An observational study: COVID-19's impact on mental health services and programs in a school-based setting

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Abstract

This study strives to describe the effects of COVID-19 on middle school students access to mental health services in their schools. The researcher did this through systematic observation. Secondary data was collected through agency published reports, surveys, and guidelines. The data was then analysed to create a written report as well as infographics. This study focuses on the mental health services middle school students receive from their school environment, the referral process, the professionals who provide services, and the threat that COVID-19 has had toward providing services.

Keywords: mental health, middle schoolers, mental health providers, referral process, benefits and barriers, school-based services, COVID-19

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Chapter 1: Introduction

Statement of the Problem

Beginning in January of 2020 the United States became aware of a new virus coming out of parts of China. The virus is an adaptation of the common cold that has developed into a very serious very contagious virus that spreads quickly through communities. The fear is that the virus will spread through schools infecting children of all ages causing permanent disability or death. In March of 2020 schools were shut down and children sent home to finish out their school year online. Throughout the summer Federal and Local governments had difficult decisions to make. Were students going to return to school full time, part time, in a hybrid format, or entirely online. Locally each school district in Ohio chose how they were going to return to school which varied by how many options there were. The problem with this inconsistency is that it affects students' access to the mental health services they may not get any other way due to barriers in telehealth, school systems, and the environment.

Scope of the Problem

According to the Center for Disease Control (CDC), since January 21, 2020 there have been 8,249,011 total cases of COVID-19, 220,000 deaths, with 414,106 new cases from October 15th to October 22nd of 2020. When it comes to who has been affected the most the CDC describes young adults - ages 18 to 29 - as the majority of cases (23.9%) and infants - ages 0 to 4 as the minority of cases (1.7%). Children and adolescents - ages 5 to 17 - fell in at 7.1% of the 6,131,659 cases where age was available (CDC Data Tracker, n.d). Leeb et al (2020) explain that "among school-aged children who were hospitalized, admitted to an intensive care unit (ICU), or who died, 16%, 27%, and 28%, respectively, had at least one underlying medical condition" from March 1st to September 19, 2020. Those underlying conditions consist of chronic lung disease, disability, immunosuppressive disorders, diabetes,

psychological disorders, cardiovascular disease, and severe obesity. These statistics indicate two things. One is that it is important to take the virus seriously because people are becoming very sick and dying. The other is that those being affected the most are those with pre-existing chronic conditions. The CDC has published on their website the importance for schools to reopen and guidelines for school systems to follow. Including the importance of mental health services for students in schools stating, "isolation and uncertainty about the COVID-19 pandemic can create feelings of hopelessness and anxiety while removing important sources of social support" (School Settings, n.d). So, while the virus is serious it is also important to remember how important school-based mental health services are to their students.

Justification of the Study

School based social work teaches the skills needed for students to build those long-lasting important relationships that will follow them for their entire lives. These relationships can be hard to make when the services are changing. Therefore, knowing how COVID-19 has affected at least one school system and its mental health services is important for knowing possible ways to adapt and provide better access to services. The changes in services don't only affect the students who are referred but also the professionals who are implementing those services. Just as the students must deal with isolation and mental health, so do the professionals themselves. The isolation of schools shutting down or changing aspects of programs can cause more stress, depression, anxiety than an average school year. It is more difficult for the professionals to maintain a relationship with their clients when schools shutting down make meetings more difficult. The go to has been telehealth when the schools shut down. Telehealth can make it difficult for the professionals to reach their clients and to keep up with appointments. Confidentiality and evaluating progress can also be more difficult resulting in more stress for the worker. Workers who have not worked with telehealth have

new technology they need to learn. Along with telehealth, when schools are open there are new guidelines to follow revolving around sanitation, changes to schedules make it hard for the professionals to meet students, removal of services cuts down on the number of students seen. All this means the professionals are not meeting the numbers required by their agencies putting stress on the relationships they have with their agencies/ school districts.

Background of the Problem

COVID-19 is an adaptation of the SARS virus which causes the common cold. This new adaptation of the virus was discovered in China in December of 2019 and quickly spread to the United states. By the end of March 2020, many schools within the U.S were closed and the country itself was rapidly shutting down all businesses that were not considered essential. Between March and August of 2020 federal, state, and local governments as well as school systems discussed and decided on whether schools should reopen to students and staff as well as how the schools should operate daily. The discussions on how schools should operate during the pandemic are ongoing and affect the school-based mental health services they provide.

Who is Affected by the Problem?

School aged children and their families from preschool through high school are affected. School aged children would include children old enough to start preschool around the age of three up to high school children around the ages of seventeen or eighteen. School aged children and their families who are being referred to school-based mental health services. Families would include intact two parent homes, single parents, grandparents who take their grandchildren, etc. Teachers, school administrators, and other school staff including office workers and janitorial staff are also affected. School psychologists, counselors, social workers, and other mental health professionals are also affected.

Significance of the Study

Understanding how COVID-19 has affected ease of access is important to future research as well as gaining an understanding on how to adapt programs in the future. This study is significant for the social work profession specifically because it speaks directly to the NASW code of ethics and values within. To provide the most appropriate services social workers need to be able to adapt to the unexpected changes. This would include adapting school-based mental health services adding aspects that may be helpful or changing the ones that are ineffective. Different cultures experience the pandemic in different ways making cultural competence an important aspect of program development. Changing and adapting programs allow for self-determination, dignity and self-worth of both clients and social workers.

Underlying Assumptions

- Only those with pre-existing conditions will contract COVID-19.

- Children are the least likely to get Covid-19.

- Children will receive the same level of care despite school closures.

- Nothing will change in services for students when it comes to mental health.

Purpose of the Research

The purpose and aims of this study are to discover and understand how COVID-19 has impacted access to mental health services in a school-based program as well as how the virus has impacted the way school-based mental health programs operate.

Qualitative, Quantitative, or Mixed Method

This study will be a qualitative that describes the changes in one middle school in Ohio between the 2018-2019 school year and the 2019-2020 school year. The study will describe the changes when it comes to the students access to their school counselors and other mental health professionals within the school. Also studied is the program changes that have been necessary because of the pandemic.

Definition of Terms

- For the purpose of this study "access" is the different avenues that a student can take to get to the mental health professionals in the school (teachers' referral, parents' referral, self-reporting, counselor referral)

- A "referral" is the official form filled out by a teacher, parent, or mental health professional to get services started.

- "Middle Schoolers" are the students in grades 6th through 8th in this particular school district.

- "Mental Health Professionals" is a wraparound term used to describe school counselors, school therapists and case managers.

- "Suicidal Ideation" are passive thoughts about wanting or wishing to be dead, or active thoughts about killing oneself. These are thoughts that happen without the preparatory actions.

Chapter 2: Literature Review

Strengths Perspective and Systems Theory

Working with children in a school-based setting requires QMHS (qualified mental health service) professionals to use both a Strengths Perspective and Systems Theory when working with students, teachers, administrators, and school counselors. Strengths perspective and systems theory compliments the educational system in several ways. Students can reach their goals educationally and mentally on their own terms and of their own volition. Teachers and school administrators learn to work with students, counselors, and parents to ease children through the system, helping them to become successful in their academics and lives in general.

When looking specifically at Systems Theory, past research supports this claim for school-based counseling. Armbruster and Lichtman (1999) explain that "The school-based

program was developed because of earlier studies which identified the urban, minority, disadvantaged, single parent as most at risk for attrition in the early stages of clinic contact. This program was developed because of these studies to provide improved access to this population." Meaning that systemic barriers prevent well-meaning parents, guardians, and caregivers from getting their children into services and those that do receive services outside of school may not continue to receive services. Another asset to school-based counseling and Systems Theory is the real advantage of school staff, parents, and peers acting as gatekeepers to services. Whitney et. al. (2011) say that we can "educate students, operating as "gatekeepers", to serve as a key referral source of peers at risk for suicide." This is also possible for the school's system itself - meaning teachers, administrators, and school mental health professionals - as said by LeCloux et al. (2017) "Schools can act as gate-keepers by implementing specific referral programs, such as schoolwide suicide screening protocols." By thinking of school-based counseling programs through the perspective of Systems Theory it can be seen that for the programs to succeed each part of the system must work together cohesively. This is because "The school environment exposes children and adolescents to a vast support system including administrators, teachers, social workers, nurses, and other caring professionals" and "As a community institution, schools have primary obligations to educate and socialize youth" (Whitney et. al., 2011).

Where Systems Theory focuses on the different systems and subsystems involved in educating and socializing children in a way that promotes physical, emotional, and mental health, Strengths Perspective looks at the minute details of working with young people in a school-based system. Specifically, it focuses on the rapport between mental health professionals, the student, and allowing that student to have their autonomy. Strengths Perspective or the Strengths Model "is devoted to identifying and amplifying the well aspects of youth and focuses on enhancing youth engagement in treatment by allowing youth to

identify personal and meaningful goals." and "should capture not only current strengths of the consumer but also past strengths to get a complete and holistic picture of the individual" (Mendenhall & Grube, 2017). Though the Strength Perspective is more individualized, and client centered it complements Systems Theory and is being used more frequently in school-based counseling programs. This is supported by Mendenhall and Grube (2017) when they clarify that when "promoting youth voice in treatment it must occur simultaneously with engaging parents and families because research has shown the importance and benefits of proper parent and family engagement in youth mental health outcomes." Strengths Perspective is different in one area when used in a school-based counseling program as compared to a more clinical setting. In a school-based setting counseling program "treatment plans are individually developed and may or may not be aligned with a particular evidence-based practice" (Kang-Yi et. al., 2018). This is because a session revolves around the goals of the student and those may change from week to week. Meaning a counselor is more likely to do activities that also change from week to week and don't follow a linear path. What a student may need could differ and so the course may change.

The Referral Process

The referral process can start a few ways. One way is when someone in the school system, a parent, the student, or a peer makes initial contact with the mental health professional of their school. A second way the referral process starts is through screening the students.

Screening can happen through different avenues depending on who is administering the screening, how the screening is taking place and, who the target of the screening is. In a school-based program there are three ways that screening can take place. According to Whitney et.al. (2011), "curriculum-based programs, staff in-service programs, and school-wide screening programs" are the most common ways to screen students (specifically for

suicide prevention). Classroom or curriculum-based programs are built into the school curriculum to be taught along other subjects such as Health. Such programs are meant to bring awareness to the students of the signs and symptoms of mental illness including anxiety, depression, and suicidal ideation. As well as the resources that are available to them and encourages students and their peers to use those resources. Staff in-service programs are directed toward teachers and school administrators. These are often required training that school staff must do yearly and follow up with throughout the year. Staff are taught the same signs, symptoms and resources as the curriculum-based programs but are also taught how to implement the curriculum-based programs and any accommodations that students may need to be successful in the classroom. Lastly, the school-wide screening programs focus on assessing students for depression, suicidal ideation, and other mental illnesses. These programs are done systematically by taking out the day and systematically assessing students. This is usually done by grade level, with a small number of school staff or school mental health professionals. They give a survey to the class before facilitating the program in which afterwards they then use it to address any students who may be at-risk. These programs are meant to increase the number of students who have access to mental health services (Whitney et. al., 2011). Students who are screened and are then referred to QMHS professionals have a better chance of succeeding in their education and in their daily lives. This is supported by Gall et. al. (2000) who claim that after screening "Identified adolescents were significantly more likely to report emotional or behavioural problems warranting attention, including problems with getting into trouble, health, and getting along with parents or peers."

After screening is when the referrals start coming into the QMHS professionals. The next step is the intake, where according to Armbruster and Litchtman (1999) "signed parental permission is necessary for any student to be seen by the clinician, as well as signed exchange of information between the school and clinic." and "The children and families seen

in the schools are assured the same evaluation and treatment they would receive if they had entered the central clinic." Meaning that after a QMHS professional acquires that referral they then reach out to the parents for permission to meet with the student and see if services are needed. After receiving the required permission, the QMHS professional can then run the same assessments with the student that would be given if the student were to go into a psychologist or counselors office outside of school.

After assessments are completed students are put on the caseload of one of the QMHS professionals to receive treatment. These professionals with either Masters or Bachelors level degrees and a supervisor. With the main goals being to "reduce mental health symptoms and improving academic outcomes. Students are permitted to receive out of school mental health services and may be referred by school mental health providers when appropriate" (Kang-Yi et al.,2018).

Mental Disorders Addressed in School-Based Mental Health Services

School-based services focus on a wide variety of mental illnesses ranging from anxiety, depression, ADHD, OCD, and ODD to the more socially awkward adolescent who needs help learning social skills and hygiene. Research and school-wide programs tend to focus on suicide the more severe and life changing/ threatening of them. This is because children and adolescents spend a large portion of their day at school making it the most logical setting to address preventative care and a large number of people. School's also give adolescents the most opportunity to experience bullying and other negative interactions resulting in suicidal ideation and behaviours. (Whitney et. al. 2011) Another reason research and school systems spend a significant amount of time on suicide prevention is because "suicidal adolescents are a group that tends to have low rates of mental health service use despite the fact that they are at high risk for depression and suicide" (LeCloux et al.,2017).

Barriers and Benefits

The research indicates several types of barriers that fall within the school system and outside of it. From within school systems mental health professionals encounter resistance from school administrators and staff, as well as with funding and choosing the most appropriate program type. "Some of the barriers include the availability of intervention resources, the effectiveness of treatment protocols, and resistances to the use of screening assessments by students, parents, teachers and administrators." and "some principals wondered if it was the responsibility of the schools to try to prevent suicide, indicating the school system was already overburdened with obligations regarding other social/emotional abilities" (Whitney at. el. 2011). Also, as stated by Armbruster and Litchtman (1999), "systems issue complicate intervention. Such issues include space, referral procedures, pressures such as the need to provide frequent crisis intervention and juggling therapeutic sessions so as not to overly conflict with school schedules."

Barriers are not concentrated within the school system. Barriers are seen throughout the larger system that includes the community. LeCloux et al. (2017) state that some community barriers include "inadequate knowledge of services available, insurance restrictions, long waiting lists, financial barriers, transportation issues, high staff turnover in mental health agencies, and not fitting the eligibility criteria for treatment." This is supported by Gall et.al. (2000) who suggest "transportation difficulties, inability to make or keep appointments during regularly scheduled hours, concerns about confidentiality, and fear of judgment or insensitivity about issues of sexuality, substance abuse, or emotional distress also keep adolescents from using health care services." These barriers within the community make it difficult for students to find the mental health care they need through the school system as well in the typical clinical setting. Most of the research agrees on one part of the system that can be the most difficult barrier to overcome: parents. "One barrier to implementation cited by the majority of principals in the study concerns parents and the

delicate role that school administrator's play when aiming to respect the importance of family, while upholding the duties of schools" (Whitney et.al. 2011). "Some of the difficulties in the school settings may be lack of parent involvement, hence, the frequent absence of the child's history, parent report measures, as well as the unavailability of the parent for any treatment intervention" (Armbruster & Litchtman,1999). And that "parents' perception of children's functional impairment significantly affects children's use of school-based and out-of-school community mental health services" (Kang-Yi et al.,2018).

While there are many barriers to getting a school-based program implemented there are just as many benefits. According to Armbruster and Litchtman (1999) there are a few reasons including: bridging the gap between service need and service utilization by providing those services to underserved populations and the programs may be effective in a school-based program as they would be in a clinical setting despite lack of parental involvement. This is supported by Ringeisen et. al (2016) who explain that "During adolescence, schools are a critical point of access for mental health services" and that adolescence may use school-based services with programs that incorporate early intervention and prevention. Also included is that students who use school-based programs are more likely to receive clinical based services as well. This is also supported by Kang-Yi et al (2018), who say that school-based programs bridge gaps between the system and students because they have the advantage of targeting behaviors that affects school functioning, improving academic outcomes, absences and suspensions, occurs during the regular school day, and can be held individually or in group sessions.

The Current Threat to Services: COVID-19

Unsurprisingly, there has not been much research published on the current Coronavirus Pandemic and school-based mental health services. What has been published focuses on the mental health of children and adolescents who have been isolated or

quarantined during past pandemics as well as the numbers and trends of students who have been infected with the current pandemic. The gray research surrounding COVID-19 is easier to find, most of which can be found through the Center for Disease Control (CDC). The CDC's website explains that the Coronavirus is a highly contagious and deadly virus that spreads mostly through saliva and mucous from the nose. The best way to prevent spreading is through consistent hand washing/ wearing a mask or face shield and isolating or quarantining when ill or encountering someone who may be ill. The primary way to prevent spread in schools and in public has been to shut down businesses that are not essential, including schools. The CDC is supported by Holmes, O'Conner, Perry et. al (2020) who suggest "behavioral change—such as the three personal protective behaviors of handwashing, not touching the T-zone of the face, and tissue use, and social or physical distancing required to control the pandemic—necessitates ensuring people know what to do, are motivated to do it, and have the skills and opportunity to enact the changed behaviors."

Leeb et al (2020) explains that children and adolescents with "underlying conditions were more common among school-aged children with severe outcomes related to COVID-19" and "among those with an underlying condition, chronic lung disease, including asthma, was most reported, followed by disability, immunosuppressive conditions, diabetes, psychological conditions, cardiovascular disease, and severe obesity." Holmes et. al. (2020) expands upon the concern for those with psychological conditions describing "concerns about exacerbation of pre-existing mental health issues, greater difficulty in accessing mental health support and services under pandemic conditions, and the effect of COVID-19 on the mental health of family members, especially children and older people."

Loades et al (2020) explains how isolation and loneliness affects children and adolescents during quarantine. Aspects of quarantine such as duration, fear of infection, boredom, frustration, and stigma can increase psychological distress. This distress can be

made worse with school closures because it creates loneliness due to decreased social interaction. "The most frequently reported diagnoses were acute stress disorder, adjustment disorder, grief, and posttraumatic stress disorder (PTSD)" as well as "the most common trauma symptoms in the quarantined/isolated group were avoidance/numbing, re-experiencing, and arousal." Holmes et.al. (2020) explain that "A major adverse consequence of the COVID-19 pandemic is likely to be increased social isolation and loneliness, which are strongly associated with anxiety, depression, self-harm, and suicide attempts across the lifespan". This means that school-based counseling programs are going to be crucial in times to come as the country reopens and students are trying to acclimate themselves to the school environment.

Chapter 3: Methodology

Research Design

My research will be done in a qualitative design. To get the answers that I'm looking for I will be using systematic observations and secondary data. This data will come from agency guidelines for meeting clients during the pandemic, surveys conducted to evaluate services, and yearly published yearly reports. By using this type of secondary data, I will be able to map out the differences between the 2019-2020 school year and the 2020-2021 school year. The differences can then be analysed and used to describe and compare the effectiveness of services from the previous year.

Type of Study

This study will be a descriptive study done through observation. The researcher will take on the role of participant observer by taking an active part in the setting. The researcher will be working as a QMHS intern to build rapport and implement interventions. This study will describe how and why the Covid-19 pandemic is affecting mental health services and students access to those services.

Research Question

How has COVID-19 impacted access to mental health services as well as the way school-based mental health programs operate?

Variables of interest/Operational definitions of variables and units of analysis

Since I am conducting a qualitative study these sections do not apply and are not relevant. Though if I were conducting a quantitative study the independent variable would be the secondary data collected. The dependent variables would be the mental health services provided and the students access to them.

Measurement Instruments

Qualitative studies do not use measurement tools, only quantitative studies. I'll be gathering secondary data through the agency as well as using a standard form for systematic observation.

Trustworthiness and Credibility

Both sources of data are both trustworthy and credible and will help to ensure the rigor of my qualitative data. The secondary data gathered will give credibility to my observations making them trustworthy.

Hypothesis

I believe that COVID-19 will have a significant impact on the programs that the school uses. I also believe that those changes will significantly impact students access to mental health professionals and the services they provide.

Setting

I will be conducting my research out of the Child Focus, Inc. office within the West Clermont Middle School building. Child Focus is a non-profit agency with departments that work within several schools and out of its brick-and-mortar buildings. The professionals that work within the different schools, work with the students through referrals from the school's

counselors and/or parents. These professionals provide mental health interventions for students with anxiety, depression, ADHD, and other social, emotional, mood disorders. The school counselors and teachers have been hired by the West Clermont School District and their focus is to provide a safe, healthy environment for learning through evidence-based interventions.

Sampling Method

The sampling for this study is both convenience and purposive. Convenient because I will be using my own observations. Purposive because the secondary data I'm choosing to analyse fits the purpose of the study. My secondary data will be coming from published Child Focus material.

Protection of Human Subjects

Only myself and my research professor will have access to the raw data. The data will be used to develop a research paper, and infographics. All identifiable information of the sample will be redacted for the completed project. My field supervisor, my senior class, and a group of chosen professionals will see the final project. My findings could be misused if the results were considered in a more generalized way, and if confidentiality were to be breached.

Human Diversity Issues

West Clermont Middle School is in a primarily white, middle to lower class county. The students being referred will also be majority white with middle to lower class families and have some form of mental or social challenge. I will not be interviewing any of the students or staff for this project reducing any risk of direct harm or any knowledge beforehand who will be referred.

Data Collection Procedures/Schedule

Data collection will be done through systematic observation using a standard form. During the school year I will be taking notes and gathering the secondary data required for

filling out a standard form. The last quarter of the school year will be used to analyze the data collected and create a written report and infographics.

Data Analysis Plan

Data will be analysed to describe if there is a relationship between COVID-19 and students access to mental health services within the school. The secondary data and observations will be analysed and placed into four categories: Before Changes, Formal Changes, Observations, and Analysis. The changes will be analysed based on physical changes to the setting, program changes, referral/attendance changes. These changes and categories will then be developed into an infographic to provide a visual aid. Also included will be an infographic on the referral process.

Limitations of the Study

This study's results cannot be generalized to apply to the country or even from one state to the next. This study is limited to the researcher's observations and the secondary data collected for the convenience and the purpose of the study. This study also is limited by the time available to conduct the research and the knowledge of the researcher. There is also a limited amount of research available about mental health referral in a school setting, benefits and barriers to school-based counseling, and the effects of COVID-19 on adolescents' mental health.

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Chapter 4: Findings

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Table 1

Changes to School-based Mental Health Services Due to COVID-19					
	Before COVID-19	**Formal Changes**	**Observations**	**Analysis**	**Themes**

Physical Attributes					
	Group and Individual Games	Use of hand sanitizer.	Frequent use of hand sanitizer and masks.	QMHS and school staff have done their part to keep the school safe for students through the use of sanitizing for both hard and soft surfaces as well as hands.	Delay in meeting and scheduling students.
	Group and Individual Crafts	Masks Required	Class Schedules were changed to prevent students from cluttering in the halls.		Less efficiency in treatment
	Toys/fidgets available in common areas and providers offices	Frequent Sanitization of hard surfaces and games/ fidgets/shared tools	Instead of limiting or sanitizing the games/crafts/ fidgets/shared tools, QMHS providers put them away and out of use from August 2020 to February 2021 when new QMHS providers were hired.	Not using games/crafts/fidgets/ and shared tools while helping to keep COVID from spreading also makes it more difficult to provide effective interventions.	
	Physical Activities	Closed waiting area/ limited number of people in the building		By not holding groups the QMHS providers and school counselors have not been able to reach the number of students they would normally be able to reach.	
	Waiting Area	No groups larger than 10 in a space large enough to keep social distancing of 6ft.	Instead of limiting the number of students in groups, the QMHS cancelled all groups.		
	Groups consisting of students and staff of up to 15.	Limited use of games/crafts and shared tools	In February of 2021 Child Focus hired two new QMHS, who brought out the games, crafts, fidgets, and shared tools for use in their offices.	By the former QMHS providers leaving and new ones being hired there was a delay in services reaching a portion of prevention students.	
	Shared tools for treatment	Fidgets can be made by staff and given away.		The new QMHS providers coming in have allowed for Child Focus to begin catching up on the prevention/case management cases left behind.	
				The new QMHS providers reimplementing use of games/crafts/fidgets/and shared tools allows for services and programs to become more effective.	

| Referral and Attendance Procedures | Referrals from school counselors on behalf of teachers, parents, peers, self-report

Referrals through suicide screening programs in classroom and group settings

Telehealth on case-by-case terms

Walk-ins acceptable

Students called down to the office | Appointments by schedule only.

Providers walk students to and from their sessions.

Telehealth is more acceptable for all cases. | At the beginning of the school year teachers and students were told by school counselors that for students to see them or Child Focus the students would need to first make an appointment through Schoology and go through the counselor's office first.

School attendance has been a problem due to the school districts use of an optional virtual learning platform.

Telehealth has been both helpful and challenging due to technical difficulties and attendance issues.

Changes in class schedules and times of when we can pull students limits the number of students that can be pulled in a day. | Councilors and QMHS providers have not been able to create the rapport needed to gain the trust of a portion of the students due to infrequent and erratic sessions for prevention, limiting access to services.

Because of the infrequent and erratic sessions for prevention there has been more delay between referral and case management, limiting access to services.

The threat of COVID-19 and the school's response to students feeling ill has led to many absences from school and sessions, limiting access to services.

The chrome books that students use for schools may be the only access they have to services when attending class virtually, these chrome books do not support the telehealth software Child Focus uses, limiting access to services. | Limited access to students.

Difficulty in reaching target productivity. |

Programs and Services	SOS – a school wide program for suicide screening	SOS was cancelled for the school year.	Cancelling SOS and Hope Squad activities eliminates some of the ways that the school screens for students in crisis and need referrals.	By cancelling programs such as SOS and limiting the activities of Hope Squad the school has limited the number of referrals for prevention through suicide and mental health screening.	Limited accesses to students
	Hope Squad – Peer group raising awareness for mental health.	Hope Squad cancelled/ adapted their program for the year.	QMHS providers eliminating subject specific small groups have hindered the ability to reach the amount of prevention/case management students they could have reached.	By eliminating subject specific small groups, the former QMHS providers limited the number of students they were able to see effectively limiting the number of students receiving services.	Difficulty in reaching target productivity.
	Case Management - Weekly, bi-weekly, or monthly sessions	Subject Specific Groups were cancelled/ adapted for the school year.		New QMHS providers have started planning for small groups over the summer and to start next year.	
	Subject Specific Groups – groups for anxiety, depression, social skills, etc.				
	Prevention - three to six sessions to address concerns from referrals				

The table above describes the formal and informal changes made to the programs provided by both the middle school and Child Focus, inc. as well as the observations I made while working as an intern. Lastly, I describe how this has impacted the way these programs and services operate and reach the students they are trying to help.

To answer the question and assumptions described, COVID-19 has impacted school-based mental health in several ways. Physical changes are the most notable and visible. Those that challenge services the most are the ones that limit numbers of people in a certain space, needing social distancing, closing waiting rooms, limiting use of treatment tools and the changing of class schedules. These changes make it difficult for mental health providers to see the number of students they would see in a pre-COVID school year. Before COVID small

groups could be seen in the amount of twelve to fifteen students and with current guidelines groups are limited to no more than 10 students in a space that can keep the students socially distanced to six feet apart. Along with limiting the number of students in a group, the way the school has changed class schedules to keep less people in the halls at one time makes it difficult for providers to pull students from class for their sessions. Teachers and counselors want providers to pull students during their specials and teacher planning times. This leaves providers either pulling their students only a couple hours a day, risking not reaching productivity with Child Focus, or getting negative feedback from teachers for pulling students during educational periods. On a more case by case nature the limited use of treatment tools such as fidgets, games, and craft utensils makes progress difficult for some students who respond better with those tools. In all, the school and Child Focus have done their best to provide a safe physical environment for the students involved in programs and services.

These physical changes have led to a less visible change in the area of referral and attendance procedures for meeting with students. With waiting rooms closed, students are able to come into the office as walk-ins as they would have before COVID. Students until recently were being escorted to and from sessions, taking time away from providers to see as many students as they would have. Due to the use of pre-recorded messages, there has been less in-person interaction between students and their counselors. This has decreased the number of students reaching out to the counselor for assistance. And telehealth has been helpful as well as challenging. Pre-COVID telehealth services were used on a case-by-case basis for those who needed it the most. When COVID became a pandemic and offices/schools closed, telehealth became more widely accepted and used for all who wanted the service. Telehealth can be helpful in that it gives those students who are learning virtually the ability to still receive and attend sessions. Telehealth is also challenging in a few ways.

The most noticeable and the hardest to fix is that the computers assigned to students by the school are not compatible with the secure software used by Child Focus. This means that some students who are learning virtually but need services are not receiving them. Another challenge is that not all students have the availability to the internet and makes reaching them difficult. There are also parents who work and leave their students to navigate their school days at home. This cuts down on the number of students who attend sessions because they forget or choose not to attend. Overall, the process for making referrals has not changed, students, peers, parents, and teachers can all reach out to a counselor for a referral to see Child Focus. The biggest change has been when the referral is initiated, and students start to receive services.

Lastly, many of the programs provided by the school and Child Focus have changed or cancelled for the 2020-2021 school year. The programs/services that have been cancelled by either the school or the Child Focus providers were SOS and subject specific small groups. SOS is a program provided by the school to screen for students with suicidal ideation. It is provided by the school counselors with the assistance of Child Focus providers. Subject specific small groups are provided by both the school and Child Focus and cover common challenges students face such as anxiety, depression, and social skills. Having cancelled these programs, the less students were seen. The services changed but not cancelled included Hope Squad, Case management, and Prevention. Hope Squad is a peer run program provided by the school. Many of the social activities they would normally do were cancelled but some that could be done in a socially distanced way continued. Case management and Prevention are programs provided by Child Focus and those changed in more physical ways as well as escorting students to and from sessions.

To conclude, all the changes and cancelations made to programs/services provided during the 2020-2021 school year influenced the students' access to providers and

interventions. These changes made seeing the students and implementing interventions difficult. On the other hand, these changes also helped to provide a safe environment for learning and allowed providers to reach the students they could.

Chapter 5: Discussion

The COVID-19 pandemic has hit our country hard for more than a year, affecting people of all ages. Much of the research that has been done until now has been focused on the economy, medical health care, and vaccine production. In March of 2020, the decision to close all schools and many other public buildings was made. In July of 2020 schools were building their plans to reopen either in-person, virtually, or both. One of the areas that professionals in the mental health field were concerned about is what were school-based mental health services going to look like. How can they keep everyone safe and still provide quality services?

This is where my concern was as well. I had been hearing about plans for different school districts and how they were going to provide quality education to their students. What I wasn't hearing was anything about how mental health services and programs were going to operate within this new way of providing quality education. Going into my internship with Child Focus, Inc. I wanted to know and understand the depth of the changes that were being made and how those changes impacted students access to programs and services.

My initial method for this study was to gather new data from teachers, counselors and mental health professionals at the school. I was going to do this through an emailed survey. When I never received any of the surveys back, I had to switch my methods. I decided that the best way to complete the project was through a systematic observational study. This meant using what I had seen while providing services as well as using secondary data.

This type of study does not have the depth that I desired when starting the project. I was unable to gather new first-hand data from those people with experience before and

during the pandemic. My experience is limited to how the programs and services operated while I was there and the secondary data, I was able to gather from Child Focus regarding telehealth services, and published guidelines provided. This study is also limited by the time that I had to be present. My internship consisted of working twice a week from August to April with a six-week winter break between December and January Another limitation to the study is that it cannot be generalized. These are one person's observations from one school in an agency that provides mental health services to schools in nine counties as well as family therapy and in office therapy services. Without further study in other schools these observations are too specific to reflect the agency's ability to provide quality services.

What can be said is that for this school, there were changes to and cancelations of programs and services that impacted students access to quality mental health services. The elimination of the SOS program and subject specific groups changed how effectively referrals were made and followed through with and the elimination of using treatment tools made providers less effective in their ability to provide services.

The results of this study are congruent with what we already know about providing school-based mental health services. Through the pandemic, systems theory and strengths perspective was still crucial in reaching students for referrals and providing services. Teachers, counselors, mental health professionals, and parents were still needed for collaboration and making the changes work to the best of their ability. Providers needed to understand the strengths and work with the students from their perspective to provide adequate services.

The referral process did not change on paper. The way students were to reach services was still through their counselors. The ability to reach their counselors became more difficult for them. This slowed down the process significantly, limiting the number of students who were able to receive services. And the benefits and barriers to services remained the same.

Reaching parents for collaboration is difficult in a normal year, reaching parents during a pandemic who are being challenged by added stressors is even more difficult. School counselors and teachers were trying to keep the classes running as normal as possible while still trying to make sure students received the mental health services they needed. On the other hand, those students who were able to receive services from Child Focus saw the benefits of having school-based mental health services. These benefits include early interventions for suicidal ideation and targeted behaviors that affect school performance.

The findings from this study show that during a pandemic and other times of worldwide stress changes will be made from necessity. Schools will close, programs will be cancelled but what doesn't change is the mental health professional's motivation and determination to provide adequate care to the students they see in a school setting. The finding also brings to light that every mental health professional is an individual with different motivations and goals. The QMHS for the first half of the year made the decision not to use shared treatment tools which may have had some effect on the quality of interventions used. The QMHS of the second half of the school year made the decision to reinstate the use of these tools, to redecorate the space, and made the service areas more inviting in hopes of providing the best services possible.

The field of social work is continuously advancing but there have been few pandemics in its history. COVID-19 has given the field a challenge that, as always, the field is rising to meet head on. The biggest change that has happened for the field of social work during this pandemic is the use of telehealth services. Social Workers and other mental health professionals have had to adapt how they reach their clients where they are. That has meant learning new technologies that give access to services while being socially distanced. Telehealth has been the way to do that. Either over a video call or just a telephone, providers can reach their clients to carry out sessions. Telehealth does not come without its

complications. Mainly the need for an internet connection where some people aren't
financially stable enough to get internet and not all secure telehealth services work on every
computer. Telehealth also has unique complications for working with youth. Unlike in-person
sessions the parent is not always available to help the youth remember their appointments for
telehealth. Maybe the parent believes the youth is trustworthy enough to attend without a
reminder or maybe the parent is busy elsewhere and is unable to be the needed reminder.
Attendance is less predictable with telehealth than it is with in-person sessions. Privacy is
also a consideration for telehealth and youth. It is more difficult to maintain confidentiality
and privacy during telehealth sessions. Parents, grandparents, friends, neighbors, etc. could
walk through the session or listen in.

For policy, the biggest change is also in telehealth. There are questions that need to be
answered and thought about. Telehealth may give providers reach across the country. Though
now providers are only able to provide services in the state they are licensed. Leaving the
question of should a social workers license be official in all states or just the one they take the
exam in. On the mezzo level the question is, should agencies provide telehealth for everyone
or just those they feel is necessary.

For continuing research into COVID-19 and school-based services I believe it would
be beneficial for studies to focus on the long-term changes that are sure to come of the
pandemic. As vaccines are becoming available, social distancing becomes less necessary and
mask mandates are removed, how likely is it the programs and services will go back to
"normal". What is going to be permanently changed and what are the long term effects of the
pandemic on youth who need mental health services from school-based services.

Overall, this study has been important to the field of social work, school-based mental
health, and the agencies that provide the services. COVID-19 has been a new challenge for
the country and the world. It is important to understand how the pandemic has affected

students' abilities to access needed services as well as how providers have responded to the

challenge.

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