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ORIGINAL ARTICLE

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Comparison of outcomes from a university counselling service before and during COVID-19: Exploring the use of remote therapy

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Abstract

Background: Research pooling data from UK university counselling services (UCSs) has allowed UCSs to compare their outcomes and demonstrate their effectiveness in improving student mental health. During the COVID-19 pandemic, UCSs moved to remote delivery. Consequently, it was necessary to understand how this impacted students' outcomes.

Aims: This evaluation aimed to (1) understand how the therapeutic outcomes of a UCS compared with established norms in UK UCS literature, and (2) understand whether delivering therapy online affected student outcomes compared with UK norms from in-person therapy.

Method: Sessional outcome data from 627 students who attended the UCS in the 2020/2021 academic year were gathered. Descriptive analyses of students' initial clinical data (determined by the CCAPS-34) were conducted. Paired sample *t*-tests determined differences between the pre- and post-therapy scores. The effect size of this difference was derived.

Results: Students presented with high levels of academic distress, social anxiety, generalised anxiety and depression. The initial severity of mental health concerns was lower than that reported in previous literature. The largest improvements were evidenced for depression and general anxiety and 25% ($n = 112$) of students achieved reliable reductions in distress. Compared with existing literature, the UCS showed similar levels of improvement over therapy. It is suggested that remote therapy increased service accessibility.

Conclusion: The delivery of remote therapy produced results consistent with norms in the UK data, highlighting the effectiveness of online therapy for university students. Further large-scale evaluations of student outcomes from remotely delivered therapy are recommended.

KEYWORDS
mental health, remote therapy, students, university counselling service

1 | INTRODUCTION

Students' experiences of mental health has long been a focus of attention in the research literature (Macaskill, 2012). Interventions such as person-centred counselling (PCC) and cognitive behavioural therapy (CBT) have been effective at reducing students' mental health concerns (Dickson & Gullo, 2015; Weston, 2015). However, most research has explored the impact of face-to-face delivery of such interventions. The recent COVID-19 pandemic and advances in digital technology have helped to promote the use of remote therapy. Many universities have since adopted a hybrid teaching model, which is mirrored in the delivery of their student counselling services. It is important to determine how this shift in practice has impacted the delivery and effectiveness of therapy as compared to face-to-face delivery.

Mental health difficulties experienced by students can impact their ability to complete their studies and negatively affect their chances of academic success (Eisenberg et al., 2009). This has been a long-established phenomenon, with the first student mental health service being founded in 1910 and embedded in Princeton University (Kraft, 2011). From the late 1900s, it has become common practice for universities to provide specialist mental health provision, often in the form of counselling services. This was an agenda supported by the creation of a division of the British Association for Counselling and Psychotherapy (BACP) in the 1970s dedicated to university counselling (BACP, 2017). The Quality Assurance Agency for Higher Education (QAA) in the UK has pushed for developments in student mental health support, outlining that students must be provided with the support they require to help them succeed and benefit in higher education (QAA, 2018). In 2019, the introduction of the University Mental Health Charter (Hughes & Spanner, 2019) outlined an evidence-based framework for supporting students in higher education in their mental health and well-being. Supporting the positive impact of university counselling services (UCSs), Scruggs et al. (2023) found that students self-reported improved academic ability following access to counselling and were less likely to leave university after accessing counselling services.

Whilst student mental health provision is now well established in higher education institutions, there continues to be increasing numbers of students enrolling to university (Bolton, 2021). Many students report clinical levels of psychological distress (Bewick et al., 2010; Thorley, 2017) and accounts highlight a sixfold increase in students experiencing mental health difficulties since 2010 (Hubble & Bolton, 2020). University counselling services have responded to increased demand by signposting students to mental health support apps (Brown, 2016) and lowering the number of sessions offered per student (Broglia et al., 2017a). Broglia et al. (2017a) found that 82% of student referrals were for high-intensity interventions, suggesting that students often present with complex mental health difficulties. Students are more likely to seek professional support when experiencing high levels of psychological distress (Wadman et al., 2018), with white students seeking peer support rather than professional support when experiencing mental health difficulties (Bryant et al., 2021).

Implications for practice and policy

- This research could influence the format of delivery of counselling for individuals who access student counselling services.
- It also provides ideas around online counselling reducing physical boundaries for those who want to access counselling support at their university.
- It provides a comparison between pre-COVID and post-COVID outcomes and allows interpretation of how the university counselling service in this study was able to support its students during COVID-19 and how the effectiveness of this support was impacted by how the service was delivered.
- It further contibutes to supporting offerings of online counselling services for students at a time where demand for support is high.

Furthermore, whilst lower than the general population, the risk of suicide amongst the student population is rising, with the Office for National Statistics (ONS) reporting 1324 student deaths by suicide in the UK between 2010 and 2019 (Pierce et al., 2020). This statistic evidences the need for student mental health support to be of good quality and available to all students.

Despite the increased emphasis on improving access to mental health support for students in higher education, there have been little generated data to support the effectiveness of UCSs within the UK. When services evaluate their effectiveness, the pool of students tends to be small and lacking in diversity. Furthermore, there is no established national data set for UCSs in the UK. Indeed, there have been calls for higher education institutions to routinely collect data in coordination with one another to contribute to a minimum national data set for these services (Barkham et al., 2019). The feasibility of a national data set for higher education counselling services has been evidenced in the United States (Castonguay et al., 2011). Broglia, Ryan, et al. (2021) recently made use of data from four UK UCSs, collected in the 2017/2018 academic year, who employed mixed outcome measures and successfully pooled the data to produce a profile of student mental health issues. The study showed that counselling services significantly reduced students' experiences of depression, anxiety, hostility, social anxiety, academic distress and improved well-being. However, this research focused on in-person counselling and the extent to which online or remote counselling contributes to positive student mental health outcomes has limited evidence.

However, the landscape of student mental health and the delivery of student support has changed, largely related to the COVID-19 pandemic. The restrictions on social gatherings imposed by the UK government in response to COVID-19 meant that universities closed their campuses and moved to remote teaching. During the initial lockdown phase, the mental health of 18- to 24-year-olds in the UK

significantly deteriorated, more so than any other age group (Pierce et al., 2020). Evans et al. (2021) reported that UK students were experiencing reduced well-being, increased depression, insufficient sleep and increased worry about contracting COVID-19 during the lockdown. In response, the delivery of counselling also moved to a remote format via video calls or telephone. This way of working was a significant shift in practice for UCSs, with some services already offering limited online therapy sessions but most offering traditional face-to-face appointments (Inglis & Cathcart, 2018). The online intervention offer was typically provided via third-party organisations prior to the pandemic via services such as remote counselling through Big White Wall (now replaced by Togetherall), or online peer-to-peer support via the new version of Togetherall (see https://account.v2.togetherall.com/register). However, such provision was not necessarily adapted to students' unique needs and had limited specialist understanding of the institutions and support offerings that could provide joined-up support to students. Considering online peer-to-peer support offerings, there is currently a limited evidence base for its impact on higher education student well-being. Drysdale et al. (2022) employed a randomised controlled trial design and found that peer support groups significantly improved higher education students' well-being, regardless of this offering being online or in person.

In light of significant changes in UCS intervention delivery, it is important to collate the experience of online offerings from embedded UCSs in relation to students' needs. Richards (2009) found that online therapy was accessible for many students and was complementary to the traditional face-to-face counselling appointments. Other research has evidenced that students may prefer the anonymity gained via online counselling and the ability to fit online sessions into busy lives (Hanley & Wyatt, 2020). Smith et al. (2021) argue that the evidence for the effectiveness of online counselling and psychotherapy is promising but lacks generalisability. Hence, further research is required to support the effectiveness of online interventions for reducing mental health concerns.

Many services, including services in the current research, have proposed a hybrid model of delivery moving forward from COVID-19, offering video, telephone and face-to-face therapy sessions, but have little evidence to support this change in delivery. To address the evidence gap, the current evaluation aimed to determine whether a UCS yields similar outcomes to those evidenced in the wider literature derived from face-to-face interventions. This will be achieved by comparing the sessional student outcome data gathered by the UCS during the pandemic in the 2020/2021 academic year to the established norms for UK UCSs based on pre-pandemic face-to-face interventions (Broglia, Ryan, et al., 2021). Furthermore, the use of the 2020/2021 academic year means that the data are gathered from remote therapy sessions only, and so the findings could inform how UCSs will deliver therapy in the future, potentially supporting a hybrid service delivery model of both remote and face-to-face therapy.

The evaluation further aimed to identify which mental health presentations respond better to online interventions whilst understanding which interventions were successfully delivered remotely.

2 | METHOD

2.1 | Design and setting

The UCS was based in a university with a population of approximately 30,000 students and was embedded within the university with a tradition of over 30 years of service. It offered short-term mental health support, typically contracting 6–10 therapy sessions. In the 2020/2021 academic year, the service supported around 1624 students, slightly lower than 1739 students in the previous academic year. Of note, many students were not on campus during this period and due to legal and ethical restrictions, only students in the UK could access the service remotely. Over the 2020/2021 academic year, due to COVID-19 restrictions, only remote therapy was offered, comprising of either video or telephone support. This retrospective quantitative evaluation made use of sessional outcome data collected by the UCS from the 2020/2021 academic year.

2.2 | Inclusion criteria

Students' data were included in the analysis if they had attended the UCS between 01/09/2020 and 28/07/2021. Students received a form of therapy intervention from the service, including CBT, person-centred therapy, eye-movement desensitisation reprocessing (EMDR), gestalt and integrative therapy. Students who received a general follow-up appointment were included as these were contact sessions with a client made after triage when they felt they needed some input/time to talk to a member of the UCS but were not yet receiving a specific therapy or did not feel therapy was appropriate at that time. Interventions such as workshop attendance were not included. Included student data comprised of those who had begun or completed their course of counselling within the defined time frame and had complete sessional outcome data for each session they attended. Students who had attended one therapy session were included for descriptive analysis but not in pre- and post-intervention data analysis due to a lack of available data points. All triage sessions were excluded from the data set as well as individuals who had missing data for their initial or final therapy session.

All participants received an online intervention, which was typically via video platforms such as Google Meet. It was at each student's discretion as to whether they kept their cameras on. All therapists had received professional qualifications relevant to the interventions they delivered, with most working in an integrative person-centred therapy, CBT or EMDR approach. Practitioners were accredited by either the United Kingdom Council for Psychotherapy (UKCP) or BACP. Therapeutic interventions were delivered as close as possible to how they would be in person, with inevitable changes, such as use of shared screens to view diagrams/images, being made.

2.3 | Outcome measures

The primary outcomes measure used was the Counseling Center Assessment of Psychological Symptoms-34 (CCAPS-34; Locke et al., 2012). The CCAPS-34 was administered prior to every counselling session following the initial assessment. This measure comprises seven subscales: depression, generalised anxiety, social anxiety, academic distress, eating concerns, hostility and alcohol use. Students were asked to complete a 5-point Likert scale for each item, with zero indicating 'not at all like me' and four indicating 'extremely like me'. This instrument also provides a measure of overall distress, referred to as the distress index. The distress index is derived from scores on the depression, generalised anxiety, social anxiety, academic distress and hostility subscales. The CCAPS-34 provides severity indicators, with scores being categorised as either low (no or minimal distress), moderate, or high (likely the person meets criteria for a formal diagnosis of a mental health condition). Within the service, the CCAPS-62 measure was administered at triage (Locke et al., 2011), and the CCAPS-34 at the first therapy session and each session thereafter. Due to this study excluding triage sessions, CCAPS-62 data were not included.

The CCAPS-34 has been evidenced as having high levels of internal consistency, with Cronbach's alpha scores for each subscale ranging from 0.82 to 0.91 (Locke et al., 2012). The measure has also been validated against the Clinical Outcomes in Routine Evaluation-10 (CORE-10; Barkham et al., 2013; Broglia et al., 2017b).

2.4 | Procedure

Using the Titanium software adopted by the UCS, raw data were exported from the 2020/2021 academic year on 28/07/2021. The option not to pull client-identifiable information was checked on the Titanium reports function. The data included client ID, age, gender, number of sessions, type of intervention received, dates of sessions they attended and the raw scores and mean raw scores for each item and subscale on the CCAPS-34. These data were stored on a secure drive and password protected. Each client's data were reviewed independently by the first author (CN) to ensure the data were eligible for inclusion and a sample of the data was checked again by a second reviewer using an inclusion and exclusion criteria sheet.

2.5 | Analysis

To allow for comparison to existing norms in the literature, this evaluation attempted to replicate the analysis used by Broglia, Ryan, et al. (2021). Data were imported into the SPSS statistics package (version 27). Descriptive analyses of all students' initial CCAPS-34 data were conducted to show the initial severity of symptoms when students entered counselling. Furthermore, descriptive analyses were used to identify the mean number of counselling sessions attended and the average age of students accessing the service.

For students who attended more than one counselling session, their first and last CCAPS-34 scores were used to understand the difference between the pre- and post-scores using paired sample *t*-tests. The effect size of this difference was also derived. Reliable improvement made on the distress index was calculated using the reliable change criterion of 0.79 as defined in the CCAPS-34 manual (Center for Collegiate Mental Health, 2019). Further analysis of changes in students' severity banding on the CCAPS-34 from the initial to final session was also conducted.

2.6 | Approvals

Due to the remit of this project falling under the service evaluation category, research ethics approval was not necessary. In the initial client contract when joining the UCS, clients stipulate their consent to their data being used anonymously for research and evaluation purposes. A formal permission letter from the manager of the UCS was obtained, permitting access to the service's outcome data and dissemination of the findings.

3 | RESULTS

3.1 | Student demographics

A total of 815 cases were pulled from the Titanium database. A final sample of 627 participants were eligible for inclusion in the evaluation. See Figure 1 for further information on how student data were processed.

The mean age of the students included in the analysis was 22 years (min = 18, max = 58, SD = 4.3) with 73% (n = 457) of students identifying as female and the remaining students identifying as male. Table 1 presents a comparison of the current evaluation's student demographics to those of Broglia, Ryan, et al. (2021).

3.2 | Counselling intervention

The average number of counselling sessions attended by students was 4.36 (min = 1, max = 22, SD = 3.63). More students (28.5%, n = 179) attended for only one session, with 26.5% (n = 166) attending for the usual service offering of 6–10 sessions. Only 6.5% (n = 41) of those included in the sample attended 11 or more sessions and the remaining 38.5% (n = 241) attended between two to five sessions. For those who attended more than one session, the average duration of treatment was 9 weeks (min = 0, max = 40, SD = 7.3), with one individual receiving two sessions in 1 day, explaining the figure for the minimum number of weeks. A range of therapeutic modalities were provided by the counsellors in the service, including gestalt (0.2%, n = 1), person-centred (9.9%, n = 62), CBT (5.3%, n = 33), EMDR (3.2%, n = 20) and process-oriented psychotherapy (2.9%, n = 18). However, most students received integrative person-centred

FIGURE 1 Participant flow diagram.

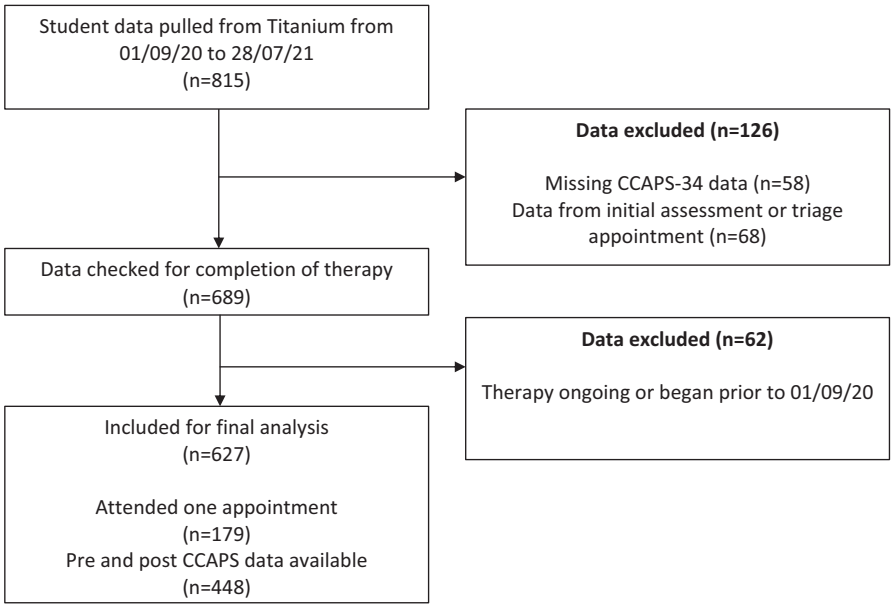

TABLE 1 Comparison of student demographics to Broglia, Ryan, et al. (2021).

	Current evaluation				Broglia, Ryan, et al. (2021)			
	N	%	Mean	SD	N	%	Mean	SD
Age	627		22	4.3	5568	–	25	6.42
Gender								
Female	457	73	–	–	3535	63	–	–
Male	170	27	–	–	1736	31	–	–
Unspecified	–	–	–	–	279	5	–	–
Non-binary	–	–	–	–	18	0	–	–

therapy (33.8%, $n=212$), or a general follow-up support session (44.8%, $n=279$).

Broglia, Ryan, et al. (2021) reported intervention data in a slightly different format, meaning a direct comparison table could not be produced. In Broglia, Ryan, et al. (2021), the average number of sessions attended was 4.46 (min = 1, max = 26, SD = 3.03), with 32% ($n=828$) of students attending for 1–2 sessions, 2% ($n=39$) attending for 11 or more and 44% ($n=1151$) attending between five and ten sessions. It was unclear how many attended six to ten sessions to allow for direct comparison. The average duration of sessions reported in Broglia, Ryan, et al. (2021) was 13.24 weeks (min = 0, max = 84.3, SD = 11.2). In terms of interventions provided, Broglia, Ryan, et al. (2021) found that staff were largely integrative and trained in humanistic, CBT, and psychodynamic psychotherapy.

3.3 | Initial psychological profile

Initial psychological profiles of the students are presented in Table 1 alongside those established in Broglia, Ryan, et al. (2021) for comparison. Descriptive analysis of the initial counselling session CCAPS-34 scores, including students who attended one session, found that students presented with average scores above the high-cut threshold on the CCAPS-34 for depression, generalised anxiety and academic distress. Mean scores on the remaining subscales of social anxiety, eating concerns, hostility and alcohol use all fell in the moderate range. The overall mean score for distress at the initial session is presented in Table 2. Broglia, Ryan, et al. (2021) reported elevated scores on the CCAPS-34 in academic distress, general and social anxiety, and depression.

3.4 | Improvement in symptoms

3.4.1 | Effect sizes

The 448 students who attended more than one appointment were included for analysis to identify changes in psychological profile over the course of counselling input. Table 3 provides an overview of students who made reliable improvement using the reliable change criterion of >.79. In summary, 25% ($n=112$) of students achieved reliable improvement on the distress index, whilst Broglia, Ryan, et al. (2021) found that 21% ($n=290$) of students made a reliable improvement on the distress index. Table 4 shows there was a moderate effect on students' overall distress ($d=.68$), as defined by Cohen's (1988) effect size criteria. Moderate effects were also found for depression

TABLE 2 Means, ranks and SDs on CCAPS-34 subscales at initial therapy session for all students.

	This study ($n=627$)		Broglia, Ryan, et al. (2021) ($n=1350$)	
CCAPS-34 subscale	Mean (rank)	SD	Mean (rank)	SD
Distress	2.10	0.75	2.31	0.69
Depression	2.09[a] (4)	0.97	2.34[a] (3)	0.78
Generalised anxiety	2.22[a] (2)	0.90	2.29[a] (4)	0.82
Social anxiety	2.25 (3)	0.92	2.41[a] (2)	0.87
Academic distress	2.60[a] (1)	0.99	2.48[a] (1)	0.85
Eating concerns	1.29 (5)	1.20	1.32 (5)	0.94
Hostility	0.89 (6)	0.81	1.32 (5)	0.87
Alcohol use	0.70 (7)	0.89	1.11 (6)	0.99

[a]Above high-cut threshold.

TABLE 3 Reliable change post-university counselling intervention compared with Broglia, Ryan, et al. (2021).

Category of change after counselling	This study ($n=448$)	Broglia, Ryan, et al. (2021) ($n=1350$)
Reliable improvement	112 (25%)	290 (21%)
No reliable change	331 (74%)	1043 (77%)
Reliable deterioration	5 (1%)	17 (1%)

and general anxiety and were .57 and .55, respectively. There were small changes found on the social anxiety, academic distress, eating concerns, hostility and alcohol use subscales.

3.5 | Improvement in severity

Figure 2 provides a breakdown of the percentage of participants in each severity banding at the initial and final sessions of therapy for those who attended more than one session. Figure 2 shows that students who met high levels of distress on the CCAPS-34 fell by 21.2% ($n=94$) over the course of therapy. Students who scored above the high-cut point for depression fell by 21.7% ($n=97$) from the initial to final session and those who met the high-cut point for generalised anxiety fell by 17.3% ($n=77$).

4 | DISCUSSION

Broglia, Ryan, et al. (2021) was the first UK-based study to pool data from multiple UCSs that administered different outcome measures. This evaluation aimed to compare the results from the analysis of a single UCS during the pandemic with the sessional outcome data reported by Broglia, Ryan, et al. (2021). In summary, students presented with high levels of academic distress, social anxiety, general anxiety and depression. The initial severity of mental health concerns was lower than reported in previous literature. The largest

TABLE 4 Means, ranks, SDs and effect sizes for pre- and post-counselling sessions from students attending two or more sessions.

	Initial mean (rank)	SD	Final mean (rank)	SD	Effect size (rank)
UCS Data ($n=448$)					
Distress	2.11	0.71	1.68[a]	0.79	0.68
Depression	2.11 (4)	0.93	1.62 (4)[a]	0.98	0.57 (1)
Generalised anxiety	2.21 (3)	0.88	1.81 (3)[a]	0.94	0.55 (2)
Social anxiety	2.26 (2)	0.89	1.99 (2)[a]	0.91	0.41 (4)
Academic distress	2.60 (1)	0.98	2.22 (1)[a]	1.09	0.41 (4)
Eating concerns	1.26 (5)	1.21	1.07 (5)[a]	1.20	0.24 (5)
Hostility	0.88 (6)	0.79	0.6 (6)[a]	0.69	0.46 (3)
Alcohol use	0.67 (7)	0.83	0.53 (7)[a]	0.83	0.22 (6)
Broglia, Ryan, et al. (2021) data ($n=1350$)					
Distress	2.31	0.69	1.86	0.82	0.65
Depression	2.34 (2)	0.78	1.82 (4)	0.99	0.67 (1)
Generalised anxiety	2.29 (4)	0.82	2.00 (3)	0.97	0.36 (3)
Social anxiety	2.41 (3)	0.87	2.20 (2)	0.96	0.25 (6)
Academic distress	2.48 (1)	0.85	2.25 (1)	1.02	0.26 (5)
Eating concerns	1.32 (5)	0.94	1.19 (5)	1.22	0.14 (7)
Hostility	1.32 (5)	0.87	0.83 (6)	0.81	0.56 (2)
Alcohol use	1.11 (6)	0.99	0.76 (7)	0.95	0.35 (4)

[a]Significant difference at .001 probability level.

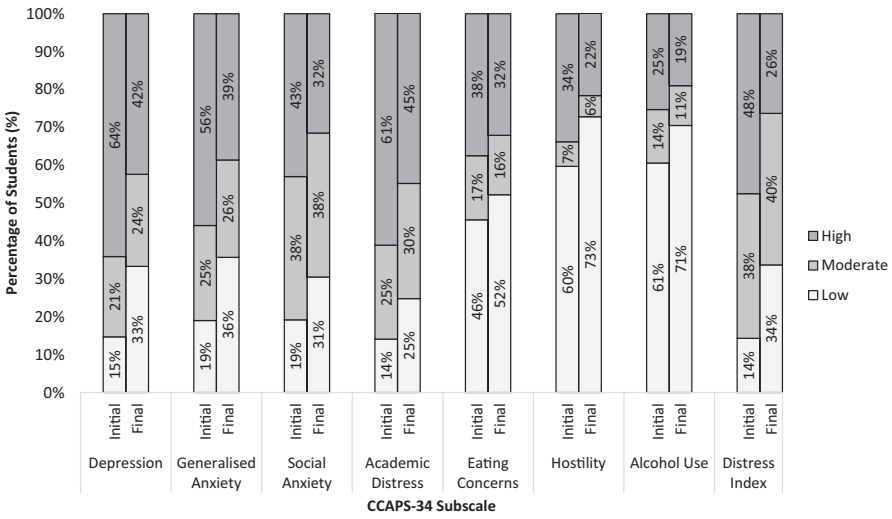

FIGURE 2 Changes in severity bandings on the CCAPS-34 from the pre- and post-counselling sessions.

improvements were evidenced for depression and general anxiety and 25% of students made reliable reductions in overall distress. The UCS showed similar rates of improvement for remote delivery compared with the extant literature.

Relating to findings on student demographics, a possible explanation for the UCS being accessed by a younger population on average could be due to Broglia, Ryan, et al. (2021) having included one institution that had a large mature student population. Other studies reporting on students accessing UCSs have, in line with this research, reported the average age of students to also be around 22 years (Murray et al., 2016). Considering the intervention received, the average number of sessions attended in this service was similar to the average session uptake reported in Broglia, Ryan, et al. (2021). Furthermore, the therapeutic modalities used within the service and listed in the literature were both largely integrative in nature. Interestingly, the UCS offered EMDR, which was not mentioned in Broglia, Ryan, et al. (2021). It could be suggested that the EMDR offering was a recent development of the UCS and that they had extended their range of interventions likely in response to more students requiring evidence-based trauma interventions. This is consistent with the literature showing a general trend for students approaching services with more complex and clinically severe needs (Broglia et al., 2017a). Whilst EMDR has been found to be effective for processing emotional memories in the student population (Lee & Cuijpers, 2013), less is known in the context of delivery in a UK-based UCS. This evaluation's findings provide evidence that moving to an online delivery of therapy did not impact the type of therapy available to students or their attendance to the service.

Like Broglia, Ryan, et al. (2021), students initially reported the highest scores on the academic distress subscale of the CCAPS-34. An interesting finding was that for those attending two or more sessions, anxiety (both social and generalised) appeared to be a higher concern than depression, dissimilar to Broglia, Ryan, et al. (2021). Considering that the service data were gathered during the time that restrictions on social gatherings were repeatedly lifted and later reinforced, a rise in anxiety may be the result of uncertainty during this time. This is supported by Kwong et al. (2021), who found that, during the COVID-19 pandemic, those experiencing anxiety had doubled, especially in the younger population, yet levels of depression remained similar to pre-pandemic levels. Although the rise in anxiety cannot be directly attributed to the pandemic, Kwong et al. (2021) concluded that the pandemic was likely to have led to this increase as post-restriction studies have shown decreased anxiety.

Considering the initial counselling session psychological profiles, students accessing this service presented with less severe scores on average than those reported by Broglia, Ryan, et al. (2021). This was the case on all subscales apart from academic distress. This is unusual given that there are consistent increases in mental health severity experienced by students, similar to that of the general population, evidenced in the literature (Macaskill, 2012). Moreover, Pierce et al. (2020) found that individuals aged 18–24 years had experienced a deterioration in mental health over the pandemic, which is not consistent with findings from the current study. Whilst it is possible that there was a decrease in the severity of mental ill health experienced by students accessing the UCS in 2020/2021, such an explanation would be contrary to reported trends. A more plausible explanation may be that students sought help sooner. In a qualitative study, Broglia, Millings, and Barkham (2021) described three phases of a student's path to seeking mental health support, with the second phase being when students acknowledge the need for help but face structural barriers. The ability to access online therapy may have curbed the perceived structural barriers meaning they could access support sooner after acknowledging their mental health difficulties as opposed to waiting until their difficulties had increased and then prioritising time to attend in-person therapy.

When reporting the effectiveness of UCSs for reducing symptoms of mental health concerns, Broglia, Ryan, et al. (2021) found that regardless of the outcome measure administered, symptoms of depression reduced following counselling, a finding also reported by Connell et al. (2008). The current study's findings showed moderate effect sizes in the reduction in depression, suggesting that remote counselling provided by this service had a moderate impact on depression symptomology, matching the reported norms in the literature. Compared with Broglia, Ryan, et al. (2021), this service

was found to have a larger effect on generalised anxiety. An explanation for this could be that students entered the UCS with higher generalised anxiety on average, allowing for larger improvements to be made. Overall, the findings could support the argument for further remote UCS offerings, particularly for individuals experiencing anxiety and depression. Internet-based, therapist-guided intervention for anxiety and depression embedded in a UCS has been found to produce clinical reductions in both depression and anxiety (Dear et al., 2019). Such findings, alongside the results of the current study, could go some way towards supporting the integration of remote intervention offerings within UCSs.

The UCS was found to produce slightly more students who achieved reliable improvement on the distress index than those included in Broglia, Ryan, et al. (2021). This finding indicates that remote therapy has still enabled students to make reliable improvements in therapy, with this service producing better rates of reliable improvement of distress than that evidenced in the literature for the CCAPS. It is important to acknowledge that Broglia, Ryan, et al. (2021) included several services as opposed to data from just one and so the extra variability in their paper would contribute to their outcomes. When considering other factors that could have contributed to successful outcomes, perhaps the therapists themselves have found online working to be beneficial, enhancing their practice, which impacts client outcomes. In a recent qualitative study, counsellors reflected that their practice had been enhanced by delivering online counselling due to the development of new skills and improvement of existing ones. These developments were particularly in reflective practice, listening and attentiveness skills and anti-oppressive practice (i.e. bridging the gap for clients who cannot access other environments for support; Smith & Gillon, 2021).

A limitation of the study is that it did not consider the impact of remote working on therapists working within the UCS context. It is vital that employees' opinions and needs are considered and addressed when considering a change in service delivery to ensure the best possible working environment. A further limitation is that the data did not cover a full academic year and so there may have been a missed opportunity to gather a larger sample of student data. A larger sample could increase the reliability and validity of the evaluation findings. However, the data collection period missed approximately 1 month's worth of data, which fell in the university summer holidays. The UCS experienced lower demand during this period, and so it is unlikely that gathering data from this period would have greatly increased the sample size.

5 | CONCLUSION

This evaluation supports the UCS remote delivery model in terms of its comparative effectiveness as evidenced in the literature. The service has produced such results whilst delivering therapy over video and telephone, suggesting that remote therapy achieves comparable therapeutic outcomes to in-person therapy for students accessing the UCS. Based on the findings of this evaluation, providing remote therapy appears to maintain the service aim of improving students' mental health when in-person therapy sessions are not available or possible to attend. Offering students the choice of either a face-to-face, telephone, or video session will allow the service to continue to support students effectively whilst adjusting to students' needs post-COVID-19. A hybrid remote and in-person service delivery is supported by this research. Wider than the specific service context, this research could have implications for UCSs nationally, suggesting that remote offerings are effective and important in the future development of UCSs.

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ETHICS STATEMENT

Data will not be available as consent did not cover this as it concerned client clinical data for the service and evaluation. This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. Students accessing the service sign a contract before joining the service acknowledging the following '*Anonymised appointment, equality and CCAPS data is also used from time-to-time for research purposes*', thus documenting their consent for data to be used in research. No other material from other sources is used in this research. This evaluation was not registered as a clinical trial. Permission was granted by the university counselling service lead to use this data for service evaluation purposes.

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