School-based mental health supports during COVID-19: School professional perspectives

Marisa E. Marraccini[1] | Megan K. R. Griffard[1,2] | Cason E. Whitcomb[3] | Caitlin Wood[1] | Dana C. Griffin[1] | Cari Pittleman[1] | Lauren Sartain[1]

[1]School of Education, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, USA

[2]College of Education, University of Nevada, Las Vegas, Nevada, USA

[3]Gillings School of Public Health, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, USA

Correspondence
Marisa E. Marraccini, School of Education, University of North Carolina at Chapel Hill, Chapel Hill, NC, USA.
Email: mmarracc@unc.edu

Funding information
National Center for Advancing Translational Sciences; Society for Study of School Psychology; National Institutes of Health, Grant/Award Number: UL1TR002489; National Institute of Mental Health, Grant/Award Numbers: K23MH122775, L30MH117655; North Carolina Collaboratory at University of North Carolina at Chapel Hill through an appropriation made by the North Carolina General Assembly

Abstract

The present study explored the ways school professionals adapted school-based mental health supports and services for remote delivery during the coronavirus disease 2019 (COVID-19) pandemic. We surveyed 81 school professionals (e.g., counselors, psychologists, and social workers) and conducted in-depth interviews with a subsample of professionals (n = 14) to explore their perceptions and experiences of supporting youth with mental health concerns and suicide-related risk during the fall and winter of the 2020–2021 school year. Commonly endorsed school-based mental health interventions (e.g., counseling services and checking in), ways of communicating (phone and email), and individuals delivering support and services to students with suicide-related risk (e.g., counselors and teachers) were identified based on school professional survey responses. Qualitative findings point to facilitators (e.g., specific platforms for connecting with students and families) and barriers (e.g., limited communication) to successful service delivery during COVID-19. Findings highlight the creative ways school support professionals adapted to provide school-based mental health supports. Implications for remote school-based mental health services during and following the pandemic are discussed.

KEYWORDS
COVID-19, school professional, school-based mental health, suicide prevention

1 | INTRODUCTION

Researchers have raised concerns that the practice of physical distancing to reduce the spread of coronavirus disease 2019 (COVID-19) could increase mental health concerns and suicide-related risk in youth (Hertz & Barrios, 2020; Reger et al., 2020). Barriers to accessing treatment (e.g., school closures) and disruptions of social connections (e.g., relationships outside of the home) are among some of the key risk factors that could have been heightened during COVID-19 due to social distancing and school closure (Hertz & Barrios, 2020). Mental health care for adolescents with psychiatric disorders is commonly provided in schools (Costello et al., 2014), with the shift to distance learning disrupting or altering provision of these services. Physical distancing also left fewer opportunities for youth to connect with peers or adults outside of their families, with multiple efforts aimed at identifying and implementing mechanisms for improving feelings of connectedness during distance learning (e.g., Aspen Institute, 2020). The potential for school-based services adapted to remote and hybrid approaches remain a critical mechanism for linking at-risk youth to care during COVID-19. Understanding facilitators and barriers to remote service adaptions could inform school-based mental health interventions delivered to youth during times of school disruption in the future.

Scholars have provided guidance for school-based approaches to support youth mental health based on best practice established before COVID-19. For example, resources provided by the National Association of School Psychologists (NASP) outline implementation strategies for curriculum-based suicide prevention programs, staff in-service trainings, and direct and indirect mental and behavioral health services, as well as the importance of collaboration between school professionals (Brock & Lieberman, 2020; Clyne et al., 2020). These guidelines were essential for practicing professionals to quickly adapt to providing supports and services during COVID-19; however, there is limited insight into the practical application of these guidelines that acknowledge the barriers and facilitators faced by school-based mental health professionals delivering services during remote learning.

One of the only studies to explore mental health practices of school professionals during COVID-19 examined the experiences of over 900 psychologists working in schools across multiple countries (United States, Germany, Canada, and Australia; Reupert et al., 2021). Reupert et al. (2021) identified services delivered by school psychologists (e.g., telehealth, mailings, videos, and virtual databases) during COVID-19 in support of social-emotional, behavioral, and academic support. The researchers called for training and resources for school professionals providing mental health services to their communities during times of school closure, as well as qualitative research that addresses barriers to these practices (Reupert et al., 2021). The present study adds to this literature by presenting school professional experiences and perceptions of providing school-based mental health services to adolescents during COVID-19. In addition to exploring barriers and facilitators to these practices, findings from this study enhance existing literature by addressing some of the unique considerations required for delivering school-based supports and services to youth with suicide-related risk.

1.1 | Mental health concerns before and during the pandemic

Rates of adolescent depression and anxiety increased over the decade before COVID-19. Based on data collected by the National Survey on Drug Use and Health, estimates of adolescent depression increased from 8.1% in 2009 to 15.8% in 2019, showing an even greater increase among adolescent girls (Daly, 2022). Parodi et al. (2022) examined data from a large midwestern county in the United States, including more than 37,000 students, and reported a significant increase in clinically significant anxiety symptoms from 2012 (34%) to 2018 (44%). Rates of suicide-related thoughts and behaviors also increased during this time (CDC, 2019). Based on data collected as part of the national Youth Risk Behavior Surveillance System (YRBSS), 18.8% of adolescents reported seriously considering attempting suicide, and 8.9% reported having attempted suicide in 2019, compared to 13.8% and 6.3% in 2009 (CDC, 2019).

Research conducted since the start of the pandemic suggests that the prevalence of clinical levels of anxiety and depressive symptoms have continued to rise among youth across the globe, especially for older, adolescent girls and during later stages of the pandemic (Luthar et al., 2021; Racine et al., 2021). Murata et al. (2021) found that among 583 adolescents, a substantial number scored in the clinical range for depression (55%), anxiety (48%), and posttraumatic stress disorder (PTSD; 45%), and 37% reported suicidal ideation. Although predictors of these symptoms varied by outcome, loneliness was identified as a significant predictor for all outcomes (yielding moderate effects), and history of suicide-related thoughts and behaviors was significantly related to ongoing concerns for suicide during the pandemic (demonstrating moderate effects). Estimates of suicide-related thoughts and behaviors collected by the YRBSS since COVID-19 have not been released, but increased concerns for depression and suicide-related risk were identified in pediatric primary care settings for adolescent girls during the pandemic (Mayne et al., 2021) and rates of hospitalization for a suspected suicide attempt were significantly higher in the winter of 2021 compared to the previous year (Yard et al., 2021).

1.2 | School-based mental health services and supports during COVID-19

Schools are a primary referral system for acute treatment of psychiatric concerns (Crepeau-Hobson, 2013; Soto et al., 2009) and considered one of the de facto mechanisms for treatment of youth with psychiatric concerns (Costello et al., 2014). School-based mental health services and supports may include upstream approaches to supporting mental health, such as social and emotional learning (SEL; Maras et al., 2015); counseling or regular check-ins with students (Whiston et al., 2011); universal mental health screenings (Dowdy et al., 2015); comprehensive suicide prevention programs (Katz et al., 2013); and referrals for community care (Pearlman et al., 2018). Schools can also play a protective role by helping youth develop close relationships with adults and fostering feelings of connectedness to school. School connectedness, or the sense that individuals in the school community care about students (Waters & Cross, 2010), has been found to correlate with lower rates of many co-occurring health risks, including substance use, mental health problems, violence, and sexual health (Rose et al., 2022).

During COVID-19, researchers called for school-community partnerships to support delivery of SEL and foster a sense of connectedness (Hertz & Barrios, 2020). NASP (2020) provided guidance on how best to shift services during remote schooling, including several considerations for adapting mental health prevention and intervention for telecommunication. Telecommunication and telehealth may bring multiple challenges, such as physical safety (e.g., knowing student location and having adults nearby), limited privacy (family members may be present during meetings), and barriers to resources (for youth in foster care, facing homelessness, and living in rural areas, access to internet or computer may be limited; NASP, 2020). Therefore, NASP recommends beginning each session by asking students to identify their location and share whether they have access to caregivers. Schools should also maintain clearly established procedures and protocols for connecting students to care during regular and off hours (NASP, 2020). Note, however, that telecommunication and telehealth also provided opportunities to enhance care, including helpful apps (e.g., Virtual Hope Box) aimed at supporting youth in crisis through the development of safety plans (NASP, 2020).

1.3 | School-based telehealth and telecommunication after COVID-19

Several studies have explored telehealth for addressing child and adolescent mental health disorders, such as depression and obsessive-compulsive disorder (Holland et al., 2021). Telehealth delivered in school has demonstrated preliminary support for the treatment of health disorders (e.g., speech and language impairments, asthma, and diabetes; Sanchez et al., 2019); however, limited research has explored school-based telehealth for mental health concerns specifically (Holland et al., 2021; Rojas et al., 2020). Yet, telehealth services were a fundamental mechanism

for meeting the social, emotional, and behavioral needs of students during the pandemic (Ward et al., 2022). Telehealth was also instrumental in meeting the physical and mental health needs of those affected by previous natural disasters and infectious pandemics, such as hurricanes (Harvey and Irma), droughts and bushfires (in Australia), and Severe Acute Respiratory Syndrome (SARS) pandemic in China (Smith et al., 2020). Thus, there is a need for schools and other systems of care to employ proactive approaches that prepare to engage in telehealth and telecommunication in anticipation of future infectious pandemics and natural disasters (Smith et al., 2020).

Telehealth and telecommunication may also be a promising approach for addressing the expected increase in student behavioral and mental health needs following COVID-19 (Centers for Medicare & Medicaid Services, 2020), supporting students even after schools have returned to in person (Goddard et al., 2021). For example, although larger, urban schools appear more likely to have in-person school-based health centers, smaller schools are less likely to have the infrastructure to support such services, making telehealth a promising longer-term solution (North, 2020). As schools move towards these creative approaches for supporting student mental health, they also must prepare to address the barriers and limitations of telehealth and telecommunication (e.g., limited broadband accessibility in rural areas; Golberstein et al., 2021).

2 | THE CURRENT STUDY

Considering the significant role schools play regarding delivery and linkage to mental health care (Hertz & Barrios, 2020; Reger et al., 2020), a deeper understanding of the remote school-based mental health supports and services provided during COVID-19 may help inform improvements to school-based telehealth and telecommunication practices. Much of the work addressing school-based telehealth and telecommunication has focused on behavioral health services in the school setting (e.g., a provider engaging in a therapy session; Ward et al., 2022). However, telecommunication practices of school professionals (e.g., school counselors, school psychologists), who work within the school environment and support students throughout the day, may require considerations unique to their roles. Therefore, this study explored school professionals' perceptions of and experiences with providing remote school-based mental health supports in the winter of 2020 and 2021 to adolescents during COVID-19. Specific study aims were to: (1) identify and describe the types of mental health supports and services delivered by school professionals; and (2) qualitatively explore school professional perceptions of facilitators and barriers to delivering school-based mental health services during remote learning.

Although many schools have since returned to in-person learning, policies and procedures regarding COVID-19 and schooling continue to evolve. Indeed, Reupert et al. (2021) underscored the need to ensure that school psychologists (and other school-based support professionals) have the skills and resources to support their communities during times of school closure, indicating a need for qualitative research that addresses barriers to these practices. Moreover, American School Counselor Association (ASCA) provided a position statement in 2017 on remote school counseling practices, explaining that school counselors "have the responsibility to provide a school counseling program and develop programs to support all students in academic, career and social/emotional development that would emulate school counseling that would take place in a face-to-face environment." Therefore, this study aims to contribute insight into practices for supporting youth with mental health concerns during times of school displacement—including virtual schooling that may or may not be due to physical distancing procedures (such as state-funded virtual educational programs; ASCA, 2017), as well as future infectious pandemics and natural disasters.

3 | METHODS

This study presents survey data collected from school professionals ($n = 81$) and in-depth interviews conducted with a subset of these school professionals ($n = 14$). School professionals were recruited to complete online surveys in one southeastern state of the US during the fall and winter of the 2020–2021 school year. Professionals were

invited to participate by way of state listservs and professional groups (e.g., state associations and alumni groups) selected to represent school mental health support professionals (e.g., school counselors, school psychologists, school social workers, and school nurses). Additionally, districts that had previously collaborated with the researchers (k = 23) were contacted to request permission to share the survey invitation with eligible staff, seven of which responded (two declined and five agreed). Professionals within approved school districts (k = 5) were also invited to participate.

A total of 104 school professionals completed online consent procedures, of whom 102 clicked on the link to begin the survey. A total of 81 participants completed questions related to the primary study aims and are included in this study (79.4% completion rate). Following survey completion, participants could provide an email address to receive a gift card (if allowable by participating districts). During survey consent procedures, participants were also asked if they were interested in completing an in-depth interview about their experiences. A total of 14 participants were recruited to complete interview procedures, with the final sample size guided by assessments of data saturation. Procedures were approved by the Institutional Review Board and consent procedures were completed online.

3.1 | Participants

Eligibility criteria for participation included working as a middle or high school support professional in one southeastern state in the US and experience with supporting adolescents with suicide-related risk. Participant demographic and school characteristics are shown in Table 1. Majority of participants completing the survey and participating in interviews identified as White, school counselors. Note that school counselors have been identified as among the most common professional involved in school-based suicide-related services (Marraccini et al., 2019).

3.2 | Instrumentation

3.2.1 | Survey

Participants completed a researcher-designed survey addressing school-based mental health service delivery during COVID-19, as well as other questionnaires addressing mental health (e.g., depression and bullying experiences; not included in the current analysis). Participants were first asked whether their district was providing learning in-person, remotely, or with a hybrid (both in-person and remote) model; participants were then directed to think about their experiences of providing services remotely for the remainder of the survey. A reminder to consider remote delivery was provided at the start of each subsection of the survey.

Although the researcher-designed survey included questions that elicited responses about a range of services (including academic and social-emotional interventions), for the current study we focused on subsections of the survey that addressed school-based mental health service delivery and included both descriptive and qualitative data. Descriptive sections included in the current study addressed: (a) the types of services and supports professionals were providing to students with mental health concerns during remote learning, as well as their perceived helpfulness for student mental health; (b) the ways school professionals communicated with students and families, as well as the frequency of these communications; and (c) the individuals providing services to students with mental health concerns. A dropdown list of specific services and supports (e.g., one-on-one counseling, SEL), methods of communication (e.g., email and video conferencing), and school professionals (e.g., teacher and counselor) was provided; participants could also select "other" and describe the specific service, method or individual. Perceived helpfulness for student mental health while schools were operating remotely included response options on a scale from 1 (*not at all helpful*) to 4 (*very helpful*), with an additional option of "*I don't know how*

TABLE 1 Participant demographics and school characteristics.

	Survey participants ($n = 81$)		Interview participants ($n = 14$)	
	N	%	*N*	%
School level				
Secondary (grades 6–12)	6	7.4	2	14.3
Middle (grades 6–8)	32	39.5	9	64.3
High (grades 9–12)	31	38.3	3	21.4
Other	12	14.8		
School rurality/urbanicity				
Rural	44	54.3	7	50.0
Suburban	26	32.1	6	42.8
Urban	11	13.6	1	7.1
School service delivery				
Hybrid (combination of remote and in-person)	48	59.3	5	35.7
Remote only	29	35.8	9	64.3
In-person only	4	4.9	0	0
Sex				
Female	75	92.6	13	93.0
Male	6	7.4	1	7.0
Race				
American Indian	3	3.7	0	0
Asian	1	1.2	0	0
Black or African American	6	7.4	1	7.0
White	70	86.4	13	93.0
Ethnicity				
Hispanic/Latinx	1	1.2	0	0
Non-Hispanic/non-Latinx	79	97.5	14	100
Profession				
School counselor	56	69.1	9	64.2
School psychologist	5	6.2	2	14.3
Social worker	6	7.4	3	21.4
School nurse	5	6.2	0	0
Teacher	1	1.2	0	0
Other	7	8.6	1	7.1

Note. One interviewee identified as working as both a school counselor and a social worker.

helpful it was." Response options for frequency of communication ranged from 0 (*never*) to 5 (*multiple times per day*). Aspects of the survey, such as the specific response options for services and supports, were adapted from a survey developed by the primary author (see Marraccini et al., 2019) to align with service options during remote schooling.

Three open-ended questions that generated qualitative data were also included in the present study. These questions asked: "In thinking about providing school-based remote mental health supports to students, what has worked well?", "What barriers have you encountered related to providing mental health support to students while schools are operating remotely?", and "Thinking about how schools can best support students who may be struggling with suicidal thoughts and behaviors during this time, what else should we know?".

3.2.2 | In-depth interviews

In-depth interviews followed a semi-structure format to address three areas: (1) school experiences (e.g., school connectedness, school influences of suicide-related thoughts and behaviors, and school services and supports) before COVID-19; (2) school experiences during remote learning due to COVID-19 (e.g., school interactions, school connections, school supports, and services); and (3) recommendations for school-based mental health services during periods of extended closure (e.g., recommendations, facilitators, and barriers). For the present study, themes from the third section (recommendations) were analyzed to better understand facilitators and barriers to supporting youth with mental health concerns generally, and youth with suicide-related thoughts and behaviors specifically, and also to identify recommendations during times of school displacement. Interviews were conducted by trained masters' and doctoral-level students who completed debrief summaries following each interview to monitor data saturation.

3.3 | Data analyses

To expand understanding of the mental health supports and services delivered by school professionals (Aim 1), we calculated descriptive statistics using Microsoft Excel (2020). Open-ended written responses and transcriptions of in-depth interviews (Aim 2) were analyzed qualitatively. To analyze open-ended written responses part of the survey, we used content analysis, which is a systematic and replicable method for segmenting text into content categories (Stemler, 2000). First, the primary author read through responses to develop a coding structure based on emergent themes. Second, the primary author trained the third and fourth authors to apply themes to text responses from separate open-ended questions. A minimum of two authors read text responses and identified themes separately, meeting to come to consensus. Final codes were identified and summarized, with illustrative quotes selected to showcase common themes.

To analyze transcribed in-depth interviews, we used applied thematic analysis, which is a systematic and inductive approach to qualitative analysis that draw from multiple theoretical orientations including basic inductive thematic analysis, grounded theory, and phenomenology (Guest et al., 2012). In-depth interviews were transcribed verbatim and redacted of identifying information. The coding structure was first developed based on the interview questions, then iteratively refined throughout the coding process. The second and third authors read transcripts, identifying emergent themes separately and meeting regularly to come to consensus. The final codes were entered into NVivo (QSR International Pty Ltd., 2020) for analysis.

3.3.1 | Data integration

Content analysis of open-ended text responses was conducted by the primary, third and fourth author. Applied thematic analysis of interview transcriptions was conducted by the second and third author. Although analyses of

open-ended text responses and interview transcriptions were conducted separately, the themes emerging from the in-depth interview transcriptions that related to facilitators, barriers, and recommendations were selected to augment comparable questions in the survey about facilitators, barriers, and other information to consider for supporting students with suicide-related risk during COVID-19. Following completion of content and applied thematic analysis, the first author applied emergent themes from the content analysis in each of the three areas (facilitators, barriers, other information) to the broad themes of facilitators, barriers, and recommendations that emerged from applied thematic analysis.

4 | RESULTS

4.1 | Aim 1

4.1.1 | Services and supports

As shown in Table 2, participants identified the types of services and support provided to their students for mental health concerns during remote learning and rated their perceptions of how helpful each intervention was for supporting student mental health. Commonly identified interventions included reaching out to check in (87.5%) and providing one-on-one counseling (80.2%). One-on-one counseling and check-in/check-out were rated as the most helpful (53.8% and 47.7% endorsed them as *very helpful*, respectively), while support of time-management and SEL were rated as the least helpful (23.4% and 20.3% endorsed them as *very helpful*, respectively). Participants also identified the school professionals involved in providing supports and services to students with mental health concerns during COVID-19, with teachers (80.2%), school counselors (79.0%), and social workers (71.6%) among the most commonly identified.

4.1.2 | Communication

The ways in which school professionals described keeping in touch with students and families, as well as the frequency of communication, are displayed in Table 3. All participants (100%) described calling students and families, and most (95.1%) reported emailing them. Methods identified outside of those listed on the survey (indicated by a selection of "other") included online platforms/apps (n = 6), social media (n = 3), home-visits (n = 7), virtual office (n = 1), mail (n = 1), church (n = 1), and face to face meetings (n = 1). The most frequently used methods were email (69.7% using email sent them multiple times per day) and phone calls (58.0% using phone calls indicated calling multiple times per day).

4.2 | Aim 2

Themes are presented separately for each of the three areas that addressed (a) facilitators and (b) barriers to school-based mental health services for youth, as well as (c) other important information and recommendations regarding school supports for adolescents with suicide-related thoughts and behaviors during distance learning. Although content analyses and applied thematic analyses were conducted separately (as described previously), themes from open-ended text responses and from in-depth interviews are presented together.

TABLE 2 Supports and services delivered remotely and their perceived helpfulness.

Supports and Services	Total		Very helpful		Moderately helpful		Somewhat helpful		Not at all helpful		I don't know	
	N	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%
Reaching out to check in	79	87.5	35	44.3	31	39.2	11	13.9	0	0	2	2.5
One-on-one counseling	65	80.2	35	53.8	17	26.2	13	20.0	0	0	0	0
Social-emotional learning	60	74.1	12	20.3	30	50.8	12	20.3	1	1.7	4	6.8
Support with time management/assignment make-up	47	58.0	11	23.4	25	53.2	10	21.3	0	0	1	2.1
Check In/Check Out (e.g. student checks in regularly with you)	44	54.3	21	47.7	15	34.1	7	15.9	0	0	0	0

TABLE 3 Methods of reaching out to students and families and frequency of communication.

Supports and Services	Total		Once per month or less		Once per week		A few times per week		Once per day		Multiple times per day	
	N	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%
Phone calls	81	100	3	3.7	9	11.1	15	18.5	6	7.4	47	58.0
Email	77	95.1	5	6.6	6	7.9	8	10.5	4	5.3	53	69.7
Video conferencing (individual)	67	82.7	5	7.5	15	22.4	28	41.8	6	9.0	13	19.4
Text messaging	53	65.4	6	11.3	8	15.1	21	39.6	4	7.5	14	26.4
Video conferencing (group/class)	33	40.7	14	42.4	10	30.3	4	12.1	1	3.0	4	12.1
Discussion boards	18	22.2	5	27.8	4	22.2	5	27.8	3	16.7	1	5.6
Other	15	18.5	2	15.4	3	23.1	6	46.2	1	7.7	1	7.7

4.2.1 | Facilitators

As displayed in Table 4, facilitators identified by school professional survey respondents were coded into six primary themes: (1) specific platforms they used to deliver interventions or contact with students and families, (2) communication with students and/or families, (3) specific interventions delivered to students and/or families, including counseling services, (4) collaborating with other professionals or students and families, (5) linking youth to care, and (6) other. Themes emerging from in-depth interviews also fell within the same six areas and are presented alongside findings from the content analysis.

4.3 | Platforms

Specific platforms identified by survey respondents ($n = 44$) included not only virtual tools, but also an endorsement of the importance of using multiple methods for communicating and connecting with students and families (e.g., Google Meet, phone/text, home-visits, multiple methods). Interviewees ($n = 4$) also identified platforms they found helpful, including school websites for providing information and resources, connecting with students via text messaging, and using electronic scheduling systems facilitating parent and student meetings, which one interviewee described as supporting increased autonomy for students when help-seeking.

4.4 | Communication

Multiple survey respondents ($n = 42$) expressed the importance of ongoing communication and check-ins with youth and families, with one participant writing "more intense one-on-one counseling is difficult but often just a simple check in once a week has been helpful." Although most ($n = 35$) specifically mentioned communicating with students, some ($n = 10$) also described the importance of communicating with families. Interviewees ($n = 3$) expanded on some of these ideas, underscoring the importance of sharing contact information frequently with students and families and the significance of having persistence when reaching out, with one explaining "we just don't stop trying." Additionally, two interviewees emphasized how conveying a message of support, and validating student concerns, helped them continue to support struggling students.

TABLE 4 Facilitators to providing school-based remote mental health supports to students.

Theme	*N*	Definition	Illustrative quote
Platform	44	A tool or system for intervention, communication, or connection (e.g., home visits, virtual platform, phone calls)	Being able to have different methods to contact students, email, phone, and video conferencing has worked well for the most part. Some students have enjoyed being able to video conference, even if they don't turn their camera on they still had direct access to me.
Communication	42	Communication or check-ins with students and/or families	Calling students and their parents. Emails are not sufficient as they can be ignored, but a phone call with the ability to conversate is valuable.
Interventions	27	Specific screenings or interventions delivered to students or families	Transportation is a huge issue for our student's and families. Remote Mental Health has reduced the barrier to transportation. Our students have laptops provided by the school and if needed a hotspot.
Collaboration	7	Descriptions of collaborations between school professionals or other school community members (e.g., parents)	Giving the benefit of the doubt in every situation and extending grace frequently and generously. Coordinating with the school social worker to address basic needs and providing community-based resources to meet those needs. Showing compassion first, before the demands of the curriculum.
Linkages to care	6	Linking or connecting students and/or families to care, including referrals for additional interventions or screenings, as well as community resources	... Coordinating with the school social worker to address basic needs and providing community-based resources to meet those needs....
Other facilitators	29	Any other facilitator not captured in previous themes, including wrap-around services provided within school, importance of having a previous relationship with students before the pandemic, and increased time and/or flexibility	We've been able to address issues much more quickly. In a normal face to face setting, time management is more difficult. In the remote setting, counselors have been able to be more efficient and check off to-do lists allowing more immediate action when there are student concerns.

4.5 | Interventions

The types of interventions recommended by survey respondents as facilitators included universal programs and SEL interventions (*n* = 27), one-on-one or group counseling (n = 7), and interventions targeting families or communities (*n* = 2). Nine interviewees elaborated on interventions, with a couple identifying the importance of providing information and resources regarding childcare, food, and other essential services. Others (n = 2) explained they felt that making school feel normal and providing consistent structure facilitated support. Several (*n* = 3) specifically described providing suicide prevention and interventions that were consistent to those provided before the pandemic and some (n = 3) also indicated that referrals provided by teachers and parents were still effective for identifying youth with suicide-related risk.

4.6 | Collaboration

Survey respondents (*n* = 7) wrote about the importance of collaborating with other professionals, including the balance between having high expectations for students and attending to their basic needs. An interviewee spoke to the helpfulness of in-person collaboration even while school was being provided remotely, with teachers and staff connecting directly. An additional interviewee acknowledged the significance of collaborating with professionals outside of their district, pointing to statewide guidance around remote services as particularly helpful.

4.7 | Linkages to care

Linkages to care, including connecting youth to care in the community and elsewhere, were described by six survey respondents. Four interviewees also spoke to connecting students to care as a facilitator to supporting students with suicide-related risk. Two specifically identified community and school-based mental health clinicians, with another identifying knowledge about community resources and referral options critical during this time. One interviewee explained how they resolved the barriers they faced in providing counseling during remote learning (i.e., concerns about confidentiality) by linking students to counseling with community referrals.

4.8 | Other facilitators

Examples of other important facilitators described by survey respondents (*n* = 29) included having a previous relationship with students and families (*n* = 8) and the increased comfort, availability, efficiency, and/or flexibility that came with virtual services (*n* = 8). Three interviewees also acknowledged the value of having flexibility in their roles as student support professionals during remote learning, with one identifying the significance of understanding the technology needed to engage in telehealth. Two interviewees described how students were also creatively adapting, for example, finding ways to have private conversations with school professionals by going outside or waiting until their parents were elsewhere.

4.8.1 | Barriers

Commonly identified barriers identified based on open-ended text responses are displayed in Table 5, which we categorized into nine primary themes: (1) communication, (2) student/family reluctance, (3) limited resources, (4) disruptions in standard protocols, (5) competing priorities, (6) family environment, (7) not being in-person, (8) restricted policies, and (9) other. Themes from in-depth interviews aligned to four of these themes: (3) limited resources, (4) disruptions in standard protocols, (6) family environment, (7) not being in-person, (8) restricted policies, and (9) other.

4.9 | Communication and student/family reluctance

Examples of communication barriers provided by survey respondents (*n* = 41) included contact information being out of date, as well as unresponsive students and families. School professionals also described student or family reluctance (*n* = 37), or a lack of engagement by students and families, as a difficult barrier.

TABLE 5 Barriers to providing school-based remote mental health supports to students.

Theme	*N*	Definition	Illustrative quote
Communication	41	Challenges resulting from communication (e.g., language barriers, out of date contact information, scheduling conflicts)	Students and parents can be hard to reach. It is very difficult to have any consistency.
Student/family reluctance	37	Student or family reluctance or delays in participation, attendance, or response	Getting students to participate in anything.
Resource limitations	22	Limited resources across systems (student, family, community, school level; e.g., lack of internet, limited training, limited community partners)	Access to specialized mental health providers has been an insurmountable barrier for our rural, socioeconomically distressed community; lack of resources and tools to provide students and families navigating additional levels of care.
Disruptions in standard protocols	21	Limitations of virtual practice to standard practice (e.g., limited privacy in counseling, technological difficulties)	It's a little tough to gauge mental health when a kid doesn't even turn on a camera during "class." We are requiring so little of them now that you don't get regular feedback in any form. Here are some issues: kids don't turn cameras on; they often don't speak during class; classes are shorter, so canvassing all students in a class is possible if the class is large (mine are near or over 30 per class); I can't see their face/bodylanguage/dress/etc; some "come" to class but may be playing games or doing something else - they don't respond to questions or stay "after class" to talk. I have had one-on-one video chats where students didn't turn on a video. This really upsets me.
Competing priorities	9	Description of changes in priorities (e.g., students taking full-time jobs, changes in school support personnel job duties)	Too many other non-counseling-related duties. I have been assigned duties relating to student electives, spent massive amounts of time scheduling, and monitoring attendance and sending attendance letters.
Family environment	8	Difficult family or home environment	Parents lack of engagement and support.
Not being in person	7	Challenges related to lack of in-person contact with students, parents, or staff	Students are more reluctant to reach out about mental health issues. When we are in person, our office is a revolving door with students constantly visiting for personal/social, career or college assistance.
Restricted policies	6	Policies or rules hindering delivery of school supports or services	Our district has limited what we can discuss with students in a remote setting due to issues with confidentiality. Thus the typical one-on-one counseling I would provide with in-person instruction is not happening. We are able to do check-ins and skill building (coping skills).

TABLE 5 (Continued)

Theme	*N*	Definition	Illustrative quote
Other barriers	18	Any other barrier not captured in previous themes, including competing priorities, developmental considerations, and screen fatigue	I work primarily with 6th grade so building relationships virtually with students who have no experience with my building has been challenging. Getting students to consistently engage has been difficult. Privacy since they're in the home with their parents/siblings.

4.10 | Resource limitations

Resource limitations identified by survey respondents ($n = 22$) spanned from basic needs, such as transportation and internet access, to minimal or inadequate specialized mental health care within the community. A survey respondent described limited resources this way: "The largest problem is the lack of internet access most of our families have in our county that would connect them to mental health professionals remotely." An interviewee also described the extensive waitlists and delays for community-based care as a barrier to supporting these youth.

4.11 | Disruptions in standard protocols

The difficulty in adapting standard protocols that impede mental health services was described by multiple survey respondents ($n = 21$). Many participants described limited privacy during virtual counseling as a concern. Nine interviewees also emphasized how disruptions to standard protocols acted as a barrier to care, with some reinforcing privacy concerns similar to those reported by survey respondents. They elaborated on the difficulties of assessing risk virtually, describing a tendency for students to leave their cameras off, making it challenging to connect more generally and to assess affect and mannerisms for risk specifically.

Interviewees also identified reliance on teacher and peer referrals for risk concerns as a barrier, since students were connecting less with one another and teachers were less able to detect concerns for risk virtually. Similar to challenges identified by clinicians in previous research (Gilmore & Ward-Ciesielski, 2019), some interviewees also shared the challenges of keeping students safe when risk is identified given their physical location is not always known and caregivers are not always accessible. Finally, interviewees noted how planned suicide prevention efforts were delayed due to remote practices, with rapid changes in risk and policy making it difficult to move forward with interventions.

4.12 | Competing priorities and family environment

Competing priorities were identified as a barrier by a smaller number of survey respondents ($n = 9$), including roles shifting in school (e.g., school counselors having to take on many non-counseling activities) and priorities shifting for students at home (e.g., students prioritizing jobs over schoolwork). Additionally, family environment was identified as a barrier by some survey participants ($n = 8$), including problems with student home lives such as a lack of adult supervision. An interviewee explained how some issues are related to the family having to work making them unable to provide student supervision that "I can't fix".

4.13 | Not being in person

Inherent to many of these categories, multiple school professional survey respondents (*n* = 7) also wrote about how not being able to see students in person served as a barrier. Interviewees (*n* = 3) also endorsed a sense that teachers were less connected to students when providing remote services, and highlighted the difficulty they and other professionals faced when trying to connect with students they did not previously know (e.g., new students, beginning middle or high school students).

4.14 | Restricted policies

A handful of survey participants (*n* = 6) also raised concerns about district-level policies for online counseling or suicide prevention, reporting confusion around what is allowable or frustration that they were not allowed to provide these services. Five interviewees described restrictions around what they could provide to students as a barrier to supporting them. Some reported not being allowed to provide telehealth at the start of the pandemic, and others explained how there were constraints around what they were and were not allowed to provide when meeting virtually that differed from in-person sessions. One interviewee concluded that this resulted in the loss of some of their "super power" for helping kids.

4.15 | Other barriers

Examples of other barriers reported by survey respondents (*n* = 18) included students spending too much time on screens and being "zoomed out," developmental considerations, lack of trainings, and the resulting difficulties for relationship building. An interviewee identified the complicated nature of providing care during this time, with services needing to be tailored to individuals. Another described how a school and societal emphasis on academics during COVID-19 prevented a much-needed focus on social and emotional health.

4.15.1 | Other important information

Responses to the final open-ended question soliciting feedback about any other important information related to suicide-related supports delivered by schools during remote learning are shown in Table 6. They included four overarching categories: (1) identification of problems or needs, (2) potential solutions to problems, (3) recommendations based on experiences, and (4) adaptations to risk assessments. To further our understanding of the specific subcategories of each the first three broad categories, we applied the previously described barrier codes to identification of problems or needs, and we applied the previously described facilitator codes to potential solutions to problems and recommendations based on experiences. Themes from in-depth interviews related to recommendations are also presented in the second and third categories: (2) potential solutions to problems and (3) recommendations based on experiences.

4.16 | Problems and needs

Problems and needs (*n* = 32) identified by survey respondents included general concerns and issues related to providing suicide-related supports to students and their families during remote learning. A number of concerns about the long-term consequences of COVID-19 for students, families, communities, and schools were reported by

TABLE 6 Other important information.

Theme	*N*	Definition	Illustrative quote
Problems and needs	32	Overall concerns or identification of problems (e.g., kids are struggling)	Parents are frustrated with their own life situations and I'm not sure they take it as seriously as they should. This may mean the students are not getting the support they need to with mental health counseling with outside resources. Also, if a student is suicidal, the very people we are reaching out to, may be part of the reason the child is considering self-harm (parent may be an abuser, etc…).
Potential solutions to problems	36	Comments or ideas about what should happen to address problems or issues, or what might solve problems	I think schools need additional training for all staff and all schools should have an on staff therapist or psychologist.
Recommendations based on experiences	7	Specific recommended resources at school, community, or individual level based on experiences	We ensured that all students knew where to access resources, such as the crisis telephone number for the school system that links them directly with a mental health clinician as well as national hotlines they could utilize.
Adaptations to suicide-related assessments and interventions	20	Any adaptations made or needed to be made during risk assessment procedures	When providing crisis counseling, we are relying on parent consent to speak with their student to conduct a risk assessment and set a safety plan (normally with students in the building, we would conduct the risk assessment and notify the parent of the emergency once the assessment interview has been completed), so a lot of parents decline (likely due to stigmas surrounding mental health) and we aren't able to assess or provide supports due to parents declining…

survey respondents. The significant role parents may play in suicide prevention after losing a student to suicide was emphasized by this participant: "Parents. If I can't see them, I can't notice anything." Other concerns highlighted the intersection between student well-being and school professional wellbeing. For example, one wrote, "…counselors and social workers are overwhelmed. We are the only ones in the school who feel comfortable handling these cases and we cannot get them all."

4.17 | Potential solutions to problems

Potential solutions to problems identified by survey respondents (n = 36) included a variety of suggestions, including professional development, collaboration, and enhanced focus on mental health in schools. Likewise, interviewees

underscored the importance of providing professional development and training to teachers, administration, and other professionals (e.g., law enforcement) about mental health, the impacts of the pandemic, and how to respond in a crisis. The need to reinforce student understanding of the virtual referral process was identified by an interviewee. Another interviewee spoke to the need for policy to address the barriers to counseling during remote learning. Related suggestions by both survey respondents and interviewees included hiring additional support personnel (both school-based and community-based) and making "adjustments that reflect the stress and difficulty of the times we're in."

School professional survey respondents identified a number of helpful resources, including anonymous hotlines or tip lines and specific interventions (e.g., SEL, crisis services, and teletherapy). Another common solution included ways to actively strengthen relationships with students in the virtual environment, such as maintaining effective lines of communication. As a school professional survey respondent commented, "it's important to have a relationship with students so they feel they can reach out and communicate via email or virtual communication."

Five interviewees also underscored the need to validate student experiences, have honest conversations with students and parents, and show compassion for families and staff. An additional interviewee emphasized how schools must attend to a positive psychosocial climate at all times, which can facilitate improved supports during times of crisis (e.g., creating a positive climate in advance of the need for remote learning). Although a handful of interviewees ($n = 4$) simply stated the need to return to school, one acknowledged that returning to school alone was not going to address all of the problems accumulating from the pandemic and remote learning.

4.18 | Recommendations based on experiences

Recommendations based on survey respondent experiences ($n = 7$) included interventions and community resources that have served students and families well during remote learning, with the most common recommendation from school professionals ensuring that students and families had access to crisis numbers and 24/7 support hotlines. Two interviewees similarly recommended ongoing needs assessments of students and families, with interventions tailored to school populations using data-based decision methods. Streamlined communication among school personnel, families, and students and "school-based counseling via teletherapy" were two additional recommendations from survey respondents, with an interviewee also calling for enhanced communication between staff.

The need to reach out to students via multiple methods (phone calls and in person visits) was also recommended by two interviewees. A counselor explained: "One thing that I've learned or kind of been thinking about more with my population is the importance of going to them." Similarly, a flexible and adaptive approach overall was recommended by this school psychologist:

> I think that we have to think a little bit outside of what our typical job has been…so it means that I'm going out and sitting in the front yard with the kid and their computer to teach them Canvas, I don't know that a lot of school counselors will think that that's part of what we need to do but it really, really works well to build connections with those kids that are on that slippery slope.

4.19 | Adaptations to suicide-related assessments and interventions

Finally, school professional survey respondents described a range of methods for adapting risk assessments and suicide-related interventions ($n = 20$). Many explained they they relied on referrals from parents and teachers, expressing concern about the challenges in identifying risk with minimal contact with students. Similar concerns were noted by interviewees ($n = 8$), who described relying more heavily on teacher reports to initiate the process.

Some described teachers as well-trained and others explained how this reliance led to a higher rate of false positives, taking time away from more high-risk students. A couple also reported on how they felt they were receiving less referrals for suicide-risk compared to typical years, perhaps because reporting usually occurs in-person in school or because parents are handling mental health care more directly. A few also described the difficulty of and necessity for gaining parent consent and support during a risk assessment remotely.

5 | DISCUSSION

This exploratory study identified and described school professionals' experiences in providing and adapting school-based mental health supports and services to students during COVID-19 and explored school professional perceptions of facilitators and barriers to delivering these services. Mental health supports provided to students during COVID-19 included telecommunication activities such as virtual counseling, ongoing check-ins with students and families, SEL, and support with time management and assignment completion. School professionals faced significant barriers when providing supports remotely, identifying some of the limitations students faced in their homelives. Despite these barriers, school professionals described how ongoing communication with students and families, as well as collaboration with other school professionals, supported student mental health. Most professionals perceived school-based interventions delivered remotely to be at least moderately helpful for supporting students' mental health, with one-on-one counseling and check-in/check-out interventions most endorsed for helpfulness. Strategies for engaging in school-based mental health supports and suicide prevention during times of school displacement can be drawn from some of these school professionals' perceptions of both needs and successes.

5.1 | Implications for future practice

In the following section, we outline five practical considerations for school professionals delivering remote mental health services that are informed by findings from the present study. First, in the remote environment, participants recognized the need for regular communication and check-ins with both families and students via preferred methods (i.e., phone call, video conference, and text message). This recommendation aligns with findings from previous work that identified telehealth or telecounseling and SEL delivered by way of mailings and prerecorded videos as a helpful approach during the pandemic (Reupert et al., 2021). Accordingly, school professionals should consider a multi-pronged approach for connecting with students and families, reaching out to students using multiple methods and at varying times. Because participants described the difficulties of connecting with students, the less commonly used in-person (and socially distanced) approach for visiting students raised by a few participants may be a helpful strategy for connecting to students and families otherwise difficult to reach. Indeed, home visits have been called for by researchers to help expand outreach strategies by schools in the context of remote services (Masonbrink & Hurley, 2020).

Second, school professionals must be prepared to collaborate with community providers and refer families for additional supports during remote learning. Multiple participants described the importance of linking families to appropriate community resources and connecting students with outside mental health care services to compensate for the lack of typically available in-person school supports. Because rural areas are less likely to have behavioral and emotional services within the community (Hodgkinson et al., 2017; Lavalley, 2018), clinical telehealth services provided by distal providers appear particularly important.

Third, school professionals suggested targeted interventions and training, not only to students, but also to families and school personnel, to support implementation of remote services. Indeed, the mental health of teachers (Baker et al., 2021) and care providers (Davis et al., 2021) has suffered during the pandemic, with a need to provide

support for online education tools and mental health supports to teachers and parents. Because intensive supports are beyond the purview of what should be expected to be provided by school student support professionals, there is a need for dedicated resources for supporting school personnel and families.

Fourth, schools should plan to make virtual adaptations to counseling sessions and interventions. Remote services appeared to disrupt the naturally occurring relationships that student support professionals can typically develop with students simply by being embedded in schools. This disruption was identified as an obstruction to delivering virtual counseling and also for identifying students with suicide-related risk. For example, virtual services do not allow for impromptu walk-in sessions that may occur when counselors are in school settings, requiring advanced scheduling and appointment reminders. In place of casual interactions with students and teachers, school professionals may consider offering longer counseling sessions or hosting "lunch dates" to allow for rapport building with students.[1]

Note, however, that increased access (e.g., google phone) for connecting with students outside of school and flexibility provided by teleconferencing for meetings about students returning from the hospital were among some of the benefits of remote practices noted by interviewees. These strategies remain useful during in-person learning, with teleconferencing potentially benefiting working parents, as well as community providers, unable to attend in-person meetings. Although telehealth is a promising solution for community care of students living in more rural areas with less access to mental health services, the significance of ensuring students and families have internet access or access to hotspots remains critical.

Fifth, the range of individuals (e.g., school support professionals, administrators, and teachers) providing a variety of mental health interventions and supports during COVID-19 underscores the importance of collaboration, support, and consultation from professionals with mental health expertise to those providing services (NASP, 2020). Indeed, school professional collaboration was a commonly identified facilitator to providing supports and services. The significant role of teachers and caregivers for referring students for risk assessments specifically points to the need for trainings directed at teachers and caregivers. There is a need to adapt teacher trainings to address virtual monitoring of mental health symptoms, and additional barriers regarding family and caregiver involvement may need to be considered when supporting caregivers in recognizing signs and symptoms of suicide.

Because research and practices addressing caregiver involvement often center hegemonic notions of how parents "should be" involved in schools (e.g., helping with homework, participating in the parent–teacher organizations, which are primarily based on White, Eurocentric norms), consideration of how involvement may vary based on race, ethnicity, and socioeconomic status is needed (Bower & Griffin, 2011; Watson & Bogotch, 2015). Practitioners should be cautious about criticizing families, and work towards a shared understanding of how they can partner with caregivers to support students. Practices that involve relationship building, advocacy, and shared decision-making may be particularly crucial to this work (Bower & Griffin, 2011; Lazarus et al., 2021; Watson & Bogotch, 2015). For families with students with mental health concerns, administration and student support staff could host listening sessions and individual check-ins to better understand family and community needs, and to reinforce caregiver expertise in understanding and supporting their student. These efforts can focus on the shared goals of keeping the student safe, and collaborative problem-solving to identify ways of supporting and protecting students while being respectful to family cultural norms.

5.2 | Limitations and future directions

Several limitations should be considered when interpreting findings from this exploratory study. The small number of both survey respondent and interview participants providing data, representing a single state in the southeastern

[1]See the American School Counselor Association (ASCA; https://www.schoolcounselor.org/Publications-Research/Publications/Free-ASCA-Resources/COVID-19-Resources) for additional resources regarding remote school counseling practices.

region of the United States, greatly limits generalizability of findings. Although school counselors have been identified as one of the most common professionals to interact with youth with suicide-related risk (Marraccini et al., 2019), because the sample primarily represents school counselors, future work addressing perceptions of services provided by school psychologists and school social workers is merited.

Supports and services, as well as patterns of psychological distress, rapidly changed and evolved throughout the pandemic, and findings from the present study reflect only one timepoint (winter of 2020 and 2021). Moreover, the researcher-designed survey administered to participants may not have accurately captured perspectives about remote learning given participants included those providing services remotely and in-person at the time of data capture. Although participants were instructed to consider their experiences when they were providing remote services with consistent reminders throughout the survey, it is possible they may have answered questions differently during the time they were providing remote services.

Because we focused on school professional experiences and perceptions, results do not address how supports and services may impact student outcomes. Although we asked school professionals about perceived helpfulness of interventions, subjective perceptions of helpfulness may not match more objective measures of improvement. Future inquiries should explore the effects of remote school-based mental health supports and services on student well-being and suicide-related behaviors, as well as students' perceptions of the helpfulness of these efforts.

Policy regarding counseling allowances and concerns for privacy appear particularly crucial to address. School policies and practices may vary based on statutes and regulations about authorization for school closures, attendance adjustments, and notifications about COVID-19 cases (Nuñez et al., 2020), and in many cases, it appears that guidance was left open to districts for interpretation and implementation. In the present study, some districts imposed strict measures preventing professionals from screening for mental health concerns, while others allowed professionals to continue providing mental health services remotely. These differences could inform how the sample responded to questions regarding the services they provided and how helpful they were. These differences also underscore the need for clear guidance around continued provision of school-based mental health services during times of school disruption.

6 | CONCLUSION

As a school counselor explained, despite the uncertainty in best practices for supporting youth mental health during remote learning due to COVID-19, school professionals demonstrated "resiliency and flexibility and ingenuity" to support student mental health. They expressed the need to continue engaging and connecting with students in creative ways, underscoring the importance of on-going needs assessments, check-ins, and interventions during remote schooling. Although providing remote school-based mental health services may bring concerns related to confidentiality and liability, it appears critically important to enhance such services during times of school disruption.

Although guidance for supporting students in the context of the COVID-19 pandemic continue to evolve, these preliminary strategies may aid school professionals during future disruptions due to infectious pandemics or natural disasters and also when integrating telehealth and telecommunication approaches within school-based mental health services. Schools may draw from professional organization resources to understand ethical and legal considerations of school-based telehealth services (e.g., NASP, 2020) that prioritize training around handling student privacy during remote counseling sessions, as well as the implementation and documentation of remote risk assessments and referrals. Considering the critical role schools play in screening for suicide, connecting students to care, and enhancing protective factors for mental health, school supports and services remain essential during times of school disruption.

ACKNOWLEDGMENTS

This project was supported by an Early Career Research Award from the Society for Study of School Psychology (SSSP), and by the North Carolina Collaboratory at the University of North Carolina at Chapel Hill (UNC) through an appropriation made by the North Carolina General Assembly awarded to Marisa E. Marraccini. The project was also supported by the National Center for Advancing Translational Sciences (NCATS), National Institutes of Health, through Grant Award Number UL1TR002489. Marisa Marraccini's effort was supported by the National Institute of Mental Health (K23MH122775; L30MH117655; Marraccini). The content is solely the responsibility of the authors and does not necessarily represent the official views of SSSP, NIH, or UNC

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ORCID

Marisa E. Marraccini http://orcid.org/0000-0002-7965-3703

REFERENCES

American School Counselor Association (2017). The school counselor and virtual counseling. https://schoolcounselor.org/Standards-Positions/Position-Statements/ASCA-Position-Statements/The-School-Counselor-and-Virtual-School-Counseling

Baker, C. N., Peele, H., Daniels, M., Saybe, M., Whalen, K., Overstreet, S., & The New Orleans, T. I. S. L. C. (2021). The experience of COVID-19 and its impact on teachers' mental health, coping, and teaching. *School Psychology Review*, *50*(4), 491–504. https://doi.org/10.1080/2372966X.2020.1855473

Bower, H. A., & Griffin, D. (2011). Can the Epstein model of parental involvement work in a high-minority, high-poverty elementary school? A case study. *Professional School Counseling*, *15*(2), 2156759X1101500.

Brock, S., & Lieberman, R. (2020). National Association of School Psychologists ask the expert webinar series: Comprehensive suicide prevention and intervention in a time of distanced learning [Webinar]. *National Association of School Psychologists*. https://www.nasponline.org/resources-and-publications/resources-and-podcasts/covid-19-resource-center/webinar-series/comprehensive-suicide-prevention-and-intervention-in-a-time-of-distance-learning

Centers for Disease Control and Prevention (CDC). (2019). Trends in the prevalence of suicide–related behaviors national YRBS: 1991—2019. https://www.cdc.gov/healthyyouth/data/yrbs/factsheets/2019_suicide_trend_yrbs.htm

Centers for Medicare & Medicaid Services. (2020). CMS issues urgent call to action following drastic decline in care for children in Medicaid and Children's Health Insurance Program due to COVID-19 pandemic. https://www.cms.gov/newsroom/pressreleases/cms-issues-urgent-call-action-following-drastic-declinecare-children-medicaid-and-childrens-health.

Clyne, A., Faustino, P., & Kelly, S. R. (2020). National Association of School Psychologists ask the expert webinar series: Strategies for providing school mental and behavioral telehealth services [Webinar]. *National Association of School Psychologists*. https://www.nasponline.org/resources-and-publications/resources-and-podcasts/covid-19-resource-center/webinar-series/strategies-for-providing-school-mental-and-behavioral-telehealth-services

Costello, E. J., He, J., Sampson, N. A., Kessler, R. C., & Merikangas, K. R. (2014). Services for adolescents with psychiatric disorders: 12-month data from The National Comorbidity Survey–Adolescent. *Psychiatric Services*, *65*(3), 359–366. https://doi.org/10.1176/appi.ps.201100518

Crepeau-Hobson, F. (2013). An exploratory study of suicide risk assessment practices in the school setting. *Psychology in the Schools*, *50*(8), 810–822.

Daly, M. (2022). Prevalence of depression among adolescents in the US from 2009 to 2019: Analysis of trends by sex, race/ethnicity, and income. *Journal of Adolescent Health*, *70*(3), 496–499.

Davis, C. R., Grooms, J., Ortega, A., Rubalcaba, J. A. A., & Vargas, E. (2021). Distance learning and parental mental health during COVID-19. *Educational Researcher*, *50*(1), 61–64.

Dowdy, E., Furlong, M., Raines, T. C., Bovery, B., Kauffman, B., Kamphaus, R. W., Dever, B. V., Price, M., & Murdock, J. (2015). Enhancing school-based mental health services with a preventive and promotive approach to universal screening for complete mental health. *Journal of Educational and Psychological Consultation*, *25*(2-3), 178–197.

Gilmore, A. K., & Ward-Ciesielski, E. F. (2019). Perceived risks and use of psychotherapy via telemedicine for patients at risk for suicide. *Journal of Telemedicine and Telecare*, *25*(1), 59–63.

Goddard, A., Sullivan, E., Fields, P., & Mackey, S. (2021). The future of telehealth in school-based health centers: Lessons from COVID-19. *Journal of Pediatric Health Care*, *35*(3), 304–309. https://doi.org/10.1016/j.pedhc.2020.11.008

Golberstein, E., Wen, H., & Miller, B. F. (2021). Coronavirus disease 2019 and effects of school closure for children and their families—reply. *JAMA Pediatrics*, *175*(2), 211–212.

Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. SAGE.

Hertz, M. F., & Barrios, L. C. (2021). Adolescent mental health, COVID-19, and the value of school-community partnerships. *Injury Prevention*, *27*, 85–86. https://doi.org/10.1136/injuryprev-2020-044050

Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2017). Improving mental health access for low-income children and families in the primary care setting. *Pediatrics*, *139*(1), e20151175.

Holland, M., Hawks, J., Morelli, L. C., & Khan, Z. (2021). Risk assessment and crisis intervention for youth in a time of telehealth. *Contemporary School Psychology*, 1–15.

Katz, C., Bolton, S. L., Katz, L. Y., Isaak, C., Tilston-Jones, T., & Sareen, J., Swampy Cree Suicide Prevention Team. (2013). A systematic review of school-based suicide prevention programs. *Depression and Anxiety*, *30*(10), 1030–1045.

Lavalley, M. (2018). *Out of the loop: Rural education in the US*. Center for Public Education. http://www.centerforpubliceducation.org/research/out-Loop-Rural-Education-Us

Lazarus, P. J., Doll, B., Song, S. Y., & Radliff, K. (2021). Transforming school mental health services based on a culturally responsible dual-factor model. *School Psychology Review*, 1–16.

Luthar, S. S., Ebbert, A. M., & Kumar, N. L. (2021). Risk and resilience during COVID-19: A new study in the Zigler paradigm of developmental science. *Development and Psychopathology*, *33*(2), 565–580.

Maras, M. A., Thompson, A. M., Lewis, C., Thornburg, K., & Hawks, J. (2015). Developing a tiered response model for social-emotional learning through interdisciplinary collaboration. *Journal of Educational and Psychological Consultation*, *25*(2-3), 198–223.

Marraccini, M. E., Lee, S., & Chin, A. J. (2019). School reintegration post psychiatric hospitalization: Protocols and procedures across the nation. *School Mental Health*, *11*, 615–628. https://doi.org/10.1007/s12310-019-09310-8

Masonbrink, A. R., & Hurley, E. (2020). Advocating for children during the COVID-19 school closures. *Pediatrics*, *146*(3).

Mayne, S. L., Hannan, C., Davis, M., Young, J. F., Kelly, M. K., Powell, M., Dalembert, G., McPeak, K. E., Jenssen, B. P., & Fiks, A. G. (2021). COVID-19 and adolescent depression and suicide risk screening outcomes. *Pediatrics*, *148*(3).

Murata, S., Rezeppa, T., Thoma, B., Marengo, L., Krancevich, K., Chiyka, E., Hayes, B., Goodfriend, E., Deal, M., Zhong, Y., Brummit, B., Coury, T., Riston, S., Brent, D. A., & Melhem, N. M. (2021). The psychiatric sequelae of the COVID-19 pandemic in adolescents, adults, and health care workers. *Depression and Anxiety*, *38*(2), 233–246.

National Association of School Psychologists. (2020). *Telehealth: Virtual service delivery updated recommendations*. National Association of School Psychologists. https://www.nasponline.org/resources-and-publications/resources-and-podcasts/covid-19-resource-center/special-education-resources/telehealth-virtual-service-delivery-updated-recommendations

North, S. (2020). Addressing students' mental health needs via telehealth. *North Carolina Medical Journal*, *81*(2), 112–113.

Nuñez, B., Stuart-Cassel, V., & Temkin, D. (2020). As COVID-19 spreads, most states have laws that address how schools should respond to pandemics. *Child Trends*. https://www.childtrends.org/blog/as-covid-19-spreads-most-states-have-laws-that-address-how-schools-should-respond-to-pandemics

Parodi, K. B., Holt, M. K., Green, J. G., Porche, M. V., Koenig, B., & Xuan, Z. (2022). Time trends and disparities in anxiety among adolescents, 2012–2018. *Social Psychiatry and Psychiatric Epidemiology*, *57*(1), 127–137.

Pearlman, D. N., Vendetti, T., & Hill, J. (2018). Linking public schools and community mental health services: A model for youth suicide prevention. *Rhode Island medical journal (2013)*, *101*(4), 36–38.

QSR International Pty Ltd. (2020). NVivo (released in March 2020). http://qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Racine, N., McArthur, B. A., Cooke, J. E., Eirich, R., Zhu, J., & Madigan, S. (2021). Global prevalence of depressive and anxiety symptoms in children and adolescents during COVID-19: a meta-analysis. *JAMA pediatrics*, *175*(11), 1142–1150. https://doi.org/10.1001/jamapediatrics.2021.2482

Reger, M. A., Stanley, I. H., & Joiner, T. E. (2020). Suicide mortality and coronavirus disease 2019—A perfect storm? *JAMA Psychiatry*, *77*(11), 1093. https://doi.org/10.1001/jamapsychiatry.2020.1060

Reupert, A., Schaffer, G. E., Von Hagen, A., Allen, K. A., Berger, E., Büttner, G., & May, F. (2021). The practices of psychologists working in schools during COVID-19: A multi-country investigation. *School Psychology*.

Rojas, S. M., Carter, S. P., McGinn, M. M., & Reger, M. A. (2020). A review of telemental health as a modality to deliver suicide-specific interventions for rural populations. *Telemedicine and e-Health*, *26*(6), 700–709.

Rose, I. D., Lesesne, C. A., Sun, J., Johns, M. M., Zhang, X., & Hertz, M. (2022). The relationship of school connectedness to adolescents' engagement in co-occurring health risks: A meta-analytic review. *The Journal of School Nursing*, 105984052210968.

Sanchez, D., Reiner, J. F., Sadlon, R., Price, O. A., & Long, M. W. (2019). Systematic review of school telehealth evaluations. *The Journal of School Nursing*, *35*(1), 61–76.

Smith, A. C., Thomas, E., Snoswell, C. L., Haydon, H., Mehrotra, A., Clemensen, J., & Caffery, L. J. (2020). Telehealth for global emergencies: Implications for coronavirus disease 2019 (COVID-19). *Journal of Telemedicine and Telecare*, *26*(5), 309–313.

Soto, E. C., Frederickson, A. M., Trivedi, H., Le, A., Eugene, M. C., Shekher, M., Weiskopf, M., Allen-Dicker, K., Dicker, R., Fornari, V., & Correll, C. U. (2009). Frequency and correlates of inappropriate pediatric psychiatric emergency room visits. *The Journal of Clinical Psychiatry*, *70*(8), 1164–1177. https://doi.org/10.4088/jcp.08m04839

Stemler, S. (2000). An overview of content analysis. *Practical Assessment, Research, and Evaluation*, *7*(1), 17.

The Aspen Institute. (2020). *Fostering Connectedness in the Pandemic Era: Policy Recommendations to Support Social, Emotional, and Academic Development*. Aspen Institute. https://www.aspeninstitute.org/publications/policy-recommendations-to-support-social-emotional-and-academic-development-fostering-connectedness-in-the-pandemic-era/

Ward, M. M., Ullrich, F., Merchant, K. A. S., Carter, K. D., Bhagianadh, D., Lacks, M., Taylor, E., & Gordon, J. (2022). Describing changes in telebehavioral health utilization and services delivery in rural school settings in pre-and early stages of the COVID-19 public health emergency. *Journal of School Health*, *92*(5), 452–460.

Waters, S., & Cross, D. (2010). Measuring students' connectedness to school, teachers, and family: validation of three scales. *School Psychology Quarterly*, *25*(3), 164–177. https://doi.org/10.1037/a0020942

Watson, T. N., & Bogotch, I. (2015). Reframing parent involvement: What should urban school leaders do differently? *Leadership and Policy in Schools*, *14*(3), 257–278.

Whiston, S. C., Tai, W. L., Rahardja, D., & Eder, K. (2011). School counseling outcome: A meta-analytic examination of interventions. *Journal of Counseling & Development*, *89*(1), 37–55. https://doi.org/10.1002/j.1556-6678.2011.tb00059.x

Yard, E., Radhakrishnan, L., Ballesteros, M. F., Sheppard, M., Gates, A., Stein, Z., Hartnett, K., Kite-Powell, A., Rodgers, L., Adjemian, J., Ehlman, D. C., Holland, K., Idaikkadar, N., Ivey-Stephenson, A., Martinez, P., Law, R., & Stone, D. M. (2021). Emergency department visits for suspected suicide attempts among persons aged 12–25 years before and during the COVID-19 pandemic—United States, January 2019–May 2021. *MMWR. Morbidity and Mortality Weekly Report*, *70*(24), 888–894.

How to cite this article: Marraccini, M. E., Griffard, M. K. R., Whitcomb, C. E., Wood, C., Griffin, D. C., Pittleman, C., & Sartain, L. (2023). School-based mental health supports during COVID-19: School professional perspectives. *Psychology in the Schools*, 60, 2460–2482. https://doi.org/10.1002/pits.22869