view that not just individuals, but actually not all services use databases and computer systems in order to hold their client notes and things like that so, it's about the investment in that and belief in that being an important thing'

(ID: Counsellor).

5.2.6 | Standardising problem areas

Standardised definitions of problem areas and presenting issues ensure uniformity in recording and interpretation across practitioners.

'That that sort of level of subjectivity is always a tension, we're always wrestling with it aren't we. A bit like when we were saying when you say a grade 11 of severity on something, what I say would be different from what the other three clinicians would say about their clients, so it doesn't mean to say that we shouldn't collect that particular data field but try and understand and interpret it then, if we're looking at it nationally.'

(ID: Counsellor).

Clients may have more than one presenting issue, although they were best assessed from a counsellor perspective or an agreed counsellor and client perspective as clients may not identify the real issue. For some presenting issues, more specific information may be needed, such as the type of anxiety. Providing reasons for presenting issues would give context during consultations.

5.3 | Theme 3. Promoting regular service evaluation to respond to fast-changing needs

Services required regular measurement of service use, outcomes and student feedback to monitor success and adapt according to demand and feedback.

5.3.1 | Demonstrating service use and impact

Service use data would demonstrate service success and was required by most institutions. It may aid provision of financial resources and enable sector benchmarking.

'Accountability for what we're asking for, I think commissioning and so forth...how do you show that the service is effective and who it's effective for and are we meeting our targets?'

(ID: Counsellor).

Important data were university dropout and service use data such as waiting times, numbers accessing the service and therapy dropout.

5.3.2 | Student voice and feedback

Satisfaction scales enabled clients to rate the service and qualitative feedback enabled therapists to see how counselling had helped students and to receive feedback on relational aspects of their work.

'The next session might say, what I found really useful about the last session was. And that's tremendous for me because I didn't think that fell on that student's ears and my goodness they got something out of that whereas I wouldn't have known unless they'd said it. So what you said there [NAME] is really important because you can learn and be more effective if you know what's working for them'

(ID: Counsellor).

The impact of counselling on academic outcomes was important and the CIAO measure was recommended for inclusion in the MDS.

5.3.3 | Using data to facilitate clinical decisions

Obtaining qualitative student feedback, satisfaction scales and outcome measures was useful to monitor and discuss client progress. Collecting feedback and outcome measures sessionally was beneficial.

'I think there's good evidence that says that the process of talking about how people are doing, and as well talking about how the relationship is going can be helpful and actually improves outcomes'

(ID: Head of Service).

5.4 | Theme 4: Adopting a whole sector approach to share best practice

The establishment of a streamlined approach across the sector requires several underlying activities including developing formalised guidance, templates, sessional data collection protocols and sector benchmarking. Formalised guidance and standardisation of baseline data collection processes (i.e. service intake information) would streamline procedures and ensure consistent messages regarding what data to collect, their definitions and reporting timescales to ensure consistency in recording and interpretation across the sector.

'I'm finding myself thinking about how useful it would be to have a shared understanding of different terms...all that sort of definition and understanding would be useful to have something to refer to rather than another place where we have to do it service by service.'

(ID: Head of Service).

Data collection templates would ensure uniformity in recording data on computer systems across the sector, including field names and response options, to facilitate efficient combining of data for analysis.

'We could even supply people with a template Excel document for people to complete, I suppose it supporting people where it feels like a big administrative task so making it easier but I suppose time constraint might be one and I suppose data sharing'

(ID: Head of Service).

Formalised processes for collecting sessional data, such as outcome measures, client satisfaction scales and qualitative feedback, means a greater likelihood this would be practised by services. The benefits of sessional data collection have previously been discussed.

'I think the biggest barrier that we've come across with outcome measures with data is staff remembering to do it and having the time to do it. I know that sounds really basic but you know if they're in front of the student, they've got the assessment to do, they've got follow up work to do, when you add in more administrative tasks it's easy to get lost'

(ID: Head of Service).

Uniform data collection across the sector would allow benchmarking and comparisons of anonymised aggregate data for overarching student trends for university or service dropout, waiting times and service access. These aggregate benchmarks would allow meaningful comparisons between services to facilitate joint discussions in a non-threatening and non-competitive manner. Other uses for benchmarking include service access presenting issues by demographics and student characteristics across institutions.

'You can see which universities are doing really well. Sharing good practice as well, best profiles'

(ID: Head of Service).

6 | DISCUSSION

This research highlights a noteworthy consensus among university counselling staff that an MDS is needed in the UK, consistent with other literature (Barkham et al., 2019; Broglia, Bewick & Barkham, 2021; Broglia, Millings & Barkham, 2021; Broglia, Ryan et al., 2021). This finding is also consistent with the development of MDS in other nations and countries, such as the CCMH in the US and Psychological Counsellors in Higher Education (PCHEI) in Ireland (Center for Collegiate Mental Health, 2022a, 2022b; Trinity College Dublin, 2021). Our findings suggest that practitioners in the UK would welcome a consensus for an MDS in counselling and mental health services within HE institutions in the UK.

6.1 | Comparing the MDS to other research

Our study highlighted specific areas to include in the MDS from the perspective of practitioners and service leads. Many of the areas identified in our study are consistent with the data areas included in the CCMH and PCHEI datasets (See Table 2). A benefit of including demographic fields in the MDS is the ability to monitor differences in therapy access and clinical presentation, variations which have previously been found based on factors such as disability, ethnic group and sexual orientation (Hayes et al., 2011; McAleavey et al., 2011; Nelson et al., 2011; O'Shea et al., 2021). Our participants believed that student preference for therapist should be included, a field not in the CCMH or PCHEI datasets (Center for Collegiate Mental Health, 2022a, 2022b; Trinity

College Dublin, 2021). Evidence shows that some clients may feel that it is beneficial for the therapeutic relationship if they are able to choose a therapist based on their demographic characteristics, such as ethnic group, gender identity and sexual orientation (Hicks & Milton, 2010; Ilagan & Heatherington, 2022). It may therefore be beneficial to accommodate their preferences where possible within the clinical team. Valid clinical measures of psychological distress are also viewed as useful, in which evidence shows they may highlight clinical changes in students after therapy, such as anxiety, depression and academic distress (Broglia, Bewick & Barkham, 2021; Broglia, Millings & Barkham, 2021; Broglia, Ryan et al., 2021; Castonguay et al., 2011; Winzer et al., 2018). The inclusion of a choice of outcome measures may be useful to reflect the various measures used across student mental health services, and evidence shows they can be pooled using computer systems (Broglia et al., 2018; Broglia, Bewick & Barkham, 2021; Broglia, Millings & Barkham, 2021; Broglia, Ryan et al., 2021). However, barriers to their use have consistently been found in previous research, which include time, resources and perceived usefulness for measuring therapeutic change (Boswell et al., 2015; Broglia et al., 2018). For service evaluation, the use of service access numbers and waiting times was viewed as important, and for students, length of waiting times may be affected by limited access to support outside term time or during course placements (Broglia et al., 2018). The next stage of developing the MDS will involve refining the fields based on other datasets and research, and piloting this dataset in HE counselling and mental health services to obtain the views of both practitioners and students.

6.2 | Barriers and enablers to implementing the MDS in HE counselling services

Although there was a consensus that an MDS was needed, this study identified barriers and enablers to implementing an MDS in HE counselling and mental health services. Fostering a positive culture for using data and moving towards data-informed services was critical for adopting an MDS. To encourage this culture, the benefits of using data within support services must be highlighted to senior leaders and service staff. Evidence suggests practitioners are more motivated to collect data if they believe it can be used to improve services (Barkham et al., 2023; Castonguay et al., 2011). Furthermore, a culture of evaluation which demonstrates making the best use of data encourages use (Broglia, Bewick & Barkham, 2021; Broglia, Millings & Barkham, 2021; Broglia, Ryan et al., 2021). Data sharing is one use, for example HE-related organisations, such as the Higher Education Statistics Agency (HESA, n.d.), collect and disseminate HE provider data on graduate outcomes and courses (HESA). The Universities and Colleges Admissions Service (UCAS) in the UK also shares data with institutions regarding student declarations of mental health issues, which enables early identification and arrangement of student support (UCAS, 2021). Data sharing may also aid partnership working between the HE sector and external

TABLE 2 Comparison between fields reported most frequently by participants for inclusion in the minimum data standard (MDS), Centre for Collegiate Mental Health (CCMH) and Psychological Counsellors in Higher Education in Ireland (PCHEI) fields.

Category	Field	Inclusion of field in other datasets	
		CCMH dataset	PCHEI dataset
Demographic information	Sex or gender identity	Yes	Yes
	Ethnic group	Yes	Yes
	Sexual orientation	Yes	Yes
	Disabled	Yes	Yes
	Nationality	Yes	Yes
Student characteristics	Degree/faculty/department	Includes subject categories	
	Level of study	Yes	Yes
	Year of study	Yes	Yes
	Student preference for therapist	No	No
	Referral route	No	No
Clinical assessment and outcomes	Presenting issue/s	Yes	Yes
	Self-harm/suicide and risk	Yes	Yes
	Alcohol/substance use	Yes	Yes
	Valid clinical measure (sessional)	Yes (CCAPS*)	Yes (various measures)
	Academic outcomes	Yes (CCAPS* Academic Distress subscale)	Yes (CIAO*)
Service evaluation	University dropout	Yes	Yes
	Student feedback	No	No
	Waiting times	Yes	Yes
	Therapy dropout	Yes	Yes
	Numbers accessing service	Yes	Yes

Abbreviations: *CCAPS, Counselling Center Assessment of Psychological Symptoms; *CIAO, Counselling Impact on Academic Outcomes.

clinical services, such as the NHS, to facilitate better efficiency and resource use (NHS, 2019; Office for Students, 2022). This may reduce the duplication of care and ensure more coordinated referrals, reducing current problems of slow referrals from HE providers and referrals not being made to the appropriate service (NHS, 2019). Current MDS, such as CCMH and NHS Talking Therapies for anxiety and depression, also guide service improvement by identifying trends in clinical presentation and service access (Center for Collegiate Mental Health, 2022a, 2022b; NHS Digital, 2022). Demonstrating these long-term benefits to staff may help to instil a positive culture surrounding service data use. Other conceptual frameworks in the implementation science field may also be useful to help guide the MDS and aid the understanding of factors that can predict a successful implementation of the MDS (Damschroder et al., 2009; Greenhalgh et al., 2017; Labin et al., 2012).

Another barrier identified in this study is the need for service investment in adequate infrastructure and IT support to efficiently use data. One issue is the time burden of data collection and interference with clinical service (Locke et al., 2012). Support from the administration element of the service is crucial and data activities should be included in routine service operations, including contractually allotting time as part of a therapist's role, an approach successfully implemented in the NHS Talking Therapies for anxiety and depression programme (Bartholomew et al., 2020; Castonguay et al., 2011;

NHS England, 2021). Being part of a Practice Research Network (PRN) of HE counselling services, such as the SCORE consortium or the CCMH, or a wider research network such as the Student Mental Health Network (SMARTEN), means services, practitioners and researchers can access a written manual with standard data management procedures, similar to the resources provided by NHS Talking Therapies for anxiety and depression (Center for Collegiate Mental Health, 2022a, 2022b; NHS Digital, 2022; SCORE, 2022). In CCMH, some services found procedures challenging initially, and support from other services helped alleviate this (Castonguay et al., 2010). Provision of suitable IT platforms for data entry and outcome measures is important and CCMH members can access individualised reports and products, such as CCAPS instruments (Castonguay et al., 2011). Through using technology, the CCMH have avoided common data collection problems, such as the potential erosion of standards due to staff turnover and paperwork changes (Center for Collegiate Mental Health, 2022a, 2022b). Useful recommendations are also made in the Student Services Partnerships Evaluation and Quality Standards (SPEQS) toolkit, which provides guidance on secure data sharing and creating a service evaluation strategy to use data to inform decisions and improve services (Brogia et al., 2022).

This research has identified important data fields, according to practitioners, and perceived as aiding clinical practice in the university counselling sector in the UK. Furthermore, it has

highlighted the need to address the challenges of promoting a positive culture surrounding data-informed services and investing in adequate infrastructure and IT support in services. The next stage will involve further development and piloting of the MDS within HE counselling services, obtaining both practitioner and student views on the MDS.

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CONFLICT OF INTEREST STATEMENT

JO, EB, AT, MF, LK and MB are members of the Student Counselling Outcomes Research and Evaluation (SCORE) consortium. JO is an employee of the British Association for Counselling and Psychotherapy (BACP), which supports this research in the form of researcher time.

PATIENT CONSENT STATEMENT

The study was approved by the University of Sheffield Ethics Review Procedure (reference number: 036289). Informed written consent was obtained from all participants before focus group participation.

ORCID

Jennifer O'Donnell  <https://orcid.org/0000-0002-1279-0084>

Emma Broglio  <https://orcid.org/0000-0003-2137-8187>

Michael Barkham  <https://orcid.org/0000-0003-1687-6376>

REFERENCES

- Barkham, M., Broglio, E., & SCORE Consortium. (2023). *Routine outcome monitoring (ROM) and feedback in university student counselling and mental health services: Considerations for practitioners and service leads*. *Counselling and Psychotherapy Research*.
- Barkham, M., Broglio, E., Dufour, G., Fudge, M., Knowles, L., Percy, A., Turner, A., Williams, C., & SCORE Consortium. (2019). Towards an evidence-base for student wellbeing and mental health: Definitions, developmental transitions and data sets. *Counselling and Psychotherapy Research*, 19(4), 351–357.
- Bartholomew, T. T., Pérez-Rojas, A. E., Lockard, A. J., & Locke, B. D. (2020). "Research doesn't fit in a 50-minute hour": The phenomenology of therapists' involvement in research at a university counseling center. In *Clinician-researchers in psychotherapy* (pp. 31–49). Routledge.
- Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2015). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research*, 25(1), 6–19.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical guide*. Sage.
- Broglio, E., Bewick, B., & Barkham, M. (2021). Using rich data to inform student mental health practice and policy. *Counselling and Psychotherapy Research*, 21(4), 751–756.
- Broglio, E., Millings, A., & Barkham, M. (2018). Challenges to addressing student mental health in embedded counselling services: A survey of UK higher and further education institutions. *British Journal of Guidance and Counselling*, 46(4), 441–455.
- Broglio, E., Millings, A., & Barkham, M. (2021). Student mental health profiles and barriers to help seeking: When and why students seek help for a mental health concern. *Counselling and Psychotherapy Research*, 21(4), 816–826.
- Broglio, E., Nisbet, K., Chow, H., Bone, C., Simmonds-Buckley, M., Knowles, L., Hardy, G., Gibbon, L., & Barkham, M. (2022). Student services partnerships evaluation and quality standards (SPEQS) toolkit.
- Broglio, E., Ryan, G., Williams, C., Fudge, M., Knowles, L., Turner, A., Dufour, G., Percy, A., Barkham, M., & SCORE Consortium. (2021). Profiling student mental health and counselling effectiveness: Lessons from four UK services using complete data and different outcome measures. *British Journal of Guidance and Counselling*, 51, 1–19.
- Castonguay, L. G., Locke, B. D., & Hayes, J. A. (2011). The center for collegiate mental health: An example of a practice-research network in university counseling centers. *Journal of College Student Psychotherapy*, 25(2), 105–119.
- Castonguay, L. G., Nelson, D. L., Boutselis, M. A., Chiswick, N. R., Damer, D. D., Hemmelstein, N. A., Jackson, J. S., Morford, M., Ragusea, S. A., Roper, J. G., Spayd, C., & Borkovec, T. D. (2010). Psychotherapists, researchers, or both? A qualitative analysis of psychotherapists' experiences in a practice research network. *Psychotherapy: Theory, Research, Practice, Training*, 47(3), 345–354.
- Center for Collegiate Mental Health. (2022a). Center for Collegiate Mental Health: Standardized dataset. <https://ccmh.psu.edu/assets/sds/SDS%20Manual%20v7.2022.pdf>
- Center for Collegiate Mental Health. (2022b). Welcome to CCMH. <https://ccmh.psu.edu/>
- Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science*, 4, 1–15.
- Erlingsson, C., & Brysiewicz, P. (2017). A hands-on guide to doing content analysis. *African Journal of Emergency Medicine*, 7(3), 93–99.
- Greenhalgh, T., Wherton, J., Papoutsi, C., Lynch, J., Hughes, G., Hinder, S., Fahy, N., Procter, R., & Shaw, S. (2017). Beyond adoption: A new framework for theorizing and evaluating nonadoption, abandonment, and challenges to the scale-up, spread, and sustainability of health and care technologies. *Journal of Medical Internet Research*, 19(11), e8775.
- Hayes, J. A., Chun-Kennedy, C., Edens, A., & Locke, B. D. (2011). Do double minority students face double jeopardy? Testing minority stress theory. *Journal of College Counseling*, 14(2), 117–126.
- Heard-Laureote, K., Creaton, J., Moss, R., Sims-Shouten, W., & Gorgyntzki, P. (2021). Mental health and wellbeing of postgraduate researchers: Exploring the relationship between mental health literacy, help-seeking behaviour, psychological distress, and wellbeing. *Higher Education Research and Development*, 41(4), 1168–1183.
- Hicks, C., & Milton, M. (2010). Sexual identities: Meanings for the counselling psychology practice. In I. R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of counselling psychology* (Third ed., pp. 3–22). Sage Publications Ltd.
- Higher Education Statistics Agency (HESA). (n.d.) <https://www.hesa.ac.uk/>
- Ilagan, G. S., & Heatherington, L. (2022). Advancing the understanding of factors that influence client preferences for race and gender

- matching in psychotherapy. *Counselling Psychology Quarterly*, 35(3), 694–717.
- Labin, S. N., Duffy, J. L., Meyers, D. C., Wandersman, A., & Lesesne, C. A. (2012). A research synthesis of the evaluation capacity building literature. *American Journal of Evaluation*, 33(3), 307–338.
- Lipson, S. K., Zhou, S., Wagner, B., Beck, K., & Eisenberg, D. (2016). Major differences: Variations in undergraduate and graduate student mental health and treatment utilization across academic disciplines. *Journal of College Student Psychotherapy*, 30(1), 23–41. <https://doi.org/10.1080/87568225.2016.1105657>
- Locke, B. D., Bieschke, K. J., Castonguay, L. G., & Hayes, J. A. (2012). The center for collegiate mental health: Studying college student mental health through an innovative research infrastructure that brings science and practice together. *Harvard Review of Psychiatry*, 20(4), 233–245.
- McAleavey, A. A., Castonguay, L. G., & Locke, B. D. (2011). Sexual orientation minorities in college counseling: Prevalence, distress, and symptom profiles. *Journal of College Counseling*, 14(2), 127–142.
- McKenzie, K., Murray, K. R., Murray, A. L., & Richelieu, M. (2015). The effectiveness of university counselling for students with academic issues. *Counselling and Psychotherapy Research*, 15(4), 284–288.
- McKerrow, I., Carney, P. A., Caretta-Weyer, H., Furnari, M., & Miller Juve, A. (2020). Trends in medical students' stress, physical, and emotional health throughout training. *Medical Education Online*, 25(1), 1–8. <https://doi.org/10.1080/10872981.2019.1709278>
- Nelson, D. L., Castonguay, L. G., & Locke, B. D. (2011). Challenging stereotypes of eating and body image concerns among college students: Implications for diagnosis and treatment of diverse populations. *Journal of College Counseling*, 14(2), 158–172.
- NHS. (2019). The NHS long term plan. <https://www.longtermplan.nhs.uk/>
- NHS Digital (2021). <https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2020-21>
- NHS Digital. (2022). Improving access to psychological therapies dataset. <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set>
- NHS England. (2021). The improving access to psychological therapies manual. <https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/>
- NHS Mental Health of Children and Young People. (2017). Trends and characteristics. <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-childrenand-young-people-in-england/2017/2017>
- Office for Students. (2019). Access and participation data analysis. Students with reported mental health conditions: Office for students. <https://www.officeforstudents.org.uk/media/d5a5c2b5-d961-49e3-89ef-94ed4847b01a/access-and-participation-data-analysis.pdf>
- Office for Students. (2022). Joint working between providers and the NHS to support student mental health. <https://www.officeforstudents.org.uk/advice-and-guidance/student-wellbeing-and-protection/joint-working-between-providers-and-the-nhs-to-support-student-mental-health/>
- O'Shea, A., Kilcullen, J. R., Hayes, J., & Scofield, B. (2021). Examining the effectiveness of campus counseling for college students with disabilities. *Rehabilitation Psychology*, 66(3), 300–310.
- SCORE. (2022). Student counselling outcomes research and evaluation. <https://score-consortium.sites.sheffield.ac.uk/>
- Singh, A., Khess, C., KJ, M., Ali, A., & Gujar, N. M. (2020). Loneliness, social anxiety, social support, and internet addiction among postgraduate college students. *Open Journal of Psychiatry & Allied Sciences*, 11(1), 10. <https://doi.org/10.5958/2394-2061.2020.00002.6>
- Skead, N. K., & Rogers, S. L. (2015). Do law students stand apart from other university students in their quest for mental health: A comparative study on wellbeing and associated behaviours in law and psychology students. *International Journal of Law and Psychiatry*, 42, 81–90. <https://doi.org/10.1016/j.ijlp.2015.08.011>
- Times Higher Education. (2023). Everything you need to know about studying in the UK. <https://www.timeshighereducation.com/student/advice/everything-you-need-know-about-studying-uk>
- Trinity College Dublin. (2021). SCS database documents. https://www.tcd.ie/Student_Counselling/3set/wp1/scs-database-documents.php
- UCAS. (2021). Starting the conversations: UCAS report on student mental health. <https://www.ucas.com/file/513961/download?token=wAaKRniC>
- Universities, U. K. (2020). Stepchange: mentally healthy universities. <https://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2020/uuk-stepchange-mhu.pdf>
- Winzer, R., Lindberg, L., Guldbbrandsson, K., & Sidorchuk, A. (2018). Effects of mental health interventions for students in higher education are sustainable over time: A systematic review and meta-analysis of randomized controlled trials. *PeerJ*, 6, e4598.

AUTHOR BIOGRAPHIES

Jennifer O'Donnell is a research fellow at the British Association for Counselling and Psychotherapy (BACP). She represents BACP as part of the Student Counselling Outcomes Research and Evaluation (SCORE) consortium and conducts research as part of the group, leading on the research in developing a minimum data standard (MDS) for university and college counselling services in the UK.

Emma Broglia is a lecturer in the Department of Psychology at the University of Sheffield. Emma is the project manager of the SCORE Consortium and leads various research projects for the group. She is also the research lead of a Research and Clinical Placements Unit (RCPU) at the University of Sheffield, dedicated to enhancing student mental health interventions.

Afra Turner is a cognitive behaviour psychotherapist in the Student Support and Wellbeing Service at King's College, London, UK. She holds a PhD, is the Chair of the SCORE Consortium and also a practitioner member of the group.

Mark Fudge is a mental health trainer at The Charlie Waller Trust. He was previously Head of Counselling and Mental Health at Keele University and is a practitioner member of the SCORE Consortium.

Louise Knowles is Head of Mental Health and Psychological Therapy Services, at the University of Sheffield Counselling Service, UK. She is the deputy chair of the SCORE consortium and also a practitioner member of the group. She is also the unit manager of a Research and Clinical Placements Unit (RCPU) at the University of Sheffield, dedicated to enhancing student mental health interventions.

Michael Barkham is a professor of clinical psychology in the Clinical and Applied Psychology Unit, Department of Psychology, at the University of Sheffield. A common thread is the complementary methodologies of practice-based evidence (large routine data sets) and pragmatic randomised controlled trials in the psychological therapies together with a commitment to student mental health. Michael is an expert advisor for SCORE (<https://www.scoreconsortium.group.shef.ac.uk/>).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.