Mental Health Service Provision at School-Based Health Centers During the COVID-19 Pandemic: Qualitative Findings from a National Listening Session

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TITL E: Mental Health Service Provision at School-Based Health Centers During the COVID-19 Pandemic: Qualitative Findings from a National Listening Session

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Key words: COVID-19, mental health, school-based health center, school health

Abstract
Mental health issues are the leading cause of disability among youth, especially among those in underserved communities. School-based health centers (SBHCs) increase equity by providing health services to more than six million youth annually, a majority of whom reside in resource-limited communities. When schools throughout the United States closed in spring 2020, many SBHCs were also forced to close physical operations. This study uses qualitative data collected from SBHC representatives nationwide to examine: 1) supports and challenges that affect the provision of mental health services in SBHCs during the COVID-19 pandemic; 2) changes in the provision of mental health services at SBHCs one year into the pandemic compared to before the pandemic; and 3) SBHCs’ priorities for assessing and supporting student mental health needs in the 2021-22 school year. Study findings highlight how SBHCs pivoted, even with limited resources, to meet students’ increasing needs for mental health care.

1. Introduction
There are myriad inequalities by race and socioeconomic status in the United States, including unequal access to quality health care.(Bloom, Cohen, & Freeman, 2012; Centers for Disease &
More than one in four youth face health care access barriers, such as lack of transportation, low health literacy, and provider shortages. (Redlener et al., 2016) Mental health issues are the leading cause of disability among youth, (School-based health centers: vital providers of mental health services for children and adolescents, 2018) and rates of mental health disorder are highest among youth of color, (Pumariega, Rogers, & Rothe, 2005) youth residing in low-income communities, (Irwin, Adams, Park, & Newacheck, 2009) and youth involved in the juvenile justice (Rogers, Pumariega, Atkins, & Cuffe, 2006) or child welfare system. (Garland et al., 2001) An estimated one in four youth experience a mental health issue (School-based health centers: vital providers of mental health services for children and adolescents, 2018) and one in five experience a mental health disorder that causes severe mental impairment, (Merikangas et al., 2010) but fewer than half of those diagnosed receive treatment. (McKay, Lynn, & Bannon, 2005; Merikangas et al., 2011) Youth is a critical period for mental health intervention as half of all mental health conditions appear by age 14 ("Improving the mental and brain health of children and adolescents," 2021) and three quarters appear by age 24. ("Mental health in schools," 2021) Untreated, mental health issues result in poor physical health outcomes, (Naicker, Galambos, Zeng, Senthilselvan, & Colman, 2013) poor social mobility, reduced social capital, (Alegria, Vallas, & Pumariega, 2010) increased welfare dependence, and unemployment. (Fergusson, Boden, & Horwood, 2007)

The Coronavirus disease of 2019 (COVID-19) and related restrictions exacerbate mental health risk and conditions (Lee, 2020; Patrick et al., 2020) and decrease access to and use of health services. ("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," 2020; Leeb et al., 2020; Leff, Setzer, Cicero, & Auerbach, 2021) Youth nationwide face new and intensified stressors like illness, death, social isolation, economic stress, food insecurity, family hardship, and increased domestic violence risk. (Abramson, 2020; Patrick et al., 2020; Policy Brief: The Impact of COVID-19 on children, 2020) These stressors are associated with outcomes like depression, behavioral problems, (Mollica, Poole, Son, Murray, & Tor, 1997) anxiety disorders, and worsened existing mental health conditions. (Garfield & Chidambaram, 2020; Golberstein, Gonzales, & Meara, 2019; Leff et al., 2021) The pandemic and restrictions affect the emotional and social development of youth more significantly than adults. (Singh et al., 2020) Preliminary research points to increased depression, anxiety, and other mental health challenges due to the pandemic, (Garfield & Chidambaram, 2020; Hamoda, Chiumento, & Alonge, 2021; Jiao et al., 2020) manifested through symptoms like disturbed sleep, nightmares, poor appetite, agitation, and separation anxiety. (Jiao et al., 2020) While these findings suggest a clear increased need for health care, there has been a precipitous decline in services delivered. Compared to the same time period in 2019, between March and May 2020 there were an estimated 44% fewer outpatient mental health services, 44% fewer cognitive development screenings, ("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," 2020) and substantial declines in reported numbers of children’s mental health-related emergency department visits. (Leeb et al., 2020; Leff et al., 2021) The World Health Organization estimated the pandemic disrupted up to 72% of mental health services delivered to youth. (The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment, 2020) Experts called for
targeted school-based mental health interventions to respond to this crisis and minimize burden on the healthcare system. (Hamoda et al., 2021)

School-based health centers (SBHCs) are a cost effective health care delivery model that increase mental and behavioral health access and utilization (Knopf et al., 2016) among more than six million youth annually throughout the United States. (Love, Schlitt, Soleimanpour, Panchal, & Behr, 2019) Many SBHC patients live in underserved communities and are at a greater risk for mental health issues. (Garland et al., 2001; Irwin et al., 2009; Pumariega et al., 2005; Rogers et al., 2006) Over three quarters of schools with access to an SBHC are eligible for Title I funding, designated to schools with high percentages of children from low-income families. Compared to schools without access to an SBHC, those with access have higher proportions of students who are youth of color or receive free or reduced price lunch. (Love et al., 2019) Furthermore, one study found that youth of color accessed services at SBHCs more frequently than other community health delivery sites, suggesting they can effectively overcome access barriers for these populations. (Juszczak, Melinkovich, & Kaplan, 2003)

SBHCs improve equity by operating on or near school campuses and overcoming access barriers like stigma, provider shortages, and lack of transportation. (School-based health centers: vital providers of mental health services for children and adolescents, 2018) The number of SBHCs nationwide has grown exponentially in recent years (Love et al., 2019) as advocates recognize the model for expanding access to disadvantaged youth who lack access to affordable health care. (Knopf et al., 2016; Love et al., 2019; Love et al., 2018) For instance, the Affordable Care
Act included a $200 million appropriation to expand SBHC services. (Paschall & Bersamin, 2018)

By integrating within a school, SBHCs normalize mental health services, build trust with students and their families, and contribute to increased use of mental health services, (Knopf et al., 2016) increased grade point average, lower suspension rates, (Keeton, Soleimanpour, & Brindis, 2012; Knopf et al., 2016) improved school life experiences, and feelings of connectedness. (Strolin-Goltzman, Sisselman, Melekis, & Auerbach, 2014) More than half of youth who access mental health services each year do so at school, (Ali et al., 2019; School-based health centers: vital providers of mental health services for children and adolescents, 2018) and youth are considerably more likely to complete mental health treatment that is provided in a school setting. (Duong et al., 2020; Green et al., 2013; McKay et al., 2005; Merikangas et al., 2011)

When schools across the United States closed in spring 2020 due to the COVID-19 pandemic, many SBHCs were also forced to close physical operations, leaving those who rely on these services with limited access to care. (Sullivan, Brey, & Soleimanpour, 2021) Throughout the aftermath of initial school closures, SBHCs found innovative ways to continue to deliver services to students and their communities, (Goddard, Sullivan, Fields, & Mackey, 2021; Sullivan, Brey, & Soleimanpour, 2021) although they faced numerous challenges. This study uses qualitative data collected from SBHC and sponsor organization representatives in March 2021 to examine: 1) supports and challenges that affected the provision of mental health services in SBHCs during the COVID-19 pandemic; 2) the provision of mental health services at SBHCs one year into the
pandemic compared to before the pandemic; and 3) SBHCs’ priorities for assessing and supporting student mental health needs in the 2021-22 school year.

2. Methods

As part of a series of ten capacity building webinars hosted through the platform “Zoom” ("Zoom," 2021) throughout spring and summer 2021, the School-Based Health Alliance (SBHA) organized a 60-minute virtual listening session focused on mental health services at SBHCs in late-March 2021 for SBHC staff and stakeholders. Participants did not need to attend other webinars in the series to participate in the listening session on mental health services. SBHA used Mentimeter, ("Mentimeter," 2021) an interactive web-based survey and polling platform to collect some of the qualitative data. SBHA posed open-ended questions on Mentimeter and asked the participants to respond individually using their personal devices (smartphones, tablets, or computers). The Zoom screen displayed these answers anonymously through data visualizations to all webinar participants to further encourage discussion. The listening session focused solely on participant sharing and discussion and did not include a formal presentation on mental health or COVID-19.

2.1 Study Design

Prior SBHA-led research informed the research questions, study design, and study tools. Shortly after schools closed in spring 2020, SBHA conducted a series of national qualitative listening sessions with SBHC clinicians, administrators, and sponsors to understand implications on SBHC patients and services. (Goddard, Sullivan, Fields, & Mackey, 2021; Sullivan, Goddard, Fields, & Mackey, 2021) Participants shared challenges related to remote learning, accessing
students, and presenting mental health concerns. Several months later in late spring/early summer 2020, SBHA administered a brief quantitative survey to further explore the pandemic’s implications on SBHC operations (Sullivan, Brey, & Soleimanpour, 2021). Several SBHA researchers and content experts used results of these analyses to frame the current study and develop and refine a semi-structured interview guide. Study procedures mirrored that of the series of listening sessions in spring 2020, which received very positive feedback from participants and stakeholders (Goddard, Sullivan, Fields, & Mackey, 2021; Sullivan, Goddard, Fields, & Mackey, 2021). This research focuses on organizational practices and did not require Institutional Review Board review.

2.2 Recruitment
SBHA maintains a database with contact information of the more than 2,500 identified SBHCs nationwide, described in detail elsewhere (Love et al., 2019) Before the session, SBHA emailed event and registration information to all database contacts, advertising the event as an opportunity for SBHC staff and stakeholders to discuss mental health service provision during the pandemic.

2.3 Participants
Two-hundred and seven people from 121 SBHCs and sponsor organizations registered to participate. Of these registrants, 143 logged into the session to attend, and 117 attended for at least 15 minutes. Of the 82 participants who chose to share their home state, a majority resided in the U.S. South (n=31) and West (n=22), (“Census Regions and Divisions of the United States,” 2010) especially in Texas (n=17), California (n=8), and Washington state (n=6). The remaining
resided in the Northeast (n=11) and Midwest (n=18). SBHA did not collect information on participant titles or organization names. Of the participants who joined the session for at least 15 minutes, the average participation time was 54 minutes. An average of 57 participants responded to each question posed through Mentimeter.

2.4 Procedure

The listening session lasted 60 minutes, but participants could choose to leave at any time. At the beginning of the session, the SBHA moderator disclosed the plan to record and transcribe the session and disseminate de-identified data. The moderator followed a semi-structured interview guide, and participants responded to open-ended questions, first in writing through Mentimeter and then orally. The moderator first posed a structured open-ended question through Mentimeter, displayed on the webinar screen. Participants responded individually using their personal devices through a Mentimeter portal. Participants’ anonymous responses displayed on the webinar screen through a real-time data visualization aiming to guide further oral discussion. Three SBHA content experts monitored the Mentimeter responses and the Zoom written chat box comments and privately flagged themes and innovations to the moderator. The moderator read these select responses aloud and invited the writers to elaborate orally. Participants could also use the Zoom chat box to answer the Mentimeter questions or volunteer to share orally. An SBHA administrator unmuted the participants’ microphones before they spoke upon their request; all participant microphones were otherwise set to mute. After each oral discussion, the moderator moved onto the next Mentimeter question.

2.5 Analysis

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SBHA staff extracted and downloaded the Zoom-generated audio transcripts, chat box text, and Mentimeter responses. To maintain anonymity, SBHA staff de-identified participants before data analysis. The primary author began analysis by reading the transcript of the discussion, chatbox text, and Mentimeter data repeatedly to achieve familiarization. The primary author then conducted an informal conceptual content analysis using Microsoft Excel, beginning with the Mentimeter data and concluding with the Zoom transcript and chat box text. The primary author first grouped data by research question and then developed and applied open coding for the existence of concepts, adding and modifying categories throughout the coding process. After the completion of the analysis, a co-author analyzed a detailed audit trail of the primary author’s methods, notes, and coding to confirm the reliability of the findings and limit researcher bias.

3. Results

Several themes emerged from the discussion: 1) SBHCs reported changes in mental health needs and screenings for needs; 2) SBHCs reported challenges affecting service provision to meet increased needs; 3) SBHCs adapted mental health services; 4) many factors facilitated service provision; and 5) SBHCs set priorities to meet demands in the 2021-22 school year.

3.1 Changes in SBHC patients’ mental health needs and screening for mental health and social needs

Throughout the pandemic, SBHC patients increasingly presented with anxiety, depression, grief, and withdrawal (Table 1). SBHC providers also observed lack of motivation, numbness, and lack of engagement with others. A participant from New York shared that there has been a loss of factors that typically promote resilience, such as after school activities, sports, and social
connection, which normally mitigate anxiety, depression, and substance abuse. In Ohio SBHCs, participants shared that parents/guardians were more likely post- than pre-pandemic to report concerns for their children’s mental health due to noticeable changes in their mood and temperament. Participants also noted an increase in parent/guardians requesting mental health supports on behalf of their children.

Participants also discussed increased acuity of presenting problems, more immediate and complex mental health challenges, and greater co-morbidities, perhaps intensified by the tendency for patients to delay accessing services during the pandemic. A participant from Colorado shared that students’ increased concerns about meeting basic needs created and exacerbated anxiety, whereas state wildfires in Oregon that displaced communities contributed to complex grief with multiple losses. Some respondents also mentioned increased domestic violence and post-traumatic stress disorder among their patients. One respondent shared that patients seemed more willing to share their thoughts and feelings post- compared to pre-pandemic months.

Some SBHCs increased screening to identify mental health needs. An SBHC in Ohio conducted pre-visit interviews with families before well-child visits, asking standard questions for all ages to determine mental health concerns. This respondent estimated that 80 to 85 percent of parents had been concerned about anxiety, depression, or changes in their child’s behavior. Another SBHC created a risk stratification tool for medical providers to identify mental health risk levels. The tool guided the provider through next steps based on this risk, such as whether the patient needs resources, a referral, follow-up by a therapist, or follow-up by a medical provider. In
Texas, mental health providers partnered with nurse practitioners to launch a survey to assess families’ needs during the pandemic. This survey included questions about timing for well visits and vaccinations, health problems, needed medications, and safety in the home. Based on responses, the SBHC made referrals to different types of providers.

### 3.2 Challenges affecting SBHC mental health service provision

SBHC representatives reported that the primary challenges affecting mental health service provision during the pandemic related to lack of available staff and lack of access to patients. SBHCs faced difficulties accessing students due to remote or hybrid (mixed in-person and remote) learning schedules, lack of student interest or engagement, students’ transportation barriers, and general lack of in-person contact with students. One participant shared that even when students signed up for telehealth sessions, they often did not log in to join the session, possibly due to video fatigue resulting from remote learning. Another participant discussed delayed diagnosis and receipt of support services, particularly among students with attention deficit hyperactivity disorder, learning disabilities, or autism, since remote learning limited teachers’ abilities to recognize nonverbal cues and behaviors. One participant explained that “referrals are down and not because there is a lack of need but there has been a struggle to coordinate and stay connected with education staff for referrals without in person connection.” Other respondents noted parental consent and buy-in, stigma, language barriers, cultural beliefs, increased demand for mental health services exacerbated by a lack of available staff, and increased acuity of mental health issues as additional concerns resulting from the pandemic and restrictions.
3.3 Adaptations to SBHC mental health service provision

Telehealth was a crucial strategy to continue to provide services to students throughout the pandemic, mentioned in over half of responses, but also presented privacy and access concerns. To mitigate these concerns, before scheduling an appointment, one SBHC discussed with the student where they would be for the session, who else would be home at that time, and what the student would need to feel comfortable. The participant referred to this technique as “front loading before an appointment.” In Oregon, a school district issued portable computers to all students, lowered the firewall to facilitate telehealth access, and used local and state funds to increase student internet connectivity and access to telehealth services. However, many SBHC representatives mentioned students’ lack of internet access as a key challenge in mental health service provision throughout the pandemic.

To overcome the challenge of accessing students, participants discussed increasing outreach. Therapists and counselors at one SBHC presented to classes at the beginning of the school year when in-person instruction re-launched, advertising service offerings. This SBHC also mailed hard copies of resource books with school and local mental health offerings to families. Another SBHC held virtual office hours, originally meant for students, but frequented by parents, particularly those with younger children. Many of these parents used the office hours to ask questions about handling their children’s increased anxiety and depression or about setting up a healthy home learning environment that encouraged children to focus and stay engaged. SBHCs also offered new innovative services to increase access and engagement during the pandemic, including art and music therapy, same-day appointments, and local resource databases. To overcome a lack of human resources and increase student engagement, one SBHC offered
various group curriculums for different age groups, mailing activity kits to participants beforehand.

3.4 Factors that support mental health service provision

Staying true to the SBHC model’s original intent as a partnership between a community, school, and health center, SBHCs increased their reliance on supportive collaborations as a mechanism for sustainability. Participants discussed increasing coordination with host schools and school districts, including proactively reaching out to teachers about referring students, teaching teachers how to lead mindfulness sessions at the beginning of classes, educating school staff about screening students for anxiety and depression, and teaching school staff how to refer through the telehealth format. SBHC primary care providers in one region were not confident in their ability to assess for anxiety and depression and prescribe medications. This led to the development of a consultative and collaborative project model in which primary care providers collaborated with consulting psychiatrists to co-manage patients and facilitate referrals. The SBHC clinicians could call a psychiatrist when facing a complex issue and the psychiatrist would provide an opinion for what to prescribe. To overcome cultural and language barriers, another SBHC partnered with a local organization to offer free services using the Spanish language to the underserved Spanish speaking population in the community.

Similarly, student acceptance and trust, student access, and family and community involvement positively impacted mental health service provision at SBHCs during the pandemic. Other key supports mentioned included financial supports, strong referral systems, and the technical and human resources necessary to establish and sustain telehealth service offerings.
3.5 SBHC mental health priorities in the 2021-22 school year

In the 2021-22 school year, SBHCs will prioritize identifying and addressing students’ increased mental health needs and ensuring staff have the capacity to meet this increased need. Participants discussed strategies like increasing screenings and integration workflows, re-orienting students to developing and sustaining positive relationships, and addressing the social isolation and trauma from the past year. To build staff capacity, some SBHCs will hire more social workers and mental health staff or train all staff on trauma-informed practices. Participants also discussed developing peer groups to discuss topics like depression and suicidality and improving the SBHC referral system.

4. Discussion

Youth is a critical period for mental health intervention ("Mental health in schools," 2021; School-based health centers: vital providers of mental health services for children and adolescents, 2018) and SBHCs have unique access to the underserved, at-risk populations most likely to develop mental health disorders and least likely to access health services. (Garland et al., 2001; Irwin et al., 2009; Pumariega et al., 2005; Rogers et al., 2006) Similar to other research, this study found that many youth face increased depression, anxiety, and withdrawal due to the pandemic. (Abramson, 2020; Garfield & Chidambaram, 2020; The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment, 2020; Jiao et al., 2020; Kataoka, Zhang, & Wells, 2002; Singh et al., 2020) Many SBHC staff throughout the country shared increases in presenting mental health concerns and acuity. A confluence of stressors in 2020—the pandemic, economic recession, social unrest, and isolation—were
intensified by a dearth of typical resiliency factors like a social network and extracurricular activities. The populations that SBHCs serve are already at higher risk of clinical mental health disorders due to confinement and related stressors, and this was aggravated by pandemic-related stressors. (Jiao et al., 2020; Singh et al., 2020; Torres-Pagán & Terepka, 2020) Future quantitative studies should assess the qualitative findings from this study on a national, representative scale.

Study findings highlight increased demand for mental health services and a lack of resources to meet this demand. Recent quantitative data triangulate these qualitative findings: SBHCs were overwhelmed by a loss of human resources and financial capital (Sullivan, Brey, & Soleimanpour, 2021) and faced difficulties in sustaining services. Relatedly, a recent unpublished report analyzing national mental health service provision at SBHCs found financial support to be the strongest predictor of an SBHC having a mental health provider on staff (Sullivan 2021, unpublished data). SBHCs located in states with designated state funds for school-based healthcare are significantly more likely to offer mental health services to their patients (Sullivan 2021, unpublished data). Future research could explore the nuances of school-based mental health funding, including predictors of funding and sustainability factors.

Consistent with prior research, (Goddard, Sullivan, Fields, & Mackey, 2021; Sullivan, Goddard, Fields, & Mackey, 2021; Sullivan, Brey, & Soleimanpour, 2021) respondents reported telehealth as a crucial strategy to sustain service provision throughout the pandemic. While telehealth can offer many opportunities for sustained and convenient care, it also introduces concerns like privacy and the digital divide. (Anderson, 2018) SBHCs and their partner school districts found
ways to assuage these concerns, including communicating with youth before appointments to troubleshoot privacy concerns and increasing access to portable computers and internet connectivity. However, lack of internet access and its impacts on mental health care access, which disparately affect the underserved communities that SBHCs serve, (Sullivan, Goddard, Fields, & Mackey, 2021) was an ongoing concern. To improve health care access for youth, resources to ensure universal telehealth technology access are needed, as well as further research to identify successful strategies to address disparities in access.

Study findings also highlight how SBHCs pivoted, even with limited resources, to meet students’ increasing needs for mental health care. In addition to providing care via telehealth, SBHCs offered new innovative services to increase patient access and engagement, including art and music therapy and virtual office hours. Future research should gather greater details about how SBHCs put innovations into practice, as well as the effectiveness and sustainability of novel services and practices. Future evaluations should also explore how and whether these transitions are sustained as schools and SBHCs return to serving students in-person, as well as the impacts on student mental health care access and outcomes.

Similar to recent quantitative study results, (Sullivan, Brey, & Soleimanpour, 2021) this study finds that buy-in and partnership with schools and school districts is key to SBHC sustainability throughout the pandemic. The school-based healthcare delivery model is built on a partnership between schools, health centers, communities, so it is not surprising that it is this partnership that allowed many to sustain operations throughout this multi-faceted crisis. Correspondingly, parental buy-in and support was mentioned as both a key challenge and a key support to mental
health service provision, suggesting that it is a crucial component of sustained care. Future research could explore different types of SBHC partnerships and supports that are particularly beneficial to sustainability.

Finally, this study confirms that, although health providers nationwide worked to maintain continued care, there are gaps that occur within a completely virtual model. A unique benefit of the school-based healthcare model is its ability to integrate within a school, build crucial trust with students and staff, and normalize community health and health seeking behavior. When physical health providers, teachers, and school staff can refer students to mental health providers in the same location, this normalizes and routinizes referrals and mental health care. (School-based health centers: vital providers of mental health services for children and adolescents, 2018) Study participants noted a particular strain on referral systems throughout the pandemic, as well as difficulties assessing the nonverbal cues that point to mental health issues and learning disabilities. Future research can determine how to best support SBHCs in conducting screenings and facilitating virtual referrals should a similar situation to the COVID-19 pandemic arise.

5. Limitations
The authors note several study limitations. As mentioned, all session participants were muted and could not unmute themselves. This could have limited oral participation and conversation. Similarly, SBHA advertised the event as a listening session, and some participants may have joined only to listen and not to share. The large group setting could have thwarted participation or encouraged only participants successfully delivering mental health services to share. Lastly, participants may not have represented the experiences of SBHCs nationwide, though there was a
broad representation of states and organizations in the participant sample. Still, these study findings confirm similar research and offer many important avenues for future exploration.

Conflicts of interest: All authors have completed the ICMJE uniform disclosure form. Dr. Soleimampour serves as a research consultant to the School-Based Health Alliance. The authors have no other conflicts of interest to declare.

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Other Common Service Settings: A Systematic Review and Meta-Analysis. 
Administration and Policy in Mental Health and Mental Health Services Research. 


Table 1. Prominent Themes Shared through Mentimeter by School-Based Health Center Representatives in a Virtual Listening Session on Mental Health Service Provision during the COVID-19 Pandemic\textsuperscript{1,2}

<table>
<thead>
<tr>
<th>Themes</th>
<th>% of Responses Shared</th>
<th>Examples of Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SBHC patients’ presenting mental health problems and/or diagnoses compared to pre-pandemic (n=60)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety, depression</td>
<td>37</td>
<td>“Increased anxiety related to COVID and returning to face-to-face instruction.” “Increased anxiety, impacts of isolation on mood, increase in substance use.”</td>
</tr>
<tr>
<td>Acuity</td>
<td>13</td>
<td>“More acute needs for those who have put off care for a while.” “Seems to be more immediate and crisis centered.”</td>
</tr>
<tr>
<td>Grief, withdrawal</td>
<td>7</td>
<td>“Grief, numbness, withdrawn, less interest in activities.” “Refusing to go back to school - Loss of motivation and social skills.”</td>
</tr>
<tr>
<td>Care seeking</td>
<td>6</td>
<td>“I also notice more students and families open to seeking help.” “Willingness to share their thoughts and feelings more.”</td>
</tr>
<tr>
<td>Violence and post-4</td>
<td>4</td>
<td>“More PTSD; more family violence; more child”</td>
</tr>
<tr>
<td>Themes</td>
<td>% of Responses Shared</td>
<td>Examples of Experiences</td>
</tr>
<tr>
<td>--------------------------------</td>
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<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>traumatic stress disorder</td>
<td></td>
<td>abuse/emotional abandonment.” “Increase bouts of physical abuse.”</td>
</tr>
</tbody>
</table>

**Change in demand for mental health services compared to pre-pandemic (n=62)**

<table>
<thead>
<tr>
<th>Increased</th>
<th>81</th>
<th>“Increased need across all ages and diagnosis.” “Increased tremendously.” “More anxiety, depression and isolation.” “More suicidal ideation.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased</td>
<td>19</td>
<td>“Decrease in access to students who are learning virtually.” “Referrals are down and not because there is a lack of need but there has been a struggle to coordinate and stay connected with education staff for referrals without in person connection.”</td>
</tr>
</tbody>
</table>

**Challenges that affect mental health service provision (n=65)**

<table>
<thead>
<tr>
<th>Access</th>
<th>31</th>
<th>“Students who are not amenable to virtual visits.” “Access to students who’ve completely disengaged from school.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff and time</td>
<td>27</td>
<td>“There is more need than available support.” “Lack of mental health care providers.”</td>
</tr>
<tr>
<td>Resources</td>
<td>12</td>
<td>“Funding.” “Insurance reimbursement.”</td>
</tr>
<tr>
<td>Themes</td>
<td>% of Responses Shared</td>
<td>Examples of Experiences</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Communication, referrals, continuity of care</td>
<td>7</td>
<td>“Schools will be re-opening but they will not allow third party staff on campus, thus all [behavioral health] services will still need to be telehealth and struggle with the connections for referrals.” “Collaborating to provide education for students and parents.”</td>
</tr>
<tr>
<td>Parents</td>
<td>6</td>
<td>“Getting parental consent.” “Parental buy in.”</td>
</tr>
<tr>
<td>Privacy</td>
<td>6</td>
<td>“Privacy for telehealth.” “Confidential billing.”</td>
</tr>
<tr>
<td>Culture and/or language</td>
<td>4</td>
<td>“Language barriers.” “Cultural beliefs.”</td>
</tr>
<tr>
<td>Technology</td>
<td>4</td>
<td>“Some families did not have internet access for Zoom or Google meets.” “Working multiple systems.”</td>
</tr>
<tr>
<td>Mental health issues</td>
<td>3</td>
<td>“High levels of trauma.” “Worse anxiety.”</td>
</tr>
</tbody>
</table>

**Strategies SBHC is employing to administer mental health services (n=46)**

<p>| Telehealth                                 | 51                    | “Many in our state have had to use telephonic telehealth b/c internet/computer access and confidentiality aren't available to all.” “We have telehealth and in person |</p>
<table>
<thead>
<tr>
<th>Themes</th>
<th>% of Responses</th>
<th>Examples of Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>primary care and therapist options.</td>
<td>25</td>
<td>“Telehealth, phone and video, virtual office hours for parents.”</td>
</tr>
<tr>
<td>Partnerships, referrals</td>
<td>22</td>
<td>“Teaching staff about the toll of trauma and living with uncertainty/trying to prevent burnout.” “The school as partnered with local services to offer free Spanish-language services to the underserved Spanish speaking population.” “Weekly meetings with school counselors, school social workers, school nurse, and SBHC team to coordinate about student needs and assist with getting students to the SBHC for the best fit and referring as needed.” “Referrals from schools and our staff to mental health professionals.”</td>
</tr>
<tr>
<td>Operations</td>
<td>12</td>
<td>“Same day appointments when possible.” “Nurse practitioner screening for depression and other [behavioral health] issues and referring to social worker. Meet and greet social worker on the same day.”</td>
</tr>
<tr>
<td>Services</td>
<td>12</td>
<td>“Art therapy &amp; music therapy.” “Classroom support by counselors and psychologists.”</td>
</tr>
</tbody>
</table>
| Seeking grants and     | 3   | “Working with our school district which received a grant -


<table>
<thead>
<tr>
<th>Themes</th>
<th>% of Responses Shared</th>
<th>Examples of Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>funding</td>
<td></td>
<td>looking at our role at our SBHCs and Community Health Center.</td>
</tr>
</tbody>
</table>

Supportive factors that affect mental health service provision (n=54)

| Collaboration, teamwork, support | 59                     | “Strong school partners.” “Teacher support.” “District support.”                       |
| Resources                       | 21                     | “Grants.” “Funding.” Screening tools.” “Telehealth connection.”                        |
| Demand, acceptance              | 14                     | “Captive audience.” “Students that want help.” “Trust with students.”                 |
| Access                          | 4                      | “School access.” “Care on their campus.”                                             |

Mental health priorities at SBHC in the 2021-22 school year (n=42)

<p>| Addressing student mental health conditions | 43                     | “Addressing social isolation concerns. Reorienting students to developing positive relationships.” “Identify the students most at risk and get them connected to services.” |
| Staff                                        | 17                     | “Adding a [behavioral health worker] on staff part time.”                             |</p>
<table>
<thead>
<tr>
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<th>% of Responses</th>
<th>Examples of Experiences</th>
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</thead>
<tbody>
<tr>
<td><strong>Themes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>% of</strong></td>
<td><strong>Responses</strong></td>
<td><strong>Shared</strong></td>
</tr>
<tr>
<td><strong>Examples of Experiences</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Collaboration with our schools and their staff to provide immediate responses to behavioral health concerns and serve additional students. Currently in the planning phase.”</td>
<td>“Training all school staff on trauma informed practices and what resources are beyond the classroom to help those tier 3 kids.”</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td>14</td>
<td>“Better streamlined referral and closed loop for follow up.” “Continuing with effective strategies implemented during pandemic ---telehealth option.” “Developing peer groups to discuss suicidology.”</td>
</tr>
<tr>
<td>Outreach and access</td>
<td>14</td>
<td>“Engagement, outreach especially with Latinx students.” “Contacting &amp; assessing students.”</td>
</tr>
<tr>
<td>Safety</td>
<td>12</td>
<td>“Keeping the kids safe.” “Assuring students and staff that we are safe.”</td>
</tr>
</tbody>
</table>

1. SBHC respondents could choose not to answer Mentimeter question(s). Percentages and n size represent respondents to each open-ended question.

2. Participants could share multiple responses to each question.