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*Corresponding author
Olga Acosta Price, The George Washington University, 950 New Hampshire Avenue NW, Suite 300 Washington, DC 20037

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Review Article

Establishing a Community of Practice among Leaders Providing Technical Assistance: Lessons Learned before and during the COVID-19 Pandemic

Olga Acosta Price[1*], Molly Jordan[2], Lauren Kazee[3] and Hanna Ozbeki[1]

[1]*The George Washington University, 950 New Hampshire Avenue NW, Suite 300, Washington, DC 20037, USA*

[2]*Boston Children's Hospital Neighborhood Partnerships, 300 Longwood Ave BCH3174, Boston, MA 02115, USA*

[3]*Living S.L.O.W., LLC, 12522 Pinecrest Dr., Plymouth, MI 48170, USA*

Abstract

The prevalence of youth behavioral health problems before and during the COVID-19 pandemic justifies continued investment in comprehensive school behavioral health systems that link education and behavioral health partners. Technical assistance (TA) providers typically build capacity among school-community partners to advance implementation of best practices in school behavioral health. The pandemic created major disruptions in the delivery of interventions and caused TA providers to adjust the what, where, when, why, and how they provided consultation and support to partners. The TA Community of Practice (TACoP) brought together seasoned TA providers to share knowledge and resources and engage in problem-solving as they struggled in their unique roles as change agents. This article describes the value of the TACoP in responding to immediate and novel challenges, such as collaboration, community-building, and practice-based issues, within the context of the pandemic. The authors share lessons learned, outline limitations, and offer ideas for future directions.

Introduction

Youth behavioral health needs have remained a prominent concern in the U.S. requiring cross-sector, collaborative solutions involving behavioral health, public health, education, and health care systems. Between 2007 and 2018 the national suicide rate for those aged 10-24 grew 57%, with increases experienced across most states [1]. Data gathered at the end of 2019 indicated over 10% of youth across the U.S. were suffering from severe major depression, yet only 27% of them were receiving consistent mental health treatment despite the gravity of their condition [2]. The stress, loss, and isolation brought by the global pandemic exacerbated already alarming prevalence rates among children and youth [3,4]. Schools are and have been a key sector in preventing, identifying, and treating emotional and behavioral disorders among school-aged children for decades and have used varied strategies to expand their reach [5,6]. A comprehensive school behavioral health systems approach expands school-based supports and integrates a broad spectrum of behavioral health interventions to "promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness [7]." More often, co-locating services and partnering across systems to reduce the prevalence and severity of behavioral health problems is neither straight-forward nor quick, and as a result, external assistance to address barriers to collaboration and implementation is often sought.

Many school districts across the country partner with institutions of higher education or other outside agencies to bolster their capacity to provide high-quality behavioral health supports by engaging in professional development/training, group or one-on-one consultation, as well as to expand their provision of direct clinical services to combat children's behavioral health challenges [8]. Employing a variety of tools, Technical Assistance (TA) providers aim to reduce the gap between research or evidence-based knowledge and real-world practices to improve the recipient's ability to achieve a desired standard or outcome [9,10]. In this case, TA providers work to improve individual skills, program implementation, policy development, and/or practice changes that shape their partner's professional and organizational capacity to achieve better behavioral health outcomes for children, youth, and their families [11,12]. Numerous strategies and methods are used by TA providers in the dissemination of best practices that comprise a comprehensive school behavioral health approach, including information dissemination, training, consultation, quality improvement, evaluation, and community-driven advocacy [13,14]. Yet, even collaboration among practitioners and researchers has not successfully overcome the many barriers inherent in translating research into practice, making the need for a collective process to assess and address gaps in system development more urgent [13]. Drawing from social learning theory, TA can facilitate change and the adoption of innovation by enabling learning through experiences and modeling to inform the implementation of successful strategies [15].

One specific social learning approach, a Community of Practice (CoP), has been used with diverse organizations and governments, as well as in fields of study such as school behavioral health, to advance broad goals. A CoP represents "groups of people who share a concern, a set of problems or a passion for something they do and learn how to do it better as they interact regularly [16]." What distinguishes a CoP from any other group that comes together is that a CoP has three main elements - the domain, which is the shared interest area that brings people together; the community, referring to members who engage in joint activities to learn and problem-solve together; and a shared practice, a repertoire of experiences, resources, and tools to address a set of challenges [16]. Another essential feature of this collective learning approach is that all members, regardless of qualifications or degrees, engage in the CoP as both "learners and leaders"- meaning that existing knowledge is deepened and new knowledge is generated because of the varied perspectives represented in a CoP. As a matter of fact, a National Community

of Practice on Collaborative School Behavioral Health has driven improvements and dissemination of best practices in school mental health since 2004 [17,18]. Actively participating in a CoP has yielded numerous benefits, including the enhanced ability to identify and solve persistent problems, facilitated sharing of best practices that ultimately lead to improved outcomes, and increased professional skills and competencies among practitioners [19].

Establishing a Technical Assistance Community of Practice

In order to share learnings among leaders working to advance the uptake of effective school behavioral health practices, the Technical Assistance Community of Practice (TACoP) assembled in 2019. This group connected several TA providers from across the country who offered consultation to K-12 educators, administrators, and behavioral health providers in their development of sustainable school behavioral health services and resources. Recognizing the challenges associated with the delivery of TA to schools, districts, or state agencies, the TACoP was informally established to promote dialogue, share resources, and engage in joint problem-solving. Preliminary meetings were held quarterly using brief check-ins and updates with the intent of sharing resources, connections, and lessons learned. Results were consistent with the benefits seen from other CoPs [19,20]. The lead authors of this paper (OP, MJ, and LK), and founding members of the TACoP, have a combined 50+ years of experience in designing and delivering TA and consultation support to local, regional and state partners seeking to advance comprehensive school behavioral health systems. Each TA provider delivers services in different states across the U.S. including the Mid-Atlantic, Midwest, and Northeast. The programs have overlapping components yet different structures and key stakeholders. One TA provider works within a school district to build the capacity of educators and school professionals to address social-emotional learning and behavioral health within their school communities, another collaborates with representatives across a region to ensure school behavioral health best practice implementation across numerous local Education Agencies (LEAs), and the third consults at the state-level to oversee policies and funding mechanisms to support youth behavioral health across the state.

Although each TA provider has a unique program model, they all utilized elements of a CoP approach with local partners to advance their respective goals. Those consistent elements include creating and facilitating a group of educators, practitioners and/or stakeholders within their localities to share expertise, expand practice and improve implementation of needed interventions. They also included a combination of professional development and follow-up consultation with their communities. This direct interaction with stakeholders proved to be important and served to inform one another's TA efforts and maximized impact across the TACoP. The varied perspectives represented by the TA providers has enabled a fairly broad understanding of the challenges and opportunities to expand school behavioral health services, pre-, during, and post-pandemic, common to many communities across the country. The aim of this paper is to describe the establishment and value of creating a CoP among school behavioral health TA providers and illuminate the positive impact of a TACoP to respond to the immediate and longer-term needs posed by the COVID-19 pandemic. Authors will outline how the TACoP facilitated ongoing professional learning among leaders, expanded practices and resources, provided consistent support around common problems of practice, and enabled collaboration across programs to enhance service delivery.

Impact of COVID-19 on School Behavioral Health

In March 2020, shortly after the TACoP was launched, the COVID-19 pandemic caused a nationwide closure of schools and businesses, and essentially halted everyday activities. The isolation resulting from the restricted interactions with others, accompanied by the uncertainties, disruptions, and grief and trauma associated with debilitating illness and loss of life, led to an increase in behavioral health challenges across the nation and the globe. The pandemic has had deleterious effects on child and adolescent behavioral health outcomes, as evidenced by numerous studies and reports [21-23] and which has resulted in the declaration of a national state of emergency by leading child mental health advocacy organizations [24]. COVID-related stressors touched everyone, but there was a disproportionate impact on members of ethnic minority groups (e.g., Black, Latinx, Native Americans) as well as low-income families and those from under-resourced communities [25-27]. Prior to the pandemic, vulnerable communities bore the brunt of many economic, social and racial injustices which undermined their health and well-being [23]. But, the pandemic exacerbated these health disparities and widened existing educational and income gaps through the escalation of discriminatory behavior, decreased healthcare access, and the inequitable availability of affordable housing and healthy foods [28]. To reduce the risk of exposure to COVID-19, schools, students, and educators quickly shifted to remote learning. Many students were at extreme disadvantage during this period as they did not have access to the basic resources for remote learning, such as unlimited or reliable internet, a quiet space, or technological devices [29]. Compounding these obstacles, feelings of worry and loneliness, along with disruptions in housing, employment, and services of all kinds, heightened the need for school behavioral health care and fueled the demand for accessible frontline mental health professionals to mitigate the anticipated traumatic stress [30,31]. In addition, the added stress of the demands of teaching during the pandemic escalated anxiety and burnout in school staff which also necessitated support from behavioral health providers working with school staff [32]. As a result, school behavioral health providers had to make a breakneck pivot toward the virtual delivery of direct services, coordination of care, and teacher consultation. Yet, the likelihood of worsening burnout and turnover among front-line behavioral health providers who were already in notably stressful professions before the pandemic has had administrators and supervisors struggling to fill and maintain qualified professionals in school behavioral health positions [33].

TA professionals were also forced to adapt and change their mode and method of consultation and support in response to changing demands [34]. These unprecedented circumstances along with the lack of clinical guidance for school behavioral health practitioners or administrators on how to manage their programs or maintain essential partnerships with school colleagues and practitioners, only intensified the need for assistance, connection and problem-solving across many districts in the U.S. The focus of TA turned to the best ways to support those on the ground who were working tirelessly to be responsive to student and family challenges while also struggling to maintain a presence in school-level meetings. When schools employed a hybrid model or were operating in-person, many schools still restricted partners' access to their buildings. Some schools were only allowing school-hired personnel and students into the buildings due to COVID safety protocols which also complicated service delivery as there was a disconnect in being able to provide timely interventions without being present in the building. The TACoP quickly became a safe space where leaders could utilize elements of a CoP and strategize about modifications and adjustments to TA delivery across the varied settings within which these leaders worked [35].

Challenges and Lessons Learned

Through consistent meetings of the TACoP, common practice challenges emerged despite geographic, programmatic, and operational differences across the TA providers' purview. With little knowledge available for how to assist school communities through these novel impediments for the implementation of best practices in school behavioral health, the TACoP members leaned on each other and provided personal and professional support. Topics of discussion within the group are categorized into two major areas, collaboration and community-building issues and practice-based issues, with several examples included to help illustrate lessons learned. The authors also describe the value of the TACoP to its members, particularly in mitigating professional isolation and validating the challenges experienced.

Collaboration and community-building issues

Across many school districts, the current ratio of school-employed student support staff (i.e., school counselors, school social workers and school psychologists) to students is significantly higher than those nationally recommended [33]. Even prior to the pandemic, the ongoing demand for behavioral health care overextended constrained professional resources. School behavioral health programs, therefore, aim to expand the interventions and supports available to students and staff in already under-resourced, overwhelmed systems. However, forging collegial relationships and effectively integrating services across internal and external behavioral health providers is complicated. Traditionally, concerns about employment security, poor delineation of roles, lack of anticipatory planning, ambiguous protocols, limited interdisciplinary teamwork, and irregular communication can fuel "turf issues" and undermine the collaborative rapport necessary to seamlessly align activities and services [36]. TA providers have addressed this common challenge by helping stakeholders clarify roles and responsibilities across school and district providers, sharing tactics to promote interdisciplinary teaming and suggesting complementary practices that facilitate collaboration and community-building. Schools already played a significant safety net role for ensuring the physical and mental well-being of vulnerable children. However, when the pandemic hit, schools across the country not only bore the primary responsibility for meeting the social and educational needs of their students and families, but also physically locating students, distributing technology, ensuring access to food, and communicating about varying education and public health policies, while trying to educate them remotely [37]. Functioning in crisis mode for a prolonged period, school decision-makers were overwhelmed and sought guidance on strategies to stabilize the school environment. The pressures on the entire school community fueled an "all hands on deck" response to move through the immediate crisis, which blurred previously defined roles or caused staff to revert back to operating in professional silos. In some

instances, this also meant some children were matched to specific behavioral health providers simply based on availability or convenience, as opposed to provider specialty or expertise.

As the influx of COVID relief funds have become available to U.S. schools and LEAs, a surge of behavioral health providers has joined the school ranks [38,39]. An increased number of funded behavioral health positions initially felt like a welcomed relief, but workforce shortages for child behavioral health providers in targeted regions led to hiring professionals with less experience or familiarity with how school mental health practices differ from those delivered in community mental health settings. Furthermore, if employed during the last school year, these providers joined their new school communities remotely. Program administrators experienced complications as they remotely oriented providers to their new roles and introduced them to school leaders and staff, while grappling with how to build collegial relationships, provide supervision, and create structures for professional development online. The need to manage difficulties with collaboration and community-building in a virtual environment became a topic of discussion between the TACoP leaders. Since teaming and collaboration are at the core of successful comprehensive school behavioral health approaches, and unrelenting stress was impacting all key stakeholders involved in schools, the early focus of the TACoP was on identifying useful self-care practices and broadly sharing stress management techniques. Acknowledging how those in helping professions often neglect their own personal well-being, there was an intentional focus on behavioral health providers' emotional state as essential to forging and maintaining relationships with others, whether students or adult peers. This point was not lost on the TACoP members themselves as they discussed the impact of the pandemic on their own TA teams, "When we talked about the effect all of this turbulence was having on our community partners, it became clear that our own internal teams were not immune to the stress and that we needed to address this head on, so hearing how another TACoP member processed and dealt with managing their own team's exhaustion gave me ideas for what I could do with my own staff".

Because the members of the TACoP reside in different states, and their relationship began virtually, they had developed an ability to engage in dialogue and build trust remotely. Examining what had helped them form close bonds, the members realized that connecting on an emotional level was critical before diving into information-sharing or problem-solving discussions. Starting with strategies that demonstrated "you are not alone" and "I care how you are doing" created a receptivity for constructive recommendations and suggested improvements that followed. One TACoP member added, "I actually look forward to this meeting because I know I will be able to laugh at the absurdity of it all with others who totally get what I am talking about-all while we try to come up with practical solutions to the challenge at hand". Furthermore, encouraging each member to assume a role as both a learner and a leader in the TACoP deepened connections. Modeling the importance of relationship-building as a way to establish a shared identity was necessary to forming this community. TACoP members also recognized that inviting others with different points of view to take part in designing solutions for emergent problems helped shape and improve their own TA delivery approach as they revised and reignited their local CoPs.

Practice-based Issues

One of the most notable benefits of co-locating community mental health providers into schools is the improved efficiency to reduce unmet student behavioral health needs [40]. Having behavioral health professionals and student support providers work in teams promotes a more streamlined delivery of services to students. Typically, as problems arise, educators and school staff notify their school behavioral health teams of emerging concerns through an established referral pathway. Ideally, these protocols are formalized, however it is not uncommon for concerns to initially be voiced through informal channels, such as when passing in the hallway, while sitting in the staff lounge, or through conversations in the office. Swift determinations can then be made about the level of urgency, how to proceed, and who else to include in deliberations about how to evaluate the situation at hand. Having regular face-to-face contact increases the likelihood that important multi-disciplinary conversations around student behavioral health occur, especially in a fast-paced environment with many competing demands that is emblematic of schools. School behavioral health professionals are also able to visit a student's classroom or observe them in other parts of the school setting to better assess the extent of the problem and to outline recommendations for next steps. In addition, physical proximity enables disclosure of sensitive information as well as the modeling of evidence-based strategies to assist teachers and staff as they work to engage and teach any struggling student.

However, because of the pandemic and the shift to remote learning, many of these scheduled and impromptu in-person interactions were no longer possible. School-based providers, especially those employed outside of the school district with limited access to information, voiced frustration about the ever-changing school context and their need to repeatedly request inclusion in communication channels available to other school staff and administrators. This caused some providers to unintentionally miss staff meetings or other team discussions where critical plans were shared or where input was sought on how to address immediate challenges. The laser-like focus on establishing online instruction at times translated into school behavioral health providers struggling with access into virtual classrooms and thus their student clients. This also resulted in disruptions to established routines between educators and behavioral health professionals as they collaborated to create safer classroom environments, identify students with emerging issues, or implement student social and emotional programming. In many cases, universal prevention approaches and whole-school behavioral health initiatives, critical parts of a comprehensive school behavioral health approach, were halted as methods for conducting online health promotion strategies felt illusive and were a lower priority at the time.

Furthermore, transitioning to the use of telehealth technology for the provision of behavioral health services was necessary but created a challenge for both students (especially younger ones) as well as behavioral health providers. Numerous modifications were needed, such as to referral practices, consent processes, treatment protocols, privacy considerations, and communication strategies. For example, screening and assessment conducted in a virtual environment proved difficult for behavioral health providers who were trained to use both verbal and non-verbal cues to inform their evaluations. If students turned their cameras off or muted themselves, clinicians found themselves unable to make informed clinical decisions or to adequately perform their jobs. The shift to telehealth also highlighted inequities for students in need of behavioral health care if they had no/unstable internet access, were forced to share computers or laptops across multiple people in the home, lacked confidential spaces to engage in private conversations, or had other social needs that prevented them from fully participating in their treatment [41]. Having formed the TACoP months before the pandemic-related stressors became pervasive, a sense of trust and shared values had been established among the members of the group that facilitated candid and productive discussions around practice-based challenges. The unprecedented circumstances facing school leaders and administrators required that the TA providers be accessible and responsive, despite the lack of evidence for how to specifically direct their partners' actions. The volume of newly developed materials and guidance documents from national and federal sources proliferated and the TACoP became a reliable source through which to examine the quality and applicability of available information. This vetting served an essential function for leaders given that their TA was desired quickly, flexibly, and efficiently.

TACoP members also shared details about practice-based problems in their respective communities and the revised protocols they helped design and implement with their partners. They brainstormed solutions together when no clear approach was evident and reviewed materials developed by individual members to maximize the likelihood of local uptake and implementation. For example, the TACoP discussed the online screening tools available for use in schools and which were more appropriate for different populations. Each member of the TACoP brought new insights and experiences around what was working well in their consultation and what could be improved. Relying on one another's expertise, experiences, and resources to help provide guidance to those receiving TA was invaluable. This function, consistent with the aim of CoPs, yielded practical and emotional benefit to individuals who had complementary expertise and were brought together to co-create solutions, generate new knowledge, and test innovative ideas. As one member stated "this TaCoP validated feelings of uncertainty and solidified new practice approaches to support my school partners during these trying times".

Limitations and Future Directions

Extensive understanding of the components that make up a comprehensive school behavioral health system, experience with assessing schools and districts against known best practices, meaningfully partnering with system gatekeepers, and then effectively delivering professional development, consultation, and/or training to key constituents to improve their practices describes what is generally required of leaders providing TA. Even under normal circumstances, the pace, scope, and sequence of TA strategies used to advance the implementation of school behavioral health are influenced by the policies, partnerships, politics, and funding mechanisms that govern what comprehensive school behavioral health means for any locality. Variability typical of TA approaches was likely exacerbated during the pandemic resulting in changes to the what, where, when, why, and how of TA delivery and which posed an additional challenge with replicating a TA-focused CoP. Despite these limitations, the TACoP was designed to enable the translation of potential solutions around common problems of practice in the delivery of TA to be tailored to the needs of their specific partnerships. Although they become more common,

the frequency of the meetings, scheduled for once per month, made it improbable that assistance for immediate challenges or consultation around crisis situations could be provided in a timely way. Members recognized that much activity occurred in between meetings and regular updates on progress could not be discussed in the time allotted each month, therefore, the group prioritized concerns that were causing stress or significant frustration in the coordination and provision of TA. Ultimately, the TACoP members balanced time between topics that lent themselves to group consultation while still dedicating a portion of the meeting to informal sharing and emotional check-ins that reinforced community-building. Committing to participation in each call was critical to reliably convey support and prevent professional isolation that each individual experienced.

In the absence of a clear model for the delivery of TA in school behavioral health, the assumption that inclusion of CoP is essential as part of TA delivery, remains untested. The same is true of the lack of evidence in the use of CoP as a process by which TA providers are brought together to effectively elevate their own practices. Although one can extrapolate from previous studies about the general value of CoPs, the absence of documentation about the impact of maintaining a CoP specifically for TA providers in their role as change makers should drive new evaluation and research efforts. The examination of outcomes associated with the use of CoPs to advance comprehensive school behavioral health systems would better describe the individual and collective merit, as well as the return on investment, of coordinated, peer-led and leadership focused activities such as this. One can expect TA providers, given their scope and reach, to be from different locations and to need to convene meetings or learning sessions remotely. Therefore, understanding how best to engage members using virtual platforms and determining the most effective structures and processes for learning among master facilitators/trainers are inquiries also worthy of future investigation. There are numerous advantages, both to the field of school behavioral health and to other sectors that utilize TA in their dissemination of knowledge, to systematically collecting information that would illuminate the consequences of promoting and utilizing CoPs as an interdisciplinary, collaborative, system-building strategy.

Conclusion

School and community mental health providers, administrators, and partners have sought solutions for how to address the interference with the on-the-ground delivery of school behavioral health support for student populations across the U.S., especially during a time of national and global turmoil. Given these demands, individual expert-led TA programs had to become even more nimble and responsive to recipients during a time of social, environmental, and professional uncertainty. How to identify and assess pressing challenges, adapt best practices in school behavioral health to address those challenges, effectively share needed adaptations, monitor and ensure fidelity of subsequent changes in practice, all while also staying attuned to guidance from state, national, and federal sources proved demanding even for veteran TA providers. Wenger argues that "The development of a community is a delicate process involving interpersonal dynamics, trust, and mutual commitment-and resulting in a new social entity [42]". Notably, consistent engagement in CoPs can provide an opportunity to foster trust and development of an interdependent network of peer leaders that can mitigate both professional challenges as well as personal stressors through community building and collaboration. During a time of isolation, trepidation, confusion, and rapid adaptations, having an established support system, as provided by the TACoP, proved to be invaluable. One member concluded, "participating in the TACoP has been instrumental in reducing feelings of isolation by being a part of a supportive community during a time of constant change. Through sharing ideas and lived experiences with others in similar roles, it also helped to inform my process when working on adapting key components of our program during the pandemic." Finding common experiences with other TA providers reduced stress, provided validation, helped strengthen the sense of community, and bolstered the practice elements being offered to the various communities receiving valued and timely TA.

Adjusting to virtual environments for all interactions, both in the provision of school behavioral health interventions as well as in the delivery of TA to maintain these systems of support, was a unique experience for which no detailed guidance or roadmap existed. Through the TACoP, participants were able to expand practice through exchanging strategies, tips, and concerns in a safe environment with colleagues mutually invested in ensuring school behavioral health systems could function during times of national crises, offered validation and opportunities for professional growth. The shared learning and development of new ideas benefited those involved in the TACoP as they strove to address persistent and novel problems of practice. Even though the catchment areas for each TACoP member varied, the general needs across each community and the utilization of a CoP approach were similar. Engaging in this collaborative space saved time and decreased the tendency to "recreate the wheel" as interventions were tested in one location with results shared across the TACoP to speed up application in another location whenever relevant. Utilizing a multi-disciplinary CoP and reaching beyond geographic boundaries can broaden leaders' perspectives and assemble a wider community of experts to engage in collaborative problem-solving and learning, rather than relying on individual efforts to address common problems of practice. Participating in a CoP during the pandemic has been critical in helping direct local and regional actions during a time when no precedent existed for how to operationalize school behavioral health best practices. Dedicated investment in CoPs, and particularly TACoPs, will be important as schools and their many partners continue to adapt to changing demands and fluctuating circumstances resulting from such an enduring crisis.

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