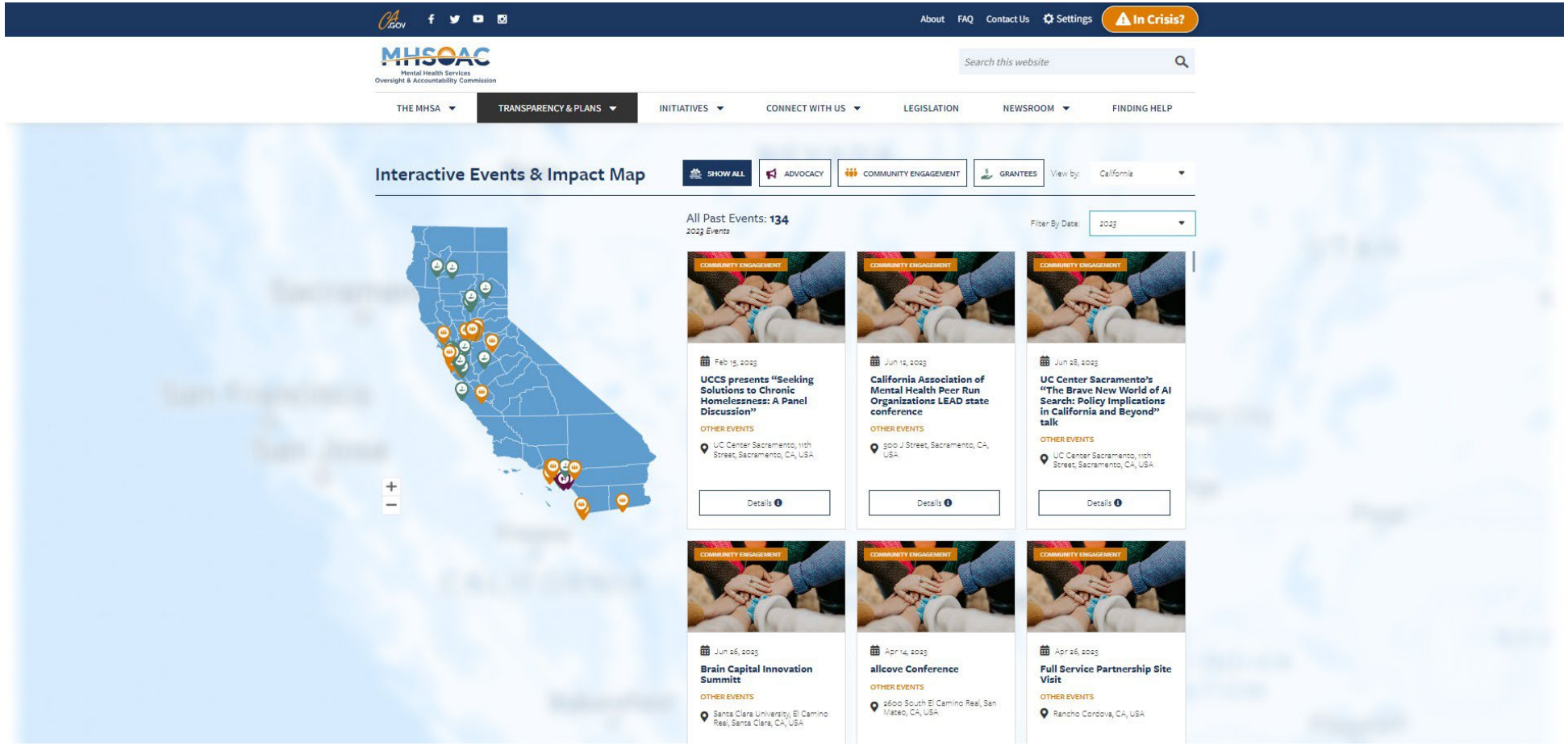
WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Teleconference Meeting
February 22, 2024
Presentations and Handouts

Announcements:	•Presentation:	Community Engagement Map Website
Agenda Item 6:	•Presentation:	Strengthening Early Intervention to Reduce Criminal Justice Involvement – Dr. Rosa Negron-Munoz, MD, DFAPA, Child Forensic Psychiatrist
	•Presentation:	A Perspective on Individuals with Serious Mental Illness and Criminal Justice Involvement – Dr. Melanie Scott, PsyD
	•Presentation:	Transforming the Los Angeles Mental Health System - Dr. Jonathan Sherin, MD, Ph.D., Chief Medical Officer, Healthy Brains Global Initiative
Agenda Item 8:	•Handout:	Universal Mental Health Screening of Children and Youth Project Phase 1 Report: Literature Review
Agenda Item 9:	•Presentation:	Full Service Partnerships: Whatever It Takes
	•Presentation:	MHSSA RFA Outline

Community Engagement Map



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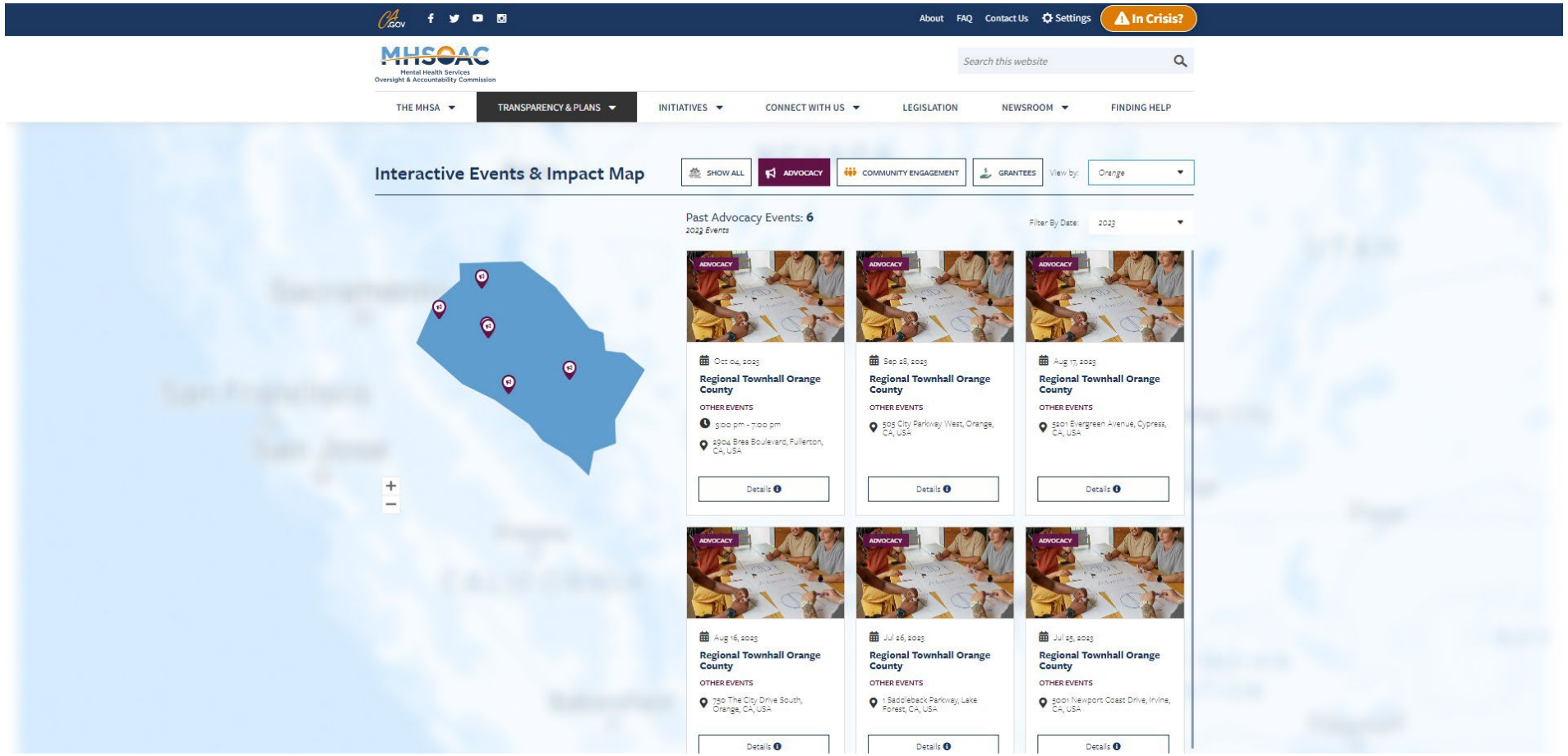
Community Engagement Map



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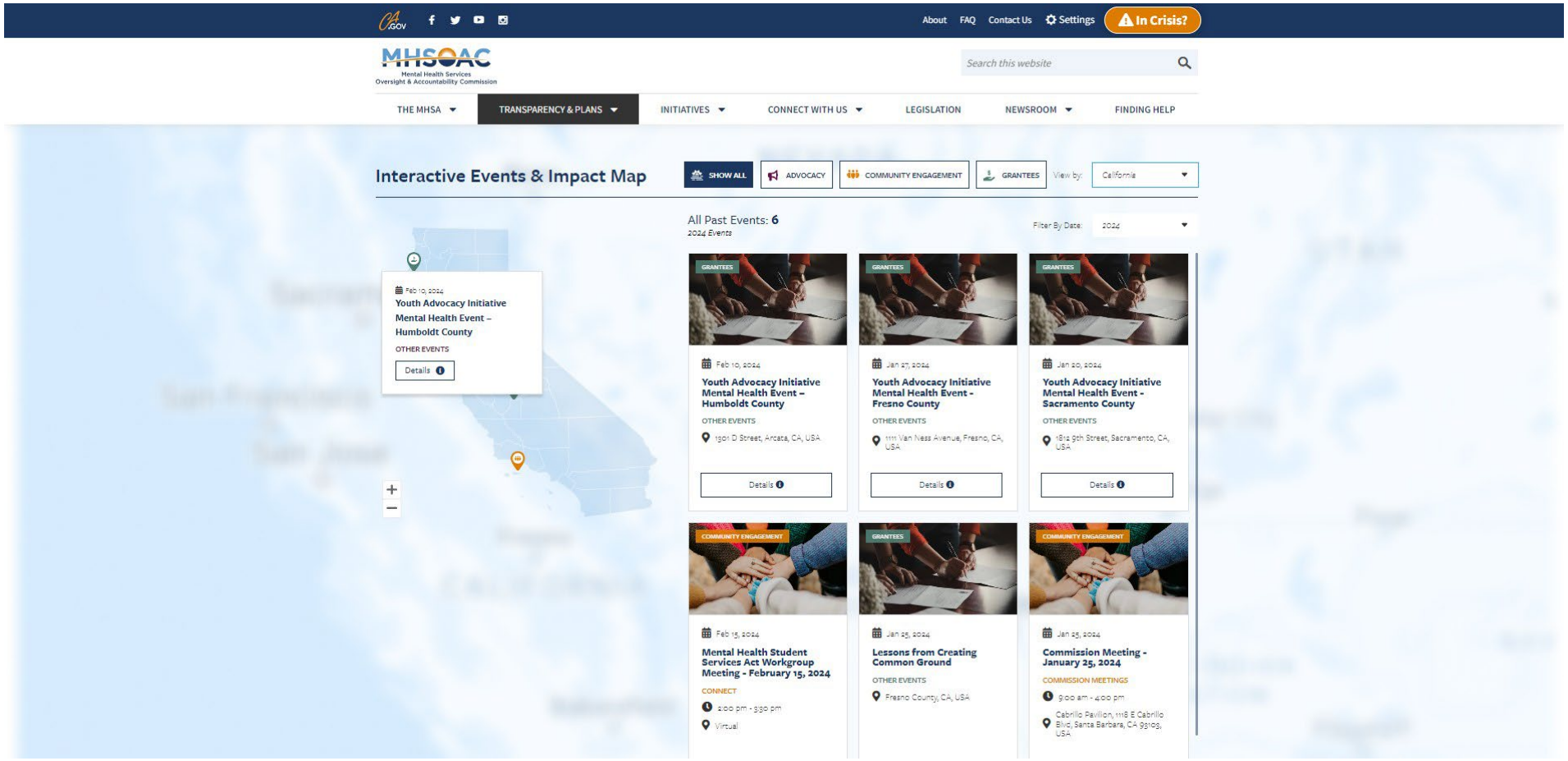
Community Engagement Map



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Strengthening Early Intervention to Reduce Criminal Justice Involvement

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Oversight & Accountability Commission

February 22, 2024
Sacramento, California

Yantra

PSYCHIATRIC SERVICES, INC

Rosa E. Negron-Munoz, MD, DFAPA, DFAACAP

Adult, Child and Adolescent, Forensic Psychiatrist

President/Medical Director

Lakeland, Florida

- 1) Description of your involvement with the justice system as it relates to mental health conditions.
- 2) Lessons learned about the type of early intervention services needed to help an individual avoid incarceration.
- 3) How early intervention services for children, youth, and young adults could shift the trajectory away from negative outcomes such as homelessness, hospitalization, and incarceration and toward a life of health and wellness.

Description of your involvement with the justice system as it relates to mental health conditions

- Training (Riker's Island, NY, Sing Sing Correctional Facility, Mental Health Court, Diversion Programs, ACT Teams
- Designated Mental Health Authority for the Florida Department of Juvenile Justice at Level 6 and 8 Residential Treatment Facilities
- Psychiatrist and Consultant for several private companies that contract(ed) services for delivery of services to juveniles in custody of Juvenile Justice
  - G4S, TrueCore, YSI, Sequel, AMIkids, Wayne Halfway House
- Lead Psychiatrist for Hillsborough County Jail, Tampa, Florida
- Consultant Pinellas County Jail, Clearwater, Florida
- Psychiatrist for the School District of Manatee County, Bradenton, Florida – School for Academic and Behavioral Excellence (SABLE)
- Forensic Cases

Lessons learned about the type of early intervention services needed to help an individual avoid incarceration

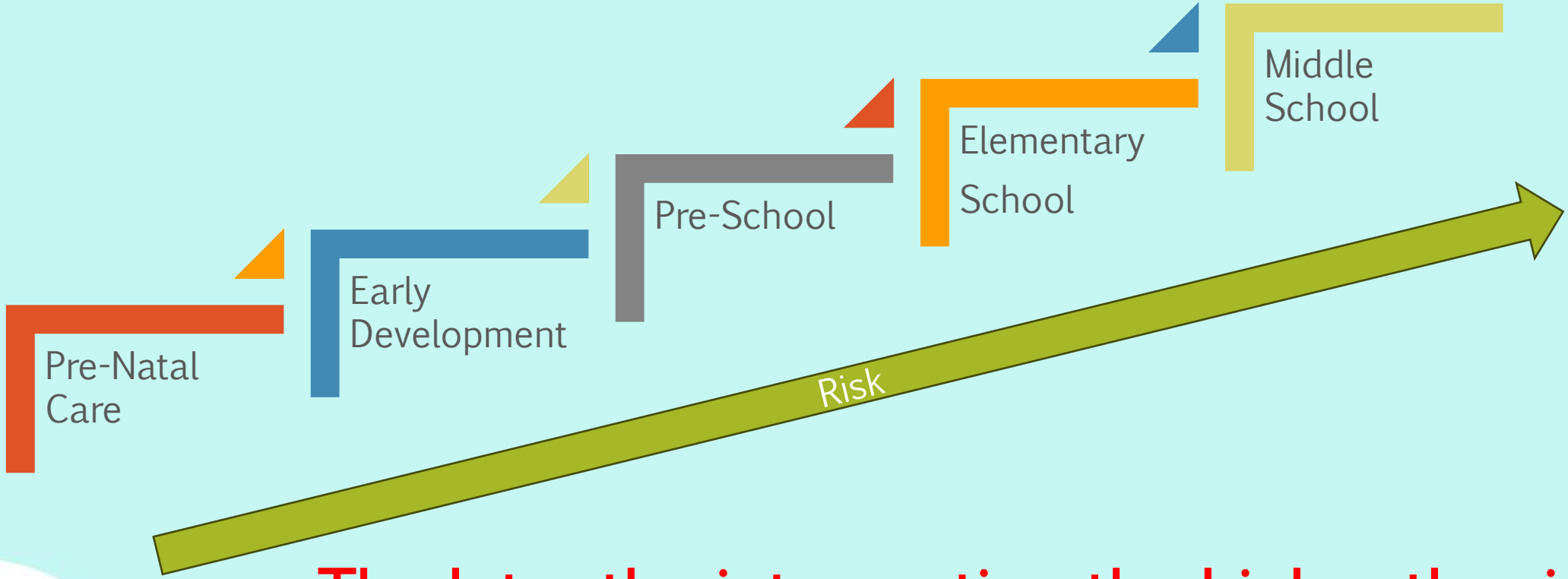
Are we the 3 wise-monkeys?

Or are WE the 3 wise monkeys?!!

Lessons learned about the type of early intervention services needed to help an individual avoid incarceration

- Never too early
  - Pre-natal care?
  - Early Development?
  - Pre-School Intervention?
  - Early School Intervention?
- Anything after this, will it already be too late?!

The real question is... how early do we want to intervene?



The later the intervention the higher the risk

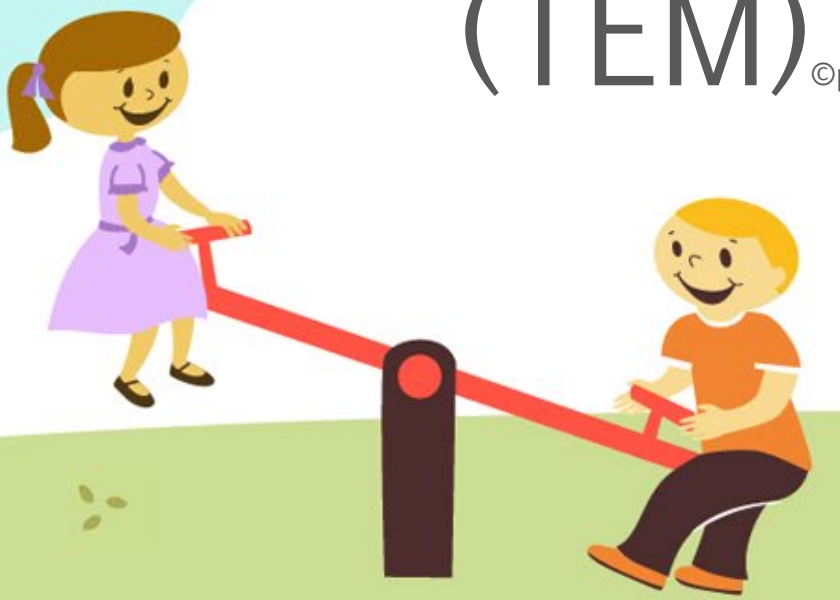
It can become a never-ending cycle...

How early intervention services for children, youth, and young adults could shift the trajectory away from negative outcomes such as homelessness, hospitalization, and incarceration and toward a life of health and wellness

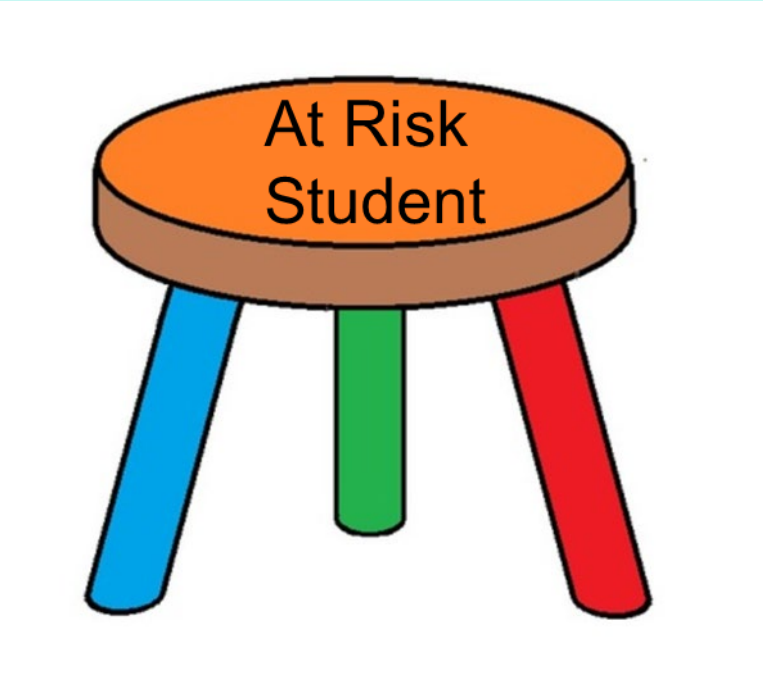
- Provide appropriate services at appropriate stages
  - Development
  - Diagnosis (es)
  - Treatment
  - Education
  - Follow-up
  - Financial**

Proposed Model

Therapeutic Education Model (TEM)



Therapeutic Education Model (TEM)©pending Karen Mills,RN, MS EDL, BCB
Elementary



- Community & Family
- Mental Health
- Education

Education Component:

- Early identification of learning barriers
- Instruction
- Curriculum
- Environment
- Learner

Mental Health Component:

- Psychiatrist
- Counseling
- Positive Behavior Program

Community & Family Component:

- Family Involvement
- Community Agency Involvement

Therapeutic Education Model (TEM) ©pending Karen Mills,RN, MS EDL, BCBA : Secondary

- Community & Family
- Mental Health
- Education
- Career Planning

Educational Factors Contributing to Juvenile Delinquency

Rosa E. Negrón-Muñoz, MD, Lakeland, FL

Karen Mills, RN, MS EdL, BCBA, (I) Bradenton, FL

Why study this?

- Noticed trend in Juvenile facilities of educational difficulties and grade retention
- Limited studies correlating education and juvenile delinquency
- Behavior in school associated with desertion and eventual involvement with delinquency ?
- Improve education to reduce involvement in juvenile delinquency
- Improve identification of educational difficulties
- Provide appropriate educational settings

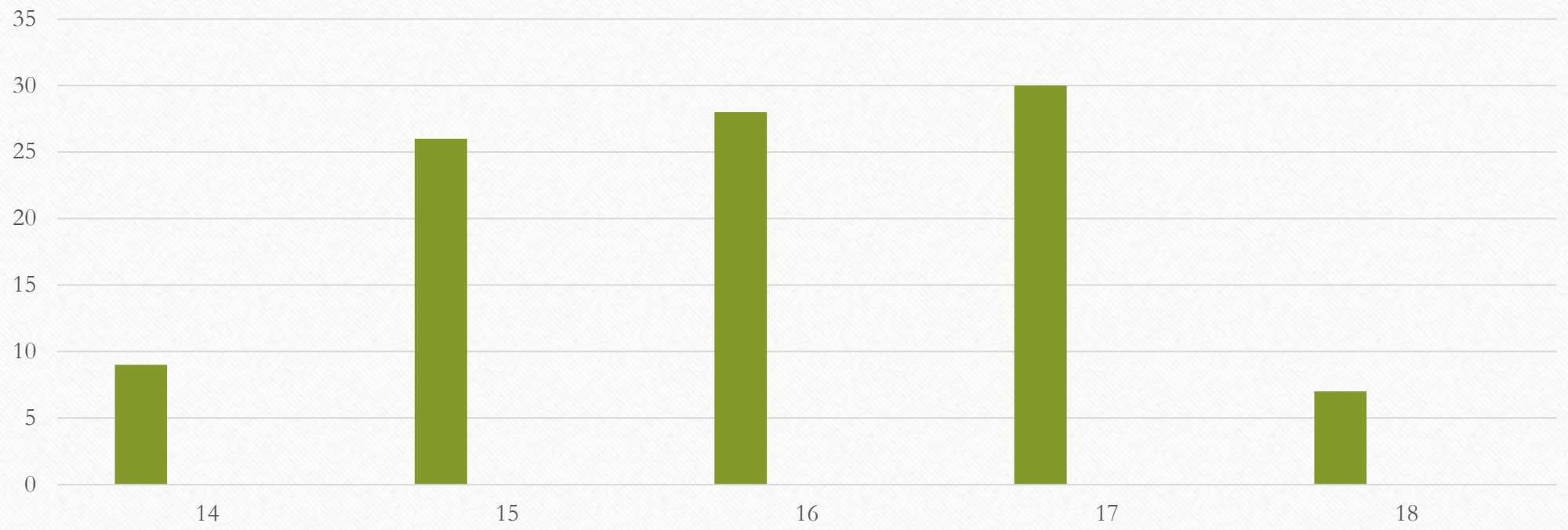
Sample

- 100 juvenile males committed to a moderate level residential facility
- 100 adult males in a County jail

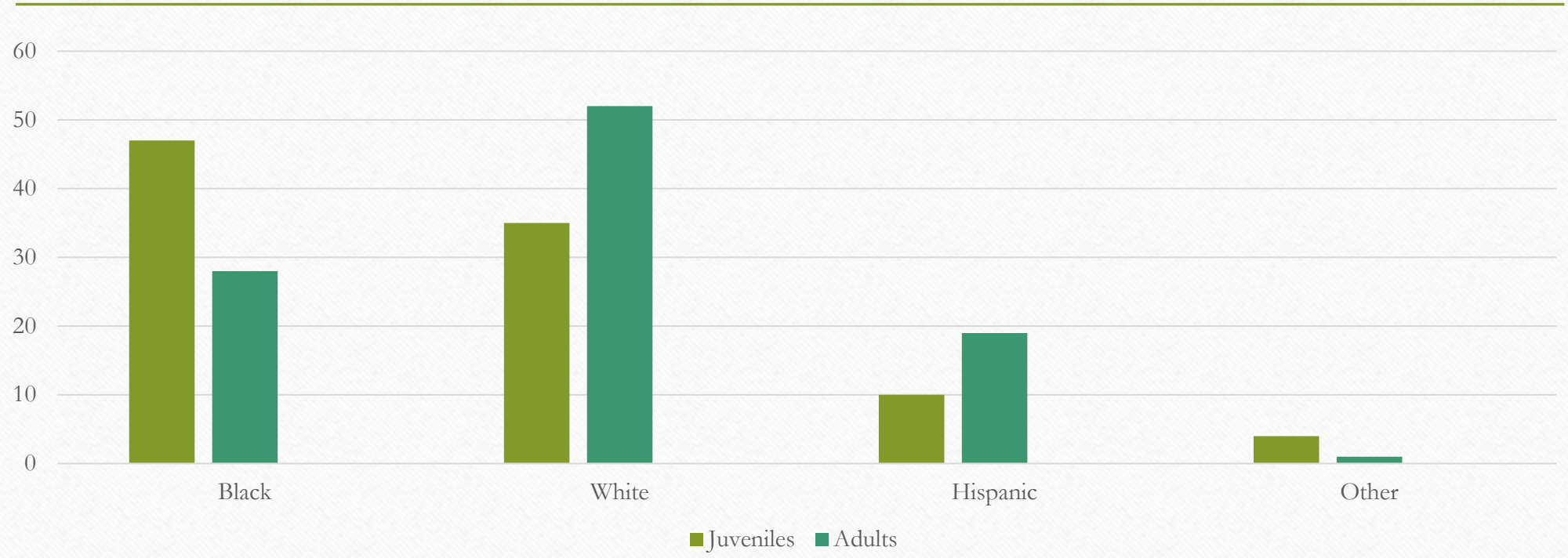
Methodology

- Chart review
- Age / Race
- Last grade completed – Level of education
- Grades Repeated
- History of placement in special education
- History of suspension and expulsions for juveniles

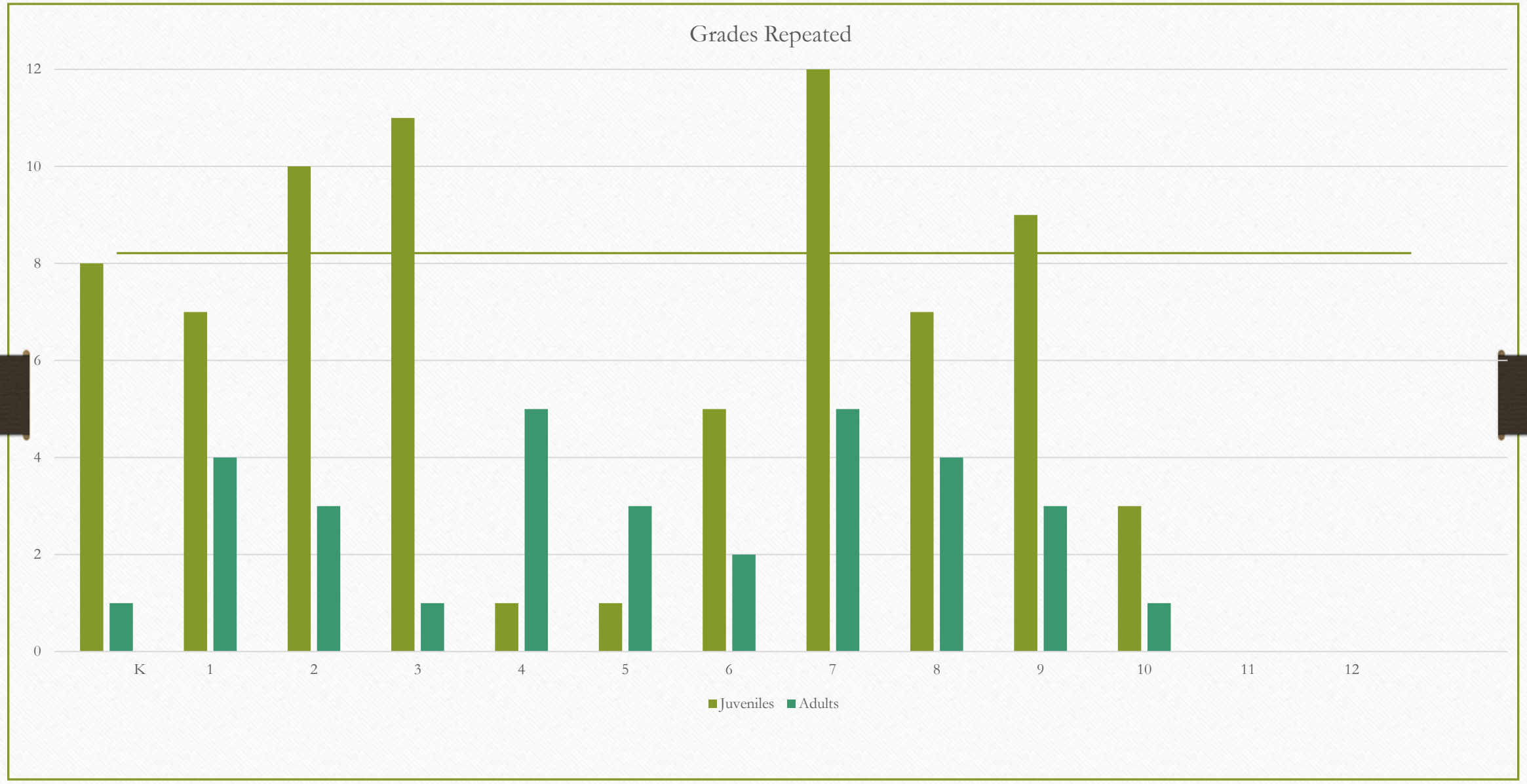
Age - Juveniles



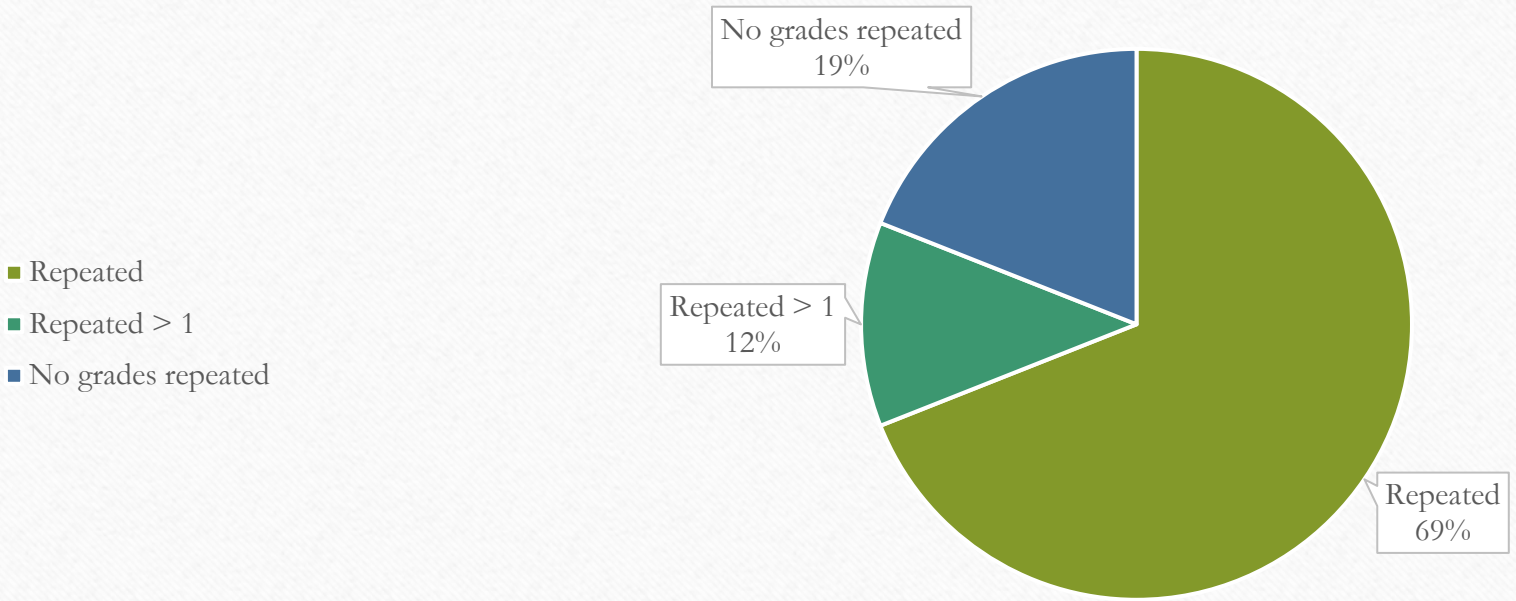
Race


60
50
40
30
20
10
0
Black
White
Hispanic
Other
Juveniles
Adults

Highest Grade Completed


Grades Repeated
12
10
8
6
4
2
0
K
1
2
3
4
5
6
7
8
9
10
11
12
Juveniles
Adults

% of Juveniles Repeating Grades



Special Education

- 22 Juveniles identified to have received special education
  - 11 Behavior
  - 6 Learning
  - 5 Reading
  - 3 Math
- 18 Adults identified having received special education


The Road Ahead

References:

- Scott, M.A., Snowden, L. & Libby, A.M. (2002) From Mental Health to Juvenile Justice: What Factors Predict This Transition?. Journal of Child and Family Studies 11, 299–311. https://doi.org/10.1023/A:1016820106641
- Robertson, Angela A., & Walker, Courtney S. (2018) Predictors of justice system involvement: Maltreatment and education. Child Abuse & Neglect 76, 408-415. https://doi.org/10.1016/j.chiabu.2017.12.002
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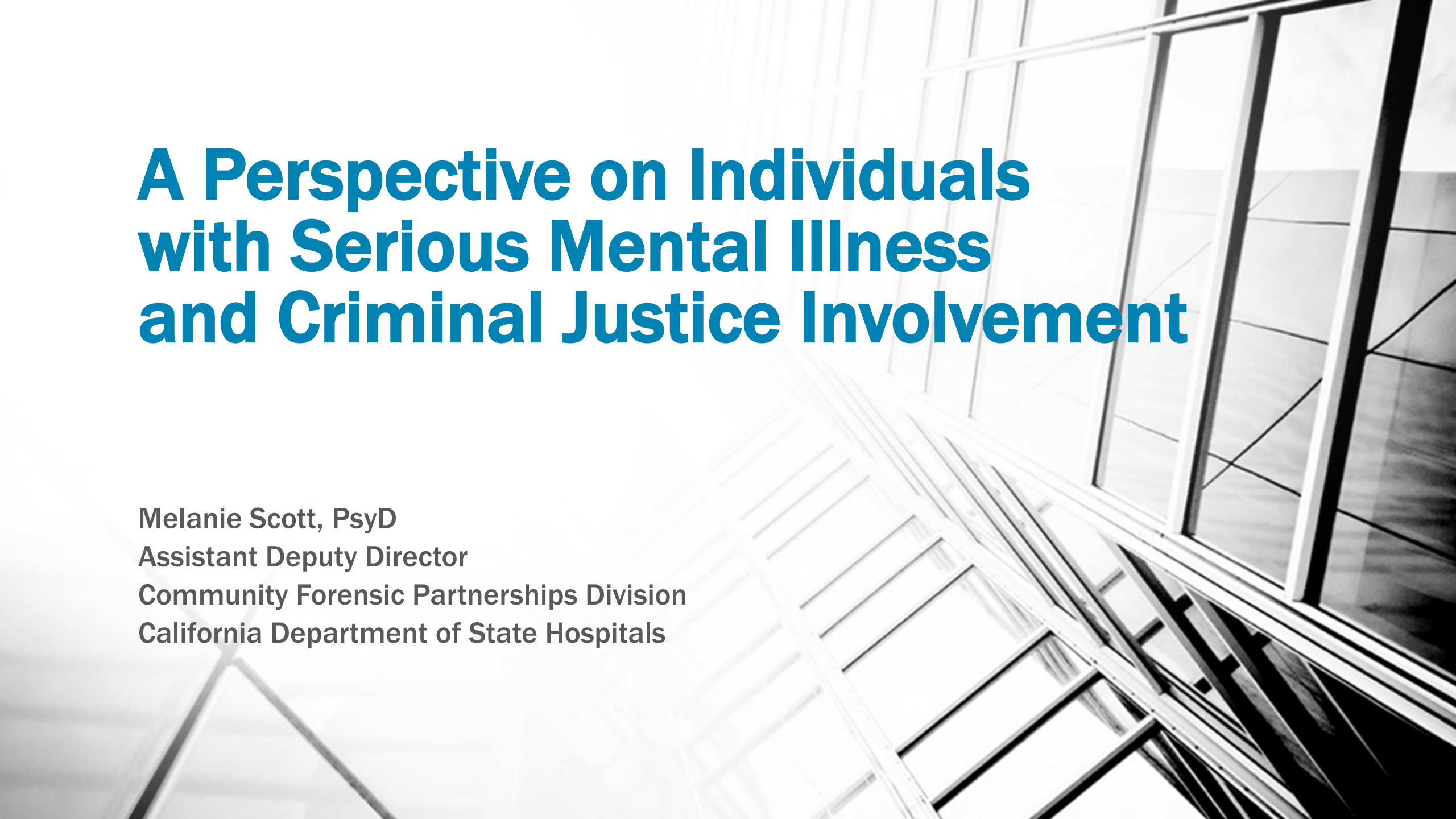
- Negron Munoz, Rosa E (2012) Comparison of IQ in Subgroups of Juvenile Delinquents (General Delinquents v Fire Setters v Sex Offenders) presented at the 43rd Annual Meeting of the American Academy of Psychiatry and the Law - October 2012, Montreal, Canada
- Negron Munoz, R.E. & Mills, K. (2015) Educational Factors Contributing to Juvenile Delinquency – Main Investigator, Presented at the 46th Annual Meeting of the American Academy of Psychiatry and the Law - October 2015, Ft. Lauderdale, FL

A Perspective on Individuals with Serious Mental Illness and Criminal Justice Involvement

Melanie Scott, PsyD
Assistant Deputy Director
Community Forensic Partnerships Division
California Department of State Hospitals



Background

- Forensically trained psychologist
- Career has moved along the continuum of care
  - children → adults → substance abuse → criminal justice
- Work in many different treatment settings
  - Outpatient - Inpatient - ACT - Diversion - Jails

SMI Population Impact on Jails

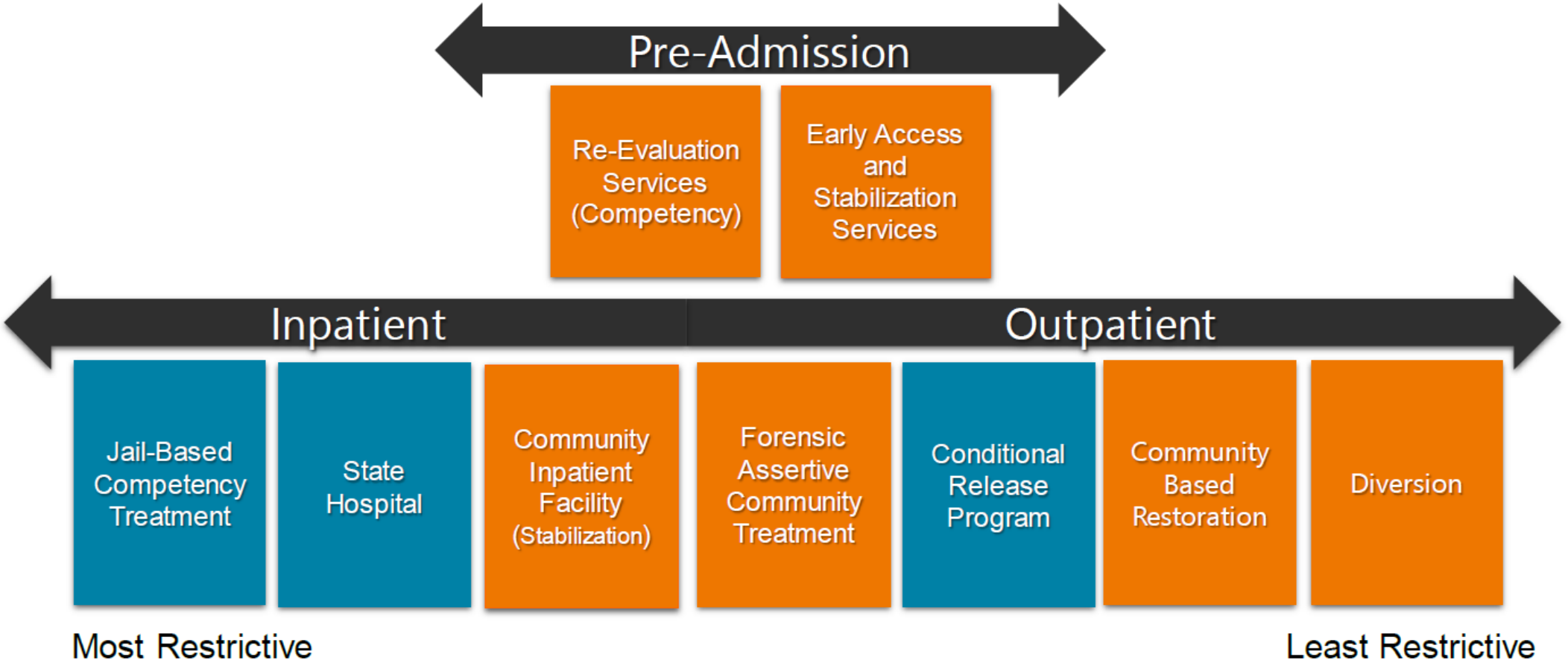
- About 16% of jail and prison inmates have a serious mental illness.[1]
- People with mental illness in the U.S. are 10 times more likely to be incarcerated than they are to be hospitalized.[2]
- In the year prior to arrest, a major mental illness diagnosis was associated with a 50% increase in the odds of a jail sentence for misdemeanor arrestees.[3]

1. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2018, www.bjs.gov/content/pub/pdf/cpus16.pdf
2. National Judicial Task Force To Examine State Courts' Response to Mental Illness, State Courts Leading Change: Report and Recommendations, Feb 2024
3. Donna Hall, Li-Wen Lee, Marc W. Manseau, Leah Pope, Amy C. Watson & Michael T. Compton, Major Mental Illness as a Risk Factor for Incarceration, 70 Psychiatric Services. 1088, 1089–91 (2019).

Jails are Impacted by Upstream Systemic Failures

1. Insufficient **immediate** availability of community mental health and substance abuse treatment for SMI populations
2. Training is needed for mental health professionals who work in the community with SMI populations
3. Shortage of mental health professionals statewide
4. People with mental illness are more likely to be arrested and incarcerated than hospitalized
5. “Warm Hand Off” must be stronger

Incompetent to Stand Trial Treatment Continuum



Incompetent to Stand Trial

Definition:

Penal Code section 1367 (a)

"A person shall not be tried or adjudged to punishment or have their probation, mandatory supervision, postrelease community supervision, or parole revoked while that person is mentally incompetent. A defendant is mentally incompetent for purposes of this chapter if, as a result of a mental health disorder or developmental disability, the defendant is unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner."

Characteristics[1]:

- Male
- Commonly diagnosed with a psychotic disorder or evidence symptoms of psychosis
- Cognitive disabilities
- Charges of assaults/battery, theft, robbery
- Unsheltered homeless
- 15+ prior arrests
- Not consistently connected with the community mental health system
- Not receiving Medi-Cal/benefits

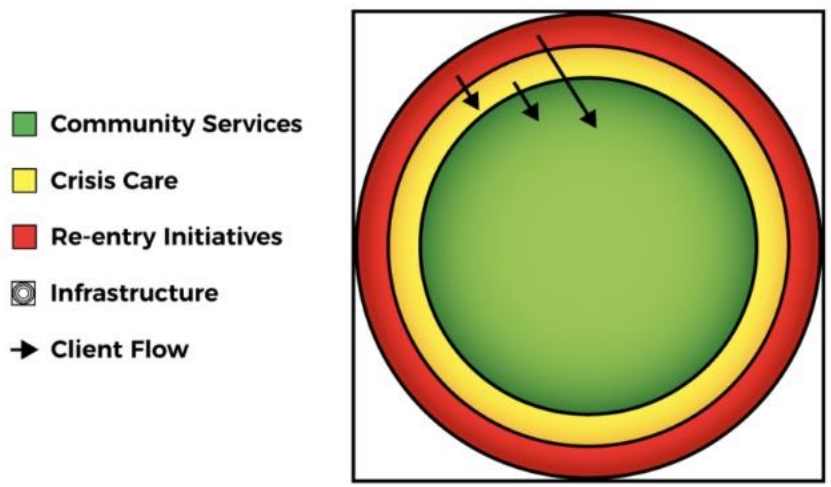
1. A longitudinal description of incompetent to stand trial admissions to a state hospital. CNS Spectr. 2020 04; 25(2):223-236. McDermott BE, Warburton K, Auletta-Young C.

Observations from Evaluations

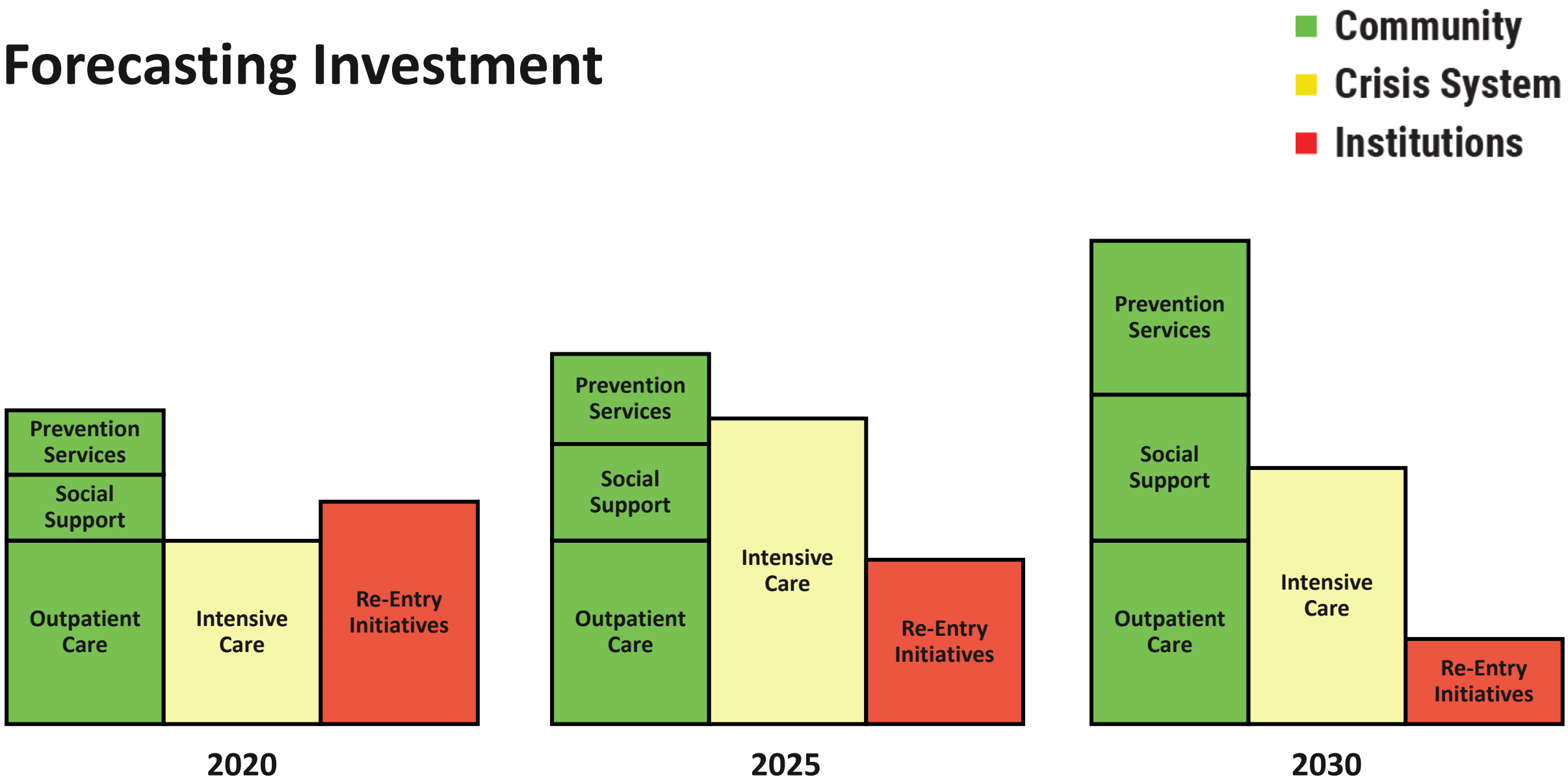
- Early signs of mental illness were never addressed
  - Unstable living arrangements and homelessness
  - Substance Abuse
  - Absent parent
- Unable to obtain immediate help before crisis
- Disjointed system of services for substance abuse and mental health
- The prevalence of trauma is high
- Not connected with community mental health system, only law enforcement
- Unable to connect with family due to privacy
- Highly reliant on crisis interventions
- Unsustained prior connections with community mental health system
- System navigator needed
- Stronger Warm Hand Off

TRANSFORMING THE LOS ANGELES COUNTY MENTAL HEALTH SYSTEM

Domains for Our Strategy



Forecasting Investment



Mental Health Services
Oversight & Accountability Commission

Universal Mental Health Screening of Children and Youth Project

Phase 1 Report: Literature Review

Report to the Legislature from the Mental Health Services Oversight and Accountability Commission

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Executive Summary

Nearly one in four children and adolescents will experience a serious mental health concern in their lifetimes, with recent national data revealing worsening trends. When mental health challenges go undetected and unsupported, significant systemic and individual consequences can arise and affect short- and long-term health and educational outcomes. Comprehensive school-based services, implemented as part of multi-tiered systems of support (MTSS), are widely recommended for increasing access to evidence-based, culturally and linguistically responsive mental health care for school-aged children across a spectrum of needs. Strategies to systematically and proactively assess the social, emotional, or behavioral strengths, risks, and needs of all students – a process referred to as *universal mental health screening (UMHS)* – can inform and guide a range of wellness promotion, prevention, and early intervention efforts within MTSS.

In recent years, California has made monumental investments to better support the mental and behavioral health needs of its young population. With these investments, the state is building a full continuum of infrastructure, workforce, and service systems that emphasize mental health promotion, prevention, and early intervention. State leaders recognize the potential for universal mental health screening within this continuum and need a path forward.

Through the 2023-24 Budget Act, the Legislature directed the Mental Health Services Oversight and Accountability Commission to conduct a study and submit a report on key considerations for implementing UMHS for children and youth, with a focus on California's K-12 schools. Through robust research and engagement conducted in collaboration with state and local partners, the Commission will develop and deliver a report to the Legislature in two phases. The first and present report provides a comprehensive review of literature related to UMHS policies and practices. The forthcoming second report will incorporate findings from a statewide survey and public engagement to describe the landscape of UMHS practices in California schools. The Commission contracted with researchers from the University of California, San Francisco, and the University of California, Riverside, to support this work.

Literature Review

This literature review has been organized by the following components: 1) evidence to support UMHS, 2) best practices for UMHS implementation, 3) equity-centered UMHS practices, 4) evaluating costs of UMHS, and finally, 5) examples of UMHS implementation in different states and countries.

Evidence to Support UMHS in Schools: Many UMHS tools have been developed and are available for use. To be effective at informing service delivery within an MTSS, schools must use tools that have sound technical properties, are appropriate for the intended use, and are usable (e.g., feasible, cost-effective). While a tool's technical properties or appropriateness are more commonly evaluated than its usability, evidence demonstrates that, compared to traditional referral methods, UMHS can identify more students with mental health needs, and can lead to earlier care. Together, the evidence supports UMHS's potential to facilitate prevention and early identification with MTSS.

Guidance on UMHS Implementation: Integrating UMHS into a school's MTSS requires a substantial and sustained investment of time, resources, and support for the staff involved. Several resource and guidance documents have been developed to support planning and implementation of UMHS. The guidance emphasizes that UMHS processes should be supported by a school-based multidisciplinary team, whose leaders have knowledge and training in mental health. Teams must engage in robust needs assessment, asset mapping, to inform screening goals and procedures. This process must include careful selection of screening instruments to meet intended goals, protocols for where, when, and by whom screenings are administered and responded to, processes for addressing parental notification and consent, decisions about data use and protection, evaluation of cost, staffing, and time requirements, and securing funding for UMHS. Starting small with a pilot is essential for refining these procedures and evaluating resource demands.

Equity-Centered UMHS: Systematic and proactive identification of students' mental health strengths and needs through UMHS can support educational and mental health equity, including reducing disproportionality in the special education referral process. Moreover, when UMHS is used to connect historically marginalized groups of students to high-quality school-based mental health services, historical inequities and disproportionalities in access to care may be reduced. To achieve this promise, UMHS should be conducted using an equity-centered approach, which is strengths-based, systems-focused, and contextually appropriate. Application of these principles informs UMHS planning and implementation and necessitates strong school-community partnerships.

Evaluating Costs of UMHS: Best practices recommend considering the cost-effectiveness and return on investment when determining UMHS tools and procedures. Published reviews of UMHS instruments provide information about the estimated costs of various tools. The limited research available suggests that cost-effectiveness of UMHS may vary based on student enrollment and the prevalence of positive screens. Although accurately estimating the costs of UMHS is complex and requires consideration of many factors, it is essential to

ensure that optimal procedures are in place and that expenditures are justified by improved student outcomes.

State and Country Experiences: Research provides a limited understanding of the landscape of school-based screening practices across social, emotional, behavioral, and mental health domains. Despite its promise, only about 6% to 13% of schools or districts across the U.S. are implementing UMHS. Surveys of school administrators and reviews of state policies and guidance documents reveal tremendous variation across the country. For this literature review we provide a summary of the experiences of several states, as well as Australia, the United Kingdom and Canada, with the implementation of UMHS.

These concepts and best practices for UMHS are described in detail in the forthcoming sections.

Introduction

Background and Purpose

Youth are in Crisis

Between 50% and 75% of mental health symptoms begin during youth and young adulthood (Kessler et al., 2007). Prior research indicates that roughly 20-25% of children and adolescents will experience a serious mental health concern (Forness et al., 2012; Merikangas et al., 2010). In California, where more than 5,800,000 students are enrolled in K-12 public schools, there is a very high number of students – potentially over 1,000,000 – at risk for social, emotional, and behavioral challenges (California Department of Education, 2023). For adolescents, estimates are even higher, with at least one in every three reporting a significant mental health challenge.

Recent national surveys further reveal increasing rates of persistent sadness or depression that interfere with young people's regular activities and suicidal behaviors (Centers for Disease Control and Prevention, 2020). In 2020, California saw 527 young people die by suicide – almost half occurred before the age of 20. In the same year, the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP) and the Children's Hospital Association (CHA) jointly declared a National State of Emergency in Children's Mental Health. In their statement, they called on policy makers at all levels to ensure *"all families and children, from infancy through adolescence, can access evidence-based mental health screening, diagnosis, and treatment"* (American Association of Pediatrics, 2021).

Yet young people's mental health needs continue to go undetected and, thus, are unsupported (Whitney & Peterson, 2019). In 2022, an estimated 60.3% (278,000) of Californians under the age of 18 experiencing major depression were not receiving any form of treatment, and the proportion of unsupported needs is likely higher for other severe mental health challenges such as psychosis. This gap in service delivery is further pronounced for children and adolescents from communities that have been systematically marginalized due to their race, ethnicity, or socioeconomic resources (Alegría et al., 2015).

When mental health challenges go undetected, significant systemic and individual consequences can arise. In the short term, unidentified mental health needs can worsen, affecting social, behavioral, and learning challenges, and in the worst case, can result in suicide for young people (Ivey-Stephenson et al., 2020). Over time, a person living with

unaddressed mental health needs is more likely to experience social, economic, and health-related challenges later in life, and can shorten their life expectancy by 10 to 20 years (Chesney et al., 2014). Fortunately, when a young person's mental health needs are identified and supported early their outcomes greatly improve (Csillag et al., 2016). Schools play a critical role in closing the mental health gap for youth.

Screening Supports a Continuum of Care

Comprehensive school-based services, implemented as part of multi-tiered systems of support (MTSS), are widely recommended for increasing access to evidence-based, culturally, and linguistically responsive mental health care for school-aged children across a spectrum of needs. Mental health screening is a critical component of a robust mental and behavioral health continuum. In a recent national review, school-based screening and intervention were identified as the most cost-effective strategy for preventing mental illness (Le et al., 2021).

Universal mental health screening (UMHS) – defined as systematic and proactive assessment of all students' social, emotional, or behavioral health needs – is particularly valuable in its ability to inform school-wide programming for all students while also identifying and supporting students with acute needs. Indeed, school-based UMHS has been recommended by major educational and health authorities including the National Association of School Psychologists, the National Research Council, the Institute of Medicine, the Healthy Schools Campaign, and Mental Health America, among others (SAMSA, 2019).

Building on a Foundation of Youth Behavioral Health

In recent years, California has made monumental investments to build a robust and responsive youth behavioral health care ecosystem that prioritizes prevention, early intervention, and school-based systems of support. Among these efforts is the California Youth Behavioral Health Initiative (CYBHI) which includes a one-time $ 4.4 billion public investment in infrastructure, workforce, and public awareness strategies to ensure all children have access to equitable, appropriate, timely, and accessible mental and behavioral health services and supports. Complimenting this work is the state's Mental Health Student Services Act (MHSSA) and accompanying $200+ million investment to enhance comprehensive school-based mental health services by strengthening partnerships between local mental health and education agencies. Through a variety of strategies, MHSSA partnerships work to identify early signs of mental health needs, reduce stigma and discrimination, and provide timely and responsive intervention to prevent student's mental health needs from becoming severe and disabling. As California lays the groundwork through these and other initiatives, there is a growing need to understand if and how universal

screening practices support the State's broader goals for youth behavioral health. Under the direction of the Legislature, the Commission aims to address this need through its Universal Mental Health Screening for Children and Youth Project.

Universal Mental Health Screening (UMHS) for Children and Youth Project

In enacting Proposition 63, the Mental Health Services Act, California voters in 2004 created and charged the Mental Health Services Oversight and Accountability Commission with the responsibility of driving transformational change in public and private mental health systems to achieve the vision that everyone who needs mental health care has access to and receives effective and culturally competent care.

Through the 2023-2024 Budget Act, the Legislature required that the Commission, in consultation with the Department of Health Care Services (DHCS), submit a report to the relevant budget and policy committees of the Legislature on universal mental health screenings of children and youth by March 1, 2024. It is the intent of the Legislature that the report be used to inform future budget and policy considerations for expanding youth mental health screenings in California, with the goal of reducing adverse health and life outcomes stemming from unaddressed mental health issues.

Project Goals and Activities

In preparation for the report called on by the Legislature, the Commission contracted with researchers from the Universities of California San Francisco and Riverside to conduct the following activities.

Literature Review: Review and summarize existing literature pertaining to universal mental health screening policies and practices for children and youth including evidence of effectiveness and cost of screening tools and strategies, and the identification of models, guiding principles, and standards specific to screening in healthcare and school settings, including those in other states and/or countries.

Policy Analysis: Consult with DHCS, CYBHI, and other relevant partners to describe existing UMHS screening policies and the degree of utilization across California, with attention on screening requirements, protocols for linkage and follow-up, and the fiscal, oversight, and technical resources needed for implementation.

Outreach and Engagement: Conduct key informant interviews and public meetings with diverse stakeholders to better understand the opportunities, perceptions, and needs related

to UMHS. Informants included researchers and subject matter experts, parents, students, and state and local partners representing legislation, education, healthcare, behavioral health, public health, and others.

California School Survey: Under the direction of the Commission and the Legislature, UCSF and UC Riverside have developed an online survey to be administered to a representative sample of California schools to learn about current UMHS practices. The survey will collect information on screening tools, procedures, and related successes, challenges, and costs. The survey also will collect information from schools which are not using UMHS.

Site visits: Attend a series of site visits to learn about existing UMHS practices in California. As of February 2024, the Commission has attended two site visits, one to Feaster Charter School in Chula Vista, California and another to Sonoma Valley High School, in Sonoma, California. The Commission will conduct at least one additional site visit at a location yet to be determined.

Final Report: Project activities will inform the Commission's final report to be presented to the Legislature in two phases. Drafts of both reports will be presented to the Commission for their consideration of adoption and approval before submitting to the Legislature.

1. **Phase One** – March 1, 2024
   The Commission will submit a report containing a comprehensive literature review of school based UMHS policies and practices.
2. **Phase Two** – August 2024
   The Commission will deliver a final report and landscape analysis that incorporates findings from the statewide survey and community engagement activities to identify best practices, costs, and barriers to implementing universal screening practices in California K-12 settings.

Preliminary Findings

Information about UMHS is limited in California, as currently there is no mechanism to systematically report or collect information about mental health screening practices in schools. However, key informant interviews and dispersed data provides a glimpse of the current UMHS landscape.

A wealth of research, tools, and guidance has been developed to support UMHS in schools, some of which will be described in detail in this report. Yet still, UMHS practices are highly underutilized. In the U.S., it is estimated that less than 15% of schools currently provide mental health screening (Bruhn et al., 2014).

Many schools in California are not using a mental health screener and are hesitant to do so, especially universal screening. The most cited concerns are related to schools' limited capacity, lack of training, and inadequate infrastructure to support screening, linkage, and care. Other consistent barriers (real or perceived) are related to liability, consent, confidentiality, lack of school and parent buy-in, and uncertainty about funding for UMHS (Humphrey & Wigelsworth et al., 2016).

Inconsistency in UMHS terminology is also an ongoing challenge. The term *universal screening* is often misconstrued as a process of assessing and diagnosis an entire population, or as a tool for collecting school or district-wide data and without identifying individual needs. The misuse of terms can inflate capacity concerns and undermine the utility of UMHS in schools.

Some schools across the state are already screening. For example, some counties are using a portion of MHSSA grants to pilot or expand mental health screening in schools, some of which are universal screening practices. While policies and practices vary across schools, existing screening efforts provide an opportunity for learning and collaboration.

The aim of the present literature review and forthcoming landscape analysis is to address such gaps in knowledge and practice and offer a path forward for school based UMHS. This literature review is organized into five parts, including 1) evidence to support UMHS, 2) considerations when implementing UMHS, 3) the importance of equity-centered UMHS, 4) evaluating the costs of UMHS, and finally, 5) examples of UMHS implementation in different states and countries.

Literature Review

1. Evidence to Support UMHS

UMHS is Part of a Multi-Tiered System of Support

Many states, school districts, and other educational jurisdictions have established multi-tiered systems of support (MTSS**)** for students to mitigate the harmful impact of social, emotional, and behavioral challenges and promote students' well-being (Briesch et al., 2018). This population-based, public health approach emphasizes prevention in addition to treatment through services provided at increasing levels of intensity and complexity (Fabiano & Evans, 2019). Following an MTSS model, universal wellness promotion and preventive supports are provided at Tier 1, targeted early-intervention supports are provided to students at risk for developing mental health concerns at Tier 2, and intensive and individualized interventions are provided for students with known mental health needs at Tier 3 (Fabiano & Evans, 2019). Strong empirical evidence backs the implementation of MTSS, with high-quality implementation associated with improvements in prosocial behavior, reductions in students' problem behaviors, and decreases in mental health difficulties (Bradshaw et al., 2010; McIntosh et al., 2011; Pas & Bradshaw, 2012; Walter et al., 2011).

Referral and intervention decisions within MTSS are guided by universal mental health screening (UMHS). For the purposes of our work, we have defined UMHS as *(a) the systematic and proactive assessment of social, emotional, or behavioral strength and risk indicators among all students within a given educational setting (e.g., classroom, school, district), with (b) a goal of informing universal programming and additional assessment or intervention for those with identified need*s (Burns & Rapee, 2021; Ikeda et al., 2007; Splett et al., 2018). In order to be conducted responsibly and effectively, UMHS is *(c) meaningfully integrated into a school's MTSS, and (d) conducted so that student data are identifiable (i.e., by student name or other identifiers)*.

UMHS, alongside extant school data (e.g., office discipline referrals, attendance), informs data-based decision-making and delivery of evidence-based interventions within MTSS (e.g., Romer et al., 2020). Data trends and patterns observed across the school population or within specific subpopulations (e.g., 3rd, one classroom, boys) inform universal programming (Tier 1). Data about individual students' strengths and needs can inform Tier 2 service delivery and, when considered alongside additional screening or assessment data that confirm student needs, referrals to Tier 3 assessment or intervention (Dowdy et al., 2010; Moore et al., 2019; Romer et al., 2020).

UMHS is Distinct from Other Screening

UMHS differs from anonymous surveys, such as the *California Healthy Kids Survey*, which assess social, emotional, or behavioral strength and risk indicators and inform universal programming but do not identify individual students needing additional assessment or intervention. UMHS also differs from direct referral-to-intervention methods, which connect students to needed services but do not inform universal programming. Instead, UMHS can *proactively provide information about students' mental health that informs wellness promotion, prevention, and early intervention supports* (Dowdy et al., 2015; Essex et al., 2009; Splett et al., 2018).

Considering other universal screening approaches, UMHS is distinct from screening and assessment of social-emotional learning (SEL) competencies, which centers on evaluating students SEL competencies (e.g., intra- and inter-personal knowledge and skills, attitudes, mindsets) and informing SEL instructional practices, but does not inform who may be experiencing distress or early signs of mental health challenges. UMHS may also be referred to as social, emotional, and behavioral (SEB) screening (Romer et al., 2020). We use the term "mental health" in this work to highlight the importance of UMHS for meeting students' mental health needs. Wisconsin's Department of Public Instruction developed a helpful resource for differentiating SEL, SEB/UMHS, and targeted SEB assessment (see Student Services/Prevention & Wellness, n.d.).

Given the scope and purpose of UMHS, evidence to support UMHS examines (1) the properties of measures (i.e., instruments or tools) used and (2) whether UMHS measures and processes are successful in identifying student and population needs. Numerous screening tools and methods have emerged, and investigations into their effectiveness have been conducted. In the following passages, we describe the appropriateness, technical adequacy, and usability of UMHS measures; how screeners identify students' social, emotional, and behavioral needs; and how UMHS yields better outcomes in comparison to other identification methods (e.g., referral systems).

Improved Outcomes

The implementation of UMHS is intended to improve the early identification of student mental health strengths and needs and, subsequently, support intervention delivery within MTSS and access to needed mental health supports. School psychologists have identified necessary inroads for examining outcome-based evidence to support UMHS practices. First, we can turn to educational professionals' experiences with screening and their perceptions of universal screening's efficacy in relation to other identification systems. District-level tiered

support system leadership teams report that implementing the Student Risk Screening Scale – Internalizing and Externalizing (SRSS-IE) screener improved their ability to identify struggling students, particularly those with internalizing behaviors (Briesch et al., 2022b). Additionally, using UMHS allowed school staff and leadership to examine behavioral health on both systemic and student levels, allowing schools to create normalized, efficient processes for implementing and monitoring support programs (Briesch et al., 2022b).

Second, comparisons between UMHS and other identification methods reveal screening's effectiveness in identifying more students with mental health needs and informing systemwide responses. Traditional referral methods, such as teacher referral or office discipline referrals, may overidentify boys and students with behavioral needs. Moreover, these historical "screening" approaches can further marginalize racially minoritized youth, as identification is dependent upon what teachers or other school staff consider "problematic" (Miller et al., 2022). In comparison, UMHS can identify more students with needs, particularly girls and those with internalizing needs who may otherwise go unidentified. For example, multiple studies comparing the Behavior Assessment System for Children, Second Edition (BASC-2) Behavioral and Emotional Screening System (BESS) Teacher Form to identification via teacher referral or office discipline referrals found that screening identified significantly higher numbers of students with social, emotional, or behavioral risk than traditional referral practices; identification as at-risk on the screener was associated with poorer academic outcomes (Eklund & Dowdy, 2014; Eklund et al., 2009; Splett et al., 2023). Comparisons of the identification reliability of the BESS Teacher Form versus office discipline referrals also support the screener's effectiveness beyond this traditional method (Naser et al., 2018).

Screening also provides empirically demonstrated improvements in connecting identified students to school and community resources (Husky et al., 2011a, b; Kuo et al., 2009) as well as to Tier 2 interventions (Moore et al., 2019); these connections can be facilitated at a more rapid rate than other identification strategies (Lyon et al., 2016). School and district partners are commonly concerned about their capacity to follow-up on identified needs. Some available evidence suggests that the number of students identified through screening (using the BASC-2 BESS) is aligned with population-based expectations for the prevalence of emotional and behavioral risk (i.e., 80% normal, 15% elevated, 5% extremely elevated). However, the number of students and types of needs identified may vary depending on who completes the screener (e.g., Schanding & Nowell, 2013). For example, in that same study, parent ratings identified fewer students with elevated or extremely elevated emotional and behavioral risk (Schanding & Nowell, 2013). These findings are consistent with work that has found low correspondence between parent and teacher ratings of children's and adolescents' internalizing and externalizing needs (De Los Reyes et al. 2015). As different raters know

students across varied settings, a multi-informant approach may provide the most comprehensive picture of student functioning. For example, other research suggests that students, especially in middle and high school, might be more accurate and reliable informants about problems like depression, anxiety, substance use, and not easily observable conduct problems (Levitt et al., 2007). Overall, the evidence suggests that increasing the number of screening occasions and the number and category of raters (i.e., students, parents, teachers) results in more generalizable data and more efficient procedures within support systems (Tanner et al., 2018).

Appropriateness, Technical Adequacy, and Usability of UMHS Measures

For UMHS to be effective at informing service delivery within an MTSS, schools must have access to UMHS measures that are appropriate for use, technically defensible, and usable (Brann et al., 2022; Glover & Albers, 2007). Most UMHS research has prioritized the appropriateness and technical properties of measures, with few studies investigating the extent to which measures can be feasibly used to achieve intended goals or are acceptable by school community members – that is, usable (Brann et al., 2022).

The **appropriateness** of a measure is determined relative to the population of focus and the goals for screening. A potential screener may be considered appropriate when (Glover & Albers, 2007; Moore et al., 2023): (1) The constructs measured, and data obtained from screening are aligned with the school's predetermined goals. This means that the type of questions asked on the measure are consistent with what the school hopes to learn. Additionally, scores or information obtained from administering the screener would be aligned with the school's screening goals. UMHS typically aims to inform universal programming and will indicate students who may need additional assessment or intervention. (2) The measure was designed for the population of focus. That is, the measure is *contextually appropriate* (e.g., can be administered in schools, intended informant is clear), *developmentally appropriate* (e.g., designed to be administered with students of a similar age or developmental level), and *culturally appropriate* (e.g., designed and evaluated for students from similar backgrounds or cultures). In research studies, information about whether measures are designed for use as screeners is often evaluated alongside their technical properties.

The **technical adequacy** of UMHS tools principally relies upon two types of psychometric evidence: (1) evidence that the screener is *reliable* – the individual items on the screener work together to effectively measure latent constructs of interest; (2) evidence that the screener is

valid. Types of validity that are particularly important in evaluating screeners include (i) *construct validity*, which is the extent to which the measurement estimates of the latent constructs align with preordained, theory- or prior knowledge-based expectations and (ii) *predictive validity* (a type of criterion validity), indicating the extent to which the screener can accurately identify which students have unmet mental health needs and may require additional support (Eklund et al., 2022b; Glover & Albers, 2007; Humphrey & Wigelsworth, 2016).

Evidence of the technical adequacy of UMHS tools can be found through studies of reliability and validity. Although researchers have conducted numerous empirical examinations into the reliability and validity of various individual screeners, fewer studies have synthesized evidence across the tools. For example, Jenkins and colleagues (2014) reviewed the content and use, standardization sample and norms, scores and interpretation, and evidence of reliability and validity of five commonly used screeners for elementary and secondary students. The authors documented variability in measures' formats (from four to over 30 items; single versus multi-stage; type of scores available) and psychometric evidence, with one measure considered to have "strong" reliability and validity and three others having at least "adequate" technical properties. More recently, a meta-analysis focused on screening to identify internalizing risk (symptoms of anxiety, depression) examined the psychometric support available for *broadband screeners* – which measure indicators of internalizing problems and externalizing problems, and *narrowband screeners*- which measure internalizing problems alone (Allen et al., 2019). This study found evidence for the reliability and validity of construct measures for both types of measures. Given the proliferation of screening tools and research into UMHS measures over the past decade, individual research studies will be the best sources of evidence for specific tools under consideration. A systematic review of currently available UMHS measures and their psychometric properties is currently being conducted, but the results are not yet available (Eklund et al., 2022a).

Evidence of UMHS measures **usability** is less well established in the literature. A recent review of UMHS screeners and progress monitoring tools found some evidence of usability for 16 of the 26 measures examined (Brann et al., 2022). However, most of the reviewed research focused on teachers' perceptions of the acceptability or feasibility (e.g., time for administration) of the screener, concluding that teachers find administering or completing UMHS measures doable and understand the benefits associated with screening. For example, a survey of parents and teachers in the US and UK found that most support the implementation of UMHS and view it as a viable means to support identified students (Moore et al., 2020; Soneson et al., 2018). Other factors that contribute to measures' usability, including evidence of treatment utility (i.e., tool can effectively guide intervention decisions),

cost-effectiveness, supported accommodations (e.g., translation) were infrequently studied. Importantly, few studies explicitly considered culturally responsive use of available measures (Brann et al., 2022).

2. Implementing UMHS

Preparing to Screen

Prior to conducting UMHS, it is essential that the individuals who will be leading the screening effort carefully consider the "full range of knowledge, skills, materials, and resources" that will be required (Moore et al., 2015, p. 254). *Fully implementing any new program can be expected to take between two-to-four years* (Metz & Bartley, 2012). Therefore, integrating UMHS into a school's MTSS and routine assessment practices can be expected to require a substantial and sustained investment of time, resources, and support for the staff involved (Moore et al., 2015). Fortunately, several resources and guides have been developed to support schools and districts to plan their UMHS processes.

Guidance Documents

Aligned with increasing calls to include systematic screening processes into schools' MTSS, multiple guidance documents have been developed to support school and district teams to plan for and implement UMHS. These include:

- The School Mental Health Collaborative's (SMHC) *Best Practices in Universal, Social, Emotional, and Behavioral Screening: An Implementation Guide*. The guide, developed by Romer and colleagues (2020), summarizes research and practice related to universal screening and provides practical and defensible recommendations for implementation.
- The National Center for School Mental Health's (NCSMH) *School Mental Health Quality Guide: Screening*. Part of a larger series of quality guides that were developed to support school mental health teams to improve the quality of their services and supports, the screening guide provides an overview of school mental health screening, best practice recommendations, suggested action steps, select examples from the field, and references additional resources.
- The California Department of Education Project Cal-Well's practical brief on *Universal Social, Emotional, and Behavioral Screening for Monitoring and Early Intervention*. The brief, developed by O'Malley (2020) for Project Cal-Well, is intended to answer key questions raised about UMHS. It provides information about evaluating measures, informants, and timing and frequency of screening, and directly responds to common concerns. Resources and an example from a California school district are also included.

- Ohio PBIS Network's *School-Wide Universal Screening for Behavioral and Mental Health Issues: Implementation Guidance*. This resource provides a general overview and practical guidance for implementing UMHS, described through six key steps.
- The U.S. Substance Abuse and Mental Health Services Administration's (SAMHSA) *Ready, Set, Go, Review: Screening for Behavioral Health Risk in Schools* toolkit. The toolkit was designed to guide schools through the process of developing comprehensive screening procedures and provides resources to support effective screening implementation.
- The Center for Health and Health Care in Schools's Issue Brief *Screening and Assessing Immigrant and Refugee Youth in School-Based Mental Health Programs*. This issue brief, developed by Birman & Chan (2008), exemplifies how screening and assessment practices can be tailored to meet the needs of specific youth populations. Their brief reviews mental health needs of immigrant and refugee youth as well as reviews and summarizes important issues that affect quality and suitability of screening and assessment measures, including considerations for increasing measures' appropriateness.

In the sections that follow, we review several key considerations for implementing UMHS that are outlined in these guidance documents and the larger UMHS literature. We first consider foundational preparation steps related to identifying and building a team and mapping the resources available to support student needs. In subsequent sections, we discuss important procedural considerations prior to screening, including decisions about instruments, informants, processes for administering screeners, methods for consent, and use of data.

Identify and Assemble a Team

UMHS processes should be supported by a school-based multidisciplinary team whose members include school, family, and community representatives (Moore et al., 2023). This team will engage in iterative planning prior to screening as well as support screening administration and follow-up efforts. For screening to be most successful, UMHS needs to be incorporated as a primary function of the school-based team (Moore et al., 2015). Rather than organizing a new team, schools may allocate responsibility for UMHS to a pre-existing MTSS team, student support team, child study team, coordination of services team, or other team who is convened to support students' social, emotional, behavioral, mental health, and related needs (Moore et al., 2015; SAMHSA, 2019). If such a team does not exist, schools can establish a new team or repurpose a leadership team (SAMHSA, 2019).

Given the intricacies of UMHS processes, it is important that this team be composed of individuals with varied roles and backgrounds (e.g., administrator, school psychologist, family advocate). Leadership roles on the team should be held by school staff with knowledge and training in mental health (NCSMH, 2023). School psychologists or other school mental health professionals, who have training in data-based decision-making and assessment, identifying mental health symptoms, and intervention implementation, are ideal leaders (NCSMH, 2023). This team must also be capable of collaborating with and obtaining feedback from a variety of school community members and partners (SAMHSA, 2019). Thus, core team members will also include community members or staff from local service organizations, students, and families (NCSMH, 2023). Interpreters and cultural liaisons who are standing or ad hoc members of this team can be critical in facilitating communication with students and families as well as in ensuring that the programs developed are culturally relevant and acceptable. The screening team will ultimately be responsible for: (1) planning the screening process, (2) administering the screening tools, (3) scoring and interpreting results, and (4) coordinating follow-up (NCSMH, 2023).

Resource Mapping and Capacity to Respond

School teams have an *ethical responsibility* to act upon the results of any screening program in a way that is "timely, meaningful, and defensible" (Romer et al., 2020, p. 18). Unsurprisingly, staff concerns about their school's capacity to respond to identified student needs pose a major barrier to UMHS (e.g., Burns & Rapee, 2021). Many share concerns that identifying a large number of students through UMHS would overwhelm their school's service capacity (Romer et al., 2020). The solution to these concerns lies in conducting UMHS as part of a robust MTSS, which includes aligning the goals and procedures of UMHS with best practices for assessment and intervention within MTSS. Schools who are conducting UMHS should have a continuum of intervention and assessment, with access to support determined by student need and available resources (Romer et al., 2020).

Engaging in **resource mapping** prior to screening can help school teams to identify the resources that are available to support the student needs that may be identified through UMHS (Moore et al., 2023). As part of the resource mapping process, the team will identify and visually depict the resources that are available (1) within the school or district and (2) within the school's surrounding community. School teams then use their maps to analyze the strengths, challenges, and gaps in the resources, services, and programs available (Lever et al., 2014). Through this process, school teams will understand what type of support can be provided at each tier of an MTSS and what additional supports may be necessary to complete the continuum (Moore et al., 2023). When done well, resource mapping results in a systematic

process that matches available resources to student needs (Lever et al., 2014). California's Student Behavioral Health Incentive Program (DHCS, n.d.) collated resource mapping toolkits and examples that may be used to inform resource mapping as part of UMHS processes.

As a part of pre-screening resource mapping processes, school teams can estimate their **capacity to respond** and plan their screening efforts accordingly (SAMHSA, 2019). Population-based, public health frameworks which underlie universal screening processes and MTSS indicate that about 15-20% of students can reasonably be expected to be identified as having social, emotional, behavioral, or mental health *risk* (e.g., Dowdy et al., 2010). That is, Tier 1 or universal supports should sufficiently support approximately 80% of students, whereas approximately 10-15% of students can be expected to be supported by Tier 2 services and approximately 1-5% by Tier 3 services (O'Malley, 2020; SAMHSA, 2019). Thus, in a school with a population of 100 students, approximately 20 students may be projected to need Tier 2 or 3 services. Screening teams can use these estimates when planning their UMHS efforts. For example, if, after resource mapping, a team determines that there is only the capacity to service 40 students at Tiers 2 and 3, then they should screen no more than 200 students (20% of 200 = 40; O'Malley, 2020). School teams can also use available data or estimates about student needs and results of resource mapping to establish **decision rules** that guide their response to UMHS data (Romer et al., 2020). The decision rules would specify criteria for accessing each available resource and may be determined based on the school's capacity to respond.

To support planning of screening to intervention processes, schools teams are encouraged to **start "slow" or "small"** (O'Malley, 2020; SAMHSA, 2019). Beginning the UMHS process with small-scale pilot administrations, for example conducted with just one grade level (e.g., all 5th graders) or at important transition points (e.g., 9th grade), allows schools to trial their procedures and obtain valuable feedback (SAMHSA, 2019). Starting UMHS on a small scale allows screening teams to practice assigning intervention resources and evaluate potential resource demands before rolling out UMHS more widely (O'Malley, 2020).

Selecting a Screening Instrument

The selection of a screening instrument should be guided by the school's or district's goals, the intended uses of the screening data, and the needs and characteristics of the school community (Miller et al., 2022). This means that for a screener to be a good fit, sites must consider the type of student data that is most important for them to gather in relation to the MTSS framework in place (Moore et al., 2015; Romer et al., 2020). The obtained screening data should be accessible and used to inform intervention and follow-up procedures. Since multiple screening tools exist, measuring different domains of students' social, emotional,

and behavioral needs, it is important to decide which domains the specific district and school are focused on (e.g., social, emotional, or academic behaviors; internalizing problems; emotional or behavioral concerns, etc.) and to choose an instrument that measures those domains (Glover & Albers, 2007; Miller et al., 2015; Miller et al., 2022). School building administrators most often endorsed screening for the domains of social skills, behavioral risk, self-esteem, depression, anxiety, and misconduct (Briesch et al., 2022a). Decisions about which domains to prioritize should be guided by the interests and needs prioritized by the school community. Importantly, if the goal is to identify both strengths and needs, the chosen measure(s) should be able to adequately capture both areas of student functioning (Moore et al., 2015).

Selected screeners should also have evidence supporting their technical adequacy for the intended use. They should be appropriate for use with the intended population's characteristics, including their age, primary language, or culture (Moore et al., 2023). This means that there is evidence that the screener can accurately and reliably identify both population and individual student needs to inform data-based decision-making processes. Appropriate measures will also have been developed with or have evidence for their use with samples similar to the population to be screened (SAMHSA, 2019). Similarly, schools and districts that serve populations whose primary language is a language other than English must also consider whether a screener can be administered in students' or families' primary language (Bertone et al., 2019). To ensure that schools are considering educational and mental health equity, information regarding the student population and the purpose of screening should be gathered while planning for screening.

Finally, other important characteristics to consider when selecting a screener include (a) the total cost to administer the screener, (b) the total time required to complete administration, (c) the ease with which data can be processed, aggregated, analyzed, interpreted, and displayed accessibly (O'Malley, 2020). Optimal screeners will be brief but informative (O'Malley, 2020).

UMHS Tools

To explore the compatibility of available UMHS tools with specific school and/or district populations, we recommend reviewing information about tools provided in these resources:

- The NCSMH's School Health Assessment and Performance Evaluation (SHAPE) System Screening and Assessment Library is a searchable library of free or low-cost screening and assessment measures related to school mental health. After creating a free SHAPE System account, users can search by focus area, assessment purpose, student age,

language, informant, and cost. One-page summaries, which include direct links to measures, administration instructions, and information about scoring and interpretation are provided for each measure.

- The Mental Health, Social-Emotional, and Behavioral Screening and Evaluation Compendium (2nd Edition; Center for School-Based Mental Health Programs, Ohio Mental Health Network for School Success, 2022) provides information on select no-cost and at-cost screening and evaluation tools. Information includes a description of the tool, target population, informant, logistics for use, and sample technical properties.
- The Center for Health and Health Care in Schools, School-Based Health Alliance, and NCSMH (2021) brief on *Assessing Social Influencers of Health and Education* reviews screening and surveillance practices for social influences of health and education and provides an overview of several measures that may be used for each purpose.

The table below describes several commonly used **teacher- and parent-reported UMHS tools**, including which measures are examined and selected evidence of their effectiveness. Nearly all of these tools are used across a wide age range of students, from elementary through high school.

Tool	Constructs Measured (Number of Items)	Informant	Student Age or Grade	Selected References for More Information
Behavior Assessment System for Children, Third Edition Behavioral and Emotional Screening System (BASC-3 BESS)	Overall behavioral and emotional risk, internalizing risk, adaptive skills risk (25 to 30 items)	Teachers, Parents	3:0 – 18:11 years	Kamphaus & Reynolds (2015) Pearson Assessments Website
Emotional and Behavioral Screener (EBS)	Risk of emotional or behavioral problems (10 items)	Teachers	Grades K-12	Cullinan & Epstein (2012, 2013)
Positive Family Support-Strengths and Needs Assessment (PFS-SaNA)	Social, emotional, and behavioral functioning (14 items)	Parents, Teachers	Elementary and Middle School	Garbacz et al. (2019), Moore et al. (2016)
Social, Academic, and Emotional Behavior Risk Screener (SAEBRS)	Risk for social behavior problems, academic behavior problems, and emotional behavior problems (19 items)	Teachers	Grades K-12	Kilgus et al. (2013, 2015, 2016a, b) https://www.fastbridge.org/saebrs/
Social Skills Improvement System Performance Screening Guide (SSIS-PSG)	Math skills, reading skills, prosocial behaviors, motivation to learn (4 items)	Teachers	Age 3:0-18:0, Grades PreK-12	Krach et al. (2017)
Strengths and Difficulties Questionnaire (SDQ)	Emotional problems, conduct problems, hyperactivity, peer problems, prosocial (25 items)	Teachers, Parents	Ages 3–16	https://www.sdqinfo.org/
Student Internalizing and Externalizing Behavior Screeners (SIBS and SEBS)	Internalizing and externalizing behavior risk (7 items each; 14 items total)	Teachers	Elementary	Cook et al. (2011), Hartman et al. (2017)
Student Risk Screening Scale – Internalizing and Externalizing (SRSS-IE)	Externalizing and internalizing behavior difficulties (14 items)	Teachers	Elementary, Middle, High School	Lane et al. (2012, 2013, 2015, 2016) https://www.ci3t.org/screening

The table below describes several commonly used **student self-reported UMHS tools**, including which measures are examined and selected evidence of their effectiveness.

Tool	Constructs Measured (Number of Items)	Informant	Student Age or Grade	Selected References for More Information
Behavior Assessment System for Children-Third Edition Behavioral and Emotional Screening System (BASC-3 BESS)	Overall behavioral and emotional risk, internalizing risk, adaptive skills risk (28 items)	Students	Age 8:00-18:11 years	Kamphaus & Reynolds, 2015 Pearson Assessments Website
Social, Academic, and Emotional Behavior Risk Screener (mySAEBRS)	Total behavior and risk for social behavior problems, academic behavior problems, and emotional behavior problems (20 items)	Students	2nd-12th grade	von der Embse et al. (2017) Fastbridge mySAEBRS
Social Emotional Health Survey-Secondary (SEHS-S)	Covitality, 4 second order strength domains, 12 core psychological assets (36 items)	Students	Middle and High School	Furlong et al. (2014, 2020a, b, 2023) https://www.covitalityucsb.info/
Strengths and Difficulties Questionnaire (SDQ)	Emotional problems, conduct problems, hyperactivity, peer problems, prosocial (25 items)	Students	Ages 11-17, 18+	https://www.sdqinfo.org/
Youth Internalizing and Externalizing Problems Screener (YIEPS)	Internalizing and externalizing problems (20 items)	Students	High School	Weeks et al. (2022) User guide available at https://osf.io/ets7c

Deciding Who will Screen Students

Decisions regarding who will complete the screeners should also center on the goals for screening and student population. Screening tools may be completed by teachers, who would complete measures for all students in their classroom (i.e., teacher-report), parents or caregivers (i.e., parent-report), or by students themselves (i.e., self-report). Recommendations regarding who will complete screeners often depend upon the developmental level of the student population. Generally, screening during preschool and at

kindergarten entry relies on parent informants. Screening in early elementary school (K-2nd) typically relies on teacher informants. In the late elementary years (3rd-6th grade), when student reading levels improve, student self-report becomes increasingly reliable. Finally, self-reporting is often the preferred method for secondary grade students (7th-12th grades; Briesch et al. 2022a; O'Malley, 2020). When deciding which informant(s) to use during screening, schools and districts should consider the strengths and potential limitations to screening using each informant to be aware of how the choice of the informant may impact screening results. For example, screening via teacher-report informant often leads to higher completion rates. Teachers, however, may be better reporters of students' externalizing behaviors, as those behaviors are more visible, and may have more difficulty identifying internalizing behavior (i.e., internal states) as readily (Kettler et al., 2017; Miller et al., 2022). Additionally, research suggests that as children age, their responses on self-report screeners become more useful and accurate (O'Malley, 2020; Romer et al., 2020). Older students may have better insight into their feelings and/or other internal aspects (i.e., internalizing behaviors) than will their teachers or parents (Kettler et al., 2017; Miller et al., 2022; Moore et al., 2015; NCSMH, 2023; Smith, 2007). Schools and districts must also consider whether their identified UMHS tool(s) have developed versions for different informants.

Administration of UMHS

To increase the potential for success and feasibility of UMHS, best practices recommend that screening be embedded within school processes and frameworks (Miller et al., 2022). For example, if a school uses an MTSS framework, UMHS should be integrated at the Tier 1 level. Additionally, key participants and processes for screening should be discussed before beginning screening (Moore et al., 2015). Best practices further recommend schools and districts begin screening by piloting their measures, administration processes, and follow-up procedures on a small scale (i.e., beginning with only one classroom or grade level), then gradually scaling up the screening efforts across the entirety of the population (NCSMH, 2023; O'Malley, 2020). Piloting UMHS processes is essential for obtaining feedback from students, staff, and families and identifying where improvements can be made before screening is rolled out on a larger scale. Additional strategies to support completion of UMHS include: (A) dedicating a "screening time" or period for all teachers or students to complete UMHS measures; (B) providing step-by-step instructions for administering the screeners, including dedicating proctors (e.g., school psychologists, counselors, administrators, other staff) who follow instructions provided on scripts; (C) and providing training and education to school staff around what screening is and how to complete the UMHS measure (Dever et al., 2012; Moore et al., 2015; NCSMH, 2023; von der Embse et al., 2018).

Timing and Frequency

Timing: Experts recommend that screening be conducted toward the beginning of the year and during important periods throughout the academic year (O'Malley, 2020). Best practices suggest planning when in the school year is most feasible and informative to have students engage in screening before administration. When teachers are completing screeners, it is important to allow time at the beginning of the school year for teachers to get to know their students and for students to adjust; about four to six weeks is typical (NCSMH, 2023; Romer et al., 2020). Younger students may need more time to adjust than older students (Romer et al., 2020). Another consideration is the impact of school breaks. For example, due to long summer breaks, screening at the end of the year can make providing intervention to students in a timely manner difficult. Thus, it is important to rescreen students at the beginning of each school year to get a current assessment of the student and school-population needs (NCSMH, 2023). When screening data are collected at multiple points during the school year and over multiple academic years, staff can use data to identify trends and patterns in student and school-level needs over time (O'Malley, 2020).

Frequency: Although there is no consensus on how frequently screening should be conducted, some recommendations suggest that schools screen three times a year – once at the beginning of the year, mid-year, and again at the end of the year (Kilgus & Eklund, 2016; NCSMH, 2023; Romer et al., 2020). A study conducted with elementary and middle school building administrators found that most schools conducted screening only once per year (40%), with other schools reportedly screening three times per year (20%), or on another interval (e.g., every other year, 24%; Briesch et al., 2022a). To evaluate the impact of universal Tier 1 programming, Romer et al. (2020) recommend that screeners should be administered at least twice per year.

Obtaining Consent and Assent

UMHS teams need to decide how parents and students will be notified about the purpose and utility of screening and what form of consent will be sought from students' caregivers (Moore et al., 2023; Romer et al., 2020). The consent process will include either active consent, which requires written permission from students' parents, or opt-out (passive) consent, wherein parents are notified that screening will take place and provided with information about how to opt their children out of the screening process (Moore et al., 2015, 2023; see Romer et al. 2020 for example forms). There are debates about whether active or opt-out parental consent should be obtained when conducting mental health screening. Whereas opt-out consent methods may lead to higher participation rates, active consent methods can ensure that

families are fully informed (Chafouleas et al., 2010; Moore et al., 2023). Active consent methods, however, may contribute to fewer students overall participating, including fewer students from historically marginalized racial or ethnic backgrounds or with greater mental health risks (Burns & Rapee, 2021; Chartier et al., 2008). Regardless of which method is used, schools must ensure that information provided to families is available in their preferred language, for example, by providing translated documents and partnering with community liaisons to help families understand the screening process and address any concerns (Bertone et. al, 2019). Information provided to families may also include a description of the screening process and goals, information about and a copy of the screening tool, and information about whom to contact with more questions (SAMHSA, 2019). Students should also be provided with the option not to participate in the screening (Romer et al., 2020; SAMHSA, 2019).

The implementation guide Romer and colleagues (2020) developed outlines important legal considerations regarding consent procedures for UMHS. Relevant federal legislation includes the Individuals with Disabilities Education Improvement Act (IDEA, 2004; see 34 C.F.R. 300.302 and S 34 C.F.R 300.300[d]2] [ii])) and the Protection of Pupil Rights Amendment (PPRA, 2002). IDEA clarifies that when screening is used to inform instruction and curriculum implementation or is conducted as part of regular school activities, it does not require parental consent. Parent consent is required, however, when assessments are individualized, either for a comprehensive evaluation or for use with one student. Therefore, screening that is conducted to inform regular school activities typically does not require written consent (Romer et al., 2020). For example, a school or district may determine that opt-out consent is appropriate when teachers complete screeners for all students in their classroom to inform school-wide and classroom-based activities. In a recent survey of school and district leaders about their screening practices, 71% reported using opt-out consent processes (Stanford, 2024). When using student self-report screening methods, however, the PPRA explains that schools may not require students to participate and may want to consider seeking written parental consent (Romer et al., 2020). The content of the screener (item content and constructs measured) may further indicate what type of consent is appropriate. If the screener includes items that may be interpreted as addressing “mental or psychological problems”, schools may need to consider families’ rights outlined in PPRA and obtain written consent (Romer et al. 2020). It is strongly recommended that readers consult the above policies and their legal counsel to inform decisions about UMHS consent processes.

Using UMHS Data

Recall that UMHS is an integral part of MTSS and thus is conducted to inform (1) universal prevention programming, and (2) additional assessment or intervention for those with identified needs. It is prudent that school and district teams are aware of the limitations of UMHS data and appropriate uses. Data obtained through UMHS about student needs can indicate who is showing early signs of potential mental health challenges. These data can function as part of an early warning system and are *not* intended to diagnose students (Romer et al., 2020). Notably, when UMHS is conducted as has been outlined in this review, it *does not* fulfill the legal "child find" requirements under IDEA (SAMHSA, 2019). Screening data should be considered alongside other student data (e.g., grades, attendance, behavioral records) to inform potential service needs and planning.

Screening teams must be prepared to act upon the information obtained through UMHS. Before conducting UMHS, screening teams should develop a plan for reviewing data in a reasonable timeframe, typically two to three weeks (Romer et al., 2020). As discussed above, resource mapping can help to identify what resources are available at each MTSS tier as well as what additional resources can be put into place, as needed (NCSMH, 2023; Moore et al., 2023). Screening data may be used to determine the focus and goal of universal or targeted (Tier 2) interventions (Moore et al., 2019). Regardless of intervention intensity, it is imperative that "treatment validity" is considered in that the interventions provided to students are robust and have empirical evidence demonstrating their effectiveness (Humphrey et al., 2016).

UMHS Data and MTSS

The use and accessibility of data following screening are important to inform intervention practices and follow-up procedures within an MTSS. To support universal programming, screening data must be analyzed with the goal of identifying population-level needs and trends. Data can be aggregated on various characteristics to identify trends in strengths and needs of the whole school as well as the needs of specific grade levels and classrooms (Moore et al., 2023). When many students in a specific grade or classroom are identified as having unmet mental health needs, screening teams should work with grade-level teams or classroom teachers to identify universal practices to support student needs. Screening teams can further investigate whether trends are observed among specific student subgroups (e.g., boys, multilingual students) to inform program planning. Therefore, it is important that prior to screening, teams understand how data will be returned to them and what level of analysis will be possible. When selecting a screener and/or data platform, school teams should

consider to what extent these tools will allow data analysis that is consistent with their goals for screening. UMHS can play a critical role in school-based prevention, but only if the data can be used to implement interventions (Cook et al., 2010; Dvorsky et al., 2014).

Screening data may also inform further assessment and intervention planning for students with identified needs. Procedures must be in place to follow up with students and parents and to discuss additional assessment or support in a timely manner. Follow-up conversations with students, referred to as "debriefing", are included in most studies implementing UMHS, but best practices considerations have not been well documented in the literature. Debriefing, often completed with a school counselor, school psychologist, or other school mental health professional, affords students the opportunity to express any concerns or questions they had while completing the screener and enables school staff to confirm the student's level of need or to clarify any of the student's responses, thereby reducing the rate of false positives (Hilt et al., 2018; Husky et al., 2011b).

Although sharing results with parents is essential for linking students to services, parents may decline further interventions even when mental health challenges are identified (Dvorsky et al., 2014). For example, in a study assessing barriers to treatment for kindergarteners who were identified as at-risk after a mental health screening, only one-third of parents believed their child had a problem (Girio-Herrera et al., 2013). To promote effective communication, school staff should discuss with parents the warning signs and potential risks observed through UMHS as well as the limitations of screening (SAMHSA, 2019). Interpreters and translation services can be used to help families whose primary language is not English to understand the implications of the UMHS data.

A recent survey conducted with school-building administrators about their screening practices examined schools' data-use practices (Briesch et al., 2022a). Sixty percent of respondents reported that screening data was reviewed individually by school staff, such as administrators and teachers, whereas only 38% of respondents indicated that screening data was reviewed using a team-based approach. Further, when determining how to identify students who were at risk from the screening data, 73% of respondents indicated that either teacher or team-based decisions were used (Briesch et al., 2022a). When asked about how screening data were used to inform intervention practices, 89% of respondents endorsed using screening data to create individualized interventions for students (Briesch et al., 2022a). Overall, findings from the study demonstrated variability in screening decision-making processes in elementary and secondary schools.

Data Security and Privacy

To facilitate the use of UMHS data, teams should make a plan for data use and storage prior to screening, including where data will be stored and who will have access (NCSMH, 2023; Romer et al., 2020). Regardless of which data management platform is used, it is essential to ensure that the data are secured and that access is limited to only those deemed necessary. Decisions regarding data management and storage depend on district and federal guidelines for maintaining student and family records within the school. Federal guidelines are provided in the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)(SAMHSA, 2019).

According to a document released by the U.S Department of Health and Human Services and U.S Department of Education, data from mental health screening may be considered "education records" and subject to FERPA, or in some instances may be considered protected health information under HIPAA if maintained by a healthcare provider that makes HIPAA transactions electronically, such as billing a health plan (U.S. Department of Education, 2008). However, most schools are not considered a HIPAA-covered entity, as providers are not making such transactions. In addition to FERPA and HIPAA, policies under the Protection of Pupil Rights Amendment (PPRA) must be considered. Knowing which laws apply to school mental health screening data is important for understanding parental rights to accessing records and if data can be shared to other school staff or officials. UMHS consent forms or releases of information for UMHS data should clearly follow the policy-informed data storage, use, and protection practices that the school has established (NCSMH, 2023).

3: Equity-Centered UMHS

UMHS to Improve Equity

Coupled with urgent calls to address the mental health of our nation's youth (American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, & Children's Hospital Association, 2021; U.S. Surgeon General. 2021) is an increasing awareness that social determinants shape young people's mental health experiences and outcomes (Abraham & Walker-Harding, 2022, McPherson & McGibbon, 2010 as cited in Moore et al., 2023). Social determinants are "malleable socioeconomic and environmental factors – such as poverty, income inequality, discrimination, trauma exposure, living conditions, housing or food in/security – that deeply influence health and wellness" (Moore et al., 2023, p. 58). The inequitable distribution of social determinants in society contributes to disparities and disproportionalities across educational, mental health, and wellness outcomes. For example, racially and ethnically minoritized (REM) students are subject to a disproportionate number of exclusionary discipline referrals and are significantly more likely to receive referrals to special education than their White peers ("California Student Mental Health Implementation Guide," 2020; Dever et al., 2012). Further, REM youth face disproportionate difficulty in accessing mental health care, such that they may be less likely to be referred for school-based services, are more likely to be misdiagnosed, and less likely to receive high-quality care than their white peers (Malone et al., 2022; Moore et al., 2023). Thus, there is an urgent need to move toward equity-centered approaches to support student mental health.

However, the most commonly used identification processes for students with mental health, social, emotional, or behavioral needs – teacher nomination and office discipline referrals (Dineen et al., 2022) – are reactive and pose a risk of further marginalizing REM students (Miller et al., 2022). These methods rely on what teachers or other school staff consider "problematic" behaviors, and thus are subject to educator biases that can be associated with the discipline disparities noted above (Miller et al., 2022). Moreover, traditional identification approaches are limited in their ability to inform changes to the environment or to school policies or practices that could address social determinants and, ultimately, reduce mental health inequities.

Conversely, UMHS is more likely to support educational and mental health equity (Bertone et al., 2019; Miller et al., 2022; Moore et al., 2023). Systematic and proactive identification of students' mental health needs via UMHS may reduce the disproportionality present in the special education referral process (Raines et al., 2012). Moreover, when UMHS is used to connect historically marginalized groups of students to high-quality school-based mental

health services, historical inequities and disproportionalities in access to mental health care may be reduced (Miller et al., 2022; NCSMH, 2023). To effectively break down barriers to mental health equity, UMHS practices must be equity-centered (Moore et al., 2023). We summarize several key features of this approach in the next section. For a more comprehensive discussion of equitable and socially just screening approaches, readers are referred to Moore et al. (2023), Kiperman et al. (2023), and Miller et al. (2022).

Using an Equity-Centered Approach

Scholars have delineated several guiding principles and critical considerations for an equity-centered approach to UMHS, which necessarily shapes the focus and processes of screening (Miller et al., 2022; Moore et al., 2023). Fundamentally, equity-centered screening requires a shift in focus from individual and risk-focused screening to holistic, systems-focused, and contextually-appropriate screening (Miller et al., 2022; Moore et al., 2023). That is, an equitable approach to screening begins with the assumption that malleable factors in the environment – social determinants – impact student mental health needs and that the data obtained from screening processes must be capable of informing systems-level change. In doing so, equitable screening approaches pivot the focus away from remedying student deficits or behavioral problems to developing school systems that promote wellbeing. Consequently, the focus of an equity-centered approach to screening considers ecological factors that impact students and communities (Miller et al., 2022). This approach further prioritizes identification of student and community strengths in addition to their needs (Moore et al., 2023). Finally, in order to realize the larger goal of addressing mental health inequities, equitable UMHS must be implemented with a comprehensive and equity-centered MTSS (Miller et al., 2022; Sullivan et al., 2022). These guiding principles translate to important practical considerations.

First, when evaluating screening instruments, schools should select measures that reflect the demographic characteristics of the student population. It is essential to select a screener that has been normed and validated with a population that matches the student population at the school (Dowdy et al., 2014). If a tool does not have evidence for use with a similar population, its data may not be as reliable, and decisions made with the data may not be valid for informing intervention decisions with the school's population (Moore et al., 2023; SAMHSA, 2019). Contextually-informed screening processes will further consider environmental risk factors, such as poverty, racism, or trauma when determining the fit and appropriateness of a screener (Glover & Albers, 2007; Miller et al., 2022; NCSMH, 2023; SAMHSA, 2011). Failing to consider these ecological factors when selecting a screener can perpetuate inequities by incorrectly characterizing students (Kim et al., 2022). Understanding community challenges

and environmental factors that confer risk on students is important also for informing which additional data should be considered alongside screening results. Further, when serving plurilingual students who are developing English proficiency, the language used to communicate about UMHS and used on any self-report screener should be accessible and at a level that is understandable to students to promote more accurate results (Bertone et al., 2019). It is important to proactively identify potential areas for misunderstanding, including questions that are unclear or unaligned with the cultural beliefs of students and families. Schools can work with cultural liaisons and community members to evaluate these properties of screeners and to identify potential improvements (Moore et al., 2023). Recommendations include rewording questions or selecting another screening tool with a better contextual fit to increase validity (SAMHSA, 2011).

Second, school-community partnerships and collaboration are essential in an equity-focused screening approach (Miller et al. 2022). Students, families, and community members should be included throughout the screening planning and implementation process. When school community members are included as valued and respected members of screening teams their perspectives are actively sought, for example, to support staff to understand contextual factors contributing to students' strengths and needs. Involving students and families can also help school teams to better understand differing cultural perspectives and beliefs regarding mental health and screening practices (SAMHSA, 2011). As multiple different terms may be used to describe screening, schools must be cautious about using language that may be potentially stigmatizing in certain groups. Miller et al. (2022) caution that "mental health screening" could "convey the idea of mental illness to some, which may carry stigma" (p. 4). Schools might consider working with community members to identify appropriate yet precise language, and then use that language consistently. A recently developed set of guidelines situates UMHS within a participatory framework (Kiperman et al., 2023). Guided by this approach, UMHS is founded upon culture-specific knowledge of mental health and wellness that is developed through trusting relationships with the partnering community. A screening protocol is then iteratively developed to align with the needs raised by the school community and to benefit students and schools (Kiperman et al., 2023).

Participatory and partnership-based approaches can also strengthen parental notification and consent processes. For example, schools can partner with cultural brokers, translators, and interpreters to develop and use accessible language to notify families about the screening process or when seeking consent. However, school teams need to understand that REM families may distrust screening and/or school processes, especially when UMHS priorities are misaligned with their culture or values (Bertone et al., 2019; NCSMH, 2023). Strong partnerships can support relationship building, develop trust, and combat stigma

(Moore et al., 2023). Ultimately, robust school-community partnerships can support student and family buy-in and facilitate more equitable and socially just screening efforts (Bender et al. 2021; Kiperman et al., 2023; O'Malley, 2020; SAMHSA, 2011). Building and maintaining relationships with community partners, including service delivery agencies, can further support schools' capacity for meeting student and family needs.

Finally, equity-centered UMHS is situated within a comprehensive and equity-centered MTSS (Miller et al., 2022; Sullivan et al., 2022). Equity-centered screening systems, thus, will be built to provide information on school- and student-level strengths and needs. For instance, screening data systems and processes will be designed to facilitate population-level analysis and observations of trends within student subgroups and over time (Moore et al., 2023). These data are then interpreted first to identify environmental or contextual contributions to observed needs and used to inform universal programming and to plan changes to school policies or practices. Universal programming will focus on promoting contextually and culturally relevant skills or assets and on building affirming, healing-centered school environments (Ginwright, 2018; Moore et al., 2023). Recommendations for subsequent follow-up with individual students who are identified as having mental health risks suggest that the administration of targeted assessment that confirms student needs also includes measures of contextually-informed risk and protective factors (Moore et al., 2023). Content and procedural adaptations can further be made to improve the relevance of targeted Tier 2 interventions (Malone et al., 2022). Importantly, partnerships maintained through the screening process can support these follow-up processes.

Screening should ultimately be of benefit to students screened (Miller et al., 2022). Universal screening, when conducted in alignment with the recommendations for equity-centered UMHS summarized above and detailed in the literature (Kiperman et al., 2023; Malone et al., 2022; Miller et al., 2022; Moore et al., 2023; Sullivan et al., 2022), is a promising step toward addressing students' unmet mental health needs.

4. Evaluating Costs of UMHS

When determining screening tools and procedures, best practices recommend considering potential cost-effectiveness and return on investment (SAMHSA, 2019). Research on the costs of implementing screening, however, is limited (Anderson et al., 2019), with heterogeneity in methods across schools challenging accurate estimates and forecasting of expenses.

There are several ways of evaluating the cost of education programs (Hunter et. al, 2018). Basic cost analysis involves calculating the cost of all components needed to implement a program. Potential factors to consider include, but are not limited to, personnel, assessments used, and tangible materials such as technology and supplies needed to administer screening and facilities, particularly if they are additional to what is used during the school day (Hunter et al., 2018; Volpe et. al, 2018). Reviews of screening instruments have provided information about the estimated cost of various tools (e.g., Jenkins et al., 2014; Feeney-Kettler et al., 2010; O'Malley, 2020). Whereas some tools are free/publicly available, several others have a cost per student (e.g., $1.45 or $3.00) or are priced and purchased in bundles (e.g., $78.50 for 10 students) and may also require purchase of scoring software or a user's manual (Jenkins et al., 2014; O'Malley, 2020). Technical adequacy, including reliability, validity, and classification accuracy, may also factor into evaluations of screeners' cost-effectiveness (Cook et al., 2010). The Center for Benefit-Cost Studies of Education has created a tool to help calculate educational program costs using previously mentioned factors (CBCSE, CostOut). Cost-effectiveness analysis (CEA) is an extension of basic cost analysis that considers the cost of implementing the intervention or practice in relation to an outcome measure of success. In the context of universal screening, an outcome measure could be rates of successful linking to services. In CEA, an incremental cost-effectiveness ratio (ICER) is calculated by dividing the cost of the intervention by the effectiveness and can be used for comparison to identify an optimal intervention. Sensitivity analysis, wherein different hypothetical scenarios are considered, may also be used to determine at what point a practice is no longer cost-effective (Bywater & Sharples, 2012).

Two studies examined the cost-effectiveness of universal emotional health screening and follow up processes during the transition to middle school in Seattle (Kuo et al. 2009; Vander Stoep et al., 2005). The costs included in Vander Stoep and colleagues' (2005) examination were for printing and scoring questionnaires, hiring translators, recruitment mailings, personnel, and incentives for staff. Their estimated cost of screening and follow-up was between $9-$15 per student, with variability due to school size (larger size being more efficient) and the rate of positive screens (higher prevalence requiring more follow-up; Vander Stoep, 2005). A subsequent study conducted by this team found screening costs to range

from $8.88 to $13.64 per enrolled student, again depending on the prevalence of positive screens (Kuo et al., 2009). The researchers summarized cost-effectiveness as the cost per student who was successfully linked to services (range 68% – 90%), with estimates varying based on the positive screen rate: $416.90 per successful link to services when 5% of students screen positive and $106.09 when 20% screen positive (Kuo et al., 2009). However, these cost-effectiveness studies are dated, and more recent work is needed to inform the current costs of screening to follow-up processes. Authors have suggested possible methods to lower costs, such as reducing the number of staff needed to complete screening or raising the positive screening threshold, but note that there are tradeoffs in early identification.

Comparisons of the cost-effectiveness of UMHS to other identification methods are limited. A systematic review of the effectiveness of school-based universal screening literature (Anderson et al., 2019) found only one study that analyzed the cost-effectiveness of different identification approaches. Ahern et. al (2018) conducted a CEA to compare various suicide prevention programs and found universal screening to be the most cost-effective intervention in preventing severe suicide ideation and attempt. One recent study introduced a technique known as discrete event simulation, which allows school personnel to calculate and compare costs of universal screening to inform prevention programming against typical intervention systems (von der Embse et. al, 2021). Simulations can be generated using a Python programming package, but depend on user-supplied estimates of staff salaries, prevalence of student outcomes such as expulsion or suspension, and their associated costs. Additionally, an estimate for the cost of universal screening must be supplied. The study used an estimated cost of $13 per student from Kuo et. al (2009) as their universal screening cost and found that a combination of universal screening and Tier II prevention services resulted in 22% less financial burden than a “business-as-usual” approach. This method may be useful for future comparison of effectiveness universal screening versus other identification and intervention methods or a baseline model of no interventions.

Although accurately estimating the costs of universal screening is complex and requires consideration of a large number of factors, it is essential to ensure that optimal procedures are in place and that expenditures are justified by improved student outcomes. Moreover, accurate estimates of the anticipated costs of UMHS are essential in informing UMHS planning and implementation processes (e.g., to ensure sufficient financial and other resources are allocated) and that screening can be sustained in the long term.

5. State and Country Experiences

Wide Variation in Implementation

Research conducted to date provides a limited understanding of the landscape of school-based screening practices across social, emotional, behavioral, and mental health domains. Although UMHS has shown great promise, only about 6% (Dineen et al., 2022) to 13% (Bruhn et al., 2014) of schools or districts across the U.S. are implementing screening (Miller et al., 2022). A survey of K-12 school-building administrators representing 409 districts across the United States demonstrated that most (70-81%) use universal screening across health and academic domains respectively, but only 9% endorsed the use of universal social, emotional, and behavioral screening (Briesch et al., 2022a). More recently, the EdWeek Research Center conducted a survey of school principals (N = 160) and district leaders (N = 266), 68% of whom reported that their district does not use UMHS (Stanford, 2024). Twenty-two percent indicated that screenings were conducted in certain grade levels, whereas only 10% reported screening in every grade level (Stanford, 2024). Across studies, discrepancies were identified with regard to (a) who reviews screening data, (b) how screening data are used to determine student risk, and (c) how interventions are designed for those students demonstrating risk (Briesch et al., 2022a; Stanford, 2024). The lack of consensus in practice calls for additional investigation concerning best practices in the implementation of social, emotional, and behavioral screening, risk identification, and intervention.

Briesch et al. (2018) articulated the inconsistencies in screening policies and practices between state contexts. As of their study's completion, no mention of universal SEB screening (i.e., UMHS) existed in nine U.S. states on state Department of Education or tiered-support websites (Briesch et al., 2018). In the remaining states, levels of guidance varied significantly. Seven states mentioned screening as an essential component of MTSS with no guidance regarding screeners or implementation strategies. Eleven states provided some guidance, yet the "information was not necessarily specific to SEB domains" (Briesch et al., 2018, p. 151). A final grouping of 22 states did explicitly mention SEB screening and some guidance regarding implementation, yet the available documents still exhibited significant variation in specificity.

State-Level Descriptions

In the following passages, we provide an analysis of different states' screening documents as interpretive cases.

New Mexico

New Mexico is one of the few states with a policy mandate (Briesch et al., 2018). New Mexico operates a three-tiered response-to-intervention (RTI) framework. Per state policy, universal screening occurs in Tier 1 and addresses a number of academic and health metrics; social and behavioral health is explicitly mentioned in state documentation (Briesch et al., 2018; New Mexico Public Education Department [NMPED], 2014). The state offers a definition of SEB screening in multiple documents and provides behavior-specific examples within its general MTSS documents, but does not articulate who the informants are, only that students are screened (Briesch et al., 2018; NMPED, 2014). Uses of screening data include student-level and class-level behavioral function monitoring. Further, schools may refer identified at-risk students to Tier 2 supports at any time, which includes targeted intervention and follow-up evaluations (NMPED, 2014). New Mexico's framework identifies parents as partners in the Tier 1 process, highlighting the importance of communication between schools and students' families. Parent consent is not required for screening, but teachers are encouraged to communicate with parents; parents may request an initial special education evaluation at any time (NMPED, 2014). New Mexico's plurilingual population informs the state's specific policy considerations around screening English learners (ELs), who must receive "culturally and linguistically appropriate programs, instruction, and assessment" (NMPED, 2014, p. 6). Additionally, implementation plans for screening allow for contextual differences in school sites, with locally devised Tier 1 to Tier 2 intervention plans. The state also differentiates individual and group failure in the screening process to help identify issues in screening procedures (NMPED, 2014).

New Hampshire

New Hampshire provides screening recommendations for internalizing and externalizing behaviors, with state documents articulating the use of multiple-gated screening including teacher nomination (gate 1) and rating scales (gate 2; Briesch et al., 2018). As opposed to New Mexico, New Hampshire does not mandate screening as a matter of policy but does offer screening within the Multi-Tiered System of Support for Behavioral Health (MTSS-B) – "a comprehensive system of social, emotional, and behavioral supports to promote student wellness and improve engagement in learning" (New Hampshire Department of Education [NHDE], 2023). MTSS-B documentation provides comparative guidance on the selection and implementation of a variety of screeners including the BASC-3 BESS, SAEBRS, SRSS-IE, and others (NH MTSS-B Technical Assistance Center, 2023). Screeners and informants are free to vary depending on the school or district context; the Department of Education provides significant support over implementation programs (NHDE, 2023). This approach is informed

by the state's adoption of the Interconnected Systems Framework (ISF), which mixes research-based mental health practices and social-emotional learning (Barrett et al., 2013; Eber et al., 2020; NHDE, 2023). In addition to a tiered system of supports, MTSS-B's other core features include an integrated delivery system highlighting school-family-community partnerships, and a focus on progress monitoring and service outcomes (NHDE, 2023).

Utah

Utah provides universal screening within an MTSS framework known as Utah Multi-Tiered System of Supports (UMTSS) in areas focused on social-behavior needs (pro-social skills). However, Briesch et al. (2018) highlighted limited information regarding the types of behaviors screened for (i.e., internalizing versus externalizing), screeners used, frequency, and follow-up procedures in Utah's state screening documents. Further, universal screening is not mandated in the state of Utah in comparison to other states (Briesch et al., 2018; Utah State Office of Education, n.d). Thus, specific screening practices and culturally responsive screening approaches within the state of Utah are quite unspecified and vague in terms of the process for identifying students at risk through screening. This case example highlights the ambiguity and variability of screening practices across U.S. states.

Washington

Washington also conducts screening through an MTSS framework. In a review of state documentation regarding universal screening, Briesch et al. (2018) found that Washington state provided a special focus on behavioral and mental health components within their MTSS structure. Screening procedures conducted in the state of Washington include screening three times per year and using rating scales. Additionally, state plan documentation showed that Washington state aimed to conduct screening from birth to third grade to identify students at risk for social-emotional, mental health, or other developmental risk (DCYF, 2010). Washington's commitment to screening is also highlighted in its state codes, which "requires that all K–12 school districts adopt a plan to screen, recognize, and respond to indicators of social, emotional, behavioral, and mental health (SEBMH) such as, but not limited to, sexual abuse, substance use, violence, or youth suicide" (Revised Code of Washington, 2013). Thus, a greater emphasis on screening procedures is placed in this state in comparison to other U.S. states.

Wisconsin

Wisconsin does not mandate UMHS in schools, but it is outlined within the mental health referral pathways component, which is part of the larger Comprehensive School Mental Health System Framework (Wisconsin Department of Public Instruction [WDPI], 2021a). It is

described as an equitable and evidence-based method to generate new information about a student's strengths and risk factors. A 10-step guide for ensuring screening success is also provided, which emphasizes creating a family engagement plan, along with streamlining follow-up protocols (WDPI, 2018). Additional state documentation provides thorough information about various national student and parental consent laws in relation to UMHS in order to help local school districts form their own procedures for screening (WDPI, 2021b). Although there are no policies that require UMHS, there is ample documentation and resources provided by the Department of Public Instruction.

Michigan

Michigan conducts universal screening under a MTSS framework and includes academic, social-emotional, behavioral, and mental health indicators. The Michigan MTSS Technical Assistance Center (MiMTSSTAC) emphasizes the need for a strong framework centered around educational equity before screening (MiMTSSTAC, 2021). This documentation emphasizes the importance of screenings in identifying a "need for systemic change to the learning environment and adult behaviors to support all learners", and cautions against their use for focusing on identifying students with "deficits" (MiMTSSTAC, 2021). In addition, it provides insight on best and problematic practices for identifying student needs and using data to make informed decisions. The Michigan Blueprint for Comprehensive Student Recovery, a multi-year student recovery plan created by the Student Advisory Council in 2021 in response to COVID-19, labeled UMHS screening as a "high leverage action", but does not require schools to conduct screening (Michigan Student Advisory Council, 2021).

Colorado

Similar to New Hampshire and Utah, Colorado does not have any mandates for universal screening, but it is included under the Colorado Framework for School Behavioral Health Services, which has a MTSS system component that emphasizes shared leadership, layered support, evidence-based instruction, and community partnering (The Colorado Education Initiative, 2019). Documentation of the framework includes two case study examples of successful UMHS implementation in Boston Public Schools and Aurora Public Schools. These examples include information about screeners used, staff involved, logistics to consider, and Tier 2 and Tier 3 interventions after screening was completed. In addition, the state provides a universal screening toolkit created by the Colorado Education Initiative, which consists of a checklist of questions that should be considered for successfully implementing screening (The Colorado Education Initiative, 2014). Questions cover topics such as selecting an appropriate screener, acquiring consent, and staff preparedness, but lack specificity.

In June 2023, a legislative bill HB23-1003 was passed that allows for allocation of $475,278 for public schools with grades 6-12 to provide mental health screening and referrals (School Mental Health Assessment Act, 2023). Schools must inform parents within the first two weeks at the start of the school year and allow them to opt their child out. Colorado, Illinois, and New Jersey are the only U.S. states with laws that allocate funding and resources for UMHS (Stanford, 2024).

Country Level Descriptions

It is also worth examining the implementation of UMHS in other countries. Here we provide a brief summary of the experience of Australia, the United Kingdom, and Canada with the implementation of UMHS.

Australia

While there is research being done to create screening tools for UMHS and evaluate feasibility, there are no policies supporting UMHS implementation across Australia's schools. The Australian National Mental Health Commission notes that there is a "key gap" in collecting measures of student wellbeing (Mental Health Commission, 2021). In a survey of 169 school psychologists, only 15% worked at schools that used UMHS (Burns & Rapee, 2021). In the same study, primary barriers that were identified to implementing UMHS included lack of time to conduct screening and inability to handle referrals that result from positive screens. Several studies evaluating the cost of implementing UMHS in schools using relevant Australia data have shown its cost effectiveness (Mihalopoulos et. al, 2012; Lee et. al, 2016). Mihalopoulos et. al (2012) highlight that UMHS is not widely adopted in Australia, but should be "seriously considered in any package of preventive health interventions".

United Kingdom

The United Kingdom Department for Education outlines the important role schools play in supporting student mental health through prevention, identification, early support, and access to specialist support (Department for Education, 2018). However, there is no requirement for schools to implement screening. Documentation for guidance highlights both effective use of data and effective "pastoral system" (school staff team) as key factors to identify students (Department for Education, 2018). However, data is further described as noting changes in student attendance and behavior, rather than administering questionnaires or standardized measures. The language of the documentation suggests identifying students with unmet mental health needs relies on the discretion of the teacher. In a national survey of 2,780 educational institutions, only 15% conducted UMHS, while 24% conducted targeted screening (Department for Education, 2017).

Canada

Compared to Australia, the United Kingdom, and the United States, Canada has very little documentation surrounding UMHS. Canada lacks a comprehensive secondary school mental health model on the national level, where most provinces have their own set of youth mental health policies and guidelines (Wei et al., 2011). Guidelines from the Joint Consortium for School Health (JCSH) about best practices for school based mental health suggest establishing policies for screening for behavioral, emotional, and learning needs (JCSH, 2010). However, there are no additional details about the screening process or emphasis on systematic screening. A report from the Mental Health Commission of Canada (MHCC) concludes that screening alongside early intervention can be a useful tool for prevention if done carefully to avoid stigmatization of students with mental health issues (MHCC, 2013). Again, there is no language surrounding universal screening. Ontario uses a MTSS framework to deliver school-based mental health services which includes early identification, but documentation only emphasizes using standardized measurement tools that are compliant with privacy legislation (Ontario Ministry of Education, 2023). Overall, there is a lack of policy and research surrounding UMHS in Canada.

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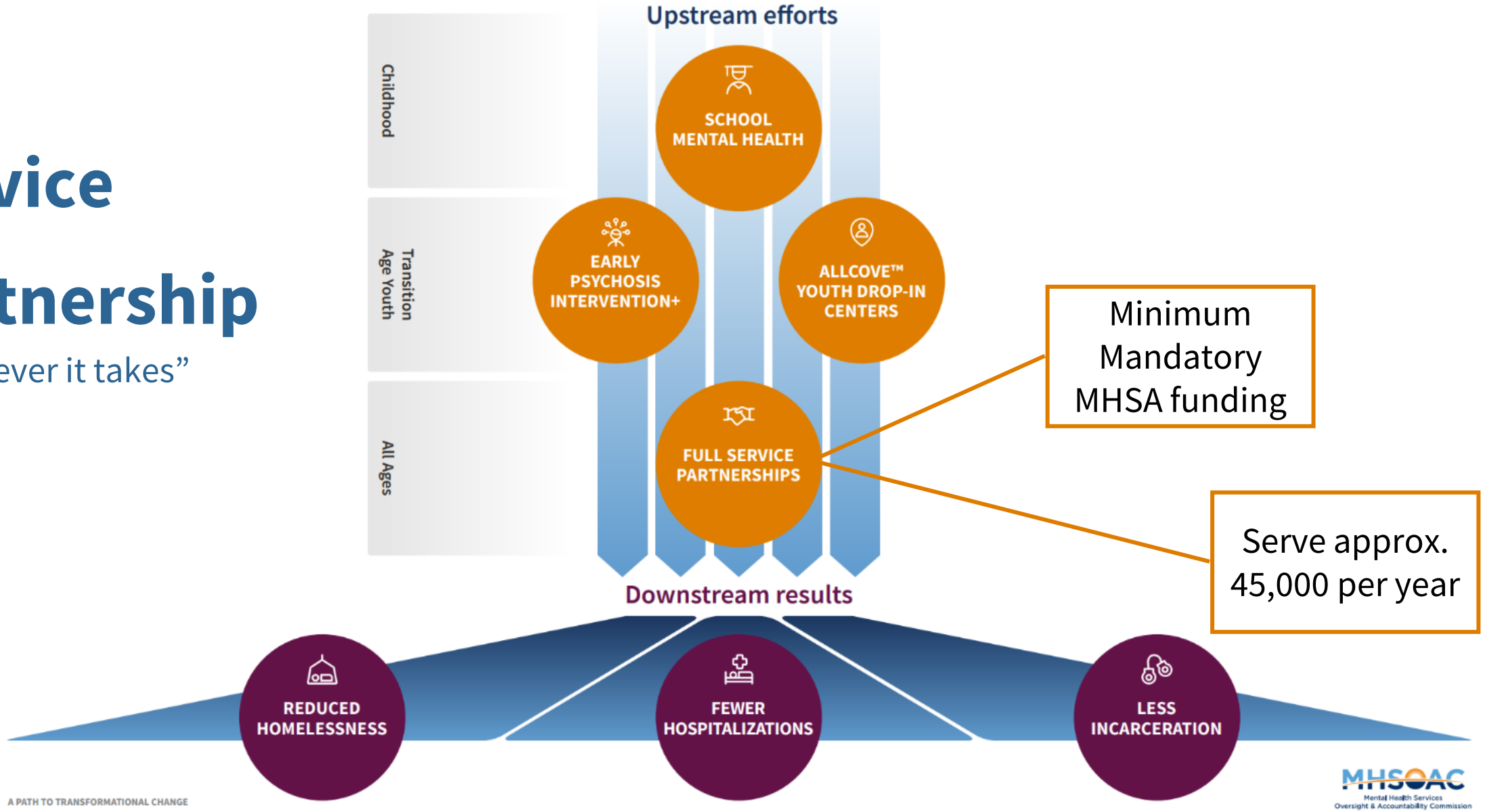
FULL SERVICE PARTNERSHIPS
WHATEVER IT TAKES

February, 2024

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Full Service Partnership

"whatever it takes"



Rising need for high-quality FSPs

Homelessness

37,000 SMI
35,000 SUD

Incarceration

30% receiving MH treatment

Hospitalization

$2 billion to operate

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Oversight & Accountability Commission

Exploring Solutions

To consider: Will the Commission set aside $20 million from the Mental Health Wellness Act for the following strategies:

- **Restructure** current funding model toward outcomes-based contracting
- **Provide** technical assistance to create a standardized model of FSPs
- **Collaborate** to improve data collection and standardize reporting
- **Support** innovative workforce development solutions
- **Foster** public trust and understanding of the role of FSPs

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Oversight & Accountability Commission

Proposed Motion

The Commission authorizes a set-aside of $20 million of Mental Health Wellness Act funding to strengthen Full-Service Partnerships and asks staff to present a specific funding proposal at a future meeting.

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Oversight & Accountability Commission

MHSSA RFA Outline

January 25, 2024

Tom Orrock, Deputy Director of Operations
Riann Kopchak, Chief of Community Engagement and Grants

MHSOAC
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Oversight & Accountability Commission

What is the MHSSA?

- 2019 Budget Bill, Senate Bill 75, included the Mental Health Student Services Act (MHSSA) to establish mental health partnerships between County Mental Health or Behavioral Health Departments and educational entities
- Commission awards grants to these partnerships to deliver school-based mental health services to young people and their families
- Supports outreach to identify early signs of unmet mental health needs, reduce stigma and discrimination, and prevent unmet mental health needs from becoming severe and disabling

Grantee Survey/Poll Results

In the Survey, over 50% of counties mentioned a need for more staff/personnel

Workforce Capacity is ranked 1st at 27% in the Poll Results

80% of counties in the Survey indicated a desire to enhance their services for marginalized and vulnerable youth

Services for marginalized and vulnerable youth ranked 2nd (18%) in Poll Results

Sustainability is an increasing concern as there are grantees who are nearing the end of their grant

Grantees are increasingly asking for an expert in sustainability, relative to future funding

Listening Session

- Sustainability and future funding to support programs
- Expand the availability of peer support programs
- Foster youth and/or kids that ‘get in trouble’ are hard to reach
- Underserved populations include ‘unnamed’ groups
- Universal screening requires adequate services
- Space and time are a constant barrier to service

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Why this approach?

Focus on key areas that will make an immediate and lasting impact on student mental health

Addresses a large section of the continuum of care for students

Includes prevention and identification of risk factors, treatment, and sustainability

Proposed $25 Million Expenditure

Areas of Funding

Marginalized and Vulnerable Student Populations ($5 million)

- Foster youth, juvenile justice involved youth, and unnamed populations

Universal Screening ($8 million)

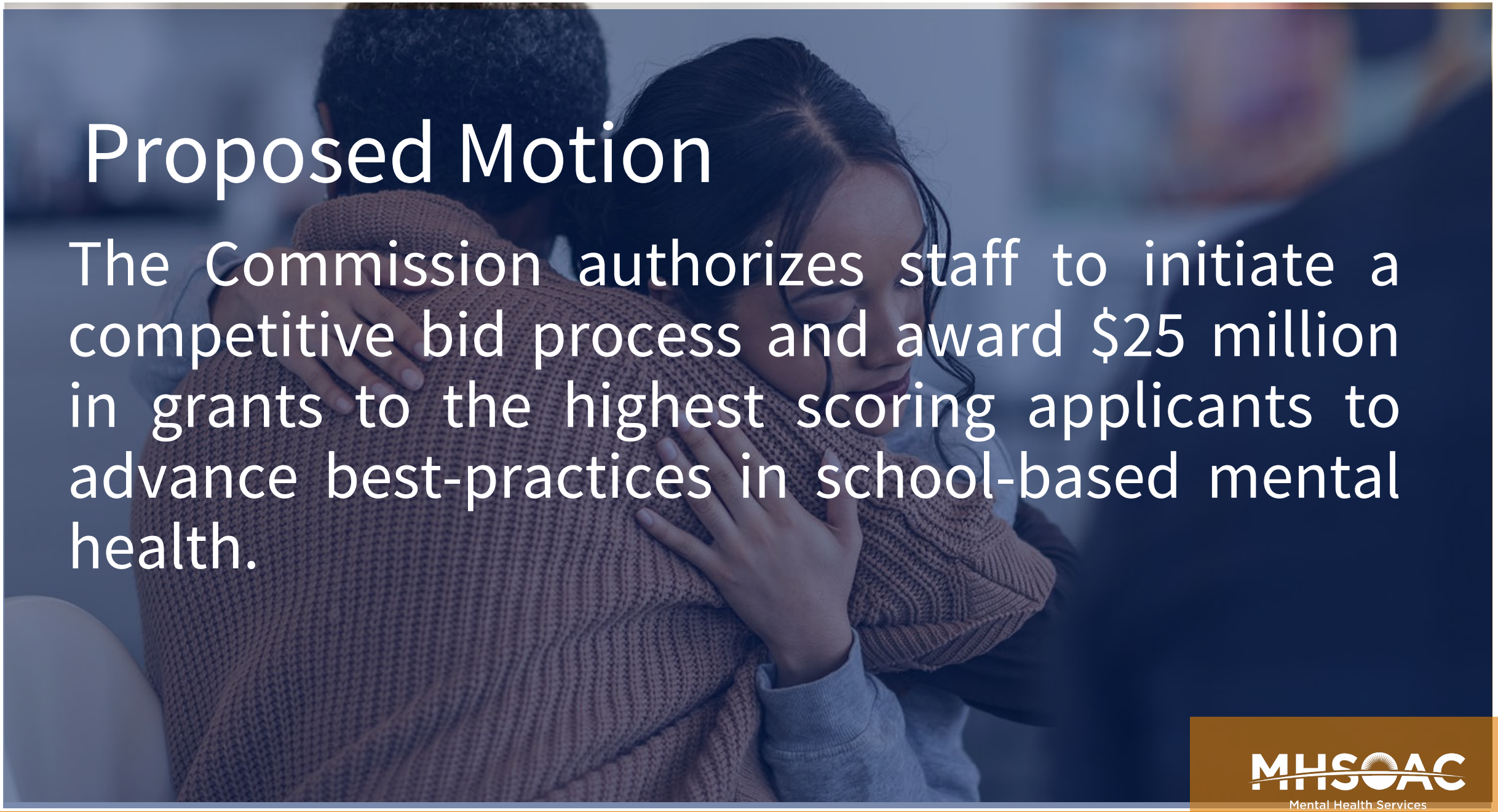
- Learning cohort of partners to develop an implementation plan

Sustainability ($9 million)

- Continuous quality improvement and long-term sustainability of school-county partnerships

Other Priorities ($3 million)

- Projects that address unique needs of their partnerships, such as wellness centers, mobile crisis support, SUD prevention, etc.



Proposed Motion

The Commission authorizes staff to initiate a competitive bid process and award $25 million in grants to the highest scoring applicants to advance best-practices in school-based mental health.

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Oversight & Accountability Commission