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ORIGINAL PAPER

Remotely Successful: Telehealth Interventions in K-12 Schools During a Global Pandemic

Ashley-Marie Hanna Daftary[1]

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Abstract
The K-12 school setting is often considered an ideal environment to provide social emotional programming for children and youths. However, the COVID-19 pandemic caused most K-12 schools to close their physical doors and shift to telehealth approaches to fulfill students' academic and non-academic needs. For the first time, school social workers (SSWs), often responsible for the social emotional well-being of students, were required to provide social emotional services virtually. Subsequently, this research study explored SSWs' experiences implementing social emotional telehealth services in K-12 public schools during the spring semester of 2020. Twenty SSWs from nine school districts across three states participated in key informant interviews related to their experiences navigating their professional role during distance learning. Data were analyzed using a constant comparative approach. The findings highlight the barriers SSWs encountered when providing social emotional telehealth interventions, including poor attendance resulting in ineffective group interventions, technology-specific barriers, and concerns for students' privacy. Opportunities and potential solutions to strengthen telehealth in schools are discussed.

Keywords COVID-19 · School social work · Telehealth · Clinical social work

In response to increasing cases of COVID-19 in the spring of 2020, most K-12 schools within the United States closed their physical doors and shifted to distance learning. During this time, media attention related to school closures largely focused on how to best fulfill students' academic needs. However, schools provide much more than an education for students. In an effort to serve the whole child, schools aim to meet students' academic and non-academic needs to support healthy cognitive, social, and emotional development (Slade & Griffith, 2013). As such, schools provide resources and support—including school social work services—for children's physical, mental, social, and emotional health and safety (National Association of Social Workers [NASW], 2012; Slade & Griffith, 2013). Although school social workers (SSWs) dispense various services within the school community, they often spend the majority of their time providing direct services (i.e., small group and individual interventions) to students based on their individual needs and responses to interventions (Allen-Meares, 1994; Kelly et al., 2010, 2015; NASW, 2012). Because of the psychological and social challenges experienced by children and families during social distancing (Golberstein et al., 2020), the purpose of this paper is to explore SSWs' experiences when implementing social emotional telehealth services in K-12 public schools during the spring semester of 2020.

School Social Workers and Crisis-Intervention Work

Nation-wide school closures, coupled with the implementation of distance learning systems, are a novel occurrence. Subsequently, little relevant literature was available to guide SSWs as they began to navigate their professional role during the pandemic. Notably, research had been conducted on the H1N1 pandemic in 2009 (Cauchemez et al., 2009; Effler et al., 2010; Gift et al., 2010) and natural disasters, such as Hurricane Katrina (Maxwell, 2008; Pyles, 2006). Although this literature may provide insights into how SSWs respond during times of crisis, the widespread impact of COVID-19

✉ Ashley-Marie Hanna Daftary
Ahanna@unr.edu

[1] School of Social Work, University of Nevada, Reno, 1664 N Virginia Street, Nazir Ansari Business Building, 523C, Reno, NV 89557-0090, USA

is unprecedented. Before the spring/winter semester of 2020 (pre-COVID-19), no literature discussed the implementation of telehealth services by SSWs, or how SSWs should respond during a global health crisis that results in the physical closure of schools.

Emerging research since the pandemic began has provided insights into the impact of COVID-19 on K-12 students and the role of SSWs during the pandemic. Although children appear to be less medically vulnerable to COVID-19 than adults are, studies have indicated that social consequences of COVID-19—including enforced isolation related to the pandemic—have negatively affected the emotional and behavioral health of children and adolescents (Jiao et al., 2020; Kelly et al., 2020; Loades et al., 2020; Nearchou et al., 2020; Sedillo-Hamann et al., 2021). For example, a systematic review indicated that the impact of COVID-19 is associated with anxiety and depression in adolescents (Nearchou et al., 2020). Preliminary research in China suggests that school-age children (aged 6–18 years) display increased inattention and persistent inquiry and that anxiety, fear, and other emotions were the most prevalent in children living in the areas most affected by the pandemic (Jiao et al., 2020). In addition, a study of 1275 SSWs during the COVID-19 pandemic revealed that 30% believed that students experienced increased severity of mental health issues during the pandemic (Kelly et al., 2020).

Research suggests that SSWs can play a critical role in mitigating the negative mental health effects of COVID-19, especially because schools often function as de facto mental health service providers for many school-age children and adolescents (Ali et al., 2019). Unfortunately, even as students have experienced increasing mental health difficulties, SSWs have reported that student participation in social work services has decreased since the pandemic began (Kelly et al., 2020).

Kelly et al.'s (2020) technical report from their survey of 1275 SSWs during the pandemic identified various challenges experienced by students, staff, and schools. For example, many SSWs were unable to contact or had limited contact with some students during the shutdown. SSWs also indicated that the majority of families and students they serve experienced urgent needs related to the lack of mental health services, food insufficiency, health concerns, and housing instability. These needs were correlated with schools that serve students of color or schools in high-poverty areas, exposing existing racial and socioeconomic inequities (Kelly et al., 2020).

Although the technical report did not differentiate between the experiences of SSWs based on their school placement in public schools, charter schools, or school-based non-profit settings, Sedillo-Hamann et al. (2021) suggest that compared with the other school settings, SSWs placed in public schools might have experienced less immediate communication and direction related to school social work practice in the initial stages of the pandemic, leaving them uncertain as to how to best support their students. By contrast, SSWs placed in non-profits or charter schools (which tend to be smaller in size and have more autonomy than public schools) were given more flexibility and opportunities for innovation during this time of crisis than SSWs placed in public school settings (Sedillo-Hamann et al., 2021).

The technical report of Kelly et al. (2020) also summarizes initial findings related to SSW service delivery during the pandemic. For example, 84.2% of SSWs who participated in the survey reported that they delivered direct services to clients during the winter/spring 2020 semester (Kelly et al., 2020). Of those participants, 69% indicated that they had virtual, synchronous, face-to-face contact with clients. Additionally, 86% of SSWs "questioned the efficacy of remote SSW services as an ongoing mode of service delivery" (Kelly et al., 2020, p. 2). Although the report includes various details related to SSWs' schedules, modes of service delivery by grade level, student participation in SSWs' services, and challenges delivering remote SSWs' services, few details specific to telehealth were included.

Current Study

Few studies have examined school social work practice during COVID-19 and, more specifically, the provision of telehealth interventions by SSWs. Recognizing the psychological and social challenges experienced by children and families during social distancing, as well as the decreased level of student participation in school social work services since the pandemic began, the purpose of this paper is to explore the challenges and solutions SSWs experienced in implementing social emotional telehealth services in K-12 public schools during the spring 2020 semester (Golberstein et al., 2020; Jiao et al., 2020; Kelly et al., 2020; Loades et al., 2020; Nearchou et al., 2020). The primary research question is as follows: "What were the challenges that SSWs experienced, and what are potential solutions, as they relate to the implementation of social emotional telehealth services for students during the spring semester of 2020?".

Methods

Participants and Procedures

An exploratory qualitative research design was used to investigate SSWs' experiences during the spring 2020 semester. Purposive and snowball sampling methods were used to identify SSWs employed in K-12 public schools during the spring of 2020 and to invite them to participate in the

study. The researchers contacted SSWs through professional networks in Nevada, Colorado, and Minnesota and asked them to participate and/or share the recruitment invitation.

Twenty SSWs completed semistructured interviews between May 4 and June 17, 2020, via video conference. Before beginning the audio-recorded interview, each researcher and participant reviewed the consent form, which included express permission to be audio-recorded. Verbal consent (not written consent) was requested to protect the identities of the participants. All participants' names were replaced with pseudonyms to protect their identities.

The interview had two parts: a semistructured interview that was audio recorded and a demographic form. The audio-recorded portion of the participant interviews averaged between 1 and 2 h. The topics of the interview questions included describing school social work practice before and during the COVID-19 pandemic (during the spring semester of 2020). Examples of the questions are as follows: (1) What has been your experience as an SSW during the COVID-19 health crisis?; (2) Can you describe your typical day as an SSW since the COVID health crisis?; (3) Since COVID-19, what are your biggest concerns or challenges as an SSW? How have you addressed them?; and (4) What has been the most helpful for you in this crisis?

Data Analysis

The audio recordings were transcribed and uploaded to Atlas.ti 8.4.4 qualitative-data-analysis software. Transcripts were then analyzed through a constant comparative approach that included three coding cycles (Charmaz, 2014; Saldaña, 2009).

In the first coding cycle, a holistic coding approach was used (Saldaña, 2009). During this process, codes were applied to large sections of data "to capture a sense of the overall contents and the possible categories that may develop" (Saldaña, 2009, p. 118). The codes were, for example, attendance, training, individual telehealth interventions, and telehealth group work.

In the second coding cycle, in vivo coding was applied to all data related to telehealth or synchronous virtual interventions (Saldaña, 2009). Within this process, codes were derived from "the participant's own language" (Saldaña, 2009, p. 66). The codes were, for example, parents right there, no interest in Zoom, students not responding, video call increased intimacy, and families dropping into session.

In the third coding cycle, a "focused coding" strategy was applied to identify telling codes or create new codes that subsumed various codes (Charmaz, 2014, p. 138). This process condensed the work from the prior coding cycles and highlighted what was most important. The codes were, for example, positive aspects of telehealth, ways to strengthen telehealth, lack of attendance, barrier to students' privacy, and technology barriers. Ultimately, this process enabled the synthesis, analysis, and conceptualization of larger segments of data than would otherwise be possible.

Throughout the data analysis, memos were written to highlight emerging themes, different or contradictory experiences, and the researcher's reflections. In addition, to reduce the potential of bias and strengthen the credibility of the findings, member checks were completed to confirm the findings (Charmaz, 2014).

Findings

Participant Characteristics

The participants worked in nine districts across three states (Colorado, Nevada, and Minnesota). Most participants (n = 14, 70%) worked urban schools. Over three quarters of the participants (n = 16, 80%) worked in general education settings; the others (n = 4, 20%) worked in alternative school settings (e.g., behavioral placements). Participants' ages ranged from 27 to 51 years, and the mean age of participants was 37 years. Nearly all the participants identified as female (n = 18, 90%). There was little racial or ethnic diversity among participants. Most identified as White (n = 15, 75%); two participants (10%) identified as Asian; two participants (10%) identified as Hispanic; one participant (5%) identified as Black. Participants reported an average of 8.6 years of post-MSW degree social work experience.

Five participants across school demographics (i.e., elementary, middle, and high schools) reported having success with synchronous telehealth interventions (mostly individual interventions). However, only two of these participants described their role as primarily student-facing in the spring of 2020 (i.e., spending 80–90% of their workday providing virtual synchronous interventions to students). Another seven participants, across school demographics, reported that they attempted to provide synchronous telehealth interventions, although these services were limited and/or not generally successful. The majority of their time was dedicated to attendance related duties, providing resources to students and families, and/or completing paperwork related to special education evaluations. Eight participants, across school demographics, did not discuss engaging in telehealth interventions. Instead, these participants reported limited student interactions after their school(s) transitioned to remote learning. These SSWs reported that they generally engaged with students and/or families on the phone. These check-ins were mostly related to the provision of resources to fulfill families' basic needs (e.g., food, housing referrals) and/or attendance checks.

Direct Practice Telehealth Interventions: Challenges and Opportunities

Participant narratives indicate that SSWs' mode of communication with parents did not notably change during remote learning because SSWs "typically communicated with parents by phone anyways". However, the mode of communication with students changed significantly. Unable to meet with students in person, SSWs indicated that they attempted "different methods of engaging the students" during distance learning, including phone calls, texts, emails, and video conference calls. The various modes of communication served different purposes and resulted in varied success that depended on the age of the students, the relationship between the SSW and student, and the purpose for the contact. The most regular tier two (small group) and tier three (individual) meetings with students during distance learning, however, were held via video conference (also described as telehealth sessions). The findings section focuses on SSWs' experiences with providing telehealth services, specifically the barriers they encountered, as well as opportunities and potential solutions to strengthen telehealth services during the crisis.

Theme 1: Barriers of Telehealth

SSWs identified various barriers to productive telehealth services, including poor attendance (especially in group interventions), technology-specific barriers (e.g., absence of curricula and tools specific to telehealth), and concerns regarding students' privacy.

Poor Attendance in Direct Practice Telehealth Interventions

The barrier to successful telehealth appointments most often reported was poor attendance. Several SSWs indicated that some students expressly stated that they did not want to meet through video conference, and others refused to meet virtually because they "don't like being on camera". Although SSWs indicated that attendance was a problem for individual and small group interventions, the latter was the most affected. SSWs that attempted to run groups virtually agreed that small group interventions were largely unsuccessful due to poor attendance.

For some SSWs, the purpose of the group and the needs of the participants made telehealth groups inappropriate. Hannah, an SSW at an urban middle school and an Affective Needs (AN) high school, stated: "I set up online groups and the one group…I was like, 'this isn't going to work on my autism group.'" Other SSWs reported that even when the group appeared to be appropriate and reasonable per its membership, poor attendance was a constant problem. Faduma, an SSW at an urban high school, stated:

> Before COVID, I had partnered with one of our school-based therapists to do a girls' group. We attempted to do the girls' group virtually. We had very bad attendance. We tried to move the time to a later time. First, we tried 12 [p.m.]… that didn't work. We went to 1 [p.m.], and we went to 2 [p.m.]. We just got really low turnout.

Although this group had met consistently during in-person learning, when schools moved to remote learning, attendance waned even when the SSW was flexible with scheduling times. Elena, an SSW at an urban high school, had a similar experience.

> I was doing a[n in-person] girls' group every Tuesday. And they loved it, and it was so much fun. And they were like, "can we do it two days a week? Can we have girls' group today?" And, so, I was like, "let's have a virtual girls' group," and nobody showed up.

Ultimately, even when students expressed interest in or appeared to be enthusiastic about a group, telehealth group sessions were poorly attended.

SSWs hypothesized that attendance for small group telehealth sessions was generally poor because there were "no physical common space and time space". Hannah, an SSW at an urban middle school and AN high school, explained:

> Pre-COVID, I would have them all because I had the ability to go physically find them [students] in the building and say, "Hey, we have group right now," whereas [for telehealth], I will spend an hour before group calling each parent, texting each kid, sending an email saying "group in an hour, group in an hour, group in an hour". Parents will be like, "Oh yeah, we know group in an hour". The kid will text back "Okay Ms., group in an hour," and then you get on and literally no one is there.

In a typical school environment, SSWs know where their students are and can meet them at their classroom for scheduled appointments as needed. This practice no longer being a possibility during distance learning resulted in a decrease in attendance.

Technology-Specific Barriers

Although technology enabled SSWs to meet virtually with students when in-person meetings were prohibited, technology also presented many barriers to student engagement. Various SSWs indicated that the insufficient accessibility to technology created a barrier for students to engage in the available social emotional telehealth interventions. Julia, an SSW at a suburban elementary school, explained that when parents do not have the necessary

computer literacy skills (e.g., "parents don't know how to sign in") or "computers break," students are not able to access the academic and social emotional resources available to them. In addition to problems with technology, not having high-speed internet created a barrier for student engagement in academic and social emotional services. Rosie, an SSW at an urban high school, stated:

> For some students, it's just really hard even to connect to the internet… We've had to spend a lot of time just working on the connection and, "Oh wait, can you say that again? It cut out. Can you say it again? It cut out. I can't hear you," things like that… The majority of my students get really annoyed by it, and they're like, "I'm done. I'm not going to keep doing this". Before our time is even up, they end it and I cannot get them to re-engage.

Ultimately, poor internet connectivity makes fluid conversation impossible, creating increased frustration and difficulty for students when engaging with the social emotional services offered.

SSWs also identified the absence of tools and curricula specific to telehealth as a barrier. Tula, an SSW at a suburban/rural elementary school, stated, "It's almost not even comparable to being at school [where] I have this cool sensory room…I just had so many more tools right at my fingertips… Now my tools are, 'how`s it going?'…Our work together feels limited". Hailey, an SSW at an urban elementary school, expressed that the social emotional curricula available to her during in-person learning were no longer accessible with distance learning: "I couldn't find my curriculum, and there weren't guided lessons… they didn't have guided lessons at home that were organized, and I was able to dole out to kids".

Although tangible materials (e.g., sensory rooms, curricula) are important, one of SSWs' most vital tools are often themselves. Being physically present to assess energy, facial expressions, or tone is helpful in gauging a student's needs. Equally important is physicality, performing an activity together (e.g., drawing), giving a high five that results in physical touch and connection, or proximity, which can all be used in the therapeutic process. These tools are not accessible through telehealth meetings. Hailey stated:

> Barriers to my work? So, it was just so different not sitting next to a kid. It was so different not starting stuff out with like a hug or a high five or like a let's sit next to each other and have really genuine check-in because I can tell by your face that you're upset.

Ultimately, SSWs felt that much of the nuance or art of their practice was lost through telehealth.

Concerns Regarding Students' Privacy

SSWs expressed various concerns about privacy that must be considered when practicing telehealth. Kate, an SSW at an urban middle school and high behavioral placement school, stated, "Everybody is saying, 'Go ahead, use Zoom. Go ahead, do it.' But, I also know from the very first webinar that [holding sessions via] anything other than face to face, their privacy and their confidentiality could be compromised". In addition to privacy concerns related to the mode of communication (i.e., Zoom), some participants reported increased privacy concerns related to family engagement during COVID-19. For example, multiple participants described holding telehealth sessions with a student when, suddenly, a family member would wander into the room or make an off-camera comment. At times, these interruptions were perceived as positive because they enabled parents to increase their engagement with and understanding of their child's social emotional interventions. However, in other cases, unannounced family engagement posed both confidentiality risks for the student and ethical concerns for the SSW. Patricia, an SSW at an urban middle and high school charter school, stated:

> [If] there's a lot of tension at home… and their parents are also right there, they're teenagers, they're not going to be like, "Yeah, things are really shitty". They're not going to say that when their dad is hovering over the screen.

In addition, two participants reported concerns that the virtual calls could feel invasive of families' rights to privacy. For example, with virtual meetings, staff have a direct view into families' homes—whether the family chose the virtual format or not. Julia, an SSW at a suburban elementary school, stated: "We have parents who don't want people to see into their homes. So, the kids aren't participating that way". These concerns are valid because the increased access to families' homes could lead to unwarranted surveillance by staff.

Theme 2: Opportunities and Potential Solutions to Strengthen Telehealth

Although SSWs acknowledged various problems with telehealth, they also shared the benefits of distance learning and the telehealth model. On a typical day before the COVID-19 pandemic, SSWs often had to multitask and little to no spare time. Patricia, an SSW at an urban middle and high school charter school, said, "It was just constant multitasking. I never had a quiet minute where I wasn't getting a message, an email, a call, or my walkie-talkie was going off". Similarly, Hannah, an SSW at an urban middle school and AN high school, stated, "It's like we're always drinking from a

firehose, but if we did prevention work maybe we wouldn't be drinking from a firehose, but there's never enough time. There's never enough time to do prevention".

No longer on campus and responsible for managing in-the-moment crises (e.g., behavioral outbursts, completing suicide risk reviews), various participants indicated that distance learning increased their accessibility to students as well as their time for planning impactful activities. Kamir, an SSW at an urban middle school, stated:

> I'm more accessible now than I ever was before, because, you [students] can just send me a message and no one's going to know you said "hi" to me, no one needs to know any of that stuff. And then whatever your need is, we can meet it and no one knows that.

Patricia, an SSW at an urban middle and high school charter school, indicated that the remote work minimized interruptions or time spent managing in-the-moment crises (e.g., behavioral outbursts, completing suicide risk reviews), which enabled her to be more intentional about the activities and interventions used with students during distance learning. With more time to plan than before the pandemic, Patricia said that she could make "an entire beautiful 7 weeks' worth of social emotional activities for kids to do".

In addition to having time for more thoughtful student interventions, some SSWs indicated that meeting virtually with their students rather than in person enabled them to gain a fuller understanding of the students and build rapport. Tula, an SSW at a suburban/rural elementary school, stated:

> In other ways it's been really eye-opening because I'm seeing in their home when we're on Zoom… so I'm hearing what's going on. I'm just getting to see another part of their life that I wouldn't have seen otherwise, and that`s been really, really cool. And that way it feels like it helps build the relationship.

Effective Supports and Strategies for Successful Telehealth Services

SSWs provided strategies to support students' engagement in and attendance of group and individual telehealth sessions. Various SSWs discussed the benefits of having prepared social emotional curricula and activities specific to the telehealth modality. Although not available for most SSWs, those with access to prepared curricula and activities felt more equipped to be successful in telehealth intervention provision. At times, this structural support was provided by the school district. Other times, SSWs were responsible for translating social emotional curriculum or creating activities appropriate for telehealth. Hailey, an SSW at an urban elementary school, stated:

> Well, the district did something really great. A high-up in our department put together Google Classroom… they created video lessons and assignments, and made it into a classroom. And so, there was already district-approved lessons, and then you could base your conversations with kids off of that, which was super helpful.

When access to online social emotional curricula and activities was not provided by a school district, some SSWs spent substantial time creating or translating social emotional curricula and activities to be used in telehealth and/or asynchronous Google Classroom activities. Although time-consuming, this preparation has long-term advantages.

In addition to preparing activities and creating structures to support social emotional telehealth innovations, SSWs reported that "soft skills", such as positive regard and empathy, were useful to engage students who might be hesitant to participate in telehealth sessions. Holly, an SSW at an urban elementary school, reflected on her discomfort with sharing her home and how she used it to connect with what her students might be feeling. She stated:

> I did not expect that my home was going to be on display as much as it is, you know? Like that feeling of–not invasion–it definitely never felt like that intense, but navigating [family interruptions] the little one's downstairs and the dog. And then, recognizing that and mirroring that in the kids that I did get to see. It's like, "Oh, wow, this is really—this is hard for you, right? Because Mom wants you upstairs in this room and the dog's barking". … I just didn't think that we would be navigating those things ever.

SSWs who provided telehealth interventions to students indicated that they minimized their expectations for each session. Even SSWs who reported success with their student telehealth interventions expressed that their interventions were less demanding or intensive than when they met with students in person. Aubree, an SSW at an urban alternative high school, explained, "It just is harder to kind of go as deep and have the same kind of connections". Rather than aiming to engage in deep therapeutic work, SSWs aimed to connect with students by simply checking in and/or playing games.

For SSWs to provide interventions, students must be willing to meet with them. Many SSWs indicated that they had positive relationships with students before distance learning. However, changing to a telehealth model necessitated developing online rapport so that students wanted to engage in telehealth sessions. Julia, an SSW at a suburban elementary school, discussed the importance of having fun so that students felt "comfortable online versus only [being] stressed

out online". She thought this strategy might help students reach out for or engage with support when needed.

In addition to prioritizing enjoyable activities over intensive interventions, Hailey, an SSW at an urban elementary school, discussed the importance of consistency. She explained that the "beginning and end [of each session] were always the same as what they are in the building". In addition to knowing what to expect from each session, another key element of consistency was related to scheduling and increased communication. Hailey stated:

> I would email the student and then the parent, "Hey, I'm going to be meeting with you on this day at this time. Go to [website]. Here's the nickname. I'll see you there". If a kid wasn't on, I could text their mom real quick and be like "Hey, did he forget again?" or "Is he reading?" And then they would remind their kid and they'd get on.

Although these reminders were important, what was most helpful was the organization and structure created by Hailey's school principal. The entire school shared calendars outlining the expected academic time and open time for interventions from special services providers (e.g., SSWs). Subsequently, the service providers uploaded their specific calendars, ensuring that no students were double booked. Hailey said, "It was a lot of work at the front end, but it really, really helped because there were no conflicts with it later". Hailey was one of two SSWs who reported maintaining her direct services hours with students during distance learning, reporting an 80% attendance and engagement rate. Hailey's experience highlights the importance of clear communication and coordination between teachers and special service providers so that schools can continue to achieve their objective—attend to the whole child.

Discussion

This study was exploratory and cannot be generalized to all school settings or all SSWs who provided telehealth services during the spring 2020 semester. Nevertheless, the participant narratives provide insights into the SSWs' experiences with synchronous virtual (telehealth) interventions during the initial stages of the COVID-19 pandemic.

Acknowledging that each home has its limitations to confidentiality, the findings suggest that SSWs should consider and openly discuss the limits to confidentiality with students and parents or guardians before receiving consent for telehealth interventions. Recognizing the barriers to successful group interventions (e.g., poor attendance) via telehealth, SSWs may want to consider other ways to connect with students in need of tier two social emotional support. For example, they could schedule regular virtual office hours or drop-in sessions. SSWs could also provide shorter, regular individual check-ins with students via telephone, text, and/or telehealth.

A necessary part of school social work practice is developing the necessary rapport with students. During a life-altering pandemic, playing a game, being present with a student, or otherwise not "forcing" an activity or intervention can be therapeutic because of the sense of normalcy these interactions provide. Moreover, maintaining relationships through this crisis can help provide the necessary groundwork for continued and more in-depth therapeutic work when school doors open. Because of the limitations of confidentiality, regular check-ins and positive rapport building should not be overlooked as meaningful interventions during distance learning.

Various SSWs indicated that technological difficulties prohibited students from engaging in academic and social emotional supports. This finding is especially problematic because students who are more likely to access mental health services in their educational setting (i.e., students in low-income homes and/or from minoritized racial or ethnic groups) are less likely to have access to the technology (i.e., high-speed internet, capable equipment) and need to access SSW telehealth services (Ali et al., 2019; Dolan, 2016). Subsequently, increased funding and resources should be funneled to schools that serve lower SES communities so that all students have equal access to academic and non-academic services. This additional funding would allow for improvements in the computers and high-speed internet hot spots provided to students and augmented supports (i.e., computer literacy training) for students and families that need it most. Increased funding is not only necessary during the pandemic but also after it ends. Funding should be prioritized for schools that have been most negatively affected by the pandemic (i.e., students who have fallen behind academically and/or who have been negatively impacted socially, emotionally, or behaviorally).

Implications for Future Practice

When schools return to in-person learning without social distancing restrictions, SSWs will probably revert to pre-COVID practices (i.e., meeting in person and eliminating telehealth for student interventions). That said, increased awareness and use of telehealth services during the COVID-19 pandemic might provide an opportunity for SSWs to improve parents' inclusion in students' interventions (or, at a minimum, to create goals and update parents on progress). This type of communication supports families' ability to reinforce interventions at home, increasing the likelihood of success (Adams et al, 2010; Witt et al, 1983). This type of telehealth service is especially important for families who are more likely to rely on the school for mental health

services (i.e., students in low-income homes and/or from minoritized racial or ethnic groups) (Ali et al., 2019). Virtual meetings and telehealth appointments also have the potential to increase parental involvement in parent–teacher conferences, behavior planning meetings, and risk/harm assessments. In addition, social emotional supports that have been made more accessible through a school's website, Google Classroom, or parent newsletters should continue.

Multiple SSWs indicated that when performing remote work, they had more time available because they were no longer responsible for managing, for example, in-the-moment emotional or behavioral outbursts and facilitating suicide risk reviews. This new setting provided SSWs with more intentional planning time for preventative interventions than was available in their original setting. Although challenging, SSWs should work with their administrators to schedule planning time and set boundaries around their role in engaging in emergent (i.e., student exhibiting suicidal ideation) and non-emergent situations (i.e., emotional or behavioral outbursts that can be managed by a teacher or administrator).

Limitations

The role of SSWs can differ substantially by the school context (i.e., grade level, student demographics, school needs). According to a review of the literature prior to data collection, the role of SSWs during the physical closure of schools during a pandemic had not been examined. Thus, this research study attempted to capture the experiences of various SSWs as they provided telehealth social emotional interventions during the initial stages of the COVID-19 pandemic (spring 2020 semester). Subsequently, the findings cannot be generalized to all school settings or SSWs. Instead, the findings offer initial insights into the experiences of the SSWs during the initial stages of the pandemic.

Many of the barriers SSWs encountered when implementing telehealth interventions with students (individual and small groups) in the spring 2020 semester might be related to schools and SSWs being thrust into remote practice without prior experience. In addition, rather than focusing on direct service to students (i.e., small group and individual student interventions), many SSWs were initially tasked with connecting with parents and families to ensure that their basic needs (e.g., food, housing, academic) were fulfilled (Daftary et al., 2021). Continued research related to the utilization of telehealth in schools is necessary to improve the understanding of the limitations and opportunities for SSW. In addition, further research should consider how lessons learned from the spring 2020 semester influence the implementation of remote interventions in the future.

Similar to the findings of the technical report of Kelly et al. (2020), findings suggest that participants from this study were not confident in the efficacy of telehealth interventions. Although twelve participants attempted (synchronous virtual) telehealth interventions with students, only two participants described their role as primarily student-facing in the spring of 2020 (spending 80–90% of their workday providing virtual synchronous interventions to students). Additionally, just five of the participants who attempted telehealth interventions reported success. Subsequently, rather than describing what worked or went well, the findings primarily focused on the difficulties and limitations SSWs experienced when providing telehealth interventions. Further research should focus on successful telehealth interventions, implications for SSWs' practice, and possible interventions.

Conclusion

The findings from this study highlight the barriers and opportunities SSWs encountered when providing social emotional telehealth interventions during this time of global crisis. Addressing the barriers described in this paper has implications for school social work practice in the short and long term. In the short term, continuing social emotional interventions during distance learning creates consistency and accessibility to social emotional supports that could reduce the burden of ground to cover when students return to their physical school. In the long term, scheduling planning time for SSWs to focus on prevention work, increasing parent engagement in social emotional interventions, and advocacy for additional funding to decrease current disparities could have positive impacts on students after distancing restrictions are rescinded.

Declarations

Conflict of interest The author declares that the author has no conflict of interest.

Ethical Approval More specifically, the research involved human participants and the Institutional Review Board at the University of Nevada-Reno determined the research to be exempt.

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Ashley-Marie Hanna Daftary is an Assistant Professor at the University of Nevada, Reno School of Social Work. Her research focuses on structural inequities and anti-oppressive practices across systems, including immigration, education, and policy-making.