Development and implementation of the Massachusetts technical assistance center for school-based behavioral health

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This report was developed by the Behavioral health Integrated Resources for Children Project (BIRCh), representing a collaboration between the University of Massachusetts Boston and the University of Massachusetts Amherst and funded by Boston Children's Hospital.

The mission of the BIRCh Project is to provide professional development and resources for schools and strengthen the coordination of behavioral health supports provided by school and community agencies. More information is available at **www.umb.edu/birch**, or contact us at **Birch.project@umb.edu**.

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EXECUTIVE SUMMARY

Introduction. The BIRCh Project at the University of Massachusetts (UMass), in partnership with the Massachusetts Association of Mental Health (MAMH), contracted with the Department of Mental Health (DMH) to create a plan for the development of a School-based Behavioral Health Technical Assistance (TA) Center. As part of this project, the BIRCh Project collaborated with educational and community organizations devoted to serving the learning and mental health needs of children across the Commonwealth to conduct a needs assessment. Three essential questions guided this assessment:

1) What ***resources*** are needed to develop and sustain a TA Center?
2) What are the essential ***operations*** and design of a TA Center?
3) What are the intended and achievable ***impacts*** of a TA Center?

Methods. To answer these questions, a comprehensive needs assessment was conducted in which experts from other states, leaders across Massachusetts, and Massachusetts school and community-based professionals were consulted through interviews, surveys from nearly 500 school and community behavioral health professionals across Massachusetts, and focus groups with school and community providers.

Recommendations. Based on this study, there are clear recommendations for a TA Center to take a phased strategy to support school districts in developing comprehensive and sustainable school mental health structures. Grounded in an Interconnected Systems Framework (ISF) and an equity driven approach, the TA Center will provide regional support to districts at varying levels of intensity according to district need. Each regional hub will develop formal partnerships with associated Community Behavioral Health Centers according to the New Behavioral Health Roadmap (Executive Office of Health and Human Services, 2021), and all TA Center operations will be coordinated by the TA Center's central office.

In its direct work with districts and community partners, the TA Center will support the implementation of social, emotional, and behavioral screening, programming and instruction related to behavioral health promotion, training and support for evidence based practices and interventions at Tiers 1, 2, and 3, and strategies for connecting students and families with community resources. In addition, the TA Center will support districts in developing the structures to sustain this work, such as clinical supervision and leadership and effective staffing models.

At the universal level, all districts will have access to online learning modules, resources on best practices, drop-in support hours, and annual live training. For a select group of schools, group supervision and Professional Learning Communities will be coordinated with Community Behavioral Health Centers (according to the New Behavioral Health Roadmap). Finally, individualized coaching will be available for targeted districts with the greatest needs. Regionally-coordinated services will be geared toward school and district behavioral health teams and community agencies. Supports will also be responsive to local and regional needs and inform workforce development efforts.

INTRODUCTION

The BIRCh Project at the University of Massachusetts (UMass), in partnership with the Massachusetts Association of Mental Health (MAMH), contracted with the Department of Mental Health to create a plan for the development of a School-based Behavioral Health Technical Assistance (TA) Center. As part of this project, the BIRCh Project collaborated with educational and community organizations devoted to serving the learning and mental health needs of children across the Commonwealth to conduct a needs assessment.

Three essential questions guided this assessment:

1) What ***resources*** are needed to develop and sustain a TA Center?
2) What are the essential ***operations*** and design of a TA Center?
3) What are the intended and achievable ***impacts*** of a TA Center?

Guided by these questions, this needs assessment culminated in a plan detailing a phased approach for the development and operations of a TA Center to meet the behavioral health needs of students across Massachusetts.

BACKGROUND

Behavioral Health Needs. The behavioral and mental health needs of children have been called a 'silent epidemic' with grave implications for families and communities (Anderson & Cardoza, 2016). Suicide is now the second leading cause of death for youth between the ages of 10 to 24 (Curtin, 2020). It is estimated that between 13-20% of children living in the United States are affected by mental illness in a given year, and yet our nation's response continues to fall short. The vast majority (80%) of children identified as in need of services receive no intervention, and these are disproportionately children of color and low-income children (Caldarella et al. 2008; Kataoka et al., 2002; Perou et al., 2013).

The COVID-19 pandemic has both exposed and enhanced this behavioral health crisis and inequitable access to treatment.

behavioral health challenges impact up to 20% of our state's students.

Behavioral health is a significant barrier to student success in Massachusetts. In Massachusetts, in 2014, 12.4% of adolescents in our state experienced a major depressive episode, only half of whom received treatment (SAMHSA, 2017). This number has grown to 13.8% as of 2021. Moreover, 19.5% of students have been identified as qualifying for special education services under the category of Serious Emotional Disability. However, only 37.7% of students received some kind of consistent mental health support (Mental Health America, 2021). Notably, 61.2% of youth with depression in our state did not receive any treatment (Mental Health America, 2021).

School Based Intervention. Among children who do access services, schools play an integral role (Farmer et al., 2003; Merikangas et al., 2011). With half of all lifetime mental illnesses beginning by age 14, and three quarters by age 24, intervention for school-age youth is key.

The school setting is a convenient location that reduces a variety of access barriers (Blake et al., 2001; Durlak et al., 2011). In Massachusetts as of July 2019, the estimated general population was 6,892,503. During the 2018-2019 academic year, each day 951,631 students entered our public schools, in addition to 134,259 full-time teachers and staff (89% white). In total, 1,085,890 people entered our schools every day. One out of every 6 people (16%) in Massachusetts enter a public school on any given weekday.

Moreover, schools are particularly important in supporting recovery from community disasters, as children are more likely to consistently access services provided in schools than in community-based settings (Jaycox et al., 2010). Yet, even within the context of school settings, access to needed behavioral health services varies tremendously across geographic regions, states, and local communities. Despite the vast number of children influenced by the education system, there is inequitable access to school-based behavioral health supports across the Commonwealth.

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Throughout the Commonwealth, schools often struggle to effectively implement a continuum of student support initiatives that promote healthy development and address mental health needs of students. Numerous overlapping agencies support the development of the whole child, yet some of our most vulnerable children experience limited access to services due to fragmented organizational systems. Even though Massachusetts is the leader in academic achievement, the lack of integrated behavioral health services results in vast disparities and a failure to address the demonstrated needs of children.

According to 2018-2019 data, 26 Massachusetts school districts were identified as having both the highest level of student economic need and poorest staffing ratios for student support personnel (i.e. school psychologists, school nurses, etc.). These districts spanned every geographic region and county in Massachusetts (with the exception of Dukes, Nantucket, and Norfolk counties). Districts near urban centers and in rural towns were overrepresented among districts with high economic need, and 54% of these districts are recognized as “Gateway Cities.” Among these districts, the proportion of Hispanic students in high needs districts was 11.4% higher than the state average and the proportion of students who spoke a first language other than English was 7.2% higher than the state average.

Districts with the highest economic need of students and the lowest staffing ratios of behavioral health providers, also received less support from outside agencies. Notably, 26.9% of identified high needs districts did not participate in an Educational Collaborative, and 34.6% of these districts did not access any Department of Elementary and Secondary Education (DESE) grants targeting behavioral health (BIRCh Project, 2020). Even when considering community-based services, such as Children's Behavioral Health Initiative (CBHI) services, schools, particularly those serving students with the greatest needs, are continuing to fall short.

In light of these resource map findings, previous recommendations included: 1) Consistent and Coordinated Professional Development, 2) Support Workforce Development Opportunities, 3) Supportive and Collaborative Partnerships, 4) Incentivizing Collaboratives, and 5) Regional Technical Assistance Centers (BIRCh Project, 2020). Each of these recommendations is addressed in the plan for TA Center development, and all recommendations are aligned with the SBBH Policy Recommendations from the SBBH Advisory Board (May 26th, 2021).

FIGURE 1. 2018-19 MAPPING RECOMMENDATIONS

Interconnected Systems Framework. To address the inequitable and fragmented educational and behavioral health service systems, school districts need a framework to organize and guide implementation of school-based behavioral health supports. The ISF effectively links School Mental Health (SMH) with the multi-tiered systems of support (MTSS) framework. The ISF is grounded in a public health approach, leverages the individual strengths of each of these processes, produces enhanced teaching and learning environments, and is guided by principles of implementation science with SMH (ISF; Barrett, Eber, & Weist, 2013). The ISF framework emphasizes capacity building of schools and integration of community-based behavioral health supports to reduce fragmented service systems. Within the school setting, educators and school professionals implement universal interventions to promote protective factors associated with resilience and positive development, thus extending interventions beyond the individual students and into the ecology of the schools, where systemic efforts include factors of students' academic and behavioral success (Doll & Cummings, 2008). The ISF addresses critical gaps by blending "education

and mental health systems and resources toward depths and quality in prevention and intervention" and allows for greater efficiency and effectiveness (Barrett et al., p. 4).

The ISF is a locally driven, community-based model that promotes collaboration among systems (schools, districts, community agencies and institutions, and medical settings) that deliver behavioral healthcare services. The model emphasizes evidence-based teaming structures (developing a multidisciplinary team at the school and district levels, crafting mission statements, clearly outlining roles and responsibilities, incorporating stakeholder input, aligning initiatives across teams), implementation of evidence-based instruction and interventions that are culturally and contextually relevant for the needs of the local community, and assessment and data-based decision making. Systems level assessment data is used to inform systems changes to foster positive school climate to support the wellbeing of students, educators, staff, and families.

the TA Center will support districts in developing the structures to sustain this work, such as clinical supervision and leadership and effective staffing models.

With its integration of implementation science, MTSS principles, and focus on inter-agency collaboration, ISF has been selected as an organizing framework for the needs assessment, development, and operations of the TA Center.

PURPOSE

The overarching purpose of a School Based Behavioral Health TA Center is to work with district level behavioral health leadership teams, in partnership with community agencies, to build and sustain district capacity to effectively meet students' behavioral health needs through the implementation of an Interconnected Systems Framework. Taking a public health approach, the TA Center will support districts at varying levels of intensity according to district needs. The TA Center will also enhance partnerships between school, community, and state agencies, and will operate in close partnership with regional CBHCs according to the New Behavioral Health Roadmap.

In its work with districts, the TA Center will support the implementation of social, emotional, and behavioral screening, programming and instruction related to behavioral health promotion, training and support for the selection and implementation of evidence based practices and interventions at Tier 1, 2, and 3, and strategies for connecting students and families with community resources. In addition, the TA Center will support districts in developing the structures to sustain this work, such as clinical supervision and leadership and effective staffing models. Ultimately, the goal of the TA center is to build local and regional capacity of schools to respond to behavioral health needs of students, with systematic and coordinated community partnerships. In line with these goals, and in collaboration with stakeholders across the state, essential questions guiding the current needs assessment included:

1) What ***resources*** are needed to develop and sustain a TA Center?,
2) What are the essential ***operations*** and design of a TA Center?,
3) What are the intended and achievable ***impacts*** of a TA Center?

METHODOLOGY

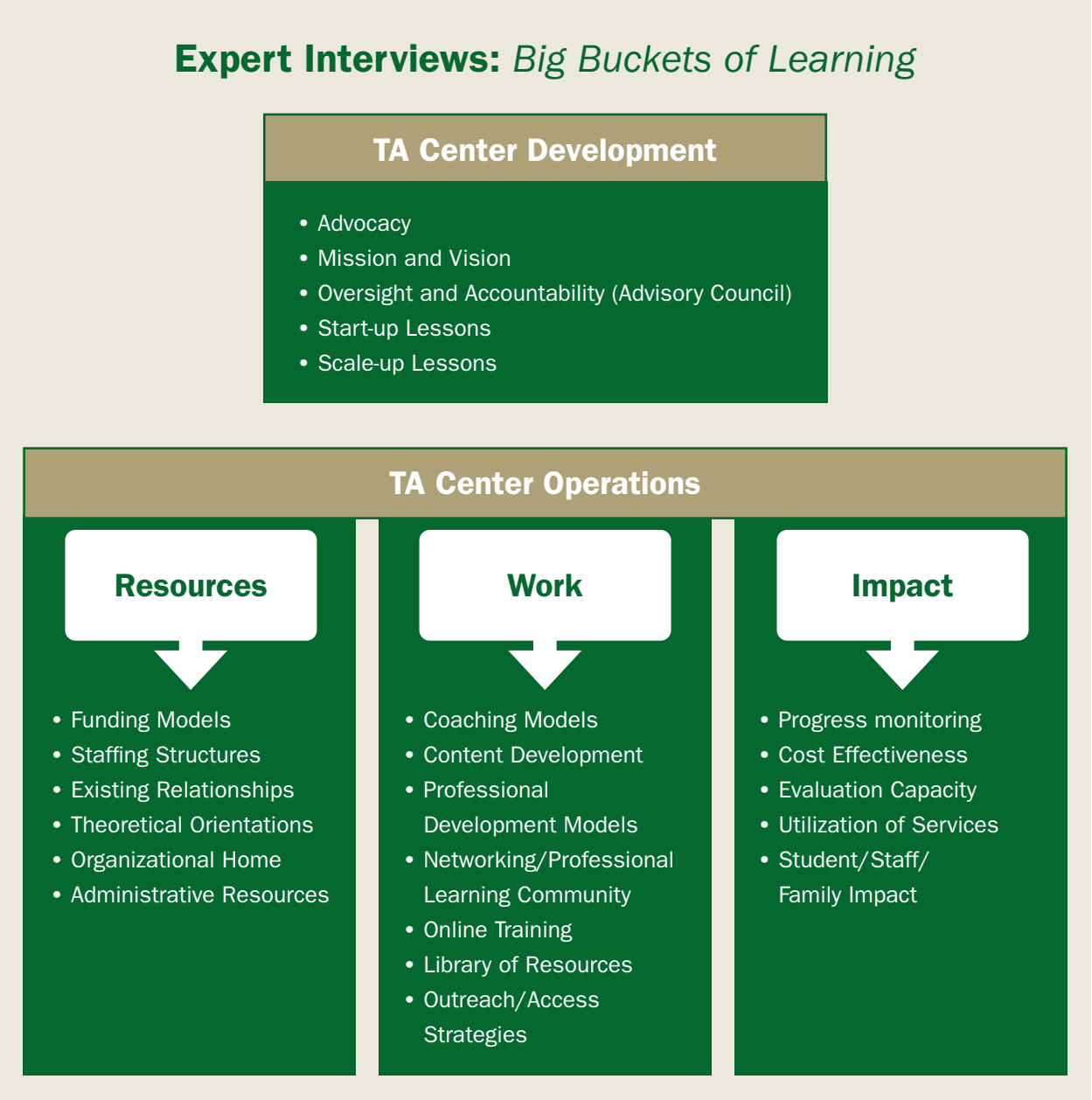
A comprehensive needs assessment was conducted in which experts from other states, leaders across Massachusetts, and Massachusetts school and community-based professionals were consulted through interviews, a survey, and focus groups. This section briefly describes the methods of data collection and findings.

EXPERT INTERVIEWS

The BIRCh Project interviewed experts within and outside of Massachusetts (February 2021-March 2021). During this phase, leaders in education and children's mental health across the state were interviewed. Expert stakeholders were recruited from DMH, the Massachusetts School Mental Health Consortium (MASMHC), DESE, the Massachusetts Association of Mental Health (MAMH), SEL4MA, as well as partners and related programs within the University of Massachusetts. In addition to conducting interviews, several frameworks for school behavioral health employed within Massachusetts were closely examined, such as the Safe and Supportive Schools framework and the Positive Behavioral Interventions and Supports (PBIS) Academy.

In addition to collecting input from leaders within the Commonwealth, interviews were conducted with experts in other states, including those coordinating and directing TA Centers. These included: Center for Social Behavior Supports/Center on Positive Behavior Interventions and Supports (PBIS); School Mental Health Training and Resource Center at the Mental Health Association in New York State, Inc. (MHANYS); MTSS Rhode Island at Bridging Research, Implementation, and Data to Guide Educators in Rhode Island (BRIDGE-RI); School Mental Health Initiative (SMHI) at the Kansas Technical Assistance Systems Network; Florida Positive Behavioral Interventions & Support Project; Child Health and Development Institute of Connecticut, Inc.; and the School Mental Health Assessment, Research, and Training Center in Washington.

FIGURE 2. INTERVIEW THEMES: TA CENTER LEADERS IN OTHER STATES



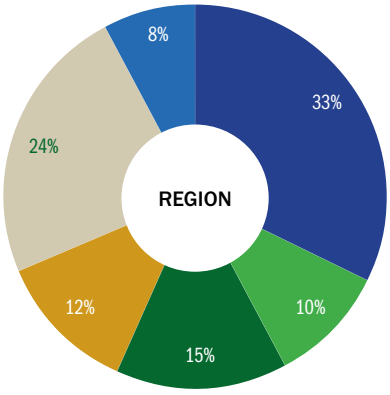
STAKEHOLDER SURVEY

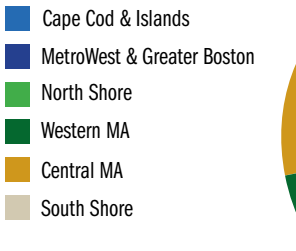
Based on the themes identified in the expert interviews, which are listed in Figure 2, these findings informed the development of a survey for stakeholders across Massachusetts (March 2021-May 2021). The survey was also informed by the ISF and Department of Elementary and Secondary Education (DESE) MTSS framework. It was piloted with several school and community-based professionals with feedback incorporated into the final version before being deployed. Survey outreach across MA regions targeted schools, districts, and community based behavioral health providers, as well as a broad range of educational and mental health networks.

In total, there were 493 respondents to the survey. Three hundred and seventy two school based professionals and 121 community based professionals completed the survey. There were a broad range of roles among the school-based participants. The largest group was school psychologists (24%), followed by district level administrators (16%), social workers (16%), school counselors (12%), general education teachers (7%), building level administrators (4%), special education teachers (4%), and school nurses (3%). Among community professionals, respondents included clinicians, program directors, executive directors, family partners, advocates, and many other roles. The majority of both groups of participants had greater than 10 years of experience. Approximately a third of the respondents were from the Greater Boston Metro area, and the vast majority of respondents identified as female (81-86%). Greater detail on the participants' demographics and regional representation are presented below, and survey findings can be found in Appendix A.

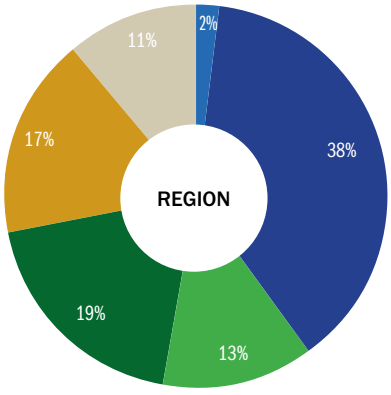
STAKEHOLDER SURVEY DEMOGRAPHICS

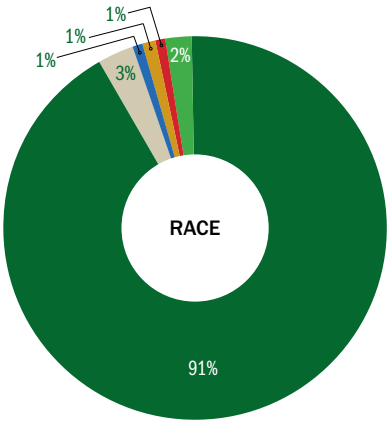
School Based Professionals (n = 372)

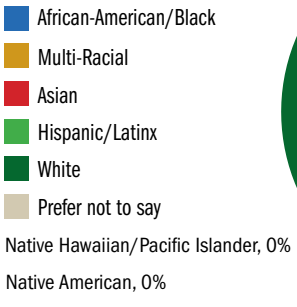


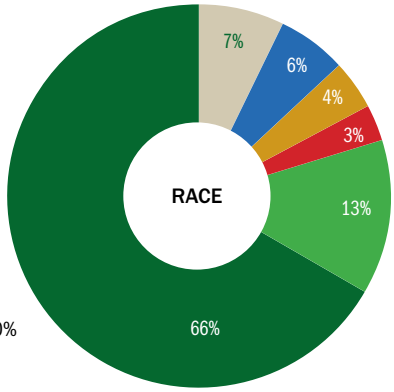


Community Based Professionals (n = 121)









FOCUS GROUPS

In May 2021, nine focus groups were conducted and included 19 school based, *n* = 10, and community based, *n* = 9, professionals. Roles ranged from school adjustment counselor, school psychologist, assistant superintendent, executive director of educational collaborative, special education and students support administrators, as well as clinical consultants and directors. Approximately one-third of the participants worked in Metro West and Greater Boston, with others representing the North Shore, Central Massachusetts, Cape Cod and Islands, South Shore, and Western Massachusetts. Roughly 75% of the participants identified as White, with others identifying as African-American/Black, Asian, and Other. Finally, similar to the survey respondents, more than 80% identified as Female. Focus group themes can be found in Appendix B.

RECOMMENDATIONS

Based on the results from the survey, focus groups, and expert interviews, the BIRCh team, in consultation with state experts, offer recommendations for an equity-based and regionalized approach to technical assistance to support schools throughout the Commonwealth in developing comprehensive and sustainable school mental health structures. Taking a multi-tiered, public health approach, the TA Center will support districts at varying levels of intensity according to district need and TA Center capacity.

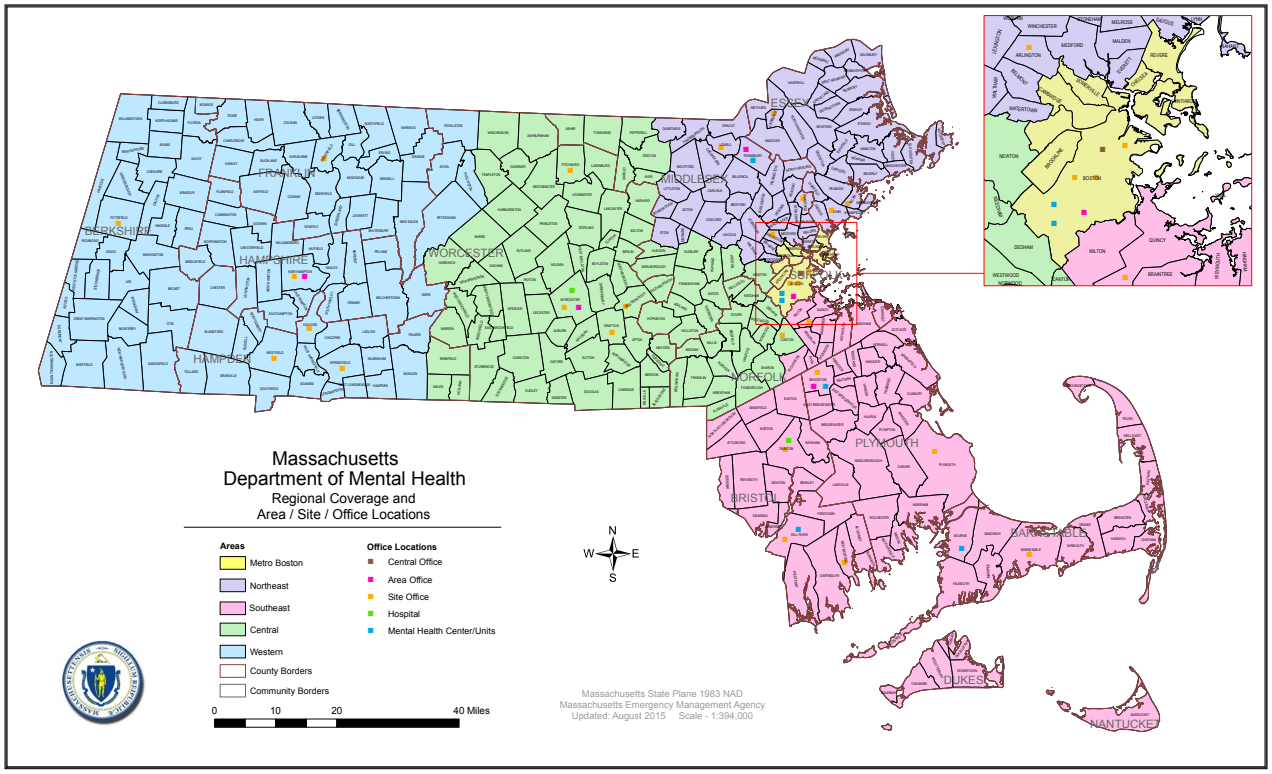
In early phases of development, the Advisory Board and Planning Committee will delineate the mission, vision, and intended outcomes of the TA Center with greater specificity. However, in its direct work with districts and community partners, the TA Center will support the implementation of social, emotional, and behavioral screening, programming and instruction related to behavioral health promotion, training and support for selection and implementation of evidence based practices and interventions at Tiers 1, 2, and 3, and strategies for connecting students and families with community resources. In addition, the TA Center will support districts in developing the structures to sustain this work, such as clinical supervision and leadership and effective staffing models. These topic areas will be addressed at each level of TA Center services and support.

At Tier 1, all districts will have access to online learning modules, resources on best practices, drop-in support hours, a centralized calendar of regional and statewide offerings, and annual live training. For a select group of districts, Professional Learning Communities will be developed in coordination with CBHCs according to the New Behavioral Health Roadmap. Finally, individualized coaching will be available for targeted districts with the greatest need, in collaboration with their CBHCs. All services and supports will be geared toward school and district team members involved in school-based behavioral health support, and will address the central areas of screening, health promotion, evidence based practices, and coordination of school and community services.

At full scale up, the TA Center will operate with a central team, in addition to five regional hubs across the state, overlapping with both DMH and the Educational Collaboratives' catchment areas (Figure 3). Each regional hub will offer direct Tier 1, 2, and 3 services to districts, while the TA Center's central office will coordinate efforts and provide administrative and programmatic support.

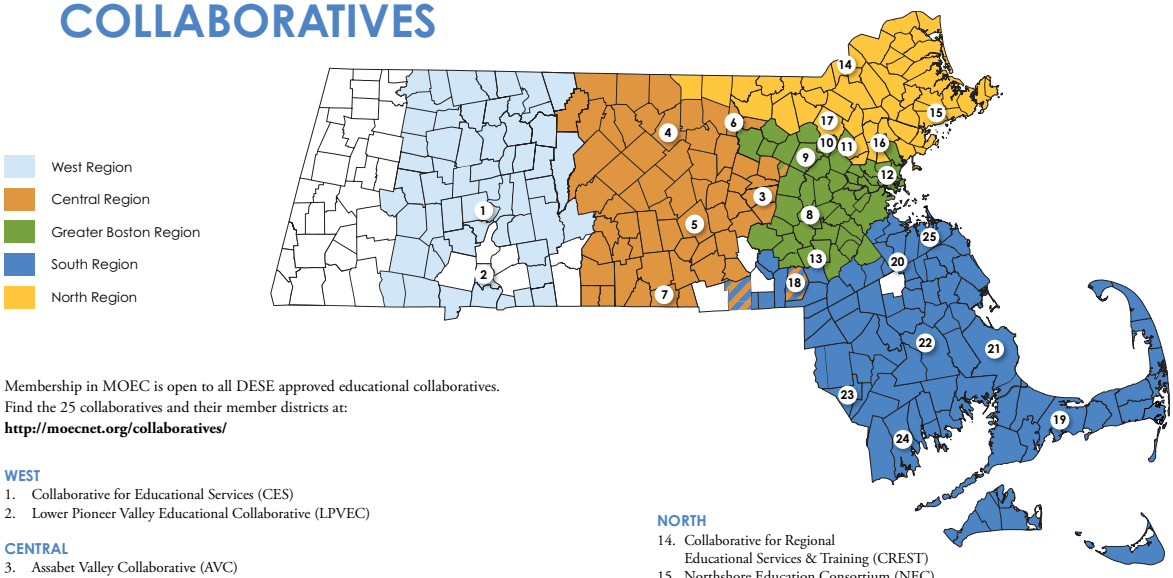
FIGURE 3. DEPARTMENT OF MENTAL HEALTH AND MASSACHUSETTS ORGANIZATION OF EDUCATIONAL COLLABORATIVES MAPS

Maps are courtesy of the Department of Mental Health and the Massachusetts Organization of Educational Collaboratives (2021)



Massachusetts

COLLABORATIVES



Membership in MOEC is open to all DESE approved educational collaboratives. Find the 25 collaboratives and their member districts at:
http://moecnet.org/collaboratives/

WEST
1. Collaborative for Educational Services (CES)
2. Lower Pioneer Valley Educational Collaborative (LPVEC)

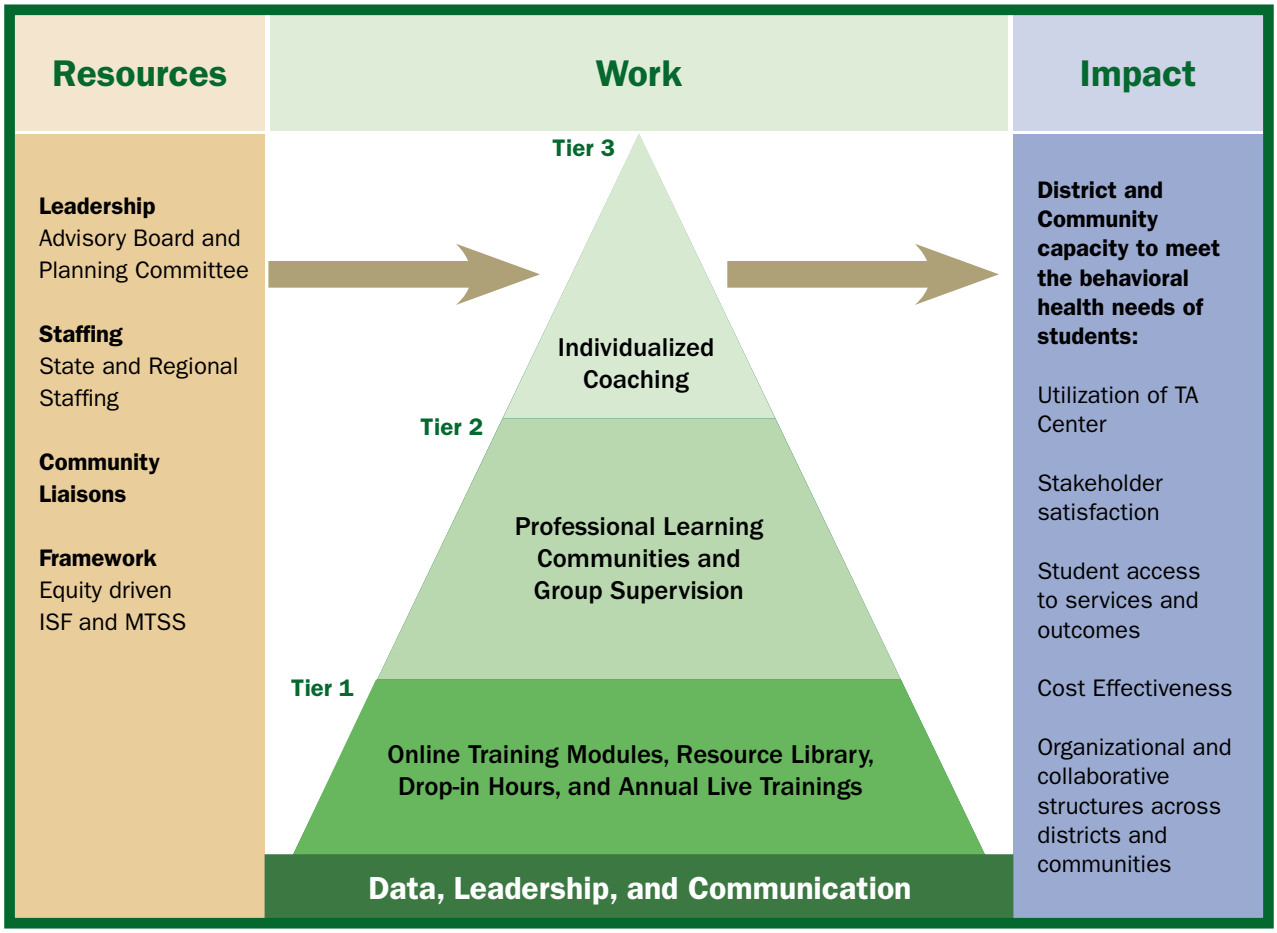
CENTRAL
3. Assabet Valley Collaborative (AVC)
4. CAPS Education Collaborative
5. Central Massachusetts Collaborative (CMC)
6. The Keystone Educational Collaborative
7. Southern Worcester County Educational Collaborative

GREATER BOSTON
8. ACCEPT Education Collaborative
9. CASE Collaborative
10. EDCO Collaborative
11. LABBB Collaborative
12. Shore Educational Collaborative
13. The Education Cooperative (TEC)

NORTH
14. Collaborative for Regional Educational Services & Training (CREST)
15. Northshore Education Consortium (NEC)
16. SEEM Collaborative
17. Valley Collaborative

SOUTH
18. Bi-County Collaborative (BICO)
19. Cape Cod Collaborative
20. North River Collaborative (NRC)
21. Pilgrim Area Collaborative (PAC)
22. READS Collaborative
23. South Coast Educational Collaborative (SCEC)
24. Southeastern Massachusetts Educational Collaborative (SMEC)
25. South Shore Educational Collaborative

FIGURE 4. TA CENTER LOGIC MODEL



The development and implementation of this tiered model of support is described below according to four of the stages of implementation: 1) Exploration and Adoption, 2) Installation, 3) Initial Implementation, 4) Full Implementation (Fixsen et al., 2005). In addition, based on expert interviews, the last phase of development added is Scale-up, in which the TA center strengthens sustainability, reach, and robustness of offerings. Each stage of implementation addresses services and supports within each tier. The timeline of the phases of implementation is summarized below, pending the availability of appropriate funding at each stage.

SUMMARY OF RECOMMENDATIONS

Phase of Implementation	Year/Districts Served
Exploration and Adoption	**Year 1 / 0 Districts**
Establish Advisory Board with Cross Agency Representation	
Define Purpose, Vision, Mission, Measurement Strategies and Outcomes	
Design TA Center with an equity driven, Interconnected Systems Framework approach	
Review Community Resources and Workforce Development Needs/Opportunities	
Engage Families and Students in Resource Development	
Gather Professional Development Trainings, Curricular Resources, and Protocols	
Installation	**Year 1 / 0 Districts**
Solidify Leadership Structures and Communication Mechanisms	
Determine Communication Structures for TA Center, Districts, Schools, and Community Partners	
Define Staffing Model, Hiring, and Onboarding Processes	
Coordinate Regional Structures and Teams in Alignment with Community Behavioral Health Centers	
Initial Implementation	**Year 2 / 60 Districts**
Tier 1 Online Training Modules, Live Annual Trainings, Resource Library, Network of Care Website, & Drop-in Support	
Tier 2 Professional Learning Communities and Group Supervision for School Based Clinicians (Western MA and Cape Cod)	
Tier 3 Coaching for District Leadership Teams (Demonstration Site in Western MA)	
Track Progress Monitoring and Outcome Data	
Full Implementation	**Year 3-4 / 120 Districts**
Strengthen Robust and Interactive Tier 1 Online Training Modules, Network of Care Website, and Resource Library	
Replicate Tier 2 Professional Learning Communities and Group Supervision for Paraprofessionals	
Replicate Tier 3 Coaching for District Leadership Teams (20 highest needs districts)	
Monitor and Advance Strategies to Address Workforce Development Needs	
Scale-up	**Year 5 / > 200 Districts**
Strategize Long-Term Funding	
Collaboration Between State Agencies in Support of TA Center	
Annual Replication of Professional Learning Communities & Coaching for District Leadership Teams	
Use Data to Improve Tier 1, Tier 2, and Tier 3 Services	

EXPLORATION AND ADOPTION

During the exploration phase, stakeholder needs, available resources, and local champions are identified, and solutions explored. Community readiness for change is also addressed and cultivated.

Recommendations for Exploration and Adoption	Year 1 / 0 Districts
Establish Advisory Board with Cross Agency Representation	
Define Purpose, Vision, Mission, Measurement Strategies and Outcomes	
Design TA Center with an equity driven, Interconnected Systems Framework approach	
Review Community Resources and Workforce Development Needs/Opportunities	
Engage Families and Students in Resource Development	
Gather Professional Development Trainings, Curricular Resources, and Protocols	

RECOMMENDATION 1:
Establish Advisory Board with Cross Agency Representation

In line with recommendations from other states' TA Centers, the TA Center Advisory Board will be developed in the exploration phase of implementation.

Representation. Several experts cited the development of their advisory group as central to their success, highlighting that state departments, professional associations, a broad range of practitioners in education and mental health, advocates, as well as youth and families should be represented. A TA Center Advisory Board will be established, and will include content experts, school and community providers, students, and families, as well as members with expertise in communications, technology, economics, and data. As the TA Center's regional hubs will coordinate closely with associated CBHCs, the TA Center Advisory Group will include CBHC leadership and staff. Notably, the Advisory Group will represent leaders from both DMH and DESE to anchor the TA Center in our state's educational and behavioral health systems, and maintain a deep focus on behavioral health with school districts as the entry point. In addition, state leaders from the Department of Public Health, MassHealth, and related agencies will be included to promote creative funding, practice, and organizational solutions.

Accountability. The advisory group will meet monthly, with the goal of promoting accountability, providing guidance, and rooting the TA center within the community. These monthly meetings will ensure transparent communication of TA Center development and operations, and hold the TA Center accountable to its mission.

RECOMMENDATION 2:
Define Purpose, Vision, Mission, Measurement Strategies and Outcomes

Mission and Vision. Leaders of TA Centers in other states emphasized the need to "anchor" the initial TA Center mission strategically for advocacy efforts (i.e. in line with state and local priorities) and the long-term investment needed for establishing relationships with state agencies, legislators, and community and school organizations. Throughout interviews, TA Center leaders advised that action-oriented discussion of core values, mission, and vision for the TA center is crucial during exploration, and that developing local capacity of schools and districts should be at the forefront of these conversations. These conversations will be facilitated within the Advisory Board, drawing on members' networks as appropriate. Ultimately, the mission and vision will include building the internal capacity of districts to build equitable and comprehensive behavioral health structures, including prevention and promotion, identification, the delivery of evidence based interventions at Tiers 1, 2, and 3, as well as the structures to sustain these services such as clinical supervision and leadership and effective staffing models.

According to the stakeholder survey, the largest majority (73%) of school-based respondents reported needing help with equitable and culturally and contextually responsive behavioral health structures, systems, and services.

Outcomes. In line with advice from other states, the expected outcomes of the TA center will be defined and will include impacts consequential for student and family success, staff wellbeing, workforce recruitment and retention, structures such as school mental health roadmaps, and capacity within schools and districts. Outcomes may include disproportionality data, out of district placements, appropriate utilization of special education services, rates of disciplinary action, hospitalizations, time and resources spent on training, social validity, and universal screening data. In addition, TA center utilization will be evaluated (at each Tier), and cost-benefit analysis may be conducted. TA centers in other states also underscored the need for consistent progress monitoring, local evaluation capacity of districts, as well as evaluation capacity of the TA Center.

RECOMMENDATION 3:
Design TA Center with an equity driven, Interconnected Systems Framework approach

Equity. An ISF will be used as a tool to promote equitable access to services, culturally responsive practices, and integration of community and school based supports. As such, it will focus on bridging the foundational aspects of a multi-tiered systems of support with school mental health. The TA Center will focus on racial, cultural, and linguistic equity by providing targeted services and support to districts with the greatest needs - communities with greater proportions of students of color and low-income students. The TA Center will also support districts in promoting equitable and culturally responsive behavioral health services.

According to the stakeholder survey, the largest majority (73%) of school-based respondents reported needing help with equitable and culturally and contextually responsive behavioral health structures, systems, and services. As one focus group participant reflected, staff need support in "talking about race and culture, and how it impact[s] students and families, [and] about the changing demographics in our part of the state." Conversations about equity will be grounded in the local priorities of each district, with a particular focus on the protective factors for positive mental health within the educational setting.

Interconnected Systems Framework (ISF). The organizing framework for the TA Center development and operations will be grounded in ISF for supporting school-teams in multi-tiered systems of support, school-based behavioral health structures, partnership development, and implementation science. One focus group participant explained:

> "My ideal of comprehensive mental health within schools…[is] the ISF model…tiered interventions of support with database decision making, and…integration with local mental health and community health providers. Schools typically don't have the resources to fund the mental health supports that are necessary, and we need those connections. There needs to be a bridge between schools and community mental health…I think there needs to be broader awareness about what the ISF model is and the benefits of it…especially at the administrative level…when you start talking [about] how much money they save through such integration, I think that speaks to administrators and creates some movement."

As this participant described, the TA Center will organize around ISF to guide districts and schools and build a common vocabulary across school and community agencies. Ultimately, the TA Center will be driven by an equity-first approach and MTSS and ISF will guide both the internal and external work of the TA Center at all levels.

staff need support in "talking about race and culture, and how it impact[s] students and families, [and] about the changing demographics in our part of the state."

Multi-Tiered Systems of Support. The TA Center will support school-based teams in a MTSS framework, serving districts according to level of need. The TA center will provide services and support to meet the needs of all districts (Tier 1), supplemental support for some districts with increased needs (Tier 2), and individualized and intensive coaching for select schools with the greatest need (Tier 3). Through its Tier 1, Tier 2, and Tier 3 structures, the TA Center will primarily serve professionals directly involved in school-based behavioral health services (i.e. members of Student Support Teams, etc.) regardless of professional roles and/or affiliation. The TA Center will be designed with a train-the-trainer model, in order to maximize reach and focus on building capacity within schools and districts.

At Tier 3, the TA Center will aim to improve access to wraparound behavioral health support by regionally convening school, district, and community providers for intensive coaching. These District Leadership Teams (DLT) will work with the TA Center to map resources and needs to determine goals and interventions in line with local context.

School Mental Health. Typically, the organization and structure of SMH efforts are highly variable, and often reflect a "co-located" arrangement of community mental health providers providing some services to some students, with school staff not knowledgeable of these efforts. With the intentional integration of community services into the school setting, children gain greater access to necessary services, and it capitalizes on collaborative relationships between school-based and community-based practitioners. The coordination of resources results in a concerted effort to address the increasing needs and the persistent challenges.

The TA Center will also support districts in implementing MTSS to meet the needs of all students through prevention and promotion programs, identification and early intervention for students at-risk, and intensive interventions for students with significant behavioral health challenges. For students with clinically significant behavioral health needs, the TA Center will support access to integrated services through collaborations with Community Behavioral Health Centers and regional service providers. The TA Center will also support districts in accessing existing statewide training efforts (i.e. DESE MTSS Training Academies, etc.).

> ***"I am seeing wonderful things happening in pockets."***

RECOMMENDATION 4:
Review Community Resources and Workforce Development Needs

Equitable Allocation of Resources. During the exploration phase, existing school-based behavioral health training, resources, and technical assistance opportunities across the Commonwealth will be reviewed to ensure that the TA center targets districts with the greatest needs and least access to resources, and aligns its work accordingly.

Building on Strengths. The review of community resources will also consider regional variance and the unique needs of specific areas. As one focus group participant described, "I am seeing wonderful things happening in pockets." In focus groups, respondents often cited current professional development topics such as trauma sensitive schools, Social Emotional Learning (SEL), anti-racism, and collaborative problem solving. The TA Center will build on this content, and address gaps. In reviewing community resources, exemplars from across the state will be identified with the hope of amplifying and extending such work.

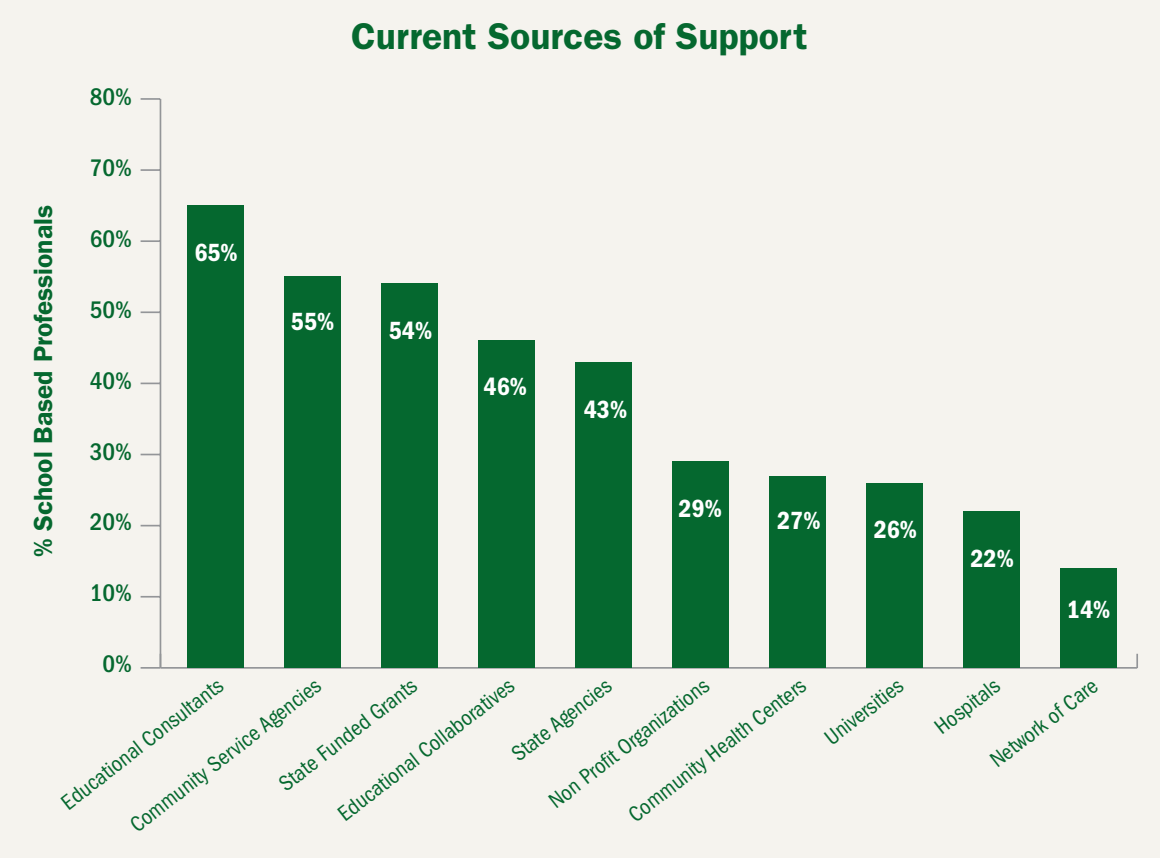
Aligning Partnerships. According to the stakeholder survey, school-based respondents most often reported partnering with educational consultants, followed by Community Service Agencies, and State Funded grants (Figure 5). Focus group participants commented that "partnerships" are often organizations that "we can reach out and refer families to." They are often grounded in individual relationships, rather than formal organizational agreements. Another participant described the challenge schools and districts face when various partners send school staff competing messages:

> "Nine different contracts with nine different agencies. The BCBA contract agency is telling them something different from the trauma-informed care contract agency, and nobody was coaching the first-year school psychologists or the first-year adjustment counselor or the first-year special-ed teacher on how to make sense of all of this different information and sort of wade through it?"

The goal in reviewing community resources and partnerships is to coordinate local and regional resources, align services and contracts, and address gaps in access.

Tapping Existing Relational Networks. As 55% of survey respondents already partner with their Community Service Agency, these relationships will inform both Tier 2 (Professional Learning Communities/Group Supervision) and Tier 3 (coaching for school and community teams) efforts.

FIGURE 5. CURRENT SOURCES OF SCHOOLS BASED BEHAVIORAL HEALTH SUPPORT, TRAINING, AND PARTNERSHIPS



Projecting TA Center Utilization. According to the survey results, 98% of school-based professionals reported that they would make use of the TA Center, compared to 67% of community based professionals. Based on these findings, the TA center will direct initial content toward school professionals, including how to build effective partnerships with community providers. Moreover, special education teachers and professionals from Cape Cod and the Islands reported the highest urgency for the TA center, with 67% and 61% of respondents respectively reporting intending to use the center "often." These populations will be targeted in content development at Tier 1.

Evaluating Regional Variance. Finally, due to the striking regional variance across communities, the TA Center will ultimately develop regional hubs to honor the unique needs of each region. The review of existing resources and evaluation of needs for the TA Center will occur regionally, in addition to statewide.

98% of school-based professionals reported that they would make use of the TA Center

Identifying Workforce Development Needs. The staffing ratios and capacity of districts to address students' needs is described in the BIRCh Project (2020) Behavioral health capacity of Massachusetts public school districts: Technical report. This report identifies the districts in which students lack adequate access to school-based behavioral health staff, according to nationally recommended ratios. Moreover, it highlights that the majority of Gateway Cities and the school districts serving students with high economic needs have less access to school-based behavioral health professionals, particularly Social Workers and School Psychologists. The unique workforce development needs, particularly in meeting the needs of culturally and linguistically diverse students, will be an area of focus.

RECOMMENDATION 5:
Engage Families and Students in Resource Development

Utilization of services by students and families requires exploration, in order for local and regional resources to be responsive to their needs. Focus groups will be conducted with students and families to inform content development at Tier 1, constitution and focus of Professional Learning Communities at Tier 2, and coaching needs at Tier 3. Sixty-nine percent of school based professionals and 87% of community professionals reported that their districts need support in using student and family voice to inform behavioral health services, systems, and structures. Focus groups will aim to integrate the needs, experiences, and ideas of students and families into the TA Center's design, before implementation occurs.

RECOMMENDATION 6: Gather Professional Development Trainings, Curricular Resources, and Protocols

Finally, during exploration, to maximize use of existing training and resources available across the Commonwealth, relevant professional development training opportunities, protocols, and resources will be gathered from across the state to promote streamlined access. This will provide the groundwork for the Tier 1 resource library and training offerings which will be developed during the initial implementation. Topic areas will include the implementation of social, emotional, and behavioral screening, programming and instruction related to behavioral health promotion, training and support for evidence based practices and interventions, and strategies for connecting students and families with community resources.

INSTALLATION

During installation, structures are put in place to support the program, such as communication processes, reporting frameworks, policy development, and funding strategies. When it came to resources and structures needed to continuously support the work of a TA center, leaders in other states emphasized the need to consider the following inputs before implementation: 1) funding, 2) staffing structures, 3) relational networks, 4) theoretical frameworks, 5) organizations home, and 6) administrative resources. The following recommendations take these components into account.

Recommendations for Installation	Year 1 / 0 Districts
Solidify Leadership Structures and Communication Mechanisms	
Determine Communication Structures for TA Center, Districts, Schools, and Community Partners	
Define Staffing Model, Hiring, and Onboarding Processes	
Coordinate Regional Structures and Teams in Alignment with Community Behavioral Health Centers	

RECOMMENDATION 1: Solidify Leadership Structures and Communication Mechanisms

In addition to the Advisory Board, a Planning Committee will be developed to focus on the implementation of tiered support for districts (online modules, training, resources, and drop in support; PLCs and group supervision; individualized coaching) as modeled after the Center for Social Behavior Supports/Center on Positive Behavior Interventions and Supports (PBIS). The Advisory Board will continue to serve as a guidance and accountability structure, while the Planning Committee will function as TA Center leadership. The Planning Committee will convene the Advisory Board monthly, and will be responsible for facilitating meetings and soliciting guidance.

RECOMMENDATION 2: Determine Communication Structures for TA Center, Districts, Schools, and Community Partners

District and Community Points of Contact. According to the stakeholder survey and focus groups, designated points of contact within school districts and community organizations are often unclear, posing organizational challenges for effective partnerships and communication. Depending on participants' professional roles, school and district based staff were aware of different partnerships. For example, school-based clinicians were more likely to know about partnerships with Community Service Agencies than building and district administrators, indicating that these partnerships are most likely occurring within the context of individual relationships rather than organizational agreements.

Memoranda of Understanding. To facilitate effective partnerships between the TA Center and districts, and between districts and schools, as well as between districts, schools, and community organizations, Memoranda of Understanding (MOU) will be developed to concretize these relationships. Within each MOU, the mode, frequency, and content of communication will be defined, as well as roles, responsibilities, and expectations for each party. The hope is to build effective, efficient, and equitable feedback loops between the TA Center and its partners.

Outreach and Communications. In addition to communication among partners, a communications strategy will be developed by the Planning Committee with guidance from the Advisory Board. The communication strategy will address equitable and accessible outreach to districts, schools, and community organizations. The plan will identify the TA center's audience, goals and objectives of communication, the content of communication, the tactical plan for messaging, as well as metrics of success.

RECOMMENDATION 3: Define Staffing Model, Hiring, and Onboarding Processes

Roles, Responsibilities, and Structure. The Planning Committee, with guidance from the Advisory Board, will finalize the staffing structure of the TA center (Figure 6) before initial implementation, as well as a scale-up plan. At this point, position descriptions will be developed for 12 Full Time Employees, including a director position, a program manager, as well as communications, research, and technology support. In addition, regional managers will be hired for direct implementation of tiered services and support. Regional managers will serve as internal coaches, trainers, and content developers for districts. Regional coordinators will work with the managers to support these tasks.

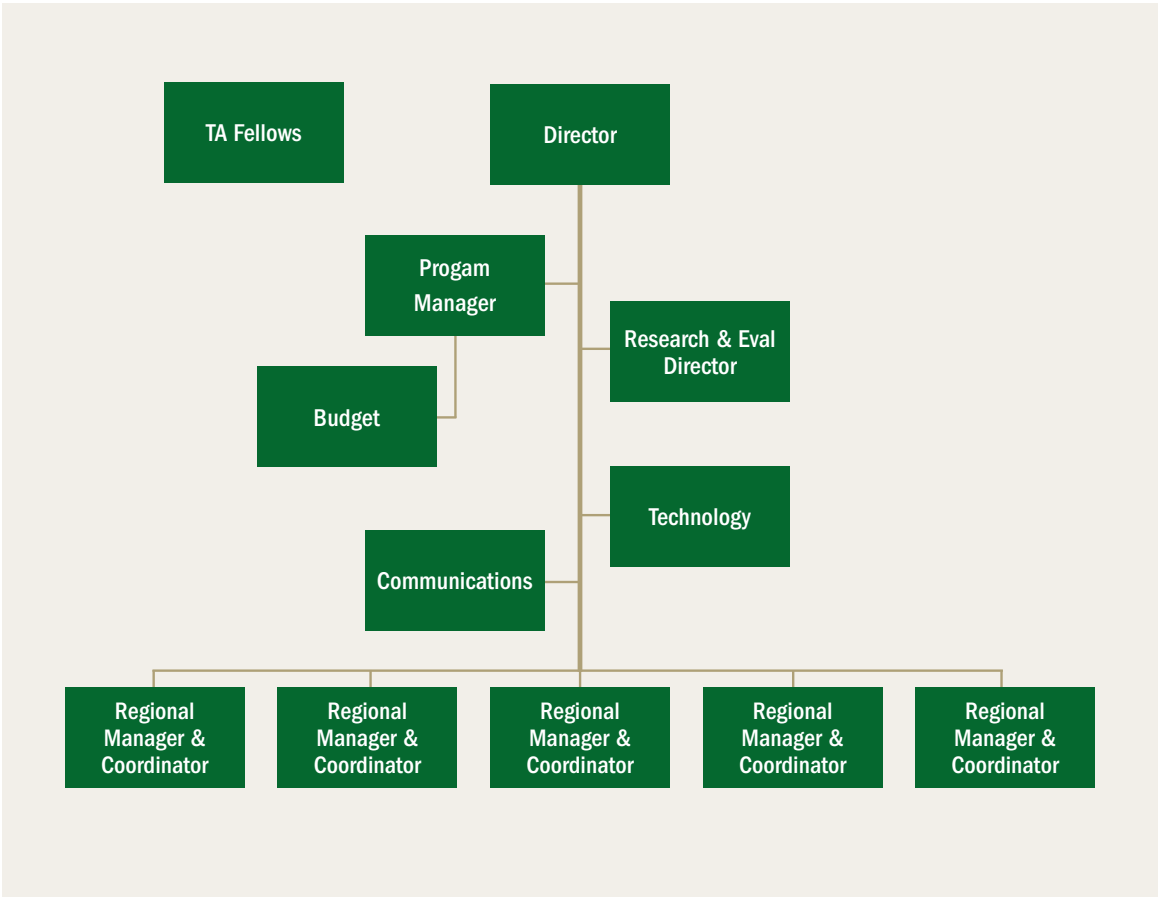
Ideal Candidates. Notably, TA center leaders in other states highlighted the importance of hiring staff with the correct training and experiences. As many reported, extensive experience working within schools, behavioral health expertise, and experience partnering with and providing consultation to district administrators will be an asset.

Onboarding and Job-Embedded Training. In addition to prior experience, members of the Kansas Technical Assistance Network (TASN) underscored the need for extensive training for all TA providers, due to the unique nature of the work. As one focus group participant engaged in similar work noted, "it's really about getting that administrator buy-in….investment, and attendance." To guide the hiring and training processes, onboarding documents will be developed before the initial implementation of the TA center.

RECOMMENDATION 4: Coordinate Regional Structures and Teams in Alignment with Community Behavioral Health Centers

As the TA Center scales, expert interviews indicate that the most efficient staffing model will continue to include both a centralized office, as well as regional hubs. TA Center hubs will serve five regions across the state: 1) Western, 2) Central, 3) Boston and MetroWest, 4) Southeast, and 5) Northeast. These regions overlap with both DMH catchment areas, as well as Educational Collaborative membership. As the ultimate scale up model includes these regionalized service areas, planning for Tier 1, 2, and 3 services will each be coordinated regionally. Each regional hub will develop close partnerships with their associated CBHCs through formal MOU's and quarterly meetings.

FIGURE 6. ORGANIZATIONAL CHART



INITIAL IMPLEMENTATION

Initial implementation refers to the first use of the innovation. During this phase, the TA center will go "live" with initial services and support. Throughout expert interviews, TA center leaders from other states reported providing extensive TA to a very small selection of schools, spending hours within each school community to understand coaching needs. A point of contact was identified in each locality, which helped the centers build relational networks across their states. Because systems work tends to take 5 to 10 years, ample time was allotted before full implementation and scaling efforts. At all tiers, the goal of initial implementation is to build the internal capacity of school districts to meet the behavioral health needs of students through screening, behavioral health promotion, evidence based practices and interventions, and service coordination.

Recommendations for Initial Implementation	Year 2 / 60 Districts
Tier 1 Online Training Modules, Live Annual Trainings, Resource Library, Network of Care Website, & Drop-in Support	
Tier 2 Professional Learning Communities and Group Supervision for School Based Clinicians (Western MA and Cape Cod)	
Tier 3 Coaching for District Leadership Teams (Demonstration Site in Western MA)	
Track Progress Monitoring and Outcome Data	

RECOMMENDATION 1: Tier 1 Online Training Modules, Live Annual Trainings, Resource Library, Network of Care Website, & Drop-in Support

Tier 1 services provided by the TA Center will be driven by two goals:

1) Coordinating existing training and resources from across the Commonwealth to promote free, accessible, and equitable availability

2) Offering follow up support and materials to help practitioners implement the content of such training.

Instead of focusing on content development, the TA Center will gather and coordinate existing resources and training, including Network of Care and the opportunities provided by the educational collaboratives. Training will be grounded in the ISF framework and will be geared toward a broad range of school based behavioral health team members. Topic areas will include the implementation of social, emotional, and behavioral screening, programming and instruction related to behavioral health promotion, training and support for evidence based practices and interventions, and strategies for connecting students and families with community resources. Examples of Tier 1 offerings can be found in Appendix C. While all Tier 1 services and resources will be available to districts across the state, content will be coordinated and disseminated regionally to ensure strong regional foundations for scaling up fully operating regional hubs.

Self-Paced Training Modules. Like most other TA centers interviewed, the MA TA Center will coordinate and make available self-paced online training modules geared toward professionals involved in school based behavioral health service delivery. As reported in focus groups, stakeholders across MA reported wanting content on Tier 1 Social-Emotional Learning, family engagement, de-escalation, peer support for students, targeted interventions to internalizing concerns, mentoring interventions, advocacy within the district for behavioral health, linguistic diversity, trauma, restorative justice, and specific content geared toward paraprofessionals and teachers.

As one participant shared, "I'm always looking for things for our teaching assistants to tap into… they're on the front lines, and there's a lot of talented people, and I feel like they get forgotten about…I often am trying to find things for them on my own…but if the system could be more systematic with that, and have more to offer, I think that would be great." Moreover, according to survey data, well over half of school and community based professionals reported that all areas on the DESE MTSS framework need to be targeted (Figure 7).

Across the board, participants surveyed and interviewed from Cape Cod reported the highest needs, least access to resources, and greatest urgency for the TA center. To meet these needs, the TA center will develop and make freely available resources, protocols, guiding documents, and online training modules for all providers in the Commonwealth.

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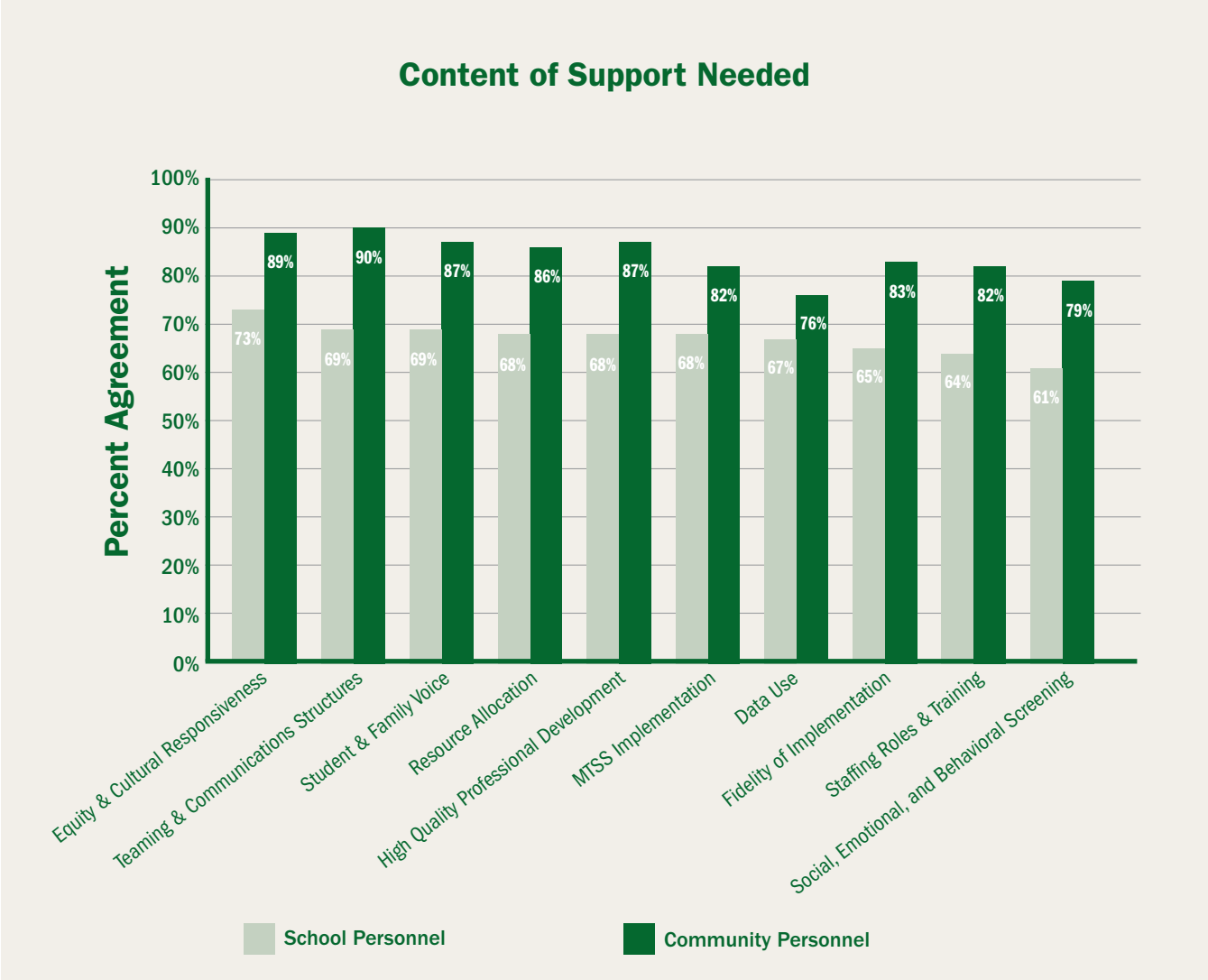
While modules will be virtual and self-paced, the TA Center will take a participatory approach to adult learning. Self-paced online training is particularly important for broad reach. Professionals from Cape Cod and the Islands reported in focus groups that virtual professional development and training opportunities are important for geographically remote communities.

FIGURE 7. TRAINING CONTENT NEEDED (DESE MTSS FRAMEWORK)



Live Annual Training. In addition to self-paced learning, annual live training will occur virtually, as well as regional in-person opportunities. The content of live training will be coordinated by the TA Center, but will be developed by existing resources and trainers across the Commonwealth.

Resource Library. In addition to synchronous and asynchronous professional learning, a document library will be developed with protocols, procedures, guidelines, and intervention materials for practitioners, educators, and leaders to access. All resources will be vetted by the TA Center for legal defensibility, equity, applicability to K-12 contexts, prior implementation in K-12 contexts, integration with MTSS, cultural responsiveness, comprehensiveness, clarity, and last update (BIRCh Project Vetting Rubric, 2021). In addition to the resource library, the Network of Care website will continue to be built up with special attention to school based behavioral health services and supports.

Drop In Support. Along with the resource library, annual training, and self-paced modules, the TA Center will hold live virtual drop in hours for all school and community professionals to access support. The goal of drop-in hours is to provide opportunities for staff to ask individual questions, troubleshoot specific situations, and provide technical support to augment training.

RECOMMENDATION 2: Tier 2 Professional Learning Communities and Group Supervision for School Based Behavioral Health staff (Western MA and Cape Cod)

Workforce Development through Support and Follow Up. According to survey data, 75% of school staff reported that they would benefit from Professional Learning Communities. This sentiment was echoed in focus groups, with many noting that "follow up" on training is lacking, burnout and stress is rampant, and that there are few opportunities for school based behavioral health providers to connect and share expertise with one another. As a workforce development strategy, Professional Learning Communities will address these concerns by building workforce capacity and promoting retention.

As one participant provided feedback on their vision for the TA center, "my first thought is that I love to have a peer supervision group…[to] talk about cases…and hear what's going on in other systems and get some ideas." Another participant shared, "people really love the opportunity on Zoom to just connect with other people and do that networking kind of thing." Yet another participant described, "I can go to a training, I can learn about it, I can read about it. Do I have confidence that I'm going to be able to do it afterwards? Heck no. Unless I've lived it, tried it, and I've got somebody who has my back to say, 'Try that other thing because that's not quite working,' that's where I get the efficacy to try that new practice."

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As with Tier 1 offerings, the PLCs will address content areas including the implementation of social, emotional, and behavioral screening, programming and instruction related to behavioral health promotion, training and support for evidence based practices and interventions, and strategies for connecting students and families with community resources.

Integrating with Existing Structures. To fill this need, the TA center will develop Professional Learning Communities for group supervision, in collaboration with Community Service Agencies (CBHCs according to the new roadmap). As 55% of participants reported already working with their Community Service Agency, the hope is that the PLCs will offer an opportunity to formalize these partnerships. In addition, the PLCs will be developed to augment any existing regional structures organized by educational collaboratives.

Western MA and Cape Cod. During initial implementation, two PLCs will be developed to address the needs in the two regions reporting the greatest urgency for support- Western Massachusetts and Cape Cod. These initial PLCs will include school-based behavioral health providers (regardless of specific licensure), and will offer an opportunity for case consultation, application of training and professional development topics, relieve stress and burnout, foster connection, and share resources. Professional Learning Communities nwill meet monthly on Zoom for 60-90 minutes, and will be facilitated by the TA Center's regional coordinators and/or rotating peer facilitators.

RECOMMENDATION 3: Tier 3 Coaching for District Leadership Teams (demonstration site- Western MA)

District Leadership Team. According to survey data, professionals from Western Massachusetts were most likely to report needing individualized coaching relating to school based behavioral health practices. Responding to this need, the first demonstration site for the development of individualized coaching for a District Leadership Team (DLT), which will include both district leaders and CBHC leadership, will be implemented in Western MA. This DLT will be modeled after work done in Kansas, and the goal of coaching will be to build internal capacity of the school district, in collaboration with their regional CBHC according to the New Behavioral Health Roadmap.

Coaching Model and Content. The coaching framework will be adapted from existing models within the University of Massachusetts at Amherst and Boston. Coaching will integrate elements of the Comprehensive Behavioral Health Model of Boston with the essential elements of assessment, instruction, and data based decision making. This model of support will also draw from the coaching network in Western MA with a focus on data, systems, and practices. To build on Tier 1 and 2 offerings, individualized coaching will address topic areas such as the implementation of social, emotional, and behavioral screening, programming and instruction related to behavioral health promotion, training and support for Tier 1, 2, and 3 evidence based practices and interventions, and strategies for connecting students and families with community resources. In addition, structures to sustain these practices will be addressed such as clinical leadership and supervision and effective staffing models. Specific coaching goals will be developed by the district and community partners.

During the initial phase of coaching, weekly coaching will occur by phone, email, and/or Zoom, and site visits will occur monthly. As teams make progress toward their goals, the intensity of coaching will decrease gradually.

Parameters of Coaching. The selected district will complete a comprehensive needs assessment, identify a point of contact, and convene a team of district staff. The expectations of all parties throughout coaching will be clearly defined in the three-way MOU (district team, TA center, and CBHC team), such as frequency of communication, work completion between sessions, attendance at events, and evaluation requirements. Due to the "red tape" reported by many focus group participants when describing their challenges building relationships with behavioral health providers, all logistical barriers will be comprehensively addressed in the MOU and initial meetings. The DLT will engage in coaching with diminishing intensity based on fidelity of implementation and progress toward goals.

Selection of Demonstration Site. The initial demonstration site will be selected according to both need and readiness, which will be assessed through review of staffing ratios, proportions of selected high needs populations, access to alternative resources, as well as the Tiered Fidelity Inventory.

RECOMMENDATION 4: Track Progress Monitoring and Outcome Data

Throughout the initial implementation of: 1) online learning modules, live training, drop-in support, and resource library, 2) development of two PLCs in Western MA and Cape Cod, and 3) intensive individualized coaching at one demonstration site in Western Massachusetts, data will be collected and progress will be monitored. Data will include utilization (i.e. online modules completed, attendance at PLC's, etc.), equity and disproportionality data (i.e. who is accessing services and support), as well as staff and student level data within the demonstration site district. The goal of all data collection will be for program improvement and evaluation of readiness for full TA Center implementation. Both the Advisory Board and Planning Committee will review data monthly.

FULL IMPLEMENTATION

Full implementation reflects the stage in which the innovation is skillfully and consistently used, is well-integrated with and supported by staff, partners, and others in the community.

Recommendations for Full Implementation	Year 3-4 / 120 Districts
Strengthen Robust and Interactive Tier 1 Online Training Modules, Network of Care Website, and Resource Library	
Replicate Tier 2 Professional Learning Communities and Group Supervision for Paraprofessionals	
Replicate Tier 3 Coaching for District Leadership Teams (20 highest needs districts)	
Monitor and Advance Strategies to Address Workforce Development Needs	

RECOMMENDATION 1: Strengthen Robust and Interactive Tier 1 Online Training Modules, Network of Care Website, and Resource Library

Driven by the TA Center's Tier 1 goals of making existing training and resources freely accessible and offering follow up support and materials to help practitioners implement the content of such training, in full implementation, Tier 1 services will continue to grow. The resource library of self-paced online learning modules and resources will continue to expand through content selected by TA center staff in partnership with the many agencies already conducting training across the state, as well as through new needs identified by local school districts and community organizations. The Advisory Board will continue to disseminate content, and progress monitoring data will continue to inform content coordination as well as the communications strategy. In addition, in full implementation, the TA Center will partner with the state university to provide Professional Development Points (PDPs) or course credits to participants, as well as to support workforce development, diversity, and retention. Similarly, drop-in hours will continue to be held regularly to provide opportunities for individual troubleshooting, planning, and practice.

RECOMMENDATION 2: Replicate Tier 2 Professional Learning Communities and Group Supervision for Paraprofessionals

With lessons learned from the initial implementation of the two PLCs for school based behavioral health staff, two more PLCs will be developed for paraprofessionals in Western MA and Cape Cod. Throughout focus groups, increased support for paraprofessionals was reported as a need, and the hope is that these Tier 2 PLCs will supplement Tier 1 training modules and resources freely available to paraprofessionals across the state. Again, as a workforce development strategy, Professional Learning Communities will build workforce capacity and promote retention.

RECOMMENDATION 3: Replicate Tier 3 Coaching for District Leadership Teams (20 highest needs districts)

Replication. Full implementation of the TA center will include 20 replications of the initial demonstration site for individualized coaching for the DLT in Western MA. District Leadership Teams will include leaders of districts and accompanying CBHCs according to the New Behavioral Health Roadmap. Four DLTs will be coached within each region of the state, comprising 5% of the Commonwealth's highest need LEAs (with annual replication, the TA center will have coached 100 districts after 5 years).

Regionalization. According to interviews with TA centers in other states, regional hubs were almost always developed to honor the local culture and context of different regions. While the point of regionalization varied, when centers worked with 100-200 schools or districts, regionalization became essential. Throughout this process, defining clear guidelines for communication, and feedback was critical. To help with this, a central office is needed to facilitate decision making. As scale up occurs, it is essential to develop a gradual plan over the course of 5-10 years. As the TA

Center replicates Tier 2 and Tier 3 services, the regional hubs will become fully operational while continuing to be coordinated by the TA Center central office.

District Selection. Districts in MA will be selected according to both readiness and need, using the TFI and comprehensive resource mapping of selected high needs populations and access to existing resources. Each DLT will engage in coaching with diminishing intensity based on fidelity of implementation and progress toward goals. The overarching goal of coaching will be to build internal capacity of school districts to meet the behavioral health needs of students, in collaboration with their CBHC, educational collaborative, and other community partners.

Coaching Model and Content. While the coaching model will be iteratively informed by the initial demonstration site and by each replication, the framework will be modeled after existing UMass models, integrating the essential elements of Assessment, Instruction, Data based Decision Making, Systems, and Practices. All coaching logistics (i.e. frequency, content, etc.) will be outlined in three-way MOUs between the TA Center, the district, and the CBHC (in addition to educational collaboratives when appropriate). Each DLT will determine individual goals and focus areas. Potential content will include the implementation of social, emotional, and behavioral screening, programming and instruction related to behavioral health promotion, training and support for evidence based practices and interventions, and strategies for connecting students and families with community resources.

RECOMMENDATION 4: Monitor and Advance Strategies to Address Workforce Development Needs.

Earlier stages of implementation focus on identifying workforce development needs, and this will need to be monitored as full implementation begins. Ongoing efforts will examine the needs of both school-based and community-based settings, with recommendations to address shortages and gaps based on regional, population, and skill-based needs.

SCALE-UP

Once the TA canter has fully implemented its tiered continuum of services, the focus will shift to scaling these supports across the Commonwealth for long term sustainability and maximal reach. Four central areas of state capacity have been cited, including administrative leadership and funding, local training and coaching capacity, behavioral expertise, and local evaluation capacity (Horner et al., 2014). Each will be addressed during this phase.

Recommendations for Scale-up	Year 5 / > 200 Districts
Strategize Long-Term Funding	
Collaboration Between State Agencies in Support of TA Center	
Annual Replication of Professional Learning Communities & Coaching for District Leadership Teams	
Use Data to Improve Tier 1, Tier 2, and Tier 3 Services	

RECOMMENDATION 1: Strategize Long-Term Funding

As all TA centers reported, substantial and long-term funding is needed to support ongoing operations. While smaller allocations and a braided funding model may support the initial implementation, more robust state department investment in the TA center will be necessary, at around 1.5 million per year to include center leadership, central staff (program manager, communications, data and evaluation, budget, technology), regional staff, substitutes and stipends for school personnel, as well as Advisory Fellows. The support of an economist will be employed to evaluate return on investment.

RECOMMENDATION 2: Collaboration Between State Agencies in Support of TA Center

While most TA centers were housed in either the states' department of education or department of mental health (or the equivalents), inter-agency collaboration will be key to support the mission of the TA Center. Representatives of relevant agencies will be invited to Advisory Board meetings to support these partnerships.

RECOMMENDATION 3: Annual Replication of Professional Learning Communities and Coaching for District Leadership Teams

After 5-10 years of full implementation and an iterative process of establishing 100-200 replication sites for Tier 3 coaching and Tier 2 PLCs (also the expected time frame for systems-level work), scaling efforts will be indicated (this was the typical time frame and number of demonstrations across TA centers). During scale up, the staffing model may be reconfigured, and additional staff added regionally and centrally.

RECOMMENDATION 4: Use Data to Improve Tier 1, Tier 2, and Tier 3 Services

Finally, data will be continuously reviewed to improve programming. Progress monitoring will include utilization of TA center Tier 1, 2, and 3 services, student, family, and staff impact, cost savings, as well as user satisfaction with the TA Center. One TA center staff member will have primary responsibility for data tracking, synthesis, and reporting, though data will be reviewed monthly with the TA center team and quarterly with the Advisory Board.

CONCLUSIONS

The BIRCh team, in consultation with state experts, offers recommendations for an equity-based approach to technical assistance to support schools throughout the Commonwealth in developing comprehensive and sustainable school mental health structures. To honor the unique local needs across the state, five regional hubs will offer direct support to districts, in partnership with CBHCs according to the New Behavioral Health Roadmap. The central TA Center office will coordinate efforts and provide administrative and programmatic support.

Taking a multi-tiered, public health approach, the TA Center will support districts at varying levels of intensity according to district need. Across tiers, the TA Center will support the implementation of social, emotional, and behavioral screening, programming and instruction related to behavioral health promotion, training and support for Tier 1, 2, and 3 evidence based practices and interventions, and strategies for connecting students and families with community resources. In addition, the TA Center will support the development of structures to sustain these practices such as clinical supervision and leadership, effective staffing models, and workforce development and retention.

At Tier 1, all districts will have access to online learning modules, resources on best practices, annual live training, and drop-in support hours. For a select group of schools, Professional Learning Communities will be developed in coordination with CBHCs. Finally, individualized coaching will be available for targeted districts with the greatest need.

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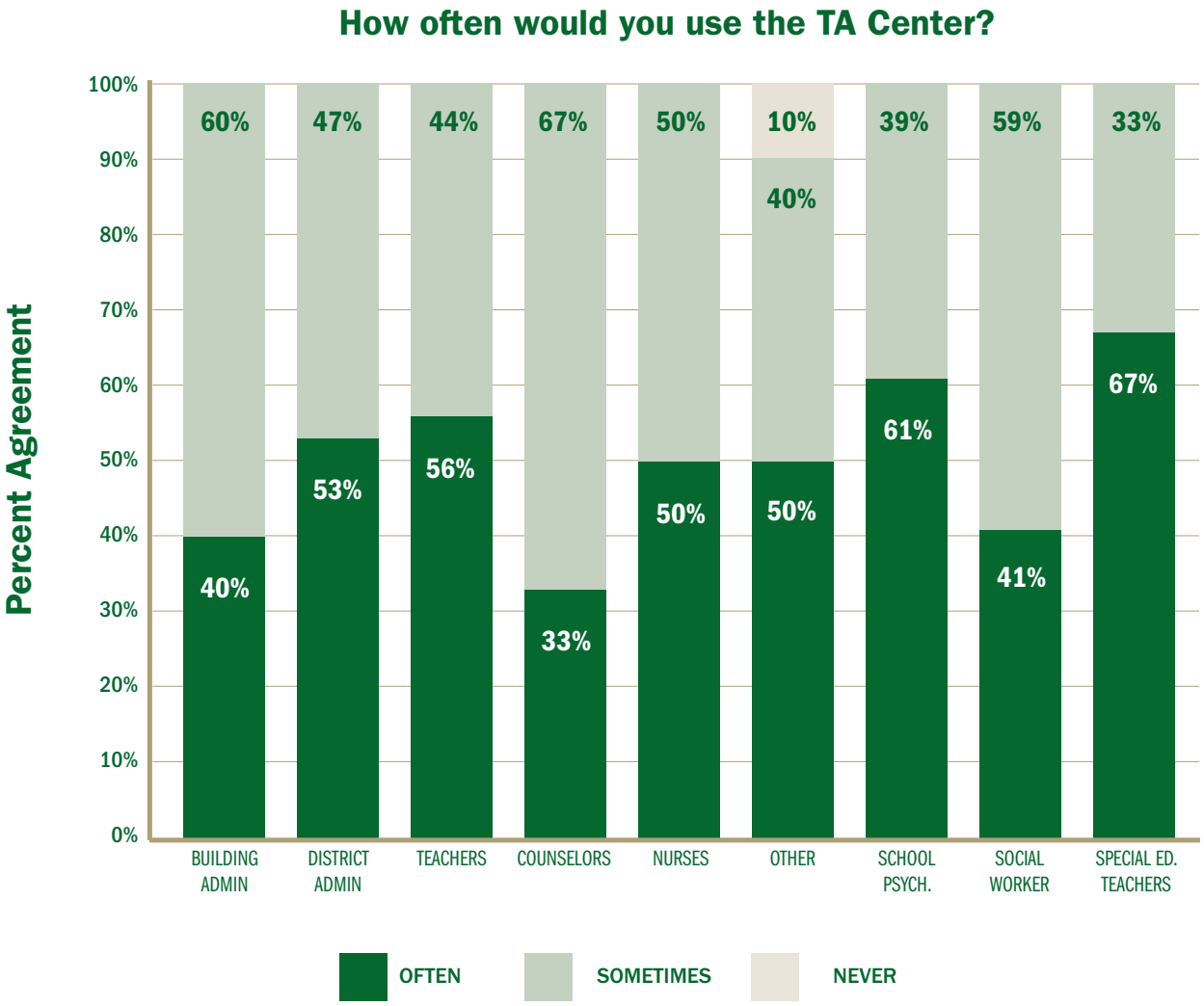
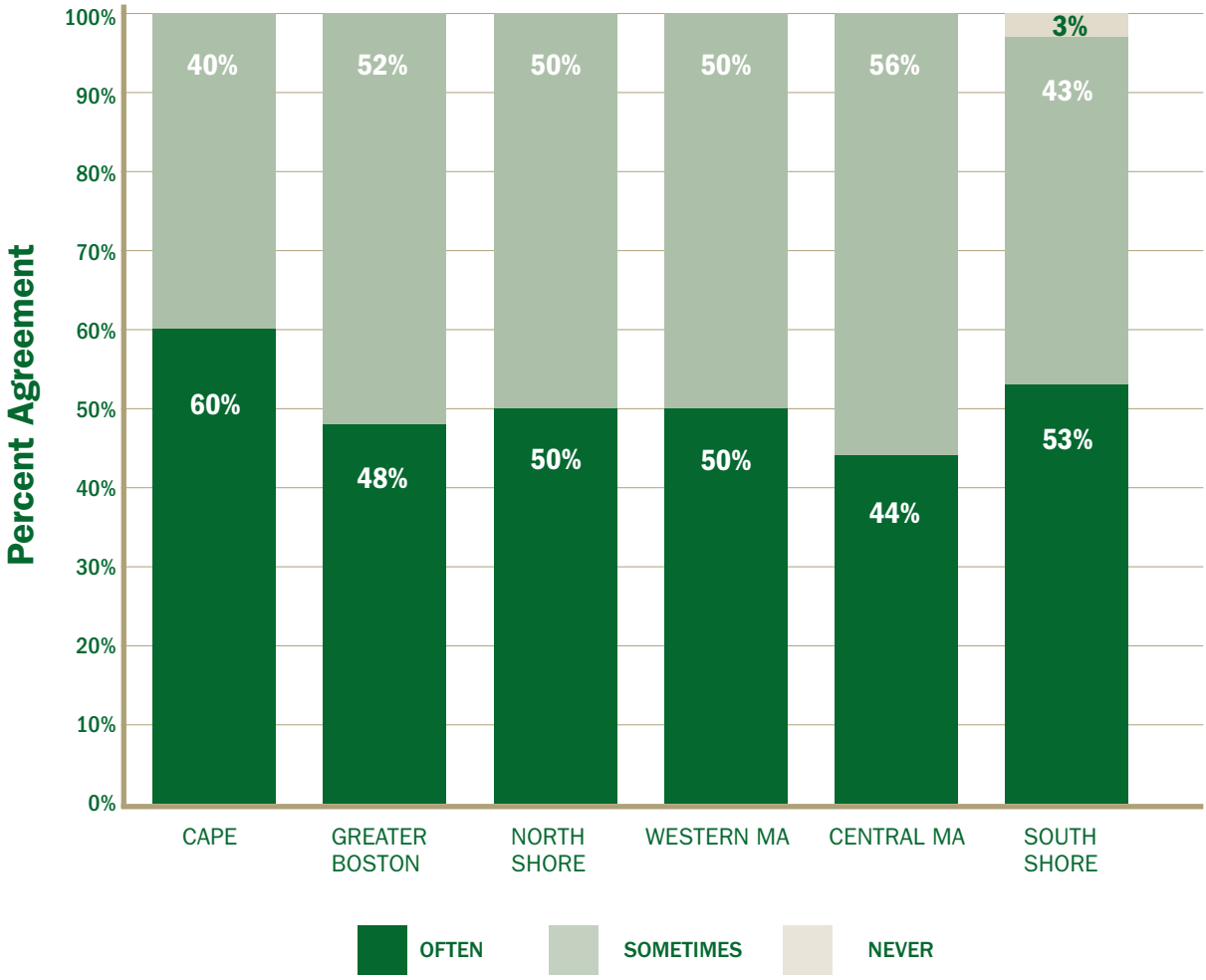
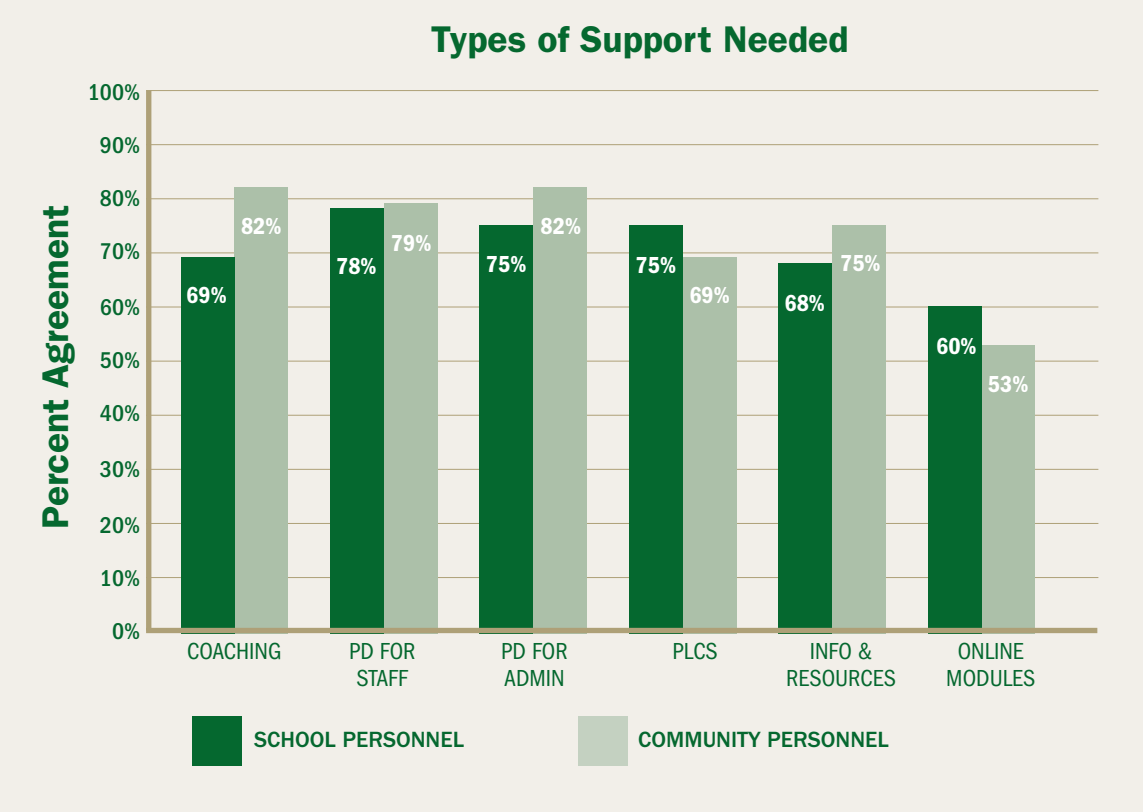
APPENDICES

APPENDIX A: STAKEHOLDER SURVEY FINDINGS



How often would you use the TA Center?





Region	Top Needs According to School Based Professionals
Cape Cod & Islands	1. Professional Development for School Staff (91%) 2. Professional Development for Administrators (82%)
Boston & Metro West	1. Professional Development for Administrators (83% 2. Professional Learning Communities (78%)
North Shore	1. Professional Development for Administrators (79%) 2. Individualized Coaching (71%)
Western MA	1. Professional Development for School Staff (86%) 2. Professional Development for Administrators (81%) 3. Individualized Coaching (81%)
Central MA	1. Professional Development for School Staff (93%) 2. Individualized Coaching (93%)
South Shore	1. Professional Development for School Staff (87%) 2. Professional Development for Administrators (77%) 3. Professional Learning Communities (77%)

APPENDIX B: FOCUS GROUP THEMES

Category	Themes
Vision for comprehensive school mental health	**Student and Family Services** • Strong Tier 1 and Tier 2 services for students aimed at promotion, prevention, and early intervention. Robust and accessible wraparound Tier 3 services, with appropriate use of special education. • Point of contact in each school for families and students relating to behavioral health concerns. • Integrated understanding of behavior, mental health, and academic learning. **Equity and Access** • All activities are aligned with racial and economic equity work within districts. • Events and services in families' and students' home languages • Increased workforce diversity in both schools and community settings. • Allocations of staff, resources, and time according to student and family need. **Training and Support for Staff** • Clinical supervision for school based clinicians. • Common planning time and better use of team members' time. • Mental health needs are addressed for all staff, in addition to student needs. • Comprehensive training and support for teachers and paraprofessionals that includes coaching. **Integration with Community Partners** • Bridge between community and school behavioral health services. • Flexible funding models to expand the range of services available and increase the feasibility of these partnerships. **Data and Team Based Decision Making** • Regular screening occurs. • Effective communications structures exist within schools as well as with community partners. • Collection and use of data relating to equity and access.

Current school mental health practices	**Committed Staff** •Across the board, school and community based staff are serving high caseloads, work tirelessly to help families navigate the educational and health case systems, and respond with empathy, skill, and commitment to student needs. **Strong Training Content** •There is a wealth of of trainings, PD events, materials, and resources to draw on from across the Commonwealth. **Fragmentation** •There is often no centralized team responsible for addressing school based behavioral health and centralized partnerships with community organizations. •Partnerships related to behavioral health often include "push in" counseling. **"Train and Hope"** •Lack of follow up on trainings and PD.
Needs from a TA center	**Centralization** •Align PD and training so that districts have a central place to go for information and support. **Follow Through** •Increased follow through on training (supervision, consultation, etc.). •Training with embedded supervision or coaching. **Team Based Approach** •Participatory learning with lots of choice for providers. •Team based approach to professional learning. •More comprehensive trainings for paraprofessionals. •Clarification of roles and responsibilities for the range of behavioral health staff in schools and community partners. **Networking and Peer Support** •More opportunities for peer supervision and job-alike groups. **Training, Coaching, and Consultation** •Availability of an "on call" clinician. •More live virtual trainings. **Convening school and community partners** •Trainings on common language (i.e. DSM vs. special education language, etc.).

APPENDIX C: SAMPLE MENU OF ONLINE TRAINING OFFERINGS

Sample ISF Modules
Integrated Systems Framework (ISF) and School Mental Health Planning
Solidifying Tier 1 Practices Utilizing an Interconnected Systems Framework Approach: Behavioral Health Screening and Data-Based Decision Making
Bolstering Multi-Tiered Systems of Social, Emotional, and Behavioral Support
Integrating Resources: Best Practices in Developing Partnerships Between Schools and Community Agencies
Developing and Implementing Your School Mental and Behavioral Health Plan
Mental Health Education as a Tier 1 Strategy
Sample Modules for Paraprofessionals
Introductory module: Overview of public health approaches
Understanding behavior: ABCs
Engagement strategies at Tier 1: Building rapport and relationships
Skill building at Tiers 2 and 3: Setting the stage for intervention implementation
Skill building at Tiers 2 and 3: Adding to your intervention toolbox
Coping Skills Instruction
Responding to Challenging Behavior
Assessment and the special education process
Introduce career paths and certifications (ABA, RBT, counselor, school psychologist, teacher)
Overview of mental health symptoms, mental health education, diagnoses
Sample Screening Modules
Introduction to Screening
Prerequisites to Social, Emotional, and Behavioral Screening
Screening Approaches
Selecting a Universal Screener
Social, Emotional, and Behavioral Screening Administration
Management of Social, Emotional, and Behavioral Screening Data
Using Social, Emotional, and Behavioral Screening Data