Commission *for* Behavioral Health

Counting What Counts

Opportunities for school-based universal behavioral health screening (SUBHS)

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

About the Commission

The Behavioral Health Services Oversight and Accountability Commission, known as the Commission for Behavioral Health (CBH) and formerly the Mental Health Services Oversight and Accountability Commission, was initially established to oversee implementation of the Mental Health Services Act of 2004 and to drive innovation and accountability in California's behavioral health system.

The CBH champions wellbeing for all Californians through behavioral health prevention and intervention, including mental health and substance use disorders. By working with community partners, individuals with lived experience, family members, State agencies, and the Legislature we help to increase public understanding, catalyze best practices, and inspire innovation. Our goal: accelerating transformational change.

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01 EXECUTIVE SUMMARY

California's commitment to youth behavioral health

Most behavioral health challenges emerge before adulthood, and currently afflict as many as one in three Californians under the age of 18. Unaddressed behavioral health challenges are one of the largest obstacles to a young person's ability to learn and thrive, yet children's behavioral health needs continue to be underserved. This gap presents tremendous opportunities for innovation, and California is rising to the challenge.

Through historic investments in service delivery, workforce, infrastructure, and public awareness, California is building a behavioral health care ecosystem that prioritizes prevention, early access, and equity. The State's approach sees schools as vital touchpoints in this ecosystem and universal screening is an important tool to help schools succeed.

School-based universal behavioral health screening (SUBHS) is a proactive assessment of all students' behavioral health risks and strengths.

Much like the routine health screenings most students already complete, such as hearing, vision, and fitness, SUBHS aims to identify potential challenges early so students can receive support before these challenges significantly impact their health, behavior, and ability to learn.

SUBHS data is versatile in its ability to describe school-wide trends while also identifying individual student needs. Schools use this information as part of their multi-tiered support system (MTSS) to ensure students receive appropriate help at the right time, whether they need universal programs or targeted support.

Many screening tools have been developed, yet not all tools are appropriate for every school or student population. Regardless of the screening tool, the effectiveness of SUBHS has more to do with the implementation process. For SUBHS to succeed, schools must have a clear follow-up plan tied to an existing MTSS that is adequately staffed and supported by community partners - especially those in behavioral health. Gaining trust, buy in, and participation from teachers, students, and their families is also essential. These elements are foundational to any school-based behavioral health system.

The potential benefits are enormous: reducing stigma, increasing help-seeking behavior and access to care, and ultimately, saving lives and dollars. But significant challenges remain. Concerns about school capacity, the stigma of diagnostic labels, and the need for adequate follow-up services have raised questions about how to implement SUBHS responsibly. Without sufficient resources and clear guidance, schools may struggle to provide the support students need after being identified.

Through the California 2023-24 Budget Act, the Legislature requested the Behavioral Health Services Oversight and Accountability Commission to conduct a landscape analysis and deliver a report on universal behavioral health screening for youth, with attention on data, best practices, and costs for implementing screening in K-12 school settings.

This report summarizes the Commission's findings and presents a set of recommendations to address gaps in knowledge and practice for implementing SUBHS in support of California's broader goals and investments for youth behavioral health. This report does not recommend specific screening tools but instead provides a framework and evidence to inform future policies and decisions related to SUBHS implementation.

Findings and recommendations

Finding 1

Evidence supports the use of SUBHS to improve students' wellbeing and ability to learn; yet without leadership, guidance, and standards, implementation varies in California and elsewhere.

Nearly half of the schools or districts represented in the statewide survey are implementing SUBHS, but practices vary. Many of those not implementing SUBHS expressed interest but lacked the guidance and resources to begin. The absence of data and standards for school-based behavioral health practices make it difficult to fully assess SUBHS practices and impact across California's school districts.

Finding 2

Myths are driving the narrative around SUBHS, reinforcing stigma, fears, and mistrust that hinder progress for school-based behavioral health.

Lack of buy-in from teachers, parents/caregivers, and students is one of the main reasons schools are choosing not to implement SUBHS. Most concerns about SUBHS are rooted in stigma and a general misunderstanding about what SUBHS is and how it is used.

For students and parents/caregivers, concerns around labeling and discrimination about behavioral health needs are ever present, as well as tensions regarding rights to consent and confidentiality. Such concerns can create a culture of mistrust and discourage student and parent participation in school-based behavioral health screening and services.

Meanwhile, confusion about what SUBHS is and how it is used only reinforces negative perceptions about SUBHS. Definitions and language used to describe SUBHS are inconsistent and often misrepresent the goal and utility of universal screening. The lack of information and public awareness means that myths are driving the narrative and decisions about SUBHS.

Real or perceived, concerns and fears among students, parents/caregivers, and teachers point to the need for greater outreach and education to gain the trust and buy-in necessary for effective SUBHS.

Finding 3

Capacity barriers are outweighing the benefits of SUBHS. Schools need resources and technical support to use SUBHS effectively and responsibly.

The majority of school representatives engaged by the Commission expressed broad support for the use of SUBHS. Yet, many schools are already stretched thin and worry that they do not have the capacity to implement SUBHS. Capacity barriers underlie many of the ethical and legal concerns about implementing SUBHS, as schools fear they may not be able to respond to identified student needs when those needs exceed available resources. Youth, parents, caregivers, and school staff alike emphasized the need for more resources – workforce, services, data systems, and funding – for schools to be able to effectively identify and support students' behavioral health needs.

Recommendation 1

California must establish a long-term strategy and leadership structure to coordinate its many partners and workstreams into an integrated and sustainable statewide youth behavioral health system.

That structure should prioritize strengthening education and behavioral health partnerships at the state and local level and should establish clear standards and guidance for implementing school-based behavioral health practices including those related to SUBHS.

Recommendation 2

To ensure success of its school-based behavioral health strategy California must do more to improve the behavioral health culture and climate in schools and diminish the stigma and fear associated with screening and seeking behavioral health support.

As part of this effort, the State must invest more in supporting the behavioral health needs and competencies of teachers and school staff, and help schools strengthen participation, buy-in, and trust in school-based behavioral health services.

Recommendation 3

In support of the statewide school behavioral health strategy, California must engage with local education and behavioral health partners, as well as students and their families, to assess and address capacity needs for implementing comprehensive school behavioral health standards, including behavioral health screening.

The State should provide incentives and resources to support the planning, testing, and scaling of effective SUBHS practices in California, as well as infrastructure and resources to support implementation of SUBHS in alignment with California's broader youth behavioral health investments.

As California faces the next chapter in its youth behavioral health strategy, it must consider how it will sustain the momentum and progress made and bring to fruition its vision to improve the behavioral health and wellbeing of California's current and future young people. Now is the time to assess where SUBHS fits within the broader youth behavioral health ecosystem, and this report is intended to guide that work.

02
INTRODUCTION

The youth behavioral health crisis puts a spotlight on schools

Half of behavioral health conditions begin before age 14; 75 percent by the age of 24.[1] Currently in the U.S., as many as one in five children and youth are experiencing a behavioral health challenge, a number that has steadily increased in the past decade.[2,3]

Despite investments in services and research demonstrating the importance of early intervention, the behavioral health needs of young people are increasingly underserved.[4] Recent data reveals that the majority of Californians under the age of 18 with an existing behavioral health challenge are not receiving services or support,[5] placing them at increased risk for negative social, educational, and health outcomes throughout their lifetimes.[6]

The COVID-19 pandemic exacerbated what was already a steady decline in youth behavioral health. Between 2011 and 2021 alone, U.S. high school students reporting poor behavioral health increased from 28 to 42 percent.[2,3]

California high schoolers in a focus group said that today's young generation is struggling socially and emotionally while dealing with ever-increasing pressures in school and in their personal lives. They report feeling lonely, unheard, and unseen and do not know where or how to get support. Many said they feel shame or embarrassment about their behavioral health, sometimes among their peers and sometimes in their homes.

In California, students' unmet behavioral health needs are impacting their ability to learn and thrive.

1 million
K-12 students are at risk of developing a behavioral health challenge.

42%
of 11th graders report chronic sadness and hopelessness.[7]

65%
of youth behavioral health challenges are not supported.[8]

3 in 20
secondary students seriously considered suicide in the past 12 months.[5]

527
California youth died by suicide in 2020.[8]

1 in 4
K-12 students were chronically absent during the 2022-2023 school year.[9]

Families are desperate for behavioral health support in schools. In the U.S., 87 percent of parents and caregivers of school-aged children say they support behavioral health services in school.[10] In a 2023 survey, behavioral health was the number one reason parents decide to switch their student to a new school, ranking higher than academic concerns.[11] In California, parents and caregivers participating in listening sessions said they are worried about the future and safety of their children but feel alone and that they do not have the resources to help them. They also report a diminishing trust in the ability of education and health care systems to support their students' behavioral health needs.

Educators and school staff have also felt the consequences of unaddressed behavioral health needs among their students, especially after the COVID-19 pandemic. School attendance is at an all-time low across California, contributing to funding concerns for many schools that are already struggling with limited resources.[12] Meanwhile, increases in disruptive behaviors and learning difficulties are making it harder for teachers and staff to do their jobs, leading to stress, burnout, and staff turnover.[13] In a 2022 U.S. survey, 73 percent of K–12 teachers and 85 percent of principals reported experiencing frequent job-related stress – about twice as high as other professions.[14] During the 2022-2023 school year, 23 percent of teachers said that they were likely to leave their job.[14]

Increases in substance abuse,[15] self-harm, and suicide among students are turning many campuses into crisis response centers, causing trauma for students and staff exposed.[16] One principal said "I've seen 10-year-olds in the bathroom [engaging in self-harm]. I realized that doing something different was not a choice, because either way, we're dealing with students' behavioral health. I'd rather do it in a way that helps them before it's too late."

Together, these firsthand accounts and data points underpin what many experts are calling a national state of emergency for youth behavioral health. In a joint statement, the American Academies of Pediatrics and Child and Adolescent Psychiatry and the Children's Hospital Association called on policymakers at all levels to ensure "all families and children, from infancy through adolescence, can access evidence-based behavioral health screening, diagnosis, and treatment."[17]

Schools offer convenience, community, and context for identifying and supporting students' needs.

Like many health and learning needs of students – such as hearing, vision, and reading skills – schools provide a natural and logical setting for preventing, identifying, and supporting young people's behavioral health needs early, which is crucial to improving outcomes.[18]

Although behavioral health screening and services can and should occur in clinical care settings, it has been reported that many youth under 18 face barriers to accessing routine medical care such as annual well child visits.[19] Children spend most of their time at school – services should be offered where kids are.

In addition to proximity, schools offer community and context. Schools are uniquely positioned to provide information, safe environments, and nurturing relationships that reduce risk and promote resiliency.[18] Unlike clinical settings which are often not equipped to address contextual risk factors impacting students' behavioral health (e.g., food insecurity, housing instability), schools possess the infrastructure and partnerships to provide and/or facilitate access to preventive services.[20]

Schools are a cornerstone of California's youth behavioral health strategy.

Under Governor Newsom's administration, California has made a landmark commitment to better serving the behavioral health needs of children through its Master Plan for Kids' Mental Health.[21] This multi-year investment works across systems and disciplines to build an integrated behavioral health care ecosystem capable of providing a full continuum of prevention, early intervention, and crisis services and support to all children, youth, and families when, where, and in the way they need it most. Like other states, California's framework recognizes the critical role of school-based behavioral health within this broader ecosystem.[22]

As California evolves its capacity for school-based behavioral health systems, there is a growing need to identify and implement strategies for identifying and supporting students' needs effectively and equitably. One area of opportunity is *school-based universal behavioral health screening (SUBHS)*.[23]

The SUBHS Project and Report

Through the California 2023-24 Budget Act, the Legislature requested the Behavioral health services oversight and accountability commission (the Commission) to conduct a landscape analysis and deliver a report on universal behavioral health screening policies and practices in school settings, with attention on data, tools, and costs for implementation.[24]

Under the direction of the Commission, and in collaboration with the Legislature, California's Children and Youth Behavioral Health Initiative, California's Department of Health Care Services, community members, and education and behavioral health partners, Commission staff conducted a robust research and engagement process to inform the present report. In the following sections, this report aims to:

- Establish key definitions, concepts, and evidence relevant to SUBHS;
- Summarize findings from public engagement activities and a statewide school survey to describe current SUBHS practices, perceptions, barriers, and opportunities in California K-12 schools; and
- Present a set of recommendations to guide future budget and policy considerations for implementing SUBHS as part of California's broader youth behavioral health care ecosystem.

A Primer on School-based Universal Behavioral Health Screening

SUBHS defined

School-based universal behavioral health screening (SUBHS) is the proactive assessment of all students' behavioral health risks and strengths.[25]

Establishing a common language and shared understanding is essential to the success of SUBHS.

A universal screener is a brief assessment given to all students to help identify which students are at risk for academic and non-academic difficulties.[26]

Common examples in schools are vision screenings and hearing screenings. The logic in providing these screenings in schools is that students learn best when they can see and hear. While we could rely on educators to notice when a child is squinting to see the board or when a child is asking for directions to be repeated, we know that it is better to not wait until the child has missed instruction, so schools perform screenings and intervene early.

The same logic holds for behavioral health screening. A child's ability to thrive and learn is hampered when they are experiencing a behavioral health challenge.[27] Teachers alone cannot be expected to notice all the small – and sometimes invisible – signs of a child's behavioral health needs.[28]

By focusing on both risks and strengths, SUBHS helps schools support a range of student needs by informing school-wide policies and programs that promote wellbeing and address environmental factors that put students at risk for various behavioral health problems.[23]

What is behavioral health?

Behavioral health is an umbrella term that refers to the following:

Mental health (e.g., wellbeing, mental distress, mental health conditions)

Suicidal thoughts or suicide attempts

Substance use or substance use disorders

Behavioral health systems facilitate access to resources and services to promote wellbeing, prevent mental distress, and treat behavioral health conditions.

Strategies to improve behavioral health outcomes work at multiple levels, including social determinants of health – supporting the environments where people live, work, learn, and play across the lifespan.*

* Adapted from the U.S. Centers of Disease Control and Prevention https://www.cdc.gov/mental-health/about/about-behavioral-health.html

Common questions about SUBHS

What are schools screening for?

SUBHS tools can be used to screen an array of indicators of behavioral health needs, risks, and strengths, depending on the student's age and purpose of screening.[29]

Examples:

- Externalized behaviors (e.g., self-injury and aggression)
- Internalized behaviors (e.g., anxiety, depression, withdrawal, and isolation)
- Resiliency traits (e.g., social and emotional skills, coping strategies, subjective wellbeing)
- Contextual or situational risk factors (e.g., economic hardships, abuse, divorce of a parent, or extreme loss)
- Contextual or situational protective factors (e.g., the presence of a caring and consistent adult in the home, access to health care and other resources that promote wellbeing).

Who is involved?

Screening practices are led by a diverse team that reflects the school community and has expertise in behavioral health assessment and intervention. In addition to behavioral health professionals, parents/caregivers, teachers, and staff are engaged throughout the planning and implementation process including the review of screening data. Screening can be administered by teachers during devoted classroom time, by parents/caregivers, or by other trained health or behavioral health professionals during the school day. Depending on the age of the student, parents/caregivers are required to provide consent for their student to be screened.[29]

When does screening occur?

Universal screening occurs at least once during the school year, usually during the first quarter of instruction. However, depending on the goal of screening, some schools may choose more frequent screening. For example, a school may elect to conduct screenings at the beginning (fall), middle (winter), and end (spring) of a school year.[29]

How is screening data used?

Universal screening helps schools understand a range of student needs and make informed decisions to help each student achieve personal and academic success.[29] Screening data can be used to:

- Identify students at risk for emotional or behavioral difficulties.
- Identify students performing at or above healthy levels of functioning.
- Establish a benchmark for measuring the improvement of a group, class, grade, school, or district (e.g., a reduction in the percentage of students identified to be at risk for behavioral difficulties).

Dispelling myths about SUBHS

Despite its potential, myths are driving the narrative around school-based universal behavioral health screening. Establishing a common language and shared understanding is essential to the success of SUBHS. In addition to defining key features, it is also important to clarify what SUBHS is not.

SUBHS is NOT:

Diagnostic
Universal screening is not used to diagnose or make high-stakes decisions, such as for crisis intervention or special education services.

Anonymous
Universal screening does not only assess school-wide trends (i.e., Healthy Kids Survey), but also collects identifiable information so that schools support students with higher needs.

Redundant
Schools cannot identify students with mental health challenges based on behavioral or academic challenges alone.

Stigmatizing
Universal screening does not result in excessive “labeling” or put children “in a box.”

Costly
Universal screening is not overly time consuming and expensive for schools to administer.

Isolated
Universal screening is not intended to replace other types of screening and services, but instead is one part of a continuum of strategies to identify and support students’ needs.

SUBHS is:

Preventative
Universal screening assess risks and strengths to inform the development and monitoring of MTSS strategies that improve behavioral, leaht, and educational outcomes.

Precise
Universal screening uses objective and contextual data rather than relying on staff referral or overt behaviors.

Destigmatizing
Universal screening helps normalize mental health needs and support-seeking behavior.

Confidential
Universal screening adheres to strict data privacy laws and policies.

Equitable
Universal screening reduces mental health and educational disparities, especially for historically underserved students and their families.

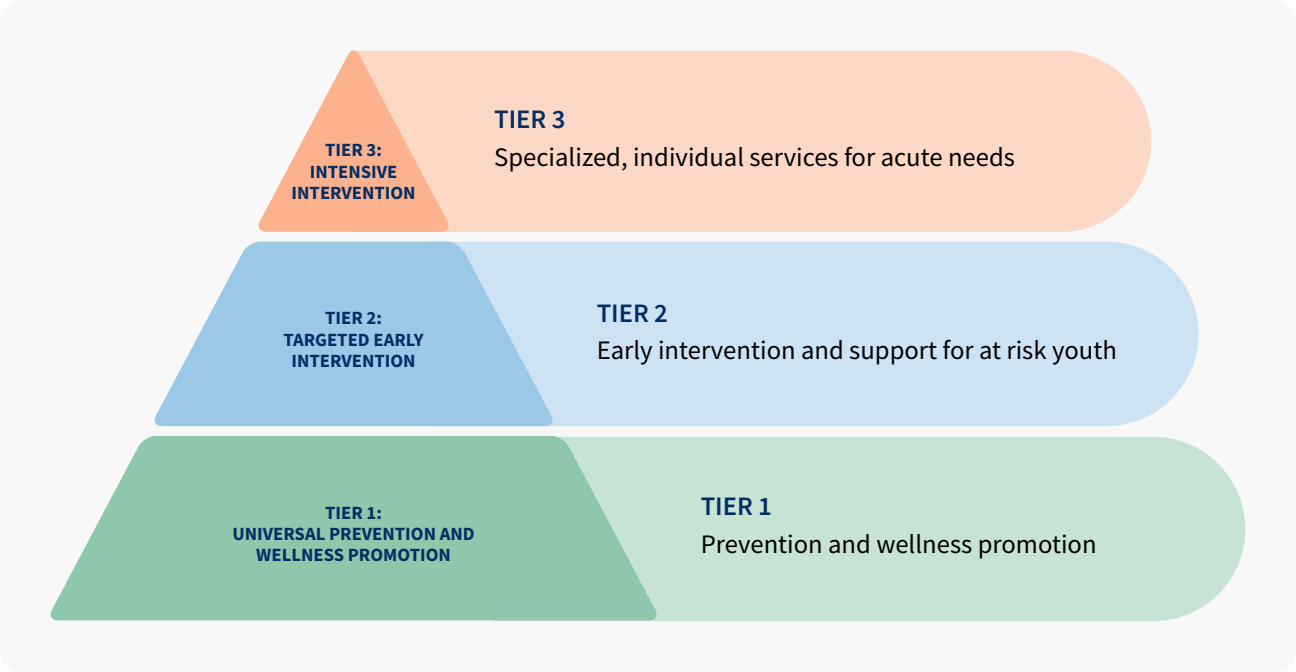
Cost effective
Universal screening requires investments in planning and resources, but results in cost savings by improving student outcomes and driving systems level change.

Integrated
Universal screening is most effective when implemented within a proactive and adequately resourced comprehensive school mental health system.

SUBHS promotes equity-centered multi-tiered systems of support

School-based universal behavioral health screening can inform schools' **multi-tiered systems of support (MTSS)**.[30] The MTSS framework involves research-based strategies to meet the needs of all students, including academic AND behavioral health needs.[31] Many schools and districts across the U.S. and California are already using MTSS.[32]

The MTSS framework mirrors a public health approach to promote student wellbeing by identifying three "Tiers" of supports:



In a well-implemented MTSS, most students would benefit from Tier 1, universal school-wide and classroom-based wellness promotion and behavioral health prevention strategies. Fewer students would receive Tier 2, targeted early intervention services, which may include small group or individual programming. Even fewer students would receive Tier 3, intensive individualized services.[31]

SUBHS data informs multi-tiered systems of support

An MTSS approach leverages student and school-wide data to inform and evaluate a full continuum of prevention, early intervention, and intensive services. Universal screening data are an important part of this continuum, acting primarily as a school's early warning system and are not intended to diagnose students.[31] Table 1 depicts a continuum of assessment within an MTSS in which the intensity (breadth and depth of assessments and data) informing intervention decisions increases at each tier. For conceptual examples of how data and services in each tier might work, see Appendix I; Fictional Examples of SUBHS Application.

TABLE 1: DATA-INFORMED MULTI-TIERED SYSTEMS OF SUPPORT

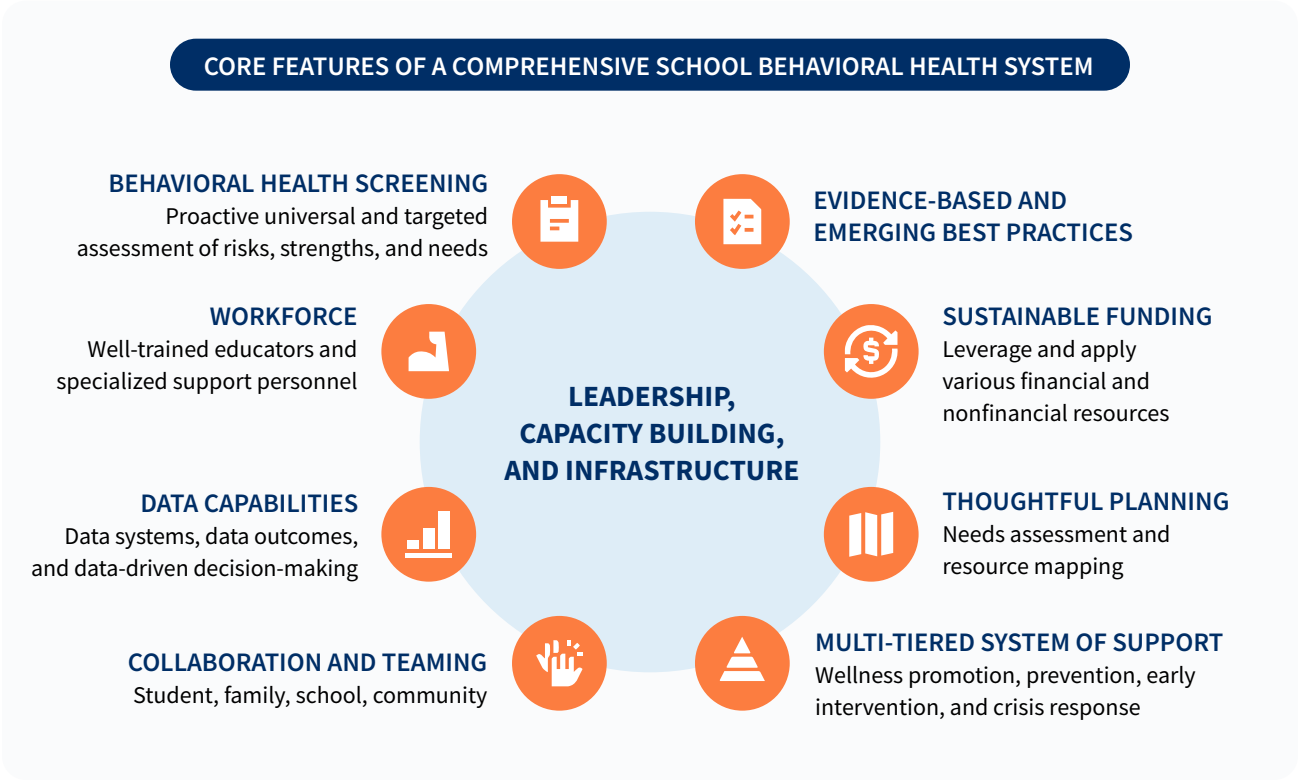
	DATA TYPE	MTSS SERVICE
1	**UNIVERSAL SCREENING DATA** Data is used to assess and respond to trends and patterns (positive and negative) across the school population or specific subpopulations (e.g., grade level, single classroom, learning cohort).[23]	**UNIVERSAL PREVENTION AND WELLNESS PROMOTION** Supports, services, and assessments are provided to all students to promote resiliency, improve school climate, and address any potential factors affecting students' wellbeing.
2	**TARGETED SCREENING OR ASSESSMENT DATA** Universal screening or other observational data can identify individual students at risk. Additional assessments may be administered to assess a student's specific needs and/or determine if additional testing or services are necessary.[29]	**TARGETED SUPPORT AND EARLY INTERVENTION** Individual or group-based supports or skill-building activities provided to students at risk of or showing early signs of developing a behavioral health challenge.
3	**CLINICAL EVALUATION OR ASSESSMENT DATA** Specialized assessments administered and interpreted by a licensed professional to determine the presence and severity of a diagnosis and inform individualized services.[33]	**INTENSIVE, SPECIALIZED SERVICES** Specialized services provided by a licensed professional to the students with the most intensive or acute needs.

Implementing SUBHS as part of a comprehensive school behavioral health system

Preparing for and administering SUBHS requires proactive and sustained investment of time, resources, and community partnerships – features which correspond with a comprehensive school behavioral health system.

A comprehensive school behavioral health system refers to a framework and set of guidelines, developed by the National Center for School Mental Health, to help schools promote positive school climate, social and emotional learning, and behavioral health and wellbeing, while reducing the prevalence and severity of illness.[30] This involves the integration of education, behavioral health, family, and community partners into a single, efficient, and equitable service delivery system.[34]

The National Center for School Mental Health identified eight core features of a comprehensive school behavioral health system – MTSS and SUBHS are among these features.



In practice, comprehensive school behavioral health systems work when each of its core components are in place and integrated. In other words, **SUBHS is not only a part of a comprehensive school behavioral health system but is dependent on that system to be effective.**[23] For this reason, implementing SUBHS must be considered within this framework.

Table 2 provides an overview of SUBHS implementation organized by the eight components of a comprehensive school behavioral health system. (A list of guidance resources for implementing SUBHS can be found in Appendix I: SUBHS Resources).

TABLE 2: SUBHS IMPLEMENTATION ALIGNED WITH A COMPREHENSIVE SCHOOL BEHAVIORAL HEALTH SYSTEM[23,29]

THOUGHTFUL PLANNING

- Process led by a team of education and community partners to establish policies and procedures and secure resources to ensure screening and follow-up practices are effective, ethical, and equitable.

WORKFORCE

- Secure a network of highly skilled and adequately paid professionals (licensed and non-licensed) to conduct behavioral health screening, follow-up, and intervention.

SCHOOL-COMMUNITY COLLABORATION AND TEAMING

- Forming a strong and collaborative relationship between schools and community behavioral health partners is essential.
- Establish trust, buy-in, and collaboration with families, students, and teachers.

BEHAVIORAL HEALTH SCREENING

- Universal Screening and targeted assessment data are considered with student and family input and other data sources to identify needs and inform MTSS services.

EVIDENCE-BASED AND EMERGING BEST PRACTICES

- Screening, referral, and interventions are selected based on their evidence of effectiveness and feasibility.
- Practices and tools must be culturally, linguistically, and developmentally appropriate.

MULTI-TIERED SYSTEM OF SUPPORT

- Screening is linked to a tiered system of support designed to respond to a range of student needs through prevention, early intervention, referral, and linkage to community-based care.

DATA SYSTEMS

- Develop integrated, responsive, and secure data systems and policies to ensure clear, consistent, and timely sharing of screening data with relevant community and school partners.
- Aggregate screening data are monitored as part of a continuous quality improvement process.

SUSTAINABLE FUNDING

- Short-term investments are needed for planning, capacity building, and piloting of SUBHS.
- Reliable financial and/or non-financial resources are necessary to secure staffing, MTSS infrastructure, and data systems to support SUBHS.

Considerations for effective, ethical, and equitable screening

Implementing SUBHS effectively and responsibly involves proactive and ongoing efforts to address what can, at times, be complex considerations.[35] Despite the potential benefits of SUBHS, some schools may determine they are not ready for the commitment. Before implementing SUBHS, schools should consider the following:

Capacity for responding to positive screens

Screening practices are assessed based on their ability to improve outcomes weighed against their potential to cause harm. Identifying a student's needs without having the capacity to provide support could be harmful. Before deciding to implement SUBHS, schools must be honest about their capacity limitations for responding to positive screens (i.e., when a student is identified as being at risk or with an acute need). Should a school decide to screen, they must have a well thought out process, procedures, and partners to ensure referral pathways are in place so that students get the help they need quickly.

Accuracy and appropriateness of screening tools and procedures

Screening tools and practices are selected based on their technical adequacy, appropriateness (i.e., based on culture and language of the student population), and feasibility to administer. Poorly selected screening practices can lead to "false positives," where screening results inflate student's actual risk – or worse, "false negatives," allowing students to slip through the cracks.[36] Furthermore, cultural differences can affect the accuracy of screenings especially when screeners are not tailored to diverse populations.

Buy-in and trust

Buy-in in from teachers, students, and parents is critical to the success of SUBHS. For one, obtaining consent from a parent/caregiver (or older student) is always required before a student can receive screening or services. Also, a student is more likely to participate in screening if they feel safe and see the value in screening. Teachers reinforce safety and encouragement among students and sometimes play a direct role in the screening process. At every level, stigma and fears about behavioral health screening and services can undermine the screening process, which is why care must be taken to build awareness and trust.[29]

Consent and data privacy

Planning and implementing SUBHS should involve ongoing collaboration with legal experts to ensure SUBHS practices adhere to legal guidelines regarding consent and data management.[37]

Schools may either use active (opt-in) consent practices, requiring written permission, or opt-out consent, where parents/caregivers are notified and given the option to decline participation. For older students, parental/caregiver consent may not be necessary if the student agrees to screening, although involving parents/caregivers is generally recommended to maintain trust. Regardless of the method, consent materials should clearly explain the screening process, be accessible in preferred languages, and allow students to opt out.[29]

Data storage and privacy policies are also important considerations and will depend on district, state, and federal guidelines for maintaining student and family records within the school.[38] Federal guidelines are provided in the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A transparent data management plan – informed by these policies and detailing where data will be stored and who will have access – should be established prior to screening and clearly communicated with staff, families, and students.[39]

Plan ahead and start small

Many of these considerations can be addressed through a planning process led by a team of school, behavioral health, and other community partners to determine the follow:[29]

- What are the goals of screening?
- What screening tools will be used?
- What procedures will be used for screening and follow-up and who is responsible?
- What resources are available and what are potential barriers?
- How will schools obtain buy-in from parents, teachers, and students?

When first implementing SUBHS, school are encouraged to start "slow" or "small".[40] Beginning with small-scale pilots – for example, screening with just one grade level (e.g., all fifth graders) or at important transition points (e.g., ninth grade) – allows schools to trial their procedures and obtain valuable feedback for quality improvement.[41] Starting SUBHS on a small scale gives schools the time to assess resource demands and to build buy in and trust from staff, parents/caregivers, and students before rolling out SUBHS more widely.[40]

Benefits of SUBHS

Proactively identifying and responding to student behavioral health needs through a systematic universal screening process has multiple advantages. When implemented as part of an equity-centered MTSS, SUBHS supports early individual identification[42] and population-level (e.g., school, district, county-wide) monitoring, reduces bias and stigma, and promotes more positive and equitable outcomes,[43] ultimately saving lives and dollars.[23]

Removes bias

Traditional methods for identifying students with behavioral health needs, such as staff nomination or reviewing attendance or disciplinary records, typically identify students based on visible behaviors that are considered "problematic." Such approaches are not only subject to bias but also overlook students whose needs are less noticeable but equally acute (e.g., internalizing depression or anxiety symptoms).[44] In contrast, the systematic and proactive nature of SUBHS processes can reduce bias in the identification process[45] and help schools support students much earlier – before problem behaviors occur – thereby reducing disparities in youth behavioral health care access and outcomes.[23]

Reduces disciplinary and special education strategies

Research has shown that an overreliance on behavioral referrals in schools can lead to unnecessary disciplinary actions and/or special education referrals in lieu of behavioral health supports.[44] This is especially true for racially and ethnically minoritized students whose behaviors are more likely to be interpreted as "problematic" by teachers and staff compared to their white peers.[44] Proactively assessing and supporting students' needs via SUBHS may reduce the need for punitive strategies[46] and special education resources, while also addressing behavioral health and academic inequities among historically marginalized youth.[23]

Comprehensive and holistic

Behavioral health and academic disparities are driven largely by factors such as access to healthy foods, housing, safe neighborhoods, and health care, and exposure to racism and discrimination, also referred to as the social determinants of health.[47] Educators often see the academic and behavioral challenges associated with these factors, but may not recognize the

underlying causes.[48] Implementing SUBHS provides a strategic opportunity for schools to identify contextual factors contributing to a student's behavioral health risk. Providing this perspective to teachers and staff not only promotes empathy and understanding of students' behavioral and academic challenges, but also helps schools intervene and provide resources to address factors contributing to student disparities.[23]

Cost effective

While dollar-for-dollar comparisons between SUBHS and other referral strategies (e.g., teacher referral) are limited, those that exist point SUBHS cost-effectiveness over other identification methods.[49] For example, studies suggest that implementing SUBHS as part of a school-based prevention-oriented intervention model, such as MTSS, may reduce schools' financial burden by as much as 20 percent compared to traditional referral approaches.[50]

By promoting prevention and early identification, SUBHS has the potential to stop behavioral health challenges from becoming severe and disabling[51] and, thereby, reduce overall behavioral health service costs. When used within a school's MTSS, this can translate to downstream benefits,[52] such as fewer referrals for special education, reduced need for intensive psychiatric care, and fewer behavioral health crises.[44] In the long run, prevention and early intervention services help reduce the widespread consequences and societal costs of unaddressed behavioral health needs such as homelessness, addiction, incarceration, and suicide.[53] A 2022 global analysis[54] revealed a $24 return for every $1 invested in behavioral health prevention and early intervention programs among adolescents. Among the interventions studied, universal school-based prevention strategies were the most cost-effective, resulting in a $147 return for every $1 spent.[54]

> "...it is imperative to re-envision how we approach [behavioral] health screening in schools to center equity. […] Equity-focused [behavioral] health screening requires a shift from individual- and deficit-focused approaches to systems- and holistic-focused approaches that (a) identify strengths and stressors among individuals, groups, and communities; (b) dismantle structural forms of oppression (c) promote positive [behavioral] health outcomes for minoritized youth..."
>
> **– Excerpt from A Roadmap to Equitable School Mental Health Screening [23]**

03
THE CALIFORNIA LANDSCAPE

As California evolves its capacity for school-based behavioral health services, there is a need to understand if and how school-based universal behavioral health screening (SUBHS) fits within its broader behavioral health strategy. Guided by the Legislature, this section provides findings from a landscape analysis of existing SUBHS practices, perceptions, and barriers in California's K-12 system.

While the landscape analysis is not exhaustive nor does it represent the perspectives of all schools and communities, it provides one of the first inquiries into SUBHS practices in California with key insights to inform future implementation and state-level guidance.

Findings have been organized by the following sections:

1 Current policies and practices

2 Awareness, perceptions, and buy-in

3 Capacity barriers and resource needs

4 Opportunities within California's youth behavioral health ecosystem

LANDSCAPE ANALYSIS ACTIVITIES

LITERATURE REVIEW

A comprehensive review of the literature to understand current research on SUBHS implementation and best practices.

STATEWIDE SCHOOL SURVEY

A voluntary survey was administered to assess screening practices among California schools and districts, including those schools not currently screening. The survey was completed by 443 respondents representing local education agencies from 55 of California's 58 counties.

SITE VISITS

The Commission conducted four site visits in San Diego, Sonoma, Yolo, and Riverside counties to inform case studies of schools modeling SUBHS practices. (Site visit summaries are provided in Appendix III)

QUALITATIVE ANALYSIS

Data was collected through interviews and virtual listening sessions to understand the perspectives and experiences of students, parents, and schools.

Refer to Appendix IV for a detailed description of landscape analysis activities.

1. Current policies and practices

Evidence supports the use of school-based universal behavioral health screening to improve students' wellbeing and ability to learn, yet without leadership, guidance, and standards, implementation varies in California and elsewhere.

The American Academy of Pediatrics recommends routine behavioral health screening for all children from birth through age 21, and the U.S. Preventive Services Task Force recommends that universal behavioral health screening occur in the same settings where physical health screenings occur. Schools are one of such settings, and because of this, school-based universal behavioral health screening has been recommended by major U.S. education and health authorities to support school-based behavioral health support systems.[41]

Although SUBHS has shown great promise, implementation has been limited the U.S. When schools are conducting SUBHS, research shows wide variability in implementation practices and policies.[55] In California, there are no existing policies or standards for implementing or monitoring SUBHS in K-12 settings, which makes it challenging to describe statewide practices. The following is a preliminary summary of SUBHS practices assessed through a statewide survey and follow-up interviews with local education agencies (LEAs).

Schools implementing SUBHS

Nearly half of the schools or districts represented in the statewide survey are implementing SUBHS.

During follow-up interviews, LEA survey respondents described why their schools/districts are implementing SUBHS. For example, one LEA said, "[Because] we know kids are falling through the cracks, and we want to find ways to ensure we are supporting all students." Others said they are using SUBHS "to use data to identify students who need more assistance" and "to better direct and support behavioral health resources."

Screening procedures

Who is being screened

Half of the survey respondents who reported conducting universal behavioral health screening were at LEAs that screened all students, while the second largest group was those LEAs that screened specific grade levels.

★ SCHOOL SURVEY HIGHLIGHT

SCREENING VS. NOT SCREENING

443 surveys
were completed by LEA representatives from **55 counties**.

43%
are implementing SUBHS

43%
are implementing SUBHS

Screening tools

Overall, LEAs are using a wide variety of tools through their screening efforts, some of which are available without charge, others that are proprietary screeners owned by publishers, and several that were developed by districts/schools. While tools vary greatly, most are collecting information about students' behavioral or emotional challenges and strengths or wellbeing. Many are also collecting information about students' social skills or social-emotional competencies.

While most (58 percent) of screening tools were evidence-based, a surprising 18 percent of schools currently implementing SUBHS were administering screening tools developed by the school or district, and 24 percent were unaware of the specific tools used.

Administering screening tools

Among those survey respondents who reported conducting SUBHS, most (66 percent) reported that students completed the screening tool, 38 percent reported that teachers completed the tool, 16 percent were completed by behavioral health professionals, and 11 percent were completed by parents/caregivers.

Equity practices

Most respondents who were conducting universal behavioral health screening reported using at least one strategy to center equity in their screening processes. Half (51 percent) focus on culturally responsive school-wide supports, 39 percent analyze disaggregated data to identify and address disparities, 34 percent provide screening tools in the primary language of students/families, and 34 percent include diverse voices in decisions about the screening process. There is room for growth to ensure that all LEAs are incorporating each of these strategies in their work, especially given that 15 percent of respondents reported not using any of these strategies.

★ **SCHOOL SURVEY HIGHLIGHT**

SUBHS FOCUS AREAS

78%
Behavioral or emotional challenges (e.g., acting out, stress, anxiety, depression)

75%
Emotional or behavioral strengths or wellbeing (e.g., social and emotional literacy, school connectedness, belonging)

56%
Social skills (e.g., communication, cooperation, responsibility)

7%
Other (e.g. academics, suicide risk, school climate)

Costs and funding

Only 16 respondents said they were familiar with the costs of implementing SUBHS which ranged from no cost to thousands of dollars when accounting for all staff and materials involved during screening and follow-up processes. Local Control Funding was the most common funding source, and many also reported using grant/foundation funds to support SUBHS.

SUBHS within MTSS

Many LEAs are intentionally integrating SUBHS into their MTSS. For example, one LEA representative described how their district behavioral health team – which includes their school psychologist, behavioral health counselor, superintendent, family resource center director, two principals, and community behavioral health partners – meet monthly to discuss results of their universal screening. The school psychologist and behavioral health counselor follow up with those whose results are designated as "moderate and severe or moderate and high scoring." Their team also uses data from their screener to inform universal programming and early intervention efforts: "We go through all the results of the screenings and look for places where someone might need individual services or if there's more Tier 2 small groups [that] can be implemented. Also, if we're seeing sort of a trend across the board, then working on what we can bring into the classrooms in a more Tier 1 universal response … at that point [we] would bring those results and either just talk about trends, or if there are specific families that need things, we can collaborate on that."

Schools not implementing SUBHS

Among the 443 LEA representatives who responded to the School Survey, 43 percent said their school/district was not implementing SUBHS. When asked what they are currently doing to identify students who need behavioral health support, 79 percent said they rely on staff referrals, and only 18 percent said such approaches were adequate.

Even with a definition provided to survey respondents, 14 percent of LEAs who participated said they were not sure if SUBHS had been implemented in their schools/districts, and several LEAs who reported using SUBHS were actually using screening practices that did not meet the survey definition of SUBHS.

★ SCHOOL SURVEY HIGHLIGHT

IMPLEMENTATION NEEDS

LEA representatives identified what schools needed to implement SUBHS.

65%
Technical assistance for planning and implementation

55%
Direction from district leadership

43%
State-level policy requiring screening

7%
State-level policy providing standards

2. Awareness, perceptions, and buy-in

Myths are driving the narrative around SUBHS, reinforcing stigma, fears, and mistrust that hinder progress for school-based behavioral health.

Findings from the Landscape Analysis (see page 94) indicate that school staff, youth, and parents/caregivers recognize the potential of SUBHS to benefit their communities. These benefits include supporting population-level prevention and early identification of student needs, as well as promoting behavioral health awareness and reducing stigma, each of which contributes to efforts to a healthier school climate. Although most expressed favorable views of SUBHS, staff, students, and parents/caregivers were clear that lack of awareness and buy-in from communities affect a school's ability to implement SUBHS effectively. Most concerns about SUBHS can be traced back to a lack of understanding about what SUBHS is and how it is used. Such concerns underscored the importance of meaningfully involving staff, youth, and families in designing and conducting SUBHS practices.

★ SCHOOL SURVEY HIGHLIGHT

SUBHS are widely endorsed yet underutilized due to perceived concerns in the school community.

92%
of LEAs – including those who *were* and those who *were not* conducting SUBHS – agree that implementing SUBHS would benefit students, staff, and school communities.

LEAs that *were not* conducting SUBHS indicated that concerns from parents/community members (58%), school staff (59%), school/district leadership (46%), or students (40%) would limit their screening efforts.

Perceived benefits of SUBHS

Promotes early intervention

SUBHS helps LEAs identify and respond to school population trends with Tier 1 services and connect students with additional needs with the appropriate level of support.

Identifies unaddressed needs

SUBHS helps LEAs identify and support students who "fall through the cracks" with traditional methods. Schools are proficient at identifying students with externalizing behaviors which disrupt classroom flow, but SUBHS can bring forth those with internalizing behaviors which are not apparent in a classroom setting.

Promotes awareness

The process of screening all students can, in and of itself, promote greater awareness and acceptance of behavioral health needs and help destigmatize support-seeking behavior. Staff who were interviewed also highlighted the potential of SUBHS in helping to raise awareness about behavioral health among different interest groups, including youth, parents/caregivers, and school staff, contributing to a more supportive and equitable school environment.

> "I feel like if you have these universal [behavioral] health screens and they start at a really young age in elementary school and they're done yearly as kids go on, it shows these kids that it is serious and there's nothing to worry about when you answer these questions. And overall, I think that could help decrease the stigma with [behavioral] health in general. So, while I feel like people won't want to really say or be truthful at first because they're uncomfortable, if it starts early enough, they will be comfortable as they go on. Overall, it will help them later."
>
> – Youth Listening Session Participant

Concerns and misunderstanding

Liability burden

One common myth about SUBHS is that the primary goal is to identify, diagnose, and treat a behavioral health condition. While SUBHS can identify "red flags" that may warrant additional assessment and intervention, SUBHS are not designed to diagnose and treat all students. Assumptions that SUBHS are diagnostic are not only inaccurate, but cause schools to inflate the perceived resource burden and liability of administering and responding to SUBHS.

Stigma

According to students, many young people feel fear or shame that keeps them from opening up about their behavioral health struggles. Their fears were often related to punitive or exploitative school or community climates around issues such as social media use, sexuality, and drugs/alcohol or based on a perception that their unique challenges were not as significant as their peers and, therefore, not worthy of support. Parents and caregivers similarly shared their concerns about their children being labeled, or that their student may, by participating in a SUBHS process, be somehow othered or "put in a box." Cultural and familial beliefs can further impact students' help-seeking behaviors as well as caregiver skepticism or privacy concerns regarding screening.

Privacy and consent

In general, most parents support school-based behavioral health services, but they also want to maintain their right to make decisions related to their child's health.[56] Many parents and caregivers were concerned about not being informed about what screening and testing their children experience. Students' concerns also focused on privacy, and wanting agency to determine if, how, and when their screening data or follow-up is communicated to their families.

Trust and transparency

Students, parents/caregivers, and school representatives were unified in the belief that providing information and transparency is essential to building trust and promoting the integrity of SUBHS processes. Some students said that schools are frequently vague about the purpose of screening, and because of this, students weren't completely honest about the information they provided. The students stressed how important it is that students and staff are informed and assured that screening is being conducted with their best interests in mind. Some parents and caregivers expressed a general lack of trust toward school systems and broader child service systems. When it comes to screening, some parents and caregivers have concerns about the "criminalization" of their families or involvement with child protective services based on the information their child shares. For other families, a lack of trust stems the shortfall of schools and behavioral health systems ability to help their children in the past.

3. Capacity barriers and resource needs

Capacity barriers are outweighing the benefits of SUBHS. Schools need resources and technical support to use SUBHS effectively and responsibly.

While schools overwhelmingly acknowledged the benefits of SUBHS, they also emphasized the need for more resources – both within schools and their surrounding community – for schools to be able to effectively meet students' behavioral health needs. As one survey respondent explained, "I think universal screenings are good, but the schools need so much financial, educational (training), and additional staff support for this to be successful." Another respondent cautioned that "schools do not need another unfunded mandate with ongoing costs and staffing needs."

★ SCHOOL SURVEY HIGHLIGHT

FACTORS SUPPORTING SUBHS IMPLEMENTATION

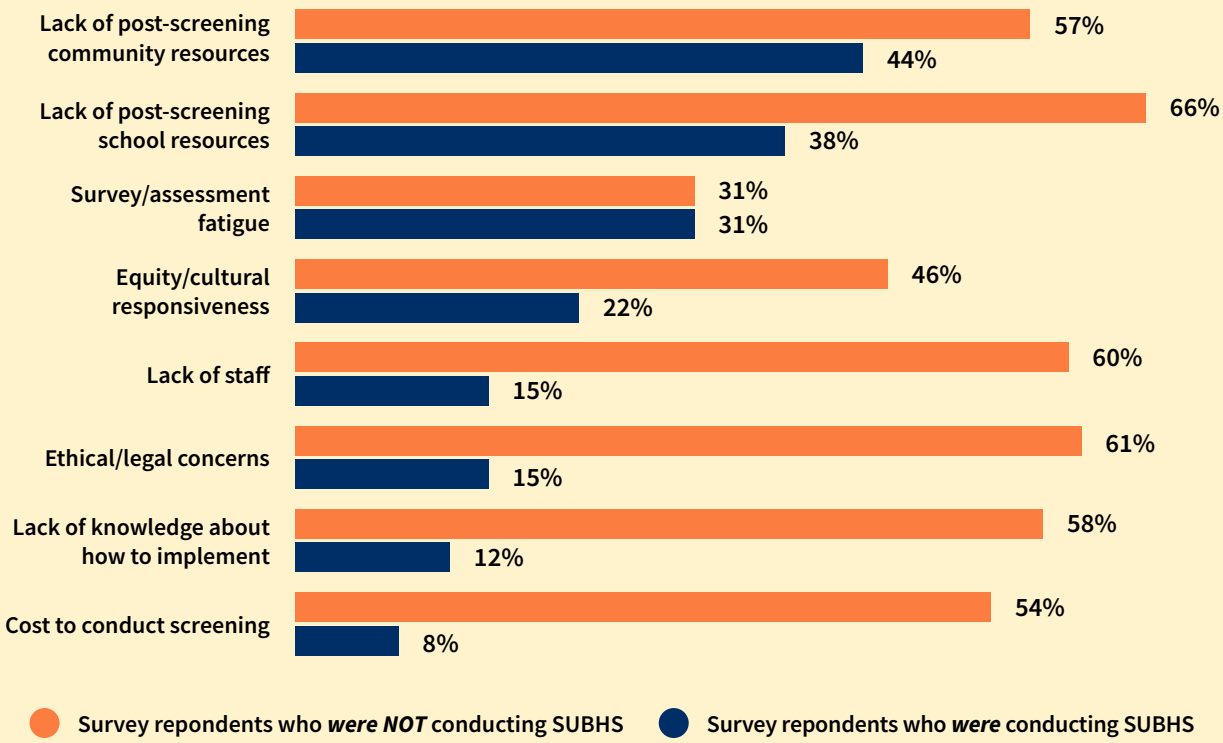
58%	Adequate school staff to handle referral needs
53%	Communication about screening and supports
48%	Dedicated school time to conduct screenings
46%	Adequate community referral sources
42%	Clear roles and responsibilities of staff involved
40%	Clearly identified student needs
38%	Alignment with school mission and district priorities
35%	Adequate funding
25%	Trainings on how to conduct screening

Barriers to implementing SUBHS

Limited resources are the number one barrier to implementing SUBHS.

Among all survey respondents, including those who were and were not screening, lack of external and internal resources were the most frequently reported barrier to implementing SUBHS. Overall, respondents who were not screening reported more barriers, specifically those related to staffing, ethical and legal concerns, lack of knowledge, and costs needed for conducting and responding to SUBHS.

★ SCHOOL SURVEY HIGHLIGHT



Staffing

Shortages of both school-employed and community-based behavioral health providers impact schools' ability to respond in a timely way to screening data. Interviewees shared anxieties that the small number of counselors available for the schools and districts could not possibly meet the need identified by SUBHS – neither in a timely way nor even at all.

Training

School staff also drew attention to the challenges that arise when teachers or other staff are insufficiently trained in student behavioral health or SUBHS systems, including further delays in responding to identified needs.

Data capabilities

Schools need data systems to quickly analyze the information gathered through screening and to follow up with students that need further support. Yet, data access and sharing are cumbersome and slow, and LEAs lack the resources and technology to navigate data privacy laws.

Sustainable funding

Short-term or temporary funding for SUBHS and follow-up services could pose challenges for some school districts. Finding and applying for grants is difficult, and unstable funding creates unstable staffing. Many local LEAs and behavioral health partners who have benefited from the recent school behavioral health incentive funds, like the Behavioral Health Student Services Act (BHSSA) and CYBHI partnerships and capacity grants, are worried about the longevity of their programs as many of these funding streams are about to expire.

Ethical and legal obligations

Capacity and procedural issues underlie many of the ethical and legal concerns about implementing SUBHS. Several survey respondents commented on the challenge of responding to identified student needs when the needs exceed their school's resource capacity. Others noted that when parents/caregivers do not follow through on referrals for counseling, they "feel ethically obligated to take on that student as a client even though our caseloads are at max capacity."

4. Opportunities within California's youth behavioral health ecosystem

A keystone moment in addressing California's youth behavioral health crisis was Governor Gavin Newsom's release of the Master Plan for Kids' Mental Health[57] and with it, a commitment to creating a more proactive, responsive, and equitable youth behavioral health ecosystem. Through broad stroke efforts, California is laying the foundation for that ecosystem by investing in strategic touchpoints where children, youth, and their families interact with service delivery systems, including health care, behavioral health, social services, justice systems, child welfare, and education systems.

Many of the investments and workstreams lay the groundwork for implementing comprehensive school behavioral health systems and can be leveraged to support SUBHS implementation in California's K-12 settings. Some of these opportunities are highlighted below (See Table 3).

TABLE 3: CALIFORNIA INITIATIVES SUPPORTING SUBHS IMPLEMENTATION

SUBHS IMPLEMENTATION	CALIFORNIA INITIATIVE EXAMPLE
Sustainable Funding	→ CYBHI Fee Schedule Program → BHSA Population-based Prevention
Workforce	→ Youth Mental Health Academy → CYBHI Certified Wellness Coaches → Healthcare Provider Training and e-Consult → CYBHI Safe Spaces: Trauma-informed Training for Education and Early Care Settings
School-Community Collaboration and Teaming	→ BHSSA Partnership Grants → California Community Schools Partnership Program
Comprehensive Planning	→ School-Linked Partnerships and Capacity Grants → BHSSA Universal Screening Planning Grant
Multi-Tiered System of Support	→ CYBHI Mindfulness, Resilience, and Wellbeing Supports → Project Cal-Well
Evidence Based and Emerging Best Practices	→ CYBHI Evidence-Based and Community-Defined Evidence Practices Grants → Youth Suicide Crisis Response Pilots → Youth Peer-to-Peer Support Program Pilots
Behavioral Health Screening	→ Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medi-Cal Benefit → BHSSA Universal Screening Planning Grant → Multi-Payer Fee Schedule (Screening and Assessment Reimbursement)
Data Systems	→ CYBHI Data Sharing and Privacy Workgroup and Guidelines → California's Data Exchange Framework → Semi-Statewide Electronic Health Record (CalMHSA)

COMPREHENSIVE SCHOOL BEHAVIORAL HEALTH SYSTEM FEATURE:

Sustainable funding

Building and sustaining comprehensive school behavioral health systems requires innovative strategies to leverage and apply various financial and nonfinancial resources in a school or district. Schools need to have reliable, efficient, and flexible base funds and billing mechanisms to support ongoing MTSS services and support. To maximize base funds, schools benefit from short-term incentive funds focused on infrastructure and capacity development. Further impact can be made by the braiding of funds across multiple agencies to achieve shared outcomes.[30]

California has already made foundational investments in youth behavioral health through its Children and Youth Behavioral Health Initiative (CYBHI). This multi-year, $4+ billion investment is spread across 20 workstreams[58] to achieve four overarching strategies: workforce training and capacity, service coverage, behavioral health care infrastructure, and public awareness. Several of these workstreams focus directly on school-linked services.[59]

Parallel initiatives and investments in education, health care, and other service systems complement California's evolving youth behavioral health ecosystem. This includes California's Community Schools Partnership[60] strategy to connect youth and families to essential services allocation of the BHSSA.

While progress has been made, many of these investments are short-term and will soon expire. As California faces the next chapter for youth behavioral health, there is a growing need for a long-term funding strategy to sustain programs, services, and partnerships serving youth.

CYBHI Fee Schedule Program

Under CYBHI, the California Department of Health Care Services established a new Fee Schedule Program[61] that is designed to ensure sustainable reimbursement for certain behavioral health services in school settings, including some screening and assessment services, to support and expand behavioral health supports in schools. It mandates Medi-Cal, commercial health plans, and disability insurers adhere to set rates for local education agencies and school-affiliated providers. This is significant because many schools and school partner organizations already provide many behavioral health services to students that are enrolled in Medi-Cal or a commercial health plan but receive no reimbursement. In addition, practitioners that haven't billed Medi-Cal in the past – such as school social workers and counselors – will be eligible to bill under the Fee Schedule Program regardless of network provider status.[61]

It is important to recognize that the Multi-Payer Fee Schedule is new. LEAs across California are currently assessing their individual capacity to provide services and handle the clinical and administrative requirements to submit and collect claims. There are a range of "Screenings and Assessments" within the Fee Schedule that are meant for one-on-one interactions between a practitioner and a student. Some of these include screening for depression, screening for Adverse Childhood Experiences (ACEs), screening for alcohol and/or substance abuse, and psychological testing and evaluation. It is unclear whether the fee schedule could be used to reimburse universal screening practices and programming.

Behavioral Health Services Act – Population-based Prevention

California's Behavioral Health Service Act, established by voters through Proposition 1, represents a renewed commitment to youth-based strategies through its funding earmarked for population-based behavioral health prevention. Lead by the California's Department of Public Health, this ongoing funding stream will support statewide prevention efforts with a focus on Californians under the age of 25. The BHSA identifies schools as a strategic setting for population-based prevention, but funding can only be used for programs serving entire schools or student populations (i.e., not individual services). As CDPH roles out its plan to implement population-based prevention under the BHSA, there is an opportunity to consider if and where universal screening plays a role.

COMPREHENSIVE SCHOOL BEHAVIORAL HEALTH SYSTEM FEATURE:

Workforce

A comprehensive school behavioral health system relies on a diverse team of trained professionals to ensure students receive the care and resources they need, from screening to services, in order to thrive academically and emotionally. This includes not only behavioral health providers, but also educators, administrators, and student peers who often encounter a student's behavioral health challenges first. Equipping front-line workers with training, knowledge, and skills can create a more supportive environment for students and for themselves, and ensure students receive the care and resources they need, from screening to services, to thrive academically and emotionally.[30]

When it comes to SUBHS, the availability of school-employed and community-based behavioral health providers impacts schools' ability to respond in a timely way to screening data.[62] As such, workforce concerns are one of the primary reasons schools are not implementing SUBHS in California according to the statewide school survey.

CYBHI Workforce Training and Capacity Investments

A key priority of CYBHI is to create a larger, more representative workforce supporting the behavioral health of California's young people. Through multiple workstreams led by California Departments of Health Care Access and Information and Health Care Services, these investments aim to fill professional gaps while also promoting an emerging workforce that is culturally and linguistically adept, enriched with lived experiences, and can better understand and serve the needs of California's children, youth, and families.[63]

Youth Mental Health Academy

CYBHI includes $25 million to support the Youth Mental Health Academy, a community-based career development program for high school students that takes place over the course of 14 months and includes mentorship, paid project-based learning, and paid internships in the behavioral health field. Through mentorship and paid training for high school students in marginalized communities, the Youth Mental Health Academy aims to close equity gaps, offering opportunities while augmenting the state's behavioral health workforce. This initiative not only paves the way for underrepresented youth into behavioral health careers but also envisions a future with high-quality behavioral health services delivered by a workforce that understands and represents the community it serves.

Wellness Coaches

A key component of CYBHI is the launch of the Certified Wellness Coach (CWC) workforce. Supported by a $278 million investment, the CWC profession was created to support young people by expanding the workforce and filling in opportunities at associate and bachelors levels with individuals who speak their language, understand their communities, and work in places that are convenient to young people such as schools. CWCs can provide services across MTSS continuums including wellness promotion, screening, and crisis referral.

Healthcare Provider Training and eConsult

The CYBHI includes a $60.1 million investment to support the Healthcare Provider Training and eConsult to provide health care and other non-traditional behavioral health practitioners (e.g., school-based services providers) access to consultation support from licensed behavioral health professionals. In addition to providing remote and real-time consultation support with behavioral health clinical experts, it will offer access to behavioral health resources and trainings to strengthen the workforce and improve the capacity providers supporting the behavioral health needs of children, youth, and young adults

CYBHI Safe Spaces: Trauma-Informed Training for Education and Early Care Settings

Funded through CYBHI, Safe Spaces is a free, online training designed to help individuals working with children and youth recognize and respond to signs of trauma and stress. Since 2023, the training helps school and childcare personnel understand and identify how stress and trauma impact their students, enabling them to foster safe, supportive relationships, better support students and create learning environments that foster wellbeing and academic success.[64]

COMPREHENSIVE SCHOOL BEHAVIORAL HEALTH SYSTEM FEATURE:

Family-school-community collaboration

Supporting student behavioral health requires codified relationships and strong coordination between schools, behavioral health professionals, community organizations, policymakers, funders, students, and families. Together, they can address the academic, emotional, and behavioral needs of students, leading to better outcomes and more efficient and sustainable support systems within schools.[65]

Community Schools Partnership Program

California Community Schools Partnership Program (CCSPP) is one of the ways California strengthening school-community relationships to ensure students and families get the resources and support they need to learn and thrive.[66] A community school model involves districts and schools working closely with teachers, students, families, and community partners to organize school and community resources, including behavioral health support, tutoring, nutrition programs, free school meals, health care, counseling and other social assistance. Through this integrated and wholistic approach, community schools can mitigate the academic and social impacts of emergencies that affect local communities, improve school responsiveness to student and family needs, and address barriers to health and learning. CCSPP includes $4.1 billion over 10 years to make one out of every three schools a community school.[67] Unfortunately like many other youth behavioral health investments, there is no guarantee for future CCSPP funding.

CalHOPE Student Support and School Initiative

CalHOPE Student Support is a youth-centered initiative that leverages California's existing support network, enabling leaders from all 58 County Offices of Education participate in statewide social-emotional learning (SEL) communities of practice, which aim to build leadership to strengthen SEL in schools across the state. Recognizing the impact of stress, trauma, anxiety and other challenges, CalHOPE Schools Initiative provides additional support materials. By partnering with County Offices of Education, the CalHOPE Student Support program serves communities in culturally competent ways and in partnership with youth.[68]

COMPREHENSIVE SCHOOL BEHAVIORAL HEALTH SYSTEM FEATURE:

Thoughtful planning

Before implementing SUBHS, schools must conduct a robust planning process led by a multidisciplinary assessment and asset mapping to inform screening goals and procedures.[29] 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 universal behavioral health screening.

Behavioral Health Student Services Act – Universal Screening Planning Grants

The Behavioral Health Student Services Act (BHSSA)[69] provides grants for partnerships between county behavioral health departments and LEAs to deliver school-based behavioral health services to young people and their families.

In August 2024, the Commission awarded $8 million of BHSSA funding to support a learning cohort of BHSSA grant partners from 10 counties, varying in size and region, to develop a plan to implement SUBHS in their school or district. Funding will support the development of a local planning team and planning activities, including the assessment of needs, assets, and challenges relative to implementing SUBHS. Using their plans, grantees will pilot a SUBHS program, and through a learning cohort, compile lessons learned into a “road map” to support SUBHS planning and implementation in California schools.[70]

COMPREHENSIVE SCHOOL BEHAVIORAL HEALTH SYSTEM FEATURE:

Multi-tiered system of support

The Multi-Tiered System of Supports (MTSS) framework ensures that every student, whether in general or special education, has access to the full range of services; from universal strategies for all students to targeted programs for those with mild challenges, and individualized support for students needing more intensive care.[30] Universal screening data are an important part of MTSS, helping schools identify school-wide trends while flagging students with higher risks, and informing continuous improvement processes to evaluate and augment implementation of behavioral health services over time.[31]

TIER 1

CYBHI Mindfulness, Resilience, and Wellbeing Supports

Under CYBHI, California invested $75 million for wellness, resilience, and wellbeing supports for children, youth, and parents.[71] A portion of this funding ($10 million) helped to scale parent and family support programs across the state. With remaining funds and in partnership with the Sacramento County Office of Education, the Department of Health Care Services (DHCS) disseminated grant funding to each of the 58 County Offices of Education to support the adoption and equitable access of evidence-based mindfulness, resilience, and wellbeing tools, resources, and programs for teachers, youth, parents, and families. The program also expanded social and emotional learning (SEL) at school sites and continue to build statewide infrastructure and regional capacity to support successful implementation.[71]

TIER 2

Project Cal-Well

Since 2014, the California Department of Education (CDE) has been implementing Project Cal-Well in partnership with local educational agencies throughout California with funding support from the Substance Abuse and Mental Health Services Administration under the Project AWARE grant. Project Cal-Well is designed to raise awareness of behavioral health, expand access to school and community-based behavioral health services for youth and families, and create sustainable student behavioral health infrastructure through leveraged resources.[72]

COMPREHENSIVE SCHOOL BEHAVIORAL HEALTH SYSTEM FEATURE:

Evidence-based and emerging best practices

Using proven, research-based strategies within an MTSS framework ensures that students receive the right support based on their individual strengths and needs. It is not enough for a screening tool or intervention to be scientifically tested; it must also be culturally relevant, practical to implement, and suited to the resources available in schools. MTSS allows schools to implement strategies designed for specific groups, making it a flexible and powerful tool to drive equity-centered youth behavioral health services.[30]

CYBHI Youth Peer-to-Peer Support Pilot Program

Peer support in California high schools is a key strategy for promoting behavioral health resilience and wellbeing among adolescents. The Youth Peer-to-Peer Support Pilot Program is an innovative collaboration between the Department of Health Care Services (DHCS) and The Children's Partnership, awarding $8 million in grants to initiate peer-to-peer support programs in up to eight high schools across diverse Californian communities. This pilot aims to establish best practices standards for a statewide school-based peer-to-peer behavioral health support systems.[73]

CYBHI Scaling Evidence-Based and Community-Defined Evidence Practices

California invested $381 million to scale evidence-based practices and community-defined evidence practices as part of an equity-focused youth behavioral health ecosystem. Toward that goal, DHCS is distributing grant funding to community-based organizations, schools or school districts, childcare centers, and health care entities to build capacity and capabilities for delivering culturally and linguistically-affirming behavioral health services to underserved Black, Indigenous, and People of Color (BIPOC) and LGBTQIA+ communities.[74]

COMPREHENSIVE SCHOOL BEHAVIORAL HEALTH SYSTEM FEATURE:

Behavioral health screening

Early identification and intervention lead to better outcomes for children. Behavioral health screening, including assessment of the social determinants of behavioral health and other contextual factors such as developmental and health-related challenges, is a foundational component of a comprehensive approach to behavioral health prevention, early identification, and intervention services.[30]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

By law, under the EPSDT benefit healthcare providers are required to provide routine developmental, social, and behavioral health screening and intervention to all Medi-Cal beneficiaries beginning at birth through age of 21.[75] Under federal Medicaid reimbursement policies, EPSDT services must be validated for young people and can be administered by any qualified provider (Medi-Cal or non-Medi-Cal) operating within the scope of his or her practice, and must be responded to with "corrective treatment," either directly or through referral for any condition detected by a screening. The location of screening is also flexible and can be administered in a range of health care and community settings, including in schools.[76]

In 2019 and again in 2022, the California State Auditor reported that millions of Medi-Cal-enrolled children are still not receiving preventive services. A consistent challenge is the absence of visible and reliable referral pathways to ensure children with positive screens receive the services they need and are entitled to. Even with such pathways exist, providers don't know how to use them. DHCS has is taking this concern seriously and is developing a standardized provider training on Medi-Cal for Kids & Teens.

COMPREHENSIVE SCHOOL BEHAVIORAL HEALTH SYSTEM FEATURE:

Data systems

Data about student and school needs obtained through SUBHS are considered alongside other student data to inform universal programming and early intervention as part of an MTSS. To be most effective, schools must be prepared to review and follow up on SUBHS data in a reasonable timeframe. A timely response is more likely when universal behavioral health screening data are readily accessible, and results are interpretable to those on the screening/response team.[29]

CYBHI Data Sharing and Privacy Guidance

California plans to provide information to help clarify federal and state laws related to disclosing/sharing sensitive health information in contexts such as behavioral health service delivery, individuals living with HIV/AIDS, and minors and foster youth.[77]

In 2023 the CYBHI created a Technical Advisory Committee and began a stakeholder engagement process to address data sharing and privacy challenges related to the new CYBHI Fee Schedule Program for school-based behavioral health services. Through this initiative, CYBHI will develop and disseminate guidance documents and actionable tools and resources for multiple audiences to clarify the application of the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and California privacy laws when delivering care to children and youth in a school setting.

California's Data Exchange Framework

The California Health & Human Services Data Exchange Framework (DxF)[78] is part of a statewide commitment to providing safe, effective, whole-person care to improve outcomes for all Californians. The DxF is not a new technology or centralized data repository, but instead establishes a set of rules for securely and appropriately exchanging health and social services information across existing standalone health and social services systems and providers. The DxF aims to fill gaps in understanding about social determinants of health and enable providers to address health inequities and disparities, especially in historically underserved and underrepresented communities.

The Data Exchange Framework includes a $47 million investment to provide participating health and social services entities with resources to address critical operational, technical, and technological barriers to DxF implementation. This includes designating Qualified Health Information Organizations to provide data exchange capabilities to under-resourced health and social service entities, especially those serving historically marginalized populations and underserved communities.

Semi-Statewide Electronic Health Record

California Mental Health Services Authority (CalMHSA) is leading an initiative to streamline and enhance county electronic health record (EHR) systems to promote holistic behavioral health and human services data aggregation and interoperability.[79]

As part of this initiative, CalMHSA is helping counties implement SmartCare™, an enterprise, cloud-based, single-platform, intelligent EHR technology designed to support data collection and coordination between multi-disciplinary service delivery systems, allowing providers to provide truly integrated care management and improve organizational efficiency.

The initial phase launched in July 2023 and involves 23 counties and over 37 percent of the state's Medi-Cal population. Additional counties are expected to join in 2024.

04
RECOMMENDATIONS FOR IMPLEMENTING SUBHS

Findings about the benefits and barriers to implementing school-based universal behavioral health screening (SUBHS) reinforce the importance of conducting SUBHS within comprehensive school behavioral health systems that have sufficient resources to provide a continuum of supports and services across multi-tiered systems of support (MTSS). They also emphasize the need to meet staff, students, and caregivers where they are by building awareness and trust so they can plan and implement SUBHS effectively.

California has already made foundational investments in workforce development, behavioral health care infrastructure, public awareness, and service coverage, many of which support comprehensive school-based behavioral health systems. As much of this funding is about to expire, California now needs a long-term strategy and comparable leadership structure to align and coordinate diverse funding and partners supporting its evolving behavioral health ecosystem.

1. Establish leadership and guidance for school-based behavioral health, including SUBHS.

California should establish a leadership structure to coordinate and align state and local partners and workstreams and oversee a long-term strategy for youth behavioral health. As part of that strategy, the State should establish standards, guidance, and build capacity for implementing comprehensive school behavioral health systems, including SUBHS practices, in California's public education system.

Standards and guidance to support SUBHS implementation should be informed by a community-participatory process to achieve the following:

- Establishing a statutory definition of SUBHS with quality standards and metrics consistent with evidence-based best practice guidelines for planning, implementing, and monitoring SUBHS within K-12 systems.
  - Standards and metrics should be tied to a broader accountability framework for statewide comprehensive school-based behavioral health systems.
- Providing guidance, tools, and technical assistance to help local education agencies (LEAs) implement SUBHS with fidelity to established standards including support and guidance for:
  - Planning activities such as conducting local needs assessments, community outreach, partnerships, tool selection, protocol development, data systems management, and quality control activities.
  - Navigating state and federal policies related to privacy, consent, confidentiality, and data sharing and management for student behavioral health screening and services.
  - Braiding existing funding streams and resources to support SUBHS implementation within MTSS, such as those under the Children and Youth Behavioral Health Initiative and Behavioral Health Services Act, among others.

2. Improve awareness, trust, and participation of students, parents, and educators.

California's youth behavioral health strategy should focus on improving the behavioral health culture and climate in schools and reducing the stigma related to screening, referral, and participation in behavioral health services. This should include:

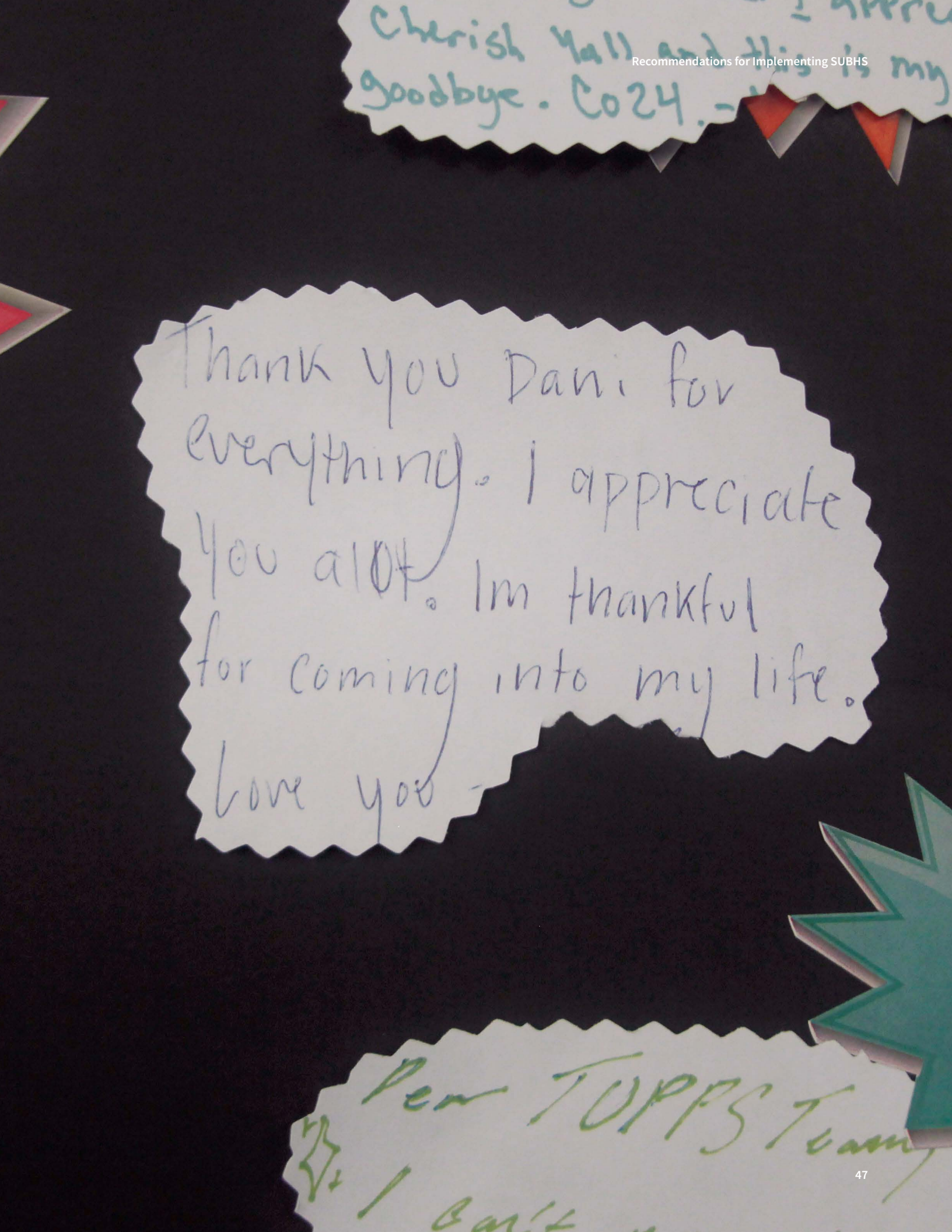
- Investing in the behavioral health of teachers and school staff through programs and practices aligned with California's standards for workplace behavioral health.
- Establishing resources, consultation, training, and curriculum requirements to improve behavioral health literacy among teachers and staff.
- Supporting districts and LEAs to strengthen family and community participation, buy-in, and trust in school-based behavioral health services.
- Leveraging and expanding youth-led awareness strategies.

3. Build capacity for implementing SUBHS

In support of the statewide youth behavioral health strategy, the State should engage with local education and behavioral health partners as well as students and their families to assess and address capacity needs for implementing comprehensive school behavioral health standards. This should include investments in infrastructure, incentives, and resources to support SUBHS practices in California schools. This may include:

- Incentive grants to support the planning and piloting of SUBHS in California schools.
- Leveraging research to practice and multi-county learning models to refine and scale best practices for implementing equity-centered SUBHS.
- Developing modernized, affordable, and universal data systems that support real-time, cross-system data sharing and coordination between local public entities serving children and their families.
- Providing sustainable funding for school-based Tier 1 and 2 resources, workforce, and services.
- Investing in research and development of innovative, holistic, and culturally affirming screening tools and practices.

One of many year-end, bulletin board thank-you notes written by high school students in the Hemet Unified School District, grateful for the people they've met and the help they received via universal screening at the district's Wellness and Community Outreach Center.


Cherish Yall and this is my
goodbye. Co24.
Thank you Dani for
everything. I appreciate
you a lot. Im thankful
for coming into my life.
Love you
Per TOPS Team

05
CONCLUSION

In summary, SUBHS is a critical step in advancing comprehensive school behavioral health systems. With thoughtful planning and preparation, SUBHS has the potential to identify behavioral health needs early, promote equitable access to support, and ensure that every young person has the opportunity to learn and thrive. However, to be successful, schools require ongoing resources, clear state-level guidance, and strong local partnerships to address challenges such as stigma, community trust, and capacity limitations. By embedding SUBHS within its broader youth behavioral health care ecosystem, California can pave the way to a brighter future for children and youth.

06 APPENDICES

Appendix I: SUBHS Resources

Guidance Documents and Toolkits for Implementing SUBHS

Multiple guidance documents have been developed to support school and district teams in planning for and implementing SUBHS.

- The School Mental Health Collaborative's (SMHC) *Best Practices in Universal, Social, Emotional, and Behavioral Screening: An Implementation Guide.*
- The National Center for School Mental Health's (NCSMH) *School Mental Health Quality Guide: Screening.*
- The California Department of Education Project Cal-Well's practical brief on *Universal Social, Emotional, and Behavioral Screening for Monitoring and Early Intervention.*
- Ohio PBIS *Network's School-Wide Universal Screening for Behavioral and Mental Health Issues: Implementation Guidance.*
- 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 Center for Health and Health Care in Schools's Issue Brief *Screening and Assessing Immigrant and Refugee Youth in School-Based Mental Health Programs.*

Screening Tools

Resources providing available SUBHS tools for specific school and/or district populations (non-exhaustive).

- 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 behavioral 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.

Fictional Examples of SUBHS Application

This appendix contains fictional examples of how schools at different grade levels conduct SUBHS for illustrative purposes.

MIDDLE SCHOOL: SCREENER AND SELECTION

Over the last few years, Mountainside Unified School District has been working closely with its County Office of Education to build school-community behavioral health partnerships to implement a trauma-informed continuum of behavioral health supports, improve Positive Behavioral Interventions and Supports implementation, and increase behavioral health awareness within its diverse school community. A few middle schools in the district are also starting to build wellness centers as part of a grant funded initiative. The district team leading these school behavioral health efforts regularly reviews data and last year identified the need for a universal behavioral health screening system to monitor the impact of their school-wide interventions and support the early identification of student behavioral health needs.

The leadership team formed a workgroup co-led by an assistant superintendent, family liaison, and school psychologist, and agreed that a planning year would be very important to get input from the school community. The district had a negative past experience with a SUBHS that was required as part of a grant program, but it was poorly implemented and focused only on student "deficits" as identified by teachers, raising concerns about teacher bias and over pathologizing certain subgroups. The workgroup started by carefully reviewing validated universal behavioral health screening processes and screeners, and how these aligned with the goals of their behavioral health and wellness programming. The workgroup also conducted listening sessions with parents, teachers, and students. The listening sessions revealed that parents generally supported school behavioral health and SUBHS, but wanted to better understand what universal Bhealth screening would mean for their children. They wanted to be assured that the SUBHS would provide information about their children's strengths – not just searching for behavioral health problems. They also expressed concerns about family privacy being protected and that participating in SUBHS would be a choice.

Educators generally felt SUBHS would support their classroom programing, but indicated that fitting in more professional development would be challenging with all of the other current initiatives. All groups expressed an interest in learning more about the SUBHS.

The workgroup wrote an article describing the SUBHS practices in the monthly school newsletter, posted information on the school website, and invited interested parents, educators, and students to join their workgroup. The workgroup also met with students from behavioral health clubs at the middle and high schools. After a year of planning, SUBHS screener selection, and co-designing a SUBHS process, the workgroup decided to pilot a SUBHS in the spring at three middle schools and train the leadership teams there on a process that could be scaled to all middle and high schools the following school year.

ELEMENTARY SCHOOL: COST TEAM

Mr. Xu is a school social worker at Morning Light Elementary School. This Title 1 school serves approximately 300 students in grades K-6 who identify as white (25%), Hispanic/Latino (45%), Black (15%), Asian American (8%), or another racial/ethnic group (7%). The Coordination of Student Services Team (COST) manages universal screening administration and follow-up as one component of their comprehensive approach to school behavioral health.

Mr. Xu is a member of the COST and is responsible for coordinating the SUBHS process. Mr. Xu participates in ongoing district-led professional development and quarterly meetings to monitor and improve SUBHS processes across the district. At Morning Light Elementary School, the COST meets three times per year with teachers in each grade level. During these meetings, teachers are provided time to complete a screener for each of the students in their class using a secure spreadsheet, which takes less than 20 minutes. Results are then reviewed by Mr. Xu, who indicates which students are scoring in the "at-risk" range and solicits additional information about student needs from teachers and school records.

The COST provides recommendations for follow-up with identified students based on reviewing multiple data sources and pre-established decision rules about

available interventions to meet a range of needs. The majority of students identified at-risk are referred to Tier 2 and classroom-based interventions that are matched to their specific needs (e.g., Check-in Check-out, Hawken et al., 2020; classroom-based social-emotional learning (SEL) activities; or to counselor-led groups). The COST contacts parents and meets individually with some students. The COST is pleased with their progress in implementing school-wide support with SUBHS and other data indicating that over 80 percent of students are responding to their school-wide efforts.

HIGH SCHOOL: STRENGTHS-BASED

Sunset High School is in a district that has been building out its MTSS to focus on students' complete behavioral health and wellbeing through a continuum of interventions that supports social-emotional strengths, as well as intervention to prevent and/or address psychological problems or diagnoses. The district has been partnering with researchers investigating strength-based approaches to SUBHS. Twice per year, students are administered two brief screeners, one focused on behavioral and emotional risk and another focused on social-emotional strengths, which they complete during their second period within a two-week screening window.

After the screening window, the team's data manager works with their partners at the local university to score the screeners and use research-based norms to create priority groups for follow-up. Students are then sorted into these priority groups based on their total risk and total strengths scores. The highest priority groups for follow-up include students whose scores indicate a high-level of emotional and behavioral risk and low levels of social-emotional strengths as well as students who report average levels of risk but low strengths. The team shares these findings with the school counselors, who follow up individually with priority individuals who are also on their advising caseload.

[Adapted from Moore et al. (2015), also available on the Covitality website.]

HIGH SCHOOL: INTERNALIZING BEHAVIOR

Emilio is a ninth grade student enrolled at Sunnyside High School. He does well in school academically, participates in class and has two close friends that he spends most of his time with in and out of school. His school district serves almost 5,000 students in grades 7-12 across two high schools and three middle schools. The school district has been building its multi-tiered system of support, including a continuum of academic and social-emotional/behavioral supports and resources, since just before the COVID-19 pandemic. Over the last year, school and district leadership developed a plan to implement SUBHS to inform decision-making within their MTSS. This year, they're piloting their SUBHS process in Emilio's high school.

During new student enrollment, Emilio's mother receives an opt-out consent form for SUBHS as part of the enrollment packet. In mid-October, Emilio's English teacher begins class with an overview of a screener that students are asked to complete. The teacher explains that this screener will help the school to remove barriers to learning and to follow up with students who may benefit from additional support. Emilio opens the screener on his Chromebook and responds to 20 questions, taking him about two minutes.

All ninth grade students at Emilio's school were invited to complete the screener that day. Following the screener administration, the school wellness team met to review a software-generated report that indicates students with normal, elevated, and extremely elevated risk of having behavioral or emotional needs. Emilio was one of the ninth graders who scored in the extremely elevated risk range. His counselor meets with him to talk about how he's doing. Emilio shares that he's been feeling very worried about everything he's managing at school and home, and is having a hard time focusing in class. Emilio is invited to participate in a 6-week small group skill-building session to bolster his coping skills and the counselor follows up with his mother for her consent.

The screening results indicated that many other ninth graders at Emilio's school were feeling stressed and anxious. The school wellness team collaborates with district and community partners to organize a series of workshops for all ninth graders to support their transition to the new school year. The wellness team also starts developing some lessons to infuse into the eighth grade spring SEL curriculum and information to help parents support their child's transition to high school.

Appendix II: Landscape Analysis Activities and Methods

Through the California 2023-24 Budget Act, the Legislature directed the Behavioral health services oversight and accountability commission, in consultation with the Department of Health Care Services (DHCS), submit a report on universal behavioral health screening for youth, with attention on data, best practices, and costs for implementing screening in K-12 school settings.

In preparation for the report called on by the Legislature, the Commission contracted with researchers from the University of California, San Francisco (UCSF), the University of California, Riverside (UCR), and WestED to conduct a Landscape Analysis of existing school-based universal behavioral health screening (SUBHS) practices, perceptions, and barriers in California's K-12 education systems.

The Commission and UC research team utilized the following strategies as part of the Landscape Analysis.

Literature Review

The UCR team led a review of the literature on SUBHS policies and practices in schools, including evidence to support SUBHS for health processes; 2) best practices in equitable SUBHS; 3) commonly used SUBHS models, including those in California, other states, and/or countries, including information on who is doing the screening, what behavioral health needs they are screening for, and what happens with the results; 4) information published on guiding principles and standards for SUBHS in school settings, including legal considerations related to parental notification and the data security and privacy framework needed to ensure confidentiality of screening results; and 5) existing information on costs related to implementing SUBHS for children and youth. (The Literature Review Report and methodology is available in this report as Appendix V.)

Survey of California Schools and Follow-up Interviews

The UCSF team conducted a voluntary survey of public school/district representatives in California to (a) understand their current SUBHS practices, including which models and tools, if any, are being used and with whom, how results are used, implementation successes and challenges, and estimated associated costs; and (b) assess perceived barriers and opportunities for implementation among those who are and are not screening. The survey invitation was sent to the list of public school administrators available from the California Department of Education (CDE) website. The invitation was also sent by the CDE and the Commission to listservs and email lists of school administrators and behavioral health professionals throughout the State. Survey respondents received $10 gift cards for their time. Data were analyzed using simple summary statistics by those who were and were not screening, as well as those not sure if they were conducting UMHS. The final sample comprised 180 representatives from local education agencies (LEAs) conducting UMHS, 171 representatives from LEAs that were not conducting SUBHS and 55 representatives who were not sure if their LEAs were conducting SUBHS.

The UCSF team identified survey respondents who were and were not implementing SUBHS and contacted them via email to see if they were willing to participate in follow-up semi-structured interviews that asked more specifically about their screening practices and needed supports. UCSF contacted 48 individuals to invite them to participate in interviews. Three individuals declined/cancelled and 35 did not respond. The final sample consisted of four representatives from LEAs that were conducting UMHS and six from LEAs that were not conducting UMHS. Interview participants received a $30 gift card for their time. Interviews were recorded with permission and transcribed. Data were analyzed for common themes and pertinent quotes. The UCSF researchers received approval from the UCSF

Institutional Review Board to conduct the survey and interviews (approval #23-40219). (Survey overview and data are provided in Appendix II)

Qualitative Analysis of Youth and Parent/Caregiver Listening Session Transcripts

The Commission held public online listening sessions with youth and parents/caregivers to understand their thoughts on schools conducting UMHS. The Commission facilitated three listening sessions with a total of 21 youth who were recruited from partner organizations that had youth advisory groups and afterschool youth-led clubs focused on behavioral health. Two parent/caregiver listening sessions were conducted with a total of 14 parents/caregivers who were recruited with the help of United Parents, a non-profit/community-based organization that advocates for, empowers, and supports parents/caregivers with children facing emotional, behavioral l health, and family challenges. Each listening session participant received a $30 gift card for their time. Listening sessions were recorded and transcribed. The research team summarized general themes and highlighted pertinent quotes from these discussions.

School Site Visits

The Commission facilitated four school site visits attended by stakeholders and Legislative staff to learn about existing SUBHS practices in disparate California communities. (Site visit summaries are provided in Appendix III)

Final Report

Project activities informed the development of two reports presented to the Legislature.

PHASE 1 REPORT

Literature review summary. – Delivered March 1, 2024

Report available at https://bhsoac.ca.gov/wp-content/uploads/MHSOAC_UMHS-Phase-1-Report-Lit-Review_Final.pdf

PHASE 2 REPORT

Landscape analysis findings and policy recommendations – Approved by the Commission February 2025

Appendix III: School Site Visit Summaries

San Diego County, Feaster Charter School: Universal Screening for High-Risk Populations

On December 13, 2023, Commissioners, Commission staff, and researchers from the University of California, San Francisco, visited Feaster Charter School, a school in Chula Vista, CA to hear from school staff, students, and community members about the school's universal screening program.

Feaster Charter School is located in a small community just nine miles from the Mexico/U.S. border, and it serves some of California's most at-risk and underserved students. At least 83 percent of its TK through eighth grade student population is socioeconomically disadvantaged, and many face the challenges that come with immigration, either themselves or others in their family. More than half (55 percent) of students are English learners, and many have to cross the U.S. Mexico border daily to come to school. According to administrators, the Feaster campus is within the vicinity of a major gang, and many students have experienced or been victims of violence starting from a very young age. In a community where hardship and trauma are considered the norm rather than the exception, there is a great need for behavioral health support.

During the visit, teachers and administrators described the ways students' unaddressed behavioral health needs were showing up at school including chronic absenteeism, behavioral and learning challenges, and students harming themselves. According to staff, crisis response services were needed on a regular basis.

With such great need for behavioral health support, Feaster Charter School has been working to meet that need through their universal screening program. The school partnered with Healthy Campus, a company helping schools across California implement on-site health and behavioral health services, to implement a universal health screener to all sixth through eighth grade students to assess risk of anxiety, depression, and self-harm.

Screening Procedures

The screening tool used by Feaster is composed of questions from two validated screening instruments, the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder 7-item (GAD-7), and included one question assessing self-harm risk, seven questions assessing for anxiety, and eight questions assessing for depression on a Likert scale. Screening takes place in a classroom with teacher supervision and is completed by students using a secure electronic device.

Prior to screening, school staff, with the help of Healthy Campus, conduct outreach to parents and caregivers to gain buy-in and trust. Written communications are also sent out to all parents in both Spanish and English in advance to allow opportunity to opt their children out of the screener (this is considered "passive consent"). Active consent is required for students younger than 12.

Post screening, data are stored and processed in a secure data system provided by Healthy Campus, which provides real-time results to designated school staff.

When students screen high for anxiety and/or depression, Healthy Campus reaches out to families and students are offered on-site behavioral health services on an ongoing basis. Parents and caregivers are able to see their student's screening score upon request.

If a child is screened as imminent risk, meaning that they responded anything other than "not at all" for self-harm risk, counselors and administrators receive an "Imminent Risk" email. The child is brought into the counseling center and further screened using the Columbia Suicidality Severity Rating Scale (CSSRS). Caregivers of all CSSRS screened students are contacted, debriefed on the results, and given resources. In severe cases, a parent or crisis service provider is called.

Outcomes and Impact

According to Feaster staff, the needs revealed by the screener were much higher than expected. Nearly half (304 students; 48.5 percent) of students were identified as having a potential risk for anxiety and/or depression, and 99 students (15.8 percent) were at risk of self-harm. Despite the high volume of needs, Feaster was able to ensure ALL students were supported with the help of Healthy Campus.

While the program is still relatively new, staff, parents, and students are already noticing the benefits, and want to see it continued. Screening scores have improved over time, indicating fewer students are at risk, especially when it comes to self-harm. Teachers report fewer problem behaviors in the classroom and the need for crisis services has decreased substantially. Instead, students report that they feel supported by the services offered by the school and Healthy Campus, and that instead of feeling embarrassed or ashamed of needing extra help for their behavioral health, they see it as something that is "normal" since many of their peers are also getting help. Parents also reported improvements in their children's overall wellbeing and academic achievements and were grateful that such services were provided at school.

Lessons Learned

LOW COST

By leveraging Medi-Cal and grant funds secured through the help of Healthy Campus, Feaster was able to administer the universal screener and services to students at no extra cost to the school or families. A key was leveraging already existing systems and resources. However, according to Feaster staff, securing ongoing funding and space for screening and services are still barriers to sustainability.

PARTNERSHIPS AND PLANNING ARE ESSENTIAL

Most of what made Feaster's program successful was the work that happened before the screener. With the help of Healthy Campus, the school was able to conduct a comprehensive planning process to establish screening goals, tools, and procedures that were effective and ethical. Through needs assessment and resource mapping, Healthy Campus helped secure funding, staffing, and data technology for screening while providing visible referral and linkage pathways to ensure every student got the care they needed in a timely manner. They also helped Feaster streamline the parental consent process and put procedures in place to ensure adherence with data privacy and confidentially laws. According to the Feaster team, stigma remains one of the biggest challenges to screening and school-based services. To overcome this barrier, Healthy Campus and Feaster prioritized relationship building during the planning phase, to gain trust and buy-in from school staff and families.

One staff member offered advice for other schools: "This program so far has been the "unicorn" program that we all wished we had a long time ago and every school should have something like it! If schools are not there yet – start small, challenge stigmas, educate all interest-holders, and build your networks."

Sonoma County Office of Education: Post-disaster Screening and Triage to Care

On February 6, 2024, Commissioners and Legislative staff visited Sonoma Valley High School to learn about Sonoma County's school-based behavioral health screening pilot program.

Trauma can have profound and lifelong effects on a person's physical and behavioral health. In addition to affecting individuals, trauma can be shared by communities. Community trauma can result from natural disasters, acts of violence such as mass shootings, or systemic adversities that impact populations such as structural racism, discrimination, and socioeconomic disparities. Symptoms of community trauma include severed social networks, a low sense of political efficacy, deteriorating living environments, neighborhood violence, and intergenerational poverty.

Research has shown that each incident of large-scale adversity increases behavioral health risks of those exposed. Cumulatively, large-scale adversity weakens a community, strips its resilience, and threatens the collective pursuit of healing and wellness.

Children's developing immune and nervous systems make them especially vulnerable to trauma. If not properly addressed, trauma can lead to social, behavioral, and cognitive challenges that can disrupt a child's learning and development, setting the stage for negative academic, relational, and health outcomes later in life.

> "California's students are increasingly affected by natural disasters, including the most recent, the COVID-19 pandemic. For students already impacted by traumatic events, the pandemic creates a compounding trauma that affects our students, families and educators."
>
> **Mandy Corbin**
> **Sonoma County Office of Education Associate Superintendent of Special Education and Behavioral Health Services**

Sonoma County School-based Universal Post-Disaster Screening Program

Sonoma County offers a unique example of how universal screening can be used to support students' emotional and behavioral needs in the aftermath of a major crisis or disaster. With its recent history of large-scale disasters – most notably wildfires – Sonoma County was poised to make an innovative investment in their students' wellbeing. The county used the Stepped Triage to Care model, involving post-disaster screenings to identify the risks of post-traumatic stress and other behavioral health needs so schools can help students get the care they need.

This project began after the Sonoma County Office of Education (SCOE) received the Substance Abuse and Mental Health Services Administration grant in 2019 and the School Emergency Response to Violence grant in 2021. The county partnered with trauma specialist and Harbor UCLA Clinical Pediatrics Director, Merritt Schreiber, Ph.D., to implement his program Stepped Triage to Care screening and brief trauma intervention program.

Screening Procedures

SCREENING TOOL

Stepped Triage to Care begins by using PsySTART, a brief universal screening tool consisting of 10 to 20 questions to assess disaster-related risk in impacted areas. The tool assess the severity, proximity, and relative impact of an event such as loss of one's home, death of a loved one, or personal injury. It also assesses preexisting risk factors such as past trauma exposure or family social or economic challenges.

The tool is administered via a secure online electronic platform and can be conducted by school staff through an interview with a student or family, or it can be delivered directly to families to complete.

Students with scores indicating "high risk" are connected with a trained provider assesses for trauma-related symptoms using a previously validated child post-traumatic stress disorder symptom scale. Students meeting a threshold of concern are provided with short term Trauma Focused Cognitive Behavioral Therapy (TF-CBT) by trained counselors. Students with more severe symptoms are provided ongoing TF-CBT services.

Outcomes and Impact

Through the Stepped Tirage to Care efforts, the district was able to provide counseling support to more than 500 students in 16 districts in Sonoma County.

POST-DISASTER RESOURCE TRIAGE

In addition to identifying and supporting individual student needs, school- and district- level screening results can be used for real-time population-level risk mapping. This kind of information allows schools, health systems, and other disaster response systems allocate resources strategically to people most impacted by the fires, while prioritizing those who are underserved.

"The PsySTART tool allows us to model the population level impact of adverse events and make ethical decisions about the allocation of limited resources. It's a way we can promote equity when responding to disasters," explained Dr. Schreiber, who developed the screening tool.

This model has been adapted and scaled to respond to other types of community adversities in the U.S. and in developing countries. In 2021 the Washington State Department of Health piloted their own version of the program to support youth ages 8-17 across the state who were at risk of developing behavioral health challenges due to the impacts of COVID-19.

Lessons Learned

Well-resourced school staff can, in turn, provide resources to others.

A strength of Sonoma County's approach was ensuring that teachers and staff were well resourced and felt supported. "Early on post-Tubbs Fire, I was told if you do not give the staff resources and a pathway to access them, you will be surprised because staff will freeze, perhaps as if the event never occurred," said county associate superintendent Mandy Corbin, who helped spearhead the project. According to Corbin, resourcing staff included having systems in place to access the supports, providing push-in support in the classroom when needed, providing psychological first aid training, and providing time during the school day for staff to support their students.

"Resourced staff who know there is a sound system in place to care for students are more likely to care for themselves and be able to care for, connect to, and educate our state's children. When adults have a sense of agency during a crisis, they are better able to provide students support, implement curriculum, and engage students in learning during the most challenging of times."

West Sacramento Elkhorn Village Elementary: Multitudes Universal Neurodevelopmental Screening

On March 22, 2024, the Commission hosted a site visit at Elkhorn Village Elementary School in West Sacramento, CA, to learn about Multitudes, a platform developed by the University of California, San Francisco (UCSF) Dyslexia Center to screen students for learning challenges.

Research shows that low reading proficiency by third grade results in higher high school drop-out rates, higher risk of system involvement, loss in earnings and productivity. It also shows that early and accurate identification of learning difficulties and strengths combined with support can improve academic outcomes and brain health by decreasing anxiety, increasing resilience, and improving self-efficacy.

Under the California Senate Bill 114, beginning in the 2025-2025 academic school year and thereafter, all local educational agencies are required to assess kindergarten through third grade students annually for risk of reading difficulties, including dyslexia.

In 2020 the State allocated funding to the UCSF, Dyslexia Center, to create a digital platform for universal literacy screening and interventions students and pilot its application in California public schools. After years of research led by a coalition of scientists and educators across the U.S., the UCSF Dyslexia Center is delivering Multitudes, a state-of-the-art digital literacy screening platform in more than 70 schools, reaching more than 12,675 of California's school-aged children. Elkhorn Village Elementary is one of the schools piloting Multitudes in preparation of statewide mandates for universal literacy screening.

Screening Procedures

Multitudes is a platform based on the latest neuroscience to identify students who may be at risk for reading difficulties. The screening assessments are not considered diagnostic, but are used to identify students who may require additional testing and/or who may benefit from some additional support to prevent the development of significant learning delays.

The screening tool consists of brief, reliable, and valid assessments of pre-reading skills such as visual-spatial abilities, short term memory, phonemic awareness, vocabulary, and spoken language skills. Beginning in kindergarten, the screener is administered to all students individually who perform tasks guided by trained "proctors" using secure electronic devices. The screener is provided in both English and Spanish.

Student scores are generated automatically via a dashboard to administrators to view class screening progress and individual results. The program also includes training modules for users to improve their ability to support children's growth.

Lessons Learned

While the Multitudes screener is different than behavioral health screening, much of the evidence around best practices for implementation holds true. For example, the UCSF team emphasized the importance of building partnerships and earning the trust of school staff, parents, and communities in order for the screener to be effective. One UCSF team member said the team "let[s] our partner districts and schools lead in how they prefer to communicate and work." They also reflected on the importance of developing screening tools and practices that are culturally and linguistically responsive. For example, by hiring staff who look like and come from the same communities as participant families they were able to increase participation and precision of the screener.

The Opportunity for Behavioral Health Screening

According to the lead investigator of Multitudes, the big opportunity is to apply modern technology to research early signs of strength and weakness in emotions (i.e. emotion appraisal, regulation, and control) that are known precursors of behavioral health struggles. Building on the Multitudes screener infrastructure, the UCSF team's next step is to pilot research on similar "objective," task-based early screeners for emotional and behavioral health. The vision is that evaluating early strengths and weaknesses in cognition and emotion through a "whole brain" early screener could lead to better interventions and precision-education approaches.

Hemet Unified School District: Whole Child Universal Screener

On May 30, 2024, the Commission visited Hemet, CA to learn about the school-based universal Adolescent Whole Person Health Screener (WPHS).

Hemet is a small, urban town in Riverside County's striking San Jacinto Valley and is known for its diverse cultural heritage and a strong farming industry. Yet, like many small towns, the Hemet community faces economic challenges, and many families struggle to meet their basic needs.

A person's wellbeing is affected by the family environment, individual relationships, and the many systems a person is influenced by in their day-to-day life; when parents are struggling, it's natural that their children struggle too. For children and youth, such need gaps impact their physical and behavioral health, and in school, can lead to behavioral challenges or poor academic performance – often it's both.

Recognizing the impact such challenges were having on students' health, behavior, and learning, the Hemet Unified School District decided to go beyond providing academic services and begin supporting the wellbeing of a whole child and their family.

Screening Procedures

In 2020, Hemet USD partnered with Riverside University Health System (RUHS) and began administering the Adolescent Whole Person Health Screener (WPHS). Supported by Behavioral Health Student Services Act funds, this screening tool is designed to create a holistic representation of needs across six health domains: physical health, emotional health, resources and resilience, socioeconomics, ownership, and nutrition and lifestyle. Administered twice a year beginning in ninth grade, this brief, 30-question survey gives each student a score for each domain.

For any student showing risk in one or more domains, Hemet USD provides services directly to them and their families through the district's Transforming Our Partnerships to Support Students (TOPSS) program. The support offered through TOPSS is comprehensive, encompassing a range of on-site supports, resources, and linkages to intensive services, depending on the individual students' needs. In addition to providing individual or group behavioral health services, support often includes clothing, food and household items for the whole family, childcare, on-site legal and financial counseling, and medical and dental care through a mobile clinic parked outside.

Outcomes and Impact

Screening and early intervention is changing the trajectory of student's lives.

In the three years that Hemet USD administered the Adolescent WPHS and the TOPSS program, the percentage of students categorized as "high risk" has decreased as much as 50 percent in some domains, with the largest improvements occurring in students' emotional health. Although such improvements may be due to other factors, it's clear that Hemet USD is unique in its ability to improve students' functioning during a time when most districts are seeing sharp increases in students' behavioral health and academic challenges.

"A person who feels like they have control and ownership of their life are more likely to seek out new opportunities and create positive upward spirals in their outlook and trajectory," said Dr. Brandon Tran, Supervising Research Specialist at RUHS. "We've done some great work in helping a person find themselves, often coming from a place where they don't think that's possible."

A wall of testimonials from students decorated the room where the Commission heard personal stories from students and parents – many told with tears in their eyes – which reinforced the success of the program. One parent who is deaf noted that the screener allowed her son to get help, which included assistance in improving the communication between her and her hearing son.

One student who was flagged by the Adolescent WPHS and received services through TOPSS said "If I wasn't being supported, I would still be doing badly. I'm grateful I got to have a support system like that."

"I'm really grateful we have this program, and I wish it would start for everybody before it's too late," said one of the parent panelists. "In high school, they're already going in with big trauma."

Lessons Learned

Success requires meaningful collaboration and trust between many partners.

Creating and implementing the universal screener and TOPSS programs required consistent effort and dedication from Hemet USD and its partners in public health, behavioral health, social services, as well as teachers, students, and families.

TRUST AND BUY-IN

An initial challenge for the TOPSS team was gaining trust and buy-in from parents. Stigma and misunderstandings about behavioral health is a persistent challenge according to administrators of the program, and many students and families aren't yet comfortable with schools playing a role in the behavioral health of their children. For this reason, gaining parent trust and consent has become a core component of the screening and TOPSS program, and outreach and transparency has been a key. Once families start seeing the benefits of screening, they become champions of the program themselves, according to the TOPSS team, and many parents now work as certified peers helping other families in the TOPSS program. Certified youth peers have also played an important role in gaining the trust of students.

DATA SHARING

While Hemet USD and its partners continue to refine the program, collecting, analyzing, and sharing data remains a challenge. Memorandums of understanding can be complicated and incomplete, according to administrators, and the lack of universal and integrated data systems makes it difficult to do the real-time, customized analysis and reporting that would serve the program well.

Appendix IV: Survey, Listening Session, and Interview Findings

SUBHS Statewide School Survey Findings

Overview

To understand the current landscape of universal behavioral health screening (SUBHS) in California schools, the University of California, San Francisco (UCSF) research team conducted a voluntary survey of local education agencies (LEAs) in California from March to June 2024. The survey was developed by the UCSF, UCR, and WestEd research team with feedback from experts in SUBHS, as well as Behavioral health services oversight and accountability commission staff and their legislative partners. The survey was sent by email to all public school administrators in a publicly available list from the California Department of Education (CDE) and distributed by Commission staff and partner CDE representatives to listservs of LEA administrators and behavioral health professionals. Each survey respondent received a $10 gift card for their time. The survey methods were approved by the UCSF Institutional Review Board.

The following is a summary of the survey findings.* While the sample sizes are small and not representative of schools or districts statewide, they provide insights into the current landscape of SUBHS screening in California.

Study Sample

LEA representatives from schools, school districts, and county offices of education throughout California completed the survey, which asked about experiences with SUBHS implementation, including barriers and facilitators, for those who were and were not conducting SUBHS. Because the survey was open to representatives from county, districts, and schools throughout California, there may be some overlap in responses, for example when a district representative completed a survey and school representatives from within that district also completed the survey. We present data from all respondents to depict the landscape of SUBHS.

At the start of the survey, respondents were given the following definition of SUBHS:

> "'Universal behavioral health screening' refers to the systematic and proactive assessment of social, emotional, and/or behavioral strength and risk indicators among all students within a given educational setting (e.g., school, district), with the goal of informing universal programming and additional assessment or intervention for those with identified needs. Universal behavioral health screening is conducted so that student data are identifiable (e.g., by student name or other identifiers)."

Based on this definition, respondents were asked whether, to their knowledge, their LEA had conducted SUBHS in recent years. Out of 443 total respondents, 43% (n=192) reported that their LEAs had conducted SUBHS, 43% (n=191) said their LEAs were not conducting SUBHS, and 14% (n=60) were not sure.

Counties Represented

Among respondents who were at LEAs that had conducted SUBHS, most respondents were from Santa Clara (8%), Los Angeles (8%), and Ventura (8%). For those at LEAs that had not or were not sure if they had conducted SUBHS, most were from Los Angeles (12% and 17% respectively; Table 1).†

* Missing data are excluded from all percentage calculations.

† Surveys were received from ≥1 LEA in all but 3 counties; their county names are suppressed to protect confidentiality.

TABLE 1: 2024 SUBHS SURVEY RESPONDENTS, PERCENTAGE OF TOTAL RESPONDENTS BY COUNTY

COUNTY	CONDUCTING SUBHS (N=192)	NOT CONDUCTING SUBHS (N=191)	NOT SURE IF CONDUCTING SUBHS (N=60)	ALL RESPONDENTS (N=443)
Los Angeles	8%	12%	17%	11%
Santa Clara	8%	6%	5%	7%
Stanislaus	4%	7%	8%	6%
Ventura	8%	2%	2%	5%
Marin	4%	5%	5%	5%
San Diego	4%	6%	0%	5%
Riverside	4%	3%	7%	4%
Orange	4%	5%	3%	4%
San Joaquin	4%	4%	3%	4%
Humboldt	3%	4%	8%	4%
San Bernardino	5%	2%	3%	3%
Imperial	4%	3%	3%	3%
Kings	5%	0%	0%	2%
Siskiyou	3%	1%	2%	2%
Sacramento	2%	2%	5%	2%
Contra Costa	2%	2%	5%	2%
Kern	2%	3%	3%	2%
Alameda	2%	2%	2%	2%
Lake	1%	2%	5%	2%
Monterey	1%	3%	2%	2%
Solano	2%	1%	3%	1%
Fresno	1%	3%	0%	2%
Mendocino	3%	1%	0%	2%
Tuolumne	2%	2%	0%	2%
San Francisco	1%	2%	0%	2%
Other counties (representing <1% each of total sample)	13%	17%	9%	14%

Survey respondents were mainly from LEAs that served elementary school students (Table 2).

TABLE 2: 2024 SUBHS SURVEY RESPONDENTS, BY GRADES SERVED

(Respondents could choose multiple options so percentages do not add up to 100%)

WHAT GRADE SPAN DOES YOUR SCHOOL SERVE?	CONDUCTING SUBHS (N=188)	NOT CONDUCTING SUBHS (N=188)	NOT SURE IF CONDUCTING SUBHS (N=60)	ALL RESPONDENTS (N=436)
Alternative or continuation	18% (33)	21% (40)	17% (10)	19% (83)
Elementary	51% (95)	54% (102)	55% (33)	53% (230)
Middle/intermediate/junior high	47% (89)	41% (77)	33% (20)	43% (186)
High school	38% (71)	38% (72)	33% (20)	37% (163)
Other	6% (12)	10% (19)	7% (4)	8% (35)

Over half of the respondents in all groups worked in school districts and one-third worked in traditional public schools (Table 3).

TABLE 3: 2024 SUBHS SURVEY RESPONDENTS, BY TYPE OF EDUCATIONAL AGENCY

(Respondents could choose multiple options)

IN WHICH TYPE OF EDUCATIONAL AGENCY DO YOU WORK?	CONDUCTING SUBHS (N=187)	NOT CONDUCTING SUBHS (N=187)	NOT SURE IF CONDUCTING SUBHS (N=60)	ALL RESPONDENTS (N=434)
County Office of Education	12% (23)	14% (27)	12% (7)	13% (57)
School district	57% (107)	53% (99)	53% (32)	55% (238)
Traditional public school	32% (60)	29% (54)	32% (19)	31% (133)
Single-site charter school	6% (12)	9% (17)	5% (3)	7% (32)
Multi-site charter school	5% (9)	6% (12)	5% (3)	6% (24)
Other	1% (1)	5% (9)	10% (6)	4% (16)

As shown below, respondents in all groups were mostly from urban counties (Table 4).‡

TABLE 4: 2024 SUBHS SURVEY RESPONDENTS, BY LEA COUNTY URBANICITY

URBANICITY	CONDUCTING SUBHS (N=192)	NOT CONDUCTING SUBHS (N=191)	NOT SURE IF CONDUCTING SUBHS (N=60)	ALL RESPONDENTS (N=443)
Urban	53% (101)	52% (100)	53% (32)	53% (233)
Rural	25% (48)	27% (52)	30% (18)	27% (118)
Suburban	22% (43)	20% (39)	17% (10)	21% (92)

‡ Counties were classified as urban, rural or suburban based on the California State Association of Counties classifications. Accessed on June 30, 2024 from: https://www.counties.org/sites/main/files/file-attachments/2020-june3-countycaucusesinfographic-4-final.pdf.

Almost half of respondents reported their primary role as administrators, and about one-fifth were school counselors (Table 5).

TABLE 5: 2024 SUBHS SURVEY RESPONDENTS, BY PRIMARY ROLE

WHAT IS YOUR PRIMARY ROLE?	CONDUCTING SUBHS (N=191)	NOT CONDUCTING SUBHS (N=190)	NOT SURE IF CONDUCTING SUBHS (N=60)	ALL RESPONDENTS (N=441)
Administrator	48% (91)	50% (95)	25% (15)	46% (201)
Teacher in grade 4 or below	5% (10)	1% (2)	0% (0)	3% (12)
Teacher in grade 5 or above	1% (1)	1% (1)	5% (3)	1% (5)
Special education teacher	1% (1)	1% (1)	2% (1)	1% (3)
Prevention staff, nurse, or health aide	0% (0)	1% (2)	3% (2)	1% (4)
School counselor	18% (34)	21% (40)	18% (11)	19% (85)
School psychologist	4% (8)	4% (8)	7% (4)	5% (20)
School social worker	6% (11)	6% (11)	10% (6)	6% (28)
Paraprofessional, teacher assistant, or instructional aide	0% (0)	1% (1)	0% (0)	0% (1)
Other (e.g., School-based behavioral health specialist, behavioral health clinician)	18% (35)	15% (29)	30% (18)	19% (82)

LEA Behavioral Health Resources Across All Respondents

Over one-half of the LEAs that were and were not conducting SUBHS were using the California Healthy Kids Survey to identify students' behavioral health needs (Table 6). About one-quarter of representatives from all groups said they were using district/school-developed surveys. *Note: This question asked all respondents about surveys used. These surveys were not necessarily the tools used for SUBHS, which was asked in a different question only of respondents whose LEAs were conducting SUBHS.*

TABLE 6: 2024 SUBHS SURVEY, SURVEYS CURRENTLY USED TO IDENTIFY STUDENTS' BEHAVIORAL HEALTH NEEDS

(Respondents could choose multiple options)

ARE YOU USING ANY OF THE FOLLOWING SURVEYS TO IDENTIFY STUDENTS BEHAVIORAL HEALTH NEEDS?	CONDUCTING SUBHS (N=158)	NOT CONDUCTING SUBHS (N=173)	NOT SURE IF CONDUCTING SUBHS (N=46)	ALL RESPONDENTS (N=377)
California Healthy Kids Survey	59% (93)	55% (96)	37% (17)	55% (206)
CoVitality	6% (9)	2% (3)	0% (0)	3% (12)
Kelvin	15% (24)	8% (13)	7% (3)	11% (40)
Panorama	26% (41)	16% (28)	4% (2)	19% (71)
District/school-developed survey	27% (42)	24% (41)	20% (9)	24% (92)
Other	15% (24)	16% (27)	11% (5)	15% (56)
Do not know	8% (13)	8% (14)	35% (16)	11% (43)
No surveys used	5% (8)	17% (29)	15% (7)	12% (44)

Among all respondents, most (92%) agreed that implementing SUBHS in California schools would benefit the community (Table 7). However, less than half (41%) agreed that their LEAs currently had sufficient resources to support students' behavioral health needs. This differed across LEAs that were and were not conducting SUBHS, as seen in the table below.

TABLE 7: 2024 SUBHS SURVEY, PERCEPTIONS OF SUBHS AND AVAILABLE RESOURCES TO SUPPORT STUDENTS' NEEDS

PARTICIPANTS WHO RESPONDED AGREE" OR "STRONGLY AGREE" TO THE FOLLOWING STATEMENTS:	CONDUCTING SUBHS (N=158)	NOT CONDUCTING SUBHS (N=171-174)	NOT SURE IF CONDUCTING SUBHS (N=44-45)	ALL RESPONDENTS (N=377)
Implementing universal screening in all California schools would benefit students, staff, and school communities.	94% (149)	90% (156)	96% (43)	92% (348)
Our school has sufficient resources to support students' behavioral health needs.	56% (89)	29% (50)	32% (14)	41% (153)

When asked whether their LEAs had organizations they could refer students to for behavioral health services in the community, most respondents said they did but availability was limited, with a higher percentage of respondents from LEAs that did not conduct SUBHS reporting this than those from LEAs that were (Table 8).

TABLE 8: 2024 SUBHS SURVEY, AVAILABILITY OF COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES

DOES YOUR DISTRICT OR SCHOOL HAVE ORGANIZATIONS YOU CAN REFER STUDENTS TO FOR BEHAVIORAL HEALTH SERVICES IN THE COMMUNITY (OFF-CAMPUS)?	CONDUCTING SUBHS (N=158)	NOT CONDUCTING SUBHS (N=173)	NOT SURE IF CONDUCTING SUBHS (N=45)	ALL RESPONDENTS (N=376)
Yes, and they have availability to meet students' needs	25% (40)	13% (23)	22% (10)	19% (73)
Yes, but availability is limited	65% (103)	83% (143)	62% (28)	73% (274)
No	3% (5)	3% (6)	9% (4)	4% (15)
Not sure	6% (10)	1% (1)	7% (3)	4% (14)

LEAs Conducting SUBHS

Among the survey respondents from LEAs that had conducted SUBHS, most reported they had conducted SUBHS in the current 2023-24 school year (79%), with 11% reporting that they conducted SUBHS in the 2022-23 school year, 4% in 2021-22 or earlier, and 6% were not sure when they conducted SUBHS. Most respondents reported using Local Control Funding Formula (52%) and/or grant/foundation (27%) funds to support their SUBHS programs, while 17% reported they used "other" funds and 19% reported they did not use any funds (data not shown in tables).

Why LEAs Implement SUBHS

When asked why they decided to conduct SUBHS, most responses related to conducting screenings as part of their MTSS, using data to identify students in need, and a desire to provide early intervention, as well as conducting screenings as part of a district-led initiative. For example:

> "To ensure the [behavioral] health needs of students were being addressed post pandemic."

> "To inform our practices and provide data so we can implement supports and activities within our MTSS."

> "To use data to identify students who need more assistance."

> "To better direct and support [behavioral] health resources."

> "[Because] we know kids are falling through the cracks and we want to find ways to ensure we are supporting all students."

> "High number of students dealing with [behavioral] health and we need to figure out resources."

> "One important factor is that students with internalizing symptoms are sometimes missed within the school environment as managing students with externalizing behaviors is more prevalent due to challenges these behaviors present in the learning environment. It also increases staff awareness of student needs."

How LEAs Implement SUBHS

Among those who reported conducting SUBHS, most reported that students complete the screening tool (70%); 39% reported that teachers complete the tool, 11% parents/caregivers, and 16% behavioral health professionals (data not shown in tables). Three-quarters of respondents reported that their schools screened for behavioral/emotional challenges (78%) and/or strengths (75%), as seen in the table below (Table 9).

TABLE 9: 2024 SUBHS SURVEY, SCREENING TOOL FOCUS AREAS

(Respondents could choose multiple options)

WHICH OF THE FOLLOWING DID YOU SCREEN FOR?	LEAS CONDUCTING SUBHS (N=172)
Behavioral or emotional challenges (e.g., acting out, stress, anxiety, depression)	78% (135)
Emotional or behavioral strengths or wellbeing (e.g., SEL, resiliency, school connectedness, belonging)	75% (129)
Social skills (e.g., communication, cooperation, responsibility)	56% (96)
Other (e.g., academics, suicide risk, school engagement/climate)	7% (12)

Half of the survey respondents that were conducting SUBHS were at LEAs that screened all students, while the second largest group were those at LEAs that screened specific grade levels (Table 10).

TABLE 10: 2024 SUBHS SURVEY, WHICH STUDENTS ARE SCREENED

WHICH STUDENTS WERE SCREENED? INDICATE THE LARGEST RELEVANT GROUP.	LEAS CONDUCTING SUBHS (N=174)
All students in the school(s)	50% (87)
All students in a specific grade level(s)	29% (50)
All students in a class	2% (3)
Students nominated or referred by staff	9% (15)
Other	7% (12)
Not sure	4% (7)
Do not know	8% (13)
No surveys used	5% (8)

The survey asked whether identifiable student data was collected during school screenings, and, while 83% of respondents said that it was, 8% said that they were not collecting identifiable student data and 9% were not sure (data not shown in tables). Furthermore, as seen in the table below, LEAs used a variety of tools to conduct SUBHS, but notably 30% were using tools that, while still informative and valuable, are potentially not identifiable and 18% were using district/school developed tools (Table 11).

TABLE 11: 2024 SUBHS SURVEY, SCREENING TOOLS USED

(Respondents could choose multiple options)

WHICH TOOL(S) WERE USED IN YOUR UNIVERSAL BEHAVIORAL HEALTH SCREENING PROCESS? PLEASE NOTE, WE ARE NOT ENDORSING ANY OF THESE TOOLS.	LEAS CONDUCTING SUBHS (N=168)
District/school-developed screener	18% (31)
Social, Academic, Emotional Behavior Risk Screener (SAEBRS)	11% (18)
Student Risk Screening Scale (SRSS)	11% (18)
BASC-3 Behavioral and Emotional Screening System (BASC-3 BESS)	7% (11)
SSIS Social-Emotional Learning Edition (SSIS SEL)	7% (11)
Strengths and Difficulties Questionnaire (SDQ)	5% (8)
Devereux Student Strengths Assessment (DESSA)	6 (4%)
Behavior Intervention Monitoring Assessment System (BIMAS-2)	2% (3)
Other (write-in responses included: Panorama, Covitality, Kelvin, Heads Up Check Up, California Healthy Kids Survey)	30% (51)
Not sure	24% (41)

Respondents shared what happens once students are identified to have behavioral health needs through the SUBHS process, including referring students to a behavioral health professional in the school (53%) and/or to a problem-solving team (38%; Table 12).

TABLE 12: 2024 SUBHS SURVEY, NEXT STEPS AFTER STUDENTS ARE IDENTIFIED AS HAVING BEHAVIORAL HEALTH NEEDS

(Respondents could choose multiple options)

WHAT HAPPENS WHEN A STUDENT IS IDENTIFIED TO HAVE BEHAVIORAL HEALTH NEEDS THROUGH THE UNIVERSAL BEHAVIORAL HEALTH SCREENING PROCESS?	LEAS CONDUCTING SUBHS (N=167)
Students are referred to a behavioral health professional within the school (e.g., school psychologist)	53% (89)
Students are referred to problem-solving team (e.g., COST, Care, Student Success Team)	38% (64)
Our school team has a written protocol to link students to services depending on level of need	37% (61)
Students' parent/guardians are alerted and advised to seek further assessment	29% (49)
Students are referred to a behavioral health professional/clinic outside the school	27% (45)
Students are referred to a school-based group program	23% (38)
Other	7% (11)
Not sure	8% (14)

Challenges with SUBHS Implementation

Respondents were asked to select the challenges they faced when implementing SUBHS from a list of potential challenges. Lack of external resources to refer students requiring follow-up (44%) and lack of school resources to refer students requiring follow-up (38%) were the most frequently reported challenges (Table 13). One respondent elaborated on the challenges:

> "Universal [behavioral] health screening tools are useful and can be helpful. Many years ago, we were utilizing them and they were helpful to identify students early and offer support early. Some of the charter schools use them as well and this can help the school identify needs. The problem though is that with funding cuts to[behavioral] health supports in schools, we are limited with the support that can be offered to students. Having screeners could potentially create an influx of need that the school [behavioral] health staff is unable to support with the limited resources and also the limited community partners to refer for additional support. We lack the infrastructure to mandate screening in schools."

TABLE 13: 2024 SUBHS SURVEY, CHALLENGES FACED WITH SUBHS

(Respondents could choose multiple options)

WHAT CHALLENGES DO YOU FACE WITH YOUR UNIVERSAL BEHAVIORAL HEALTH SCREENING EFFORTS?	LEAS CONDUCTING SUBHS (N=165)
Lack of external (community) resources to refer students requiring follow-up	44% (72)
Lack of internal (school) resources to refer students requiring follow-up	38% (62)
Survey/assessment fatigue	31% (51)
Time taken away from classroom instruction	25% (42)
Concerns related to equity/cultural responsiveness	22% (37)
Accessing data after screening is conducted	16% (26)
Ethical/legal concerns, e.g., legal responsibility to serve students identified with needs	15% (25)
Lack of staff to conduct screening	15% (24)
Lack of knowledge about how to implement (e.g., which tools to use, resources needed, etc.)	12% (19)
Cost to conduct screening	8% (13)
Other	15% (25)
No challenges	10% (17)

Ethical Challenges

Survey respondents shared the following thoughts on their concerns related to the ethical challenges of screening:

> "We end up with more need identified than capacity to meet the need, which feels unethical. We are working to increase our resources through grant funding so that more resources are available for identified students."

> "The length of time to have students considered and referred is taking too long and when the student does not qualify for a specific program there needs to be another service available to meet the student's needs."

> "Ensuring all students who have identified as high/moderate risk are met with and supported in a timely manner. The concerns also are the legality piece; offering it multiple times in a school year, running out of support/resources for these students, staff buy in (refusing to administer)."

> "We reach out to parents and inform them that their child requires [behavioral] health counseling, parents do not follow through with obtaining counseling for their child, so we feel ethically obligated to take on that student as a client even though our caseloads are at max capacity."

Screening Concerns

When asked whether concerns from different groups limited their screening efforts, more than half (55%) of respondents said that none of those groups (students, school staff, leadership, or parents/caregivers) expressed concerns that limited screening efforts, though some respondents reported that they did:

- 24% indicated that concerns from school staff limited screening efforts, such as insufficient time to dedicate to screening and not supporting the screener used.
- 20% indicated that concerns from students limit efforts, such as survey fatigue and lack of interest.
- 13% noted parent/caregivers' concerns, such as questions being invasive and equity/cultural concerns.
- 8% noted concerns from school and/or district leadership, such as having sufficient community resources and staff to conduct screening.

Facilitators of SUBHS Implementation

Respondents also selected the factors that support SUBHS implementation in their schools. The most common factor selected was having adequate school staff to handle referral needs (Table 14).

TABLE 14: 2024 SUBHS SURVEY, FACTORS THAT FACILITATE SUBHS

(Respondents could choose multiple options)

WHAT FACTORS HELP YOUR UNIVERSAL BEHAVIORAL HEALTH SCREENING EFFORTS SUCCEED?	LEAS CONDUCTING SUBHS (N=161)
Adequate school staff to handle referral needs	58% (93)
Ongoing communication about screening and related behavioral health initiatives	53% (86)
Dedicated time during the school day to conduct screenings	48% (77)
Adequate community referral sources	46% (74)
Clear roles and responsibilities across staff involved in screening efforts	42% (67)
Clear identified student needs	40% (64)
Alignment with school mission and district priorities	38% (61)
Adequate funding	35% (57)
Availability of trainings on how to conduct the screenings	25% (41)
Other	4% (6)
None of the above	4% (6)

Centering Equity in SUBHS

Given the importance of centering equity in SUBHS efforts, respondents were asked to indicate which strategies they used to center equity in their SUBHS processes. Most respondents indicated that they were implementing several strategies (60%, n=94), as evidenced by their selection of two or more options from the list of strategies. One-quarter selected one of the listed strategies (26%) and 15% reported they were not implementing any of the listed strategies. As seen in the table below, half were focusing on culturally responsive school-wide supports (51%) and over one-third reported analyzing disaggregated data (39%), using tools in the primary languages of students and families (34%), and involving diverse voices in decisions made about the screening process (34%; Table 15).

TABLE 15: 2024 SUBHS SURVEY, STRATEGIES USED TO CENTER EQUITY IN SUBHS

(Respondents could choose multiple options)

WHAT STRATEGIES ARE YOU USING TO CENTER EQUITY IN YOUR SUBHS PROCESS?	LEAS CONDUCTING SUBHS (N=158)
Focus on culturally responsive school-wide supports	51% (80)
Analyze disaggregated data to identify and address disparities	39% (62)
Screening tools are provided in the primary language of students/families	34% (54)
Decisions made about the screening process include diverse staff, student, and family voices	34% (54)
Staff involved in screening processes are representative of the broader school community	28% (44)
Other	3% (5)
None of the above	15% (23)

Success of SUBHS

When asked, overall, if they felt their SUBHS efforts were successful in identifying students who needed additional behavioral health supports and why, most respondents felt that it was successful. Yet, some shared mixed feedback, reinforcing the need to ensure that SUBHS efforts are well-planned, well-resourced, and use an equity-focused approach. For example:

> "Yes, we were able to identify trends amongst the student body to better direct resource, and intervene for individual student needs."

> "Certainly. It has helped us identify student [behavioral] health needs, allow us to monitor student progress and measure as well as evaluate small group interventions. We have strong parent and administrator support at this point."

> "Yes, a [behavioral] health questionnaire helps to identify students struggling with [behavioral] health problems. Once identify they are able to be referred to appropriate services."

> "Yes. The universal screening has helped us identify areas needing improvement for individual students, small groups of students, whole classes and whole schools. It helps us be more proactive in addressing student needs."

> "Yes, there were some students identified who are very good at 'masking' at school. We were able to identify some challenges they were facing and provide them with support."

> "Our universal [behavioral] health screening efforts have been hugely successful in identifying students who need additional [behavioral] health supports, because it offers us equitable data for all students -- not just the ones acting out. We've been able to implement early intervention strategies with students who may have otherwise "flown under the radar."

> "While it is successful, the lack of outside resources creates difficulty, and the great need outweighs the amount of time one counselor has to serve all students. Often my requests for a student to receive counseling are not followed through due to the lack of time and personnel to service students."

> "Not really, kids were unclear about questions, and the kids who had 'problems' were often resolved before we got the data."

> "No, because we did not have the proper system in place to use the information after the screenings."

LEAs That Were Not or Were Not Sure If They Were Conducting SUBHS

Among respondents who reported that their LEAs did not conduct SUBHS or were not sure if they were conducting SUBHS, few planned to conduct SUBHS in the near future (Table 16).

TABLE 16: 2024 SUBHS SURVEY, FUTURE PLANS TO CONDUCT SUBHS

HAS YOUR SITE EVER SERIOUSLY CONSIDERED CONDUCTING UNIVERSAL BEHAVIORAL HEALTH SCREENING?	LEAS NOT CONDUCTING SUBHS (N=181)	NOT SURE IF LEA WAS CONDUCTING SUBHS (N=50)
Yes, we are planning to	19% (35)	8% (4)
Yes, but we are not planning to conduct anytime in the near future	29% (52)	14% (7)
No	17% (30)	6% (3)
Not sure	35% (64)	72% (36)

How LEAs Identify Youth with Potential Behavioral Health Needs

When asked what they are currently doing to identify students who need behavioral health supports, most respondents indicated that "school staff refer students to community partners," "school [behavioral] health staff screen individual students who are referred to them," or "identified students' needs are discussed at school committee meetings" (Table 17).

TABLE 17: 2024 SUBHS SURVEY, METHODS TO IDENTIFY STUDENTS WITH BEHAVIORAL HEALTH NEEDS

(Respondents could choose multiple options)

WHAT ARE YOU CURRENTLY DOING TO IDENTIFY STUDENTS WHO NEED BEHAVIORAL HEALTH SUPPORT?	LEAS NOT CONDUCTING SUBHS (N=175)	NOT SURE IF LEA WAS CONDUCTING SUBHS (N=46)
School behavioral health staff screen individual students who are referred to them	79% (139)	67% (31)
School staff refer students to community partners	70% (123)	57% (26)
Identified students' needs are discussed at school committee meetings (e.g., COST, SST, etc.)	79% (139)	57% (26)
Other	19% (34)	13% (6)
Not sure	2% (3)	9% (4)
We are not currently identifying students	1% (2)	4% (2)

Overall, only 18% of survey respondents from LEAs that were not conducting SUBHS said that current approaches to identifying students with behavioral health needs adequately meet the needs of their school community, while 73% felt they "somewhat" met their needs. The percentage that felt they had adequate approaches was slightly higher in LEAs that were not sure if they conducted SUBHS (Table 18).

TABLE 18: 2024 SUBHS SURVEY, ADEQUACY OF APPROACHES TO IDENTIFY STUDENTS WITH BEHAVIORAL HEALTH NEEDS

DO YOUR CURRENT APPROACHES TO IDENTIFYING STUDENTS WITH BEHAVIORAL HEALTH NEEDS ADEQUATELY MEET THE NEEDS OF YOUR SCHOOL COMMUNITY?	LEAS NOT CONDUCTING SUBHS (N=176)	NOT SURE IF LEA WAS CONDUCTING SUBHS (N=46)
Yes	18% (32)	24% (11)
Somewhat	73% (129)	59% (27)
No	9% (15)	17% (8)

Challenges to SUBHS Implementation

Similar to LEAs that were conducting SUBHS, most survey respondents from LEAs that were not or were not sure if they were conducting SUBHS noted a lack of resources to refer students to as a factor that limits SUBHS. However, over half also noted not having staff to conduct screenings, ethical/legal concerns, lack of knowledge about how to do it, and costs as other concerns (Table 19).

TABLE 19: 2024 SUBHS SURVEY, FACTORS LIMITING SUBHS

(Respondents could choose multiple options)

WHAT FACTORS MAY LIMIT SCREENING EFFORTS?	LEAS NOT CONDUCTING SUBHS (N=178)	NOT SURE IF LEA WAS CONDUCTING SUBHS (N=48)
Concerns related to equity/cultural responsiveness	46% (82)	46% (22)
Cost to conduct screenings	54% (97)	48% (23)
Ethical/legal concerns, e.g., legal responsibility to serve students who are identified	61% (108)	50% (24)
Lack of staff to conduct screening	60% (106)	40% (19)
Lack of internal (school) resources to refer students requiring follow-up	66% (117)	48% (23)
Lack of external (community) resources to refer students requiring follow-up	57% (101)	35% (17)
Lack of knowledge about how to do it (e.g., which tools to use, what resources are needed, etc.)	58% (104)	50% (24)
Survey/assessment fatigue	31% (56)	33% (16)
Other	6% (10)	2% (1)
Not sure	3% (6)	13% (6)
None of the above	0 (0%)	0 (0%)

Screening Concerns

Respondents were asked about whether concerns from various groups would limit screening efforts. More than half of respondents selected from the provided list that concerns were related to parents/community members, such as questions about sensitive topics like gender identity, privacy, lack of information/knowledge, and fear of stigma associated with a child being flagged; or school staff, such as lack of resources and availability, capacity to conduct screenings, and extra workload. Less than half noted concerns were related to school and/or district leadership, such as the capacity to respond and follow-through, legal and financial liability, lack of resources; and parent/caregiver concerns about survey questions, or students, such as confidentiality, survey fatigue, and worrying about what families/friends may think (Table 20).

TABLE 20: 2024 SUBHS SURVEY, INTEREST HOLDER CONCERNS LIMITING SUBHS

(Respondents could choose multiple options)

WOULD CONCERNS FROM ANY OF THE FOLLOWING GROUPS LIMIT SCREENING EFFORTS AND, IF SO, WHAT SPECIFIC CONCERNS?	LEAS NOT CONDUCTING SUBHS (N=142)	NOT SURE IF LEA WAS CONDUCTING SUBHS (N=40)
Students	40% (57)	35% (14)
Parents/community members	58% (82)	57% (23)
School staff	59% (84)	40% (16)
School and/or district leadership	46% (66)	40% (16)
Other	6% (9)	3% (1)
None of the above	17% (24)	33% (13)

Support for SUBHS

Survey respondents noted high levels of potential support from these groups for conducting SUBHS in their school communities, with lower levels of perceived support from parents/guardians and school board members than school behavioral health staff, administrators, and students (Table 21).

TABLE 21: 2024 SUBHS SURVEY, INTEREST HOLDERS' SUPPORT OF SUBHS

HOW MUCH DO YOU AGREE OR DISAGREE THAT THE FOLLOWING GROUPS WOULD SUPPORT CONDUCTING UNIVERSAL BEHAVIORAL HEALTH SCREENING IN YOUR SCHOOL COMMUNITY? (PERCENT RESPONDING "AGREE" OR "STRONGLY AGREE")	LEA NOT CONDUCTING SUBHS (N=171-173)	NOT SURE IF LEA WAS CONDUCTING SUBHS (N=43-44)
School behavioral health staff (e.g., school psychologists or social workers)	93% (159)	95% (42)
School administrators	85% (147)	91% (39)
Students	84% (144)	91% (39)
Teachers and other school staff	83% (143)	84% (37)
Parents/guardians	76% (131)	74% (32)
School board	71% (122)	74% (32)

What LEAs Need to Implement SUBHS

When asked what their LEAs need to conduct SUBHS, the most common responses that respondents who were from LEAs that were not conducting SUBHS selected were "additional staff to handle referral needs" and "information about measures/tools to use" (Table 22).

TABLE 22: 2024 SUBHS SURVEY, NEEDED SUPPORTS TO IMPLEMENT SUBHS

(Respondents could choose multiple options)

WHAT WOULD YOU NEED TO CONDUCT UNIVERSAL BEHAVIORAL HEALTH SCREENING?	LEAS NOT CONDUCTING SUBHS (N=183)	NOT SURE IF LEA WAS CONDUCTING SUBHS (N=50)
Additional school staff to handle referral needs	64% (118)	52% (26)
Information on measures/tools to use	63% (116)	46% (23)
Dedicated time during school day to conduct screenings	57% (105)	50% (25)
Clear roles and responsibilities across staff	55% (101)	56% (28)
Additional funds	51% (93)	48% (24)
Identification of community referral sources to refer students with identified needs	41% (75)	36% (18)
Information on costs	38% (70)	24% (12)
Other	10% (18)	4% (2)
Not sure	3% (6)	24 (12)
None of the above	1% (2)	0% (0)

When asked which resources participants think would be helpful in implementing SUBHS, more than half selected "technical assistance on how to develop and use a SUBHS process" and "direction from district leadership" (Table 23). More respondents from LEAs that were not conducting SUBHS selected "state-level policy providing standards" or "state-level policy requiring it" would be helpful than those who were not sure if their LEAs were conducting SUBHS.

TABLE 23: 2024 SUBHS SURVEY, HELPFUL RESOURCES TO IMPLEMENT SUBHS

(Respondents could choose multiple options)

WOULD ANY OF THE FOLLOWING RESOURCES BE HELPFUL IN IMPLEMENTING UNIVERSAL BEHAVIORAL HEALTH SCREENING?	LEAS NOT CONDUCTING SUBHS (N=182)	NOT SURE IF LEA WAS CONDUCTING SUBHS (N=50)
Technical assistance on how to develop and use a universal screening process	65% (119)	64% (32)
Direction from district leadership	55% (101)	54% (27)
State-level policy requiring it	43% (78)	26% (13)
State-level policy providing standards	43% (78)	26% (13)
Other	8% (15)	0 (0%)
Not sure	7% (12)	22% (11)
None of the above	2% (3)	2% (1)

Youth and Parent/Caregiver Listening Sessions

Summary of Perspectives on School-based Universal Behavioral Health Screening

Overview

The Commission prioritizes community engagement to inform the design and implementation of all initiatives. In order to better understand the perspectives of youth and parents/caregivers on school-based universal behavioral health screening (SUBHS), the Commission conducted listening sessions with groups of youth and parents/caregivers. These listening sessions were held with each group independently (i.e., youth listening sessions and parent/caregiver listening sessions were conducted separately). Three sessions were conducted with youth throughout California and two with parents/caregivers in May 2024. Youth were recruited from partner organizations that had youth advisory groups and afterschool youth-led clubs that were focused on behavioral health. Parents/caregivers were recruited with the help of United Parents, a non-profit/community-based organization that advocates for, empowers, and supports parents with children facing emotional, behavioral health, and family challenges. Twenty-one youth and 14 parents/caregivers participated in the listening sessions. Listening sessions were recorded, transcribed, and analyzed for common themes and pertinent quotes.

In each session, participants were asked to respond dialogically to a semi-structured set of questions. These questions covered several topics related to SUBHS. Participants were first asked to reflect on the current state of youth behavioral health, including contributing factors to behavioral health challenges, consequences of an insufficient support system, and the role of schools in identifying and connecting youth to behavioral health supports. Next, participants provided input on how the schools in their communities identify students with behavioral health concerns. In this stage of the listening sessions, participants provided their own definitions or examples of SUBHS, which were considered alongside the Commission's definition. Each group was then asked what they felt the benefits of screenings might be and how their respective group (youth/students or parents/caregivers) would respond to schools conducting SUBHS. For the remainder of the listening sessions, questions diverged between the two groups. Youth were asked about which school staff should be involved in SUBHS, their experiences with school staff after they were screened, and how SUBHS might improve outcomes for marginalized groups. Parents/caregivers were asked what potential challenges schools interested in conducting SUBHS may face.

These listening sessions resulted in numerous important insights into how youth and parents/caregivers conceptualize SUBHS amid the current school and cultural climates surrounding behavioral health. Below, we summarize the results of these listening sessions. Specifically, we present participants' articulations of both (1) barriers/concerns and (2) facilitators/helpful practices in the landscape of behavioral health and SUBHS in California schools. Additionally, we address the similarities and distinctions between the perspectives of youth and parents/caregivers that manifested during the listening sessions.

Sources of Youth Behavioral Health Struggle in Schools

Respondents felt that youth behavioral health challenges are the result of multiple factors. These factors are multidimensional and often the direct result of school climate, which makes it difficult for schools to address them effectively. Students discussed how home and family life, community wellbeing, and peer groups all exert significant influence on their behavioral health. Additionally, external and/or educational pressures, such as the difficulties balancing academic, co-curricular, and personal responsibilities, contribute significantly to youth burnout, anxiety, and depression.

As respondents shared, life circumstances and school circumstances all have the potential to place youth at risk for behavioral health challenges. Across youth and parent/caregiver listening sessions, participants

agreed that the stigmas surrounding behavioral health and support seeking behavior fundamentally hinder help-seeking behavior and the delivery of appropriate interventions that could improve students' wellbeing. As two youth participants discussed:

> "I think despite [behavioral] health being something more commonly talked about nowadays, it's still really scary to open up. So lots of people still won't feel comfortable or feel like they're able to open up and go ask an adult for help because it's seen as something like attention craving or like, "oh, my problems aren't as big as others." So I feel like that is really diminishing."

> "I think it's really going to be dependent on the person and if they're willing to open up or not, because lots of people don't like the idea of people knowing their personal business; [it's] a sign of weakness."

Despite increased political and educational efforts to destigmatize behavioral health, it is clear from these youths' testimony that asking for help is still a significant barrier for young people who may want support, including support from school staff such as counselors, psychologists, and educators. Some participants identified that schools are taking direct approaches to removing this barrier by creating a positive culture and climate around behavioral health support, but these schools' efforts are mediated by a lack of available resources, staffing, and/or prioritization to transform culture and climate into actionable support/intervention plans, including SUBHS. We now turn to participants' identification of challenges in the SUBHS process.

Challenges to Effective Implementation of SUBHS to Address Behavioral Health

In the face of endemic behavioral health struggle, parents/caregivers and youth alike felt that SUBHS must overcome significant hurdles to be as effective as possible. Parents/caregivers often felt as though student needs were not being met by schools, or were only met once those needs were significantly impacting their children's education and quality of life. Parents/caregivers felt as though they needed to take the lead to advocate for proactive identification of their children's needs and for school behavioral health supports. Additionally, although the parent/caregiver participants had favorable views of SUBHS, they noted that resistance to SUBHS exists among many parent communities. Parent/caregiver participants identified community concerns about their children being stigmatized:

> "I've been on state discussions and I know that the kids are ready and will embrace this. The parents will not. It is a measurement, a judgment, and something that they feel that would label their child. I know specific subcultures in our community where just even bringing it up is insulting. And so it is going to take several years of just refining and describing as you did to us today, what a [behavioral] health screening tool will do. And it has to assure confidentiality and all these other things."

This response demonstrates the challenge parents and schools face in establishing trust and buy-in among their students' families. While youth participants tended to agree with parents/caregivers that SUBHS will be embraced by students, they identified some issues on their side. For example, some youth associate universal screening as a diagnostic or punitive measure and feel that schools are frequently vague about the purpose of screening and how screening data are used. Also, the youth noted that teacher messaging can impact how seriously students take these surveys, and teachers may not feel that SUBHS is important or believe it takes up valuable class time. Youth also expressed concerns over anonymity and confidentiality and disclosed that these concerns may lead to them not answering screeners truthfully or seriously. As one respondent discusses:

> "I feel like people tend to lie because they get scared that their parents are going to find out because some parents don't really believe in behavioral health, so their parents don't really want them to get the help they need because they find it useless. And I feel like also they tend to lie because they just feel scared I guess. And they just don't want to be called out in a way; they don't want to be truthful with themselves because they don't want to feel like there's something wrong with them."

SUBHS can only be an effective way to identify at risk youth and connect them with appropriate resources insofar as the responses to screeners are valid. If youth cannot trust their campus to maintain their privacy, or if they do not feel comfortable with the support offered by school counselors or psychologists, screening data may not accurately reflect the landscape of student needs. In the next section, we discuss listening session participants' ideas for the ways in which schools can improve behavioral health services to better capitalize on SUBHS's potential and help students.

Facilitators and Helpful Practices

Despite the challenges discussed above, SUBHS was broadly supported by both youth and parents/caregivers in the listening sessions. Many participants felt that even if screening is not implemented with the same integrity across contexts, having a system in place to identify both individual and collective behavioral health needs early contributes positively to youth wellbeing above and beyond other referral methods. This was especially true for parents who were involved in educational/community activities around behavioral health. These participants - and many students - noted that school investment in normalizing struggle and destigmatizing support seeking behaviors, particularly as early as possible in a student's education, established trust among youth and families for SUBHS, which in turn opens channels for staff to offer support to identified students.

As evidence, parent/caregiver participants often noted the impact of schools' efforts to educate parents and community partners about the importance of students' behavioral/emotional wellbeing. One explained, "This is a way for us to come in and tailor these resources and approach your family, your children, with a more proactive approach. So there needs to be an educational component to it so that it breaks down that stigma."

The educational component that this parent/caregiver identifies is an important step in getting parents/caregivers involved and invested in screening; coalition building between schools and families can demystify SUBHS processes and democratize student behavioral health support. Respondents' recommendations to improve SUBHS and its impact in matching youth with appropriate supports include tangible action items for practitioners, administrators, and policymakers:

- Hire additional counselors and training them in culturally sustaining capacities.
- Provide robust education to students regarding SUBHS measures and give them multiple modes for screener completion.
- Establish transparency about SUBHS implementation to address stigma among families and community members.

Youth believe in the important role their schools play in supporting their behavioral health, particularly when they may not be able to access external resources. As one explained, "My school offers really amazing counselors and things like that. And for me it saved my life. It was amazing and I got the help that I needed and I think that a lot of people have been helped too, and I just think it's really important and great to do."

Yet, many remain skeptical - about their privacy, about how their parents/caregivers will respond to their screening data, and about placing their trust in school officials. To combat youth hesitancy and improve SUBHS outcomes, listening session respondents offered the following points.

Youth believe that counselors and psychologists should be primarily responsible for SUBHS, as they are trained in behavioral health issues. However, school behavioral health staff need to introduce themselves to and build relationships with students as early and as often as

possible to establish trust. Transparency around follow-up and the use of screening data, including students' privacy rights and when parents/caregivers are contacted, is also crucial. Additionally, students need to understand why they are being screened. Rather than feeling as though they are having screening done to them, students should feel as though screening is being conducted by staff who stand with them and have their best interests at heart.

One parent/caregiver, in discussing how they talk with their child about their needs, described this with distinct clarity:

> "She's still struggling like, 'oh, I have autism, something's wrong with me. What is wrong?' I'm like, 'nothing's wrong. Just so we can better identify what you need. If [timed test taking] doesn't work for you, then it doesn't work for you. We need to identify that first, then we can better help you.' So I think that kind of goes with this universal screening thing. People might be afraid, 'what is this going to look like for me?' So be very transparent, this is what this test or questionnaire is trying to do for all of us."

Distinctions and Connections between Youth and Parents/Caregivers

Youth tend to consider SUBHS in a more immediate capacity, since they are or would be directly affected by these practices at their schools. The listening sessions revealed their significant experiential knowledge about how behavioral health initiatives struggle or succeed in school contexts. They also articulate a clear desire for safety and wellbeing in school, and call on adult decision-makers to take SUBHS seriously. Parents tend to think outward into their communities and how district politics and cultural climates influence the way behavioral health programming occurs in schools. Additionally, they are concerned with how their students, particularly students with disabilities, might interact with school behavioral health networks and discussed the importance of appropriate planning and resources to maximize the impact of SUBHS programs.

Although these differences in viewpoint are certainly important, parent/caregiver and youth listening sessions indicated broad alignment about contributing factors to youth behavioral health issues and critical issues in screening. Both sets of participants want broader, more personal access to school behavioral health professionals for students. Both groups highlight the importance of peer relationships on students' mindsets, suggesting that while peers may push some youth toward social, emotional, and behavioral risk, encouraging a positive, open behavioral health climate can make peers a powerful source of support and encouragement for youth. Most importantly, they tend to support the implementation of SUBHS as an effective method for both (1) identifying individual students in need of more targeted intervention and (2) gauging the overall behavioral health of the student population in a given school setting.

School Staff Interviews

Summary of Findings

Overview

In June 2024, the UCSF research team identified a small sample of LEA representatives to conduct semi-structured interviews with to learn more about their experiences with SUBHS. Individuals were identified from the sample of respondents to the SUBHS Survey based on whether they were or were not implementing SUBHS. Some survey respondents also indicated in the survey that they would be willing to participate in follow-up interviews. The research team aimed to identify representatives from LEAs that were in different parts of California. Of the 48 total individuals contacted to participate in interviews, 35 did not respond and three declined or cancelled. Interviews were conducted over Zoom with four representatives from four LEAs that had conducted SUBHS and eight representatives from six LEAs that had not (two of the latter interviews had two participants). Interviews were recorded, transcribed, and analyzed for common themes and pertinent quotes.

Interviewees held a diverse range of roles related to behavioral health in their LEAs, including program coordinators, school psychologists, counselors, social workers, administrators, and specialists focused on student support services, family engagement, and equity. Their years of experience in these roles ranged from six months to over 20 years.

The following is a summary of the interview findings. While the sample size is small and not representative of schools or districts statewide, the findings provide insights into the current landscape of SUBHS screening in California.

Implementing SUBHS

Those working in LEAs that conduct SUBHS defined it as a tool administered to all students to identify strengths, needs, and risk factors through student self-report and teacher ratings. They described using formal screening tools, such as the Student Risk Screening Scale (SRSS), Devereux Student Strengths Assessment, or custom surveys, administered 2-3 times per year. The screenings were often integrated into their multi-tiered system of supports (MTSS) frameworks. Participants described detailed protocols for reviewing screening data in school teams, matching students to appropriate Tier 2 and 3 interventions, notifying parents/guardians, and monitoring progress over time. The representatives from LEAs that were conducting SUBHS used general education, special education, and grant funds to support screenings. Costs included those related to purchasing screening tools, creating data systems, and staff time for administration and follow-up. When asked about their screening implementation, one interviewee shared:

> "We go through all the results of the screenings and look for if there are places where someone might be in need of individual services or if more tier two small groups can be implemented. Also, if we're seeing sort of a trend across the board, then working on what we can bring into the classrooms in a more tier one universal response. … I would say it starts with us [school psychologist and behavioral health counselor] and then the moderate and severe or moderate and high scoring - that's what they call it on the SRSS – we have what we call a behavioral health team. That's our superintendent, our two principals, our family resource center director. We have a mindfulness … program. Anyone who would be involved with behavioral health for students and families in the community, we come together about once a month. And so we at that point would bring those results and either just talk about trends or if there's specific families that are in need of things, we can collaborate on that. We also have a small rural health clinic that provides behavioral health and so sometimes referrals go there …"

Benefits of SUBHS

Those who work in LEAs that conduct SUBHS described the benefits as including raising awareness, identifying students with internalizing concerns, informing allocation of resources, and monitoring intervention effectiveness over time. Screening helped identify students with significant unmet behavioral health needs, leading to increased access to services. Screening data also informed school- and district-level prevention and early intervention efforts. As one interviewee shared:

> "I think a real pro for universal screening is that it provides our people with a common language. They have an understanding of what behavioral health needs can look like or what they can be because of the language that's in screeners and so on. And it provides more understanding even at our parent level when we're communicating to our parents that, 'Hey, we're doing this not to identify that your kid is, there's something wrong with your kid, but to figure out how we can support your family, support you guys as a whole.' …. Honestly, knowledge is power. And when we do the screening, sometimes it's very surprising. Oh my gosh, I had no idea that that child felt that way. And so it's been super impactful in that way. It's allowed our staff, not just our teachers, but also our classified staff to build more meaningful relationships with our students because they know which kids need an intentional, deliberate check-in. They know which kids are just trying to fly low under the radar. Sometimes we learn things about family circumstances or what's going on inside and outside of school that we would've had no other way to know that. So I think it's had a huge impact in that way for all of our school community. One of the things we're really working hard to do is to remove the stigma of behavioral health challenges, because families will often decline services because that stigma is there. Nope, that would never be my child. Nope. They are not struggling with those kinds of things. Or just culturally, maybe receiving professional support isn't a part of what their culture supports. And so we have to be mindful of that too. But just bringing awareness."

Challenges of SUBHS

Those who did not conduct SUBHS emphasized the limited capacity to respond to identified needs, concerns about student privacy and parental consent, and the potential for screening to overload already strained behavioral health resources. The lack of dedicated funding for behavioral health services was a significant barrier to implementing SUBHS. Participants noted that short-term grants needed to be increased to build sustainable systems. Among those who were not conducting SUBHS, they typically relied on teacher or parent/guardian referrals to identify students in need. Follow-up often involved connecting students to school counselors or community providers on a case-by-case basis. They also noted that the lack of SUBHS made it difficult to accurately assess student needs and evaluate the impact of services. Referral-based approaches were seen as less equitable and proactive.

Participants who were and were not conducting SUBHS shared the following thoughts on the challenges of SUBHS:

> "I think [a benefit of SUBHS is] equity. So if you have bad behavior, you might get referred. If someone knows you really well, you might get referred. But I think there's a lot of missed potential to help students, especially historically marginalized student groups ... So right now, I see people are getting [behavioral] health, but it's not really clear what they're getting or is it working and when it's there, how are we allocating resources intentionally and being effective and intentional with what we're doing."

> "I think we always have to be aware of our own biases, both our own personal biases as well as maybe our team members' biases the way we see our community, those biases because almost any screening tool that you use has some room for biases to sneak in."

"As a person who's worked in schools for a long time, I think the staff or logistical focused reasons are that we do not have enough [behavioral] health professionals or the systems or facilities to address what I believe would be the result of the universal screener. We did in our district try … and even that with the list of students that was generated, it was quite a lot of students. And then we have one counselor who's at a middle school with 600 students. So if I get a list in one day of 150 students who may be at risk of something is very challenging to feel that I can get to them in time or to triage that communicate to parents because they're minors who may not have the facilities to supervise as many students who, especially if they were at an immediate risk. So there are a lot of, I call those logistical, even fiscal considerations because I know there's money that's available for [behavioral] health professionals, but even when we have grant funds and money, we don't even always have enough people to hire enough candidates who would be willing to work in a school setting who are trained clinical professionals."

"I think my two big takeaways would be one, there is no tool that I have seen that is really, I would say, yes, let's do that. And two, if I magically have that tool tomorrow, do I have the infrastructure and the human beings to deal with it? I do not."

"There's a fear around unmasking the real need and what it's really truly going to look like. I think people really already know what it is, but just to see it in data form."

"And one of the challenges is if you do the screener and you don't have a system in place, system support and resources in place to address the needs that might come up, I don't know what you say, like a double slap in the face, or that's like a kid discloses, and then if the system's not there and you don't catch that, it's a huge disservice to the kid and the family."

"… I feel like many of our teachers do not feel adequately trained to address the issues that come up. And so two things. One is they may be reluctant to do it because they don't know what to do when the information comes out … So that if we don't have a system in place of them being trained and knowing what to do when the information comes out and how to interact with that child to not trigger them and best support them, then yeah, there's a high risk of us not catching the information of being able to respond to it in a timely manner or even at all."

"I would say one of the biggest hurdles would be misconception around behavioral health. People just not wanting to admit that there's a need. As far as the screener, I think the second biggest challenge we may face is the staffing and capacity to be able to do it with fidelity. Just dependent upon, if it's something that teachers are able to facilitate within a classroom, then they're going to, oh, it's one more thing taking away from my instructional time. Or if we had to have counselors, psychologists, therapists doing that screening, I could see that because of our rural title, we live up to it. And it's difficult to find staff to be able to do that. So I think that may be another hurdle."

"The stigma around it with the community, our families here. And then additionally the capacity to address needs that may come up when you screen. And then what if you don't have folks to be able to provide services or support the capacity on the other side of that."

Recommendations and Summary

Those who work in LEAs that conduct SUBHS recommended the importance of securing buy-in from district leaders and school staff, investing in high-quality screening tools and data systems, providing clear guidance and training for staff, partnering with families and community providers, and monitoring implementation fidelity and outcomes over time. Those whose LEAs do not conduct SUBHS emphasized the need for state and district mandates and funding to support SUBHS, technical assistance for implementation, and greater investment in school-based behavioral health staffing to ensure adequate follow-up services.

> "I think something that might be helpful… is just to have the various screeners reviewed and maybe compared and for different needs, which ones might be for different schools or if there's ways to help counties have sort of a universal screener for their whole county and all the districts so that we're kind of all in the same program. Something like that might be nice."

> "Honestly, I think if it's a district initiative, there just needs to be an expectation that it's not optional. This is really important. We have to build the why, right? We have to help staff to understand why it matters so much, how it's going to positively impact our kids and our families. And when we establish that, why it's really hard to dispute. And then from there, it's just setting the expectation and then holding people accountable when it's not being done. It is, 'no, we're all doing this. It's really important. Here's the data we're going to get from it,' and then some follow through."

> "But the biggest deal is … having the screening, but you don't have the tools or the systems to intervene. You have the knowledge ... but you need to work on those interventions. The biggest deal is those tier two interventions and solid tier one schools are pretty good at tier three interventions because those are students who have stood out. But having those interventions across tier one and tier two in place so that you can identify them and put them in there with ease."

> "I think it all depends on the climate of where you are and what's happening and the leadership. And then students I think are cautious about, if it's not disseminated clearly, 'where's my data going? Who's going to look at this?' Yeah, it just seems to be about clarity, transparency, good leadership … And the other component is, is it accessible? So is it for our students and families that are different languages? Some of our students speak indigenous languages that aren't in written form, can they listen to the question in a preferred language? So it depends on what tool you also choose and how you ask those questions."

> "I feel like it's a question of resources. Right now in our middle schools, we don't have anyone who is a full-time therapist that can provide ongoing service to a student who's identified with needs. We're in line for that to change, but it's not a permanent solution. It's because one of our community partners happens to have funding to provide that. So we don't have an internalized resource, essentially money to pay for that to be an ongoing sustainable support in our middle schools. And the same thing with our elementary schools right now, we're putting together money that we're getting from the city and from various different places so that we can have the contracted supports in place. But, as we know, foundations can decide to use their money in different ways. The city could decide to use their money in different ways. So it's not necessarily sustainable until there is realistic funding to meet the need of [behavioral] health services at our schools. And we know that while students can be referred off campus, the supply off campus is also very taxed. It's hard to find. And we've found that students who get services on campus, it's more likely that they attend all the time and potentially more effective for that reason. But to me, it comes down to money to pay for the people that are actually going to provide the service. And we have very limited of that money because it's grant funded for the most part."

> "I think that goes back … having systems in place and having everyone trained and educated about what it is, what the purpose is, and what's going to happen after it happens. Because I think what happens, I think, especially with classroom teachers is if they're implementing this [behavioral] health screener and one of their students is identified, then they need to know what is going to happen after that and not feel like they are the owners of that next necessarily. And so I think it depends on how we purposefully, strategically set up a system in which we can realistically address whatever is found through the universal screening ... it kind of doesn't make sense to do a universal screening if we know that we don't have everything in place to address the issues that come up. And so I think that to me is the larger issue, is having a strategic plan in place of how we're going to address even the issues that come up without a universal screener now."

> "I think there's a lot out there and it's new and there's funding for it. I think what would be helpful, honestly, if CDE just said, 'Here it is. Here, it's required.' Then we could just fall back on fact. 'This is the mandate' and in our world and our work, both [my colleague] and I, sometimes we have to do things that are hard for us personally, but it makes it little bit easier when we say, 'Oh, nope, it's a state mandate. We're sorry. Here's the CDE website.' So I think it'd be wonderful. I think it is what's best for all children, schools as a whole and communities. If we were to have something that were standardized across the board and mandated from the CDE and then time for training, implementation, stakeholder engagement, opportunity for public viewing and things like that, people are often worried about, 'what is this you're asking my child and wanting?' So I think having opportunity for the public and family to view whatever the tool is, I think would be super helpful too."

> "… Unless they make it a requirement, it's going to be pretty difficult for us overall to add one more thing just with the capacity that we have, and then to also be able to defend why we're doing it. Not that we don't believe in it, we do. It's just okay, because we've been talking about this on the other side of things since 2018, and we just cannot seem to pull the pieces together. And so unless it's kind of required and mandated, I don't know that it [will] ever be something that we actually pull the trigger on. You know what I mean?"

Overall, representatives from LEAs implementing SUBHS reported significant benefits in identifying students in need, targeting limited resources more effectively, and informing school- and district-level prevention efforts. However, they also faced challenges regarding staff capacity, parental concerns, and sustainable funding. Representatives from LEAs not currently implementing SUBHS recognized the potential value but cited a lack of resources, competing priorities, and logistical barriers as significant impediments. Both groups emphasized the importance of strong leadership, stakeholder buy-in, ongoing monitoring, and quality improvement in successfully implementing SUBHS in schools.

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07

SCHOOL-BASED UNIVERSAL MENTAL HEALTH SCREENING: LANDSCAPE ANALYSIS

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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 assess systematically and proactively 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 Behavioral Health Services Oversight and Accountability Commission to conduct a study and submit a report on key considerations for implementing UMHS for children and youth, focusing 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 effectively inform 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 the 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 and 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, strengths-based, systems-focused, and contextually appropriate approach. Applying 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 the 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.[1] Prior research indicates that roughly 20-25% of children and adolescents will experience a serious mental health concern.[2,3] In California, where more than 5,800,000 students are enrolled in K-12 public schools, a very high number of students – potentially over 1,000,000 – are at risk for social, emotional, and behavioral challenges.[4] 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.[5] 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."*[6]

Yet young people's mental health needs continue to go undetected and, thus, are unsupported.[7] 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.[8]

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.[9] 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.[10] Fortunately, when a young person's mental health needs are identified and supported early, their outcomes greatly improve.[11] 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. A recent national review identified school-based screening and intervention as the most cost-effective strategy for preventing mental illness.[12]

Universal mental health screening (UMHS) – defined as a 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.[13]

Building on a Foundation of Youth Behavioral Health

In recent years, California has made monumental investments to build a robust and responsive youth behavioral healthcare 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 Behavioral Health Student Services Act (BHSSA) 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, BHSSA partnerships work to identify early signs of mental health needs, reduce stigma and discrimination, and provide timely and responsive intervention to prevent students' 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 Behavioral 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, to reduce 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 on universal mental health screening policies and practices for children and youth, including evidence of the 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, related successes, challenges, and costs. The survey will also collect information from schools that 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 submission 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 incorporating 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 provide 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, UMHS practices are still highly underutilized. In the U.S., it is estimated that less than 15% of schools currently provide mental health screening.[14]

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.[15]

Inconsistency in UMHS terminology is also an ongoing challenge. The term universal screening is often misconstrued as a process of assessing and diagnosing an entire population or as a tool for collecting school or district-wide data 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 learning and collaboration opportunities.

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 multitiered systems of support (MTSS) for students to mitigate the harmful impact of social, emotional, and behavioral challenges and promote students' wellbeing.[16] This population-based, public health approach emphasizes prevention in addition to treatment through services provided at increasing levels of intensity and complexity.[17] 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.[17] 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.[18,19,20,21]

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 needs.*[22,23,24] *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.[25] Data trends and patterns observed across the school population or within specific subpopulations (e.g., third, 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.[25,26,27]

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*.[24,25,28]

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, and 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.[25] 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.[29]

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 the efficacy of universal screening 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.[30] 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.[27]

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."[31] 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.[32,33,34] Comparisons of the identification reliability of the BESS Teacher Form versus office discipline referrals also support the screener's effectiveness beyond this traditional method.[35]

Screening also provides empirically demonstrated improvements in connecting identified students to school and community resources[36,37,38] as well as to Tier 2 interventions;[27] these connections can be facilitated at a more rapid rate than other identification strategies.[39] 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.[40] For example, in that same study, parent ratings identified fewer students with elevated or extremely elevated emotional and behavioral risk.[39] 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.[41] Different raters know students across varied settings, so 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.[42] 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.[43]

Appropriateness, Technical Adequacy, and Usability of UMHS Measures

For UMHS to effectively inform service delivery within an MTSS, schools must have access to UMHS measures that are appropriate for use, technically defensible, and usable.[44,45] 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.[43]

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:[44,46] (1) The constructs measured and data obtained from screening are aligned with the school's predetermined goals. This means that the 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 needing 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 measure latent constructs of interest effectively; (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.[15,44,47]

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 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.[48] 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.[49] 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.[50]

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.[43] 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.[51,52] Other factors contributing 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.[43]

2. Implementing UMHS

Preparing to Screen

Before 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.[53] *Fully implementing any new program can be expected to take between two to four years*.[54] 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.[52] Fortunately, several resources and guides have been developed to support schools and districts in planning their UMHS processes.

Guidance Documents

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

- The School Mental Health Collaborative's (SMHC) Best Practices in Universal, Social, Emotional, and Behavioral Screening: An Implementation Guide.[55] The guide, developed by Romer and colleagues,[25] 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.[56] 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.[57] The brief, developed by O'Malley for Project Cal-Well,[56] 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.[58] 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.[13] The toolkit was designed to guide schools through the process of developing comprehensive screening procedures and provide 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.[59] This issue brief, developed by Birman & Chan, exemplifies how screening and assessment practices can be tailored to meet the needs of specific youth populations. Their brief reviews the mental health needs of immigrant and refugee youth as well as reviews and summarizes important issues

that affect the quality and suitability of screening and assessment measures, including considerations for increasing measures' appropriateness.

In the following sections, we review several key considerations for implementing UMHS outlined in these guidance documents and the larger UMHS literature. We first consider foundational preparation steps for 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.[45] 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.[52] 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.[13,52] If such a team does not exist, schools can establish a new team or repurpose a leadership team.[13]

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.[55] 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.[55] This team must also be capable of collaborating with and obtaining feedback from a variety of school community members and partners.[13] Thus, core team members will also include community members or staff from local service organizations, students, and families.[55] Interpreters and cultural liaisons who are standing or ad hoc members of this team can be critical in facilitating communication with students and families and 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.[55]

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."[25] Unsurprisingly, staff concerns about their school's capacity to respond to identified student needs pose a major barrier to UMHS.[22] Many share concerns that identifying a large number of students through UMHS would overwhelm their school's service capacity.[25] 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 that are conducting UMHS should have a continuum of intervention and assessment, with access to support determined by student needs and available resources.[25]

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.[45] 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.[60] 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.[45] When done well, resource mapping results in a systematic process that matches available

resources to student needs.[61] California's Student Behavioral Health Incentive Program collated resource mapping toolkits and examples that may be used to inform resource mapping as part of UMHS processes.[61]

As a part of pre-screening resource mapping processes, school teams can estimate their **capacity to respond** and plan their screening efforts accordingly.[13] Population-based, public health frameworks that 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 risks.[25] 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.[13,56] 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[56]). 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.[25] 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 the planning of screening to intervention processes, school teams are encouraged to **start "slow" or "small."**[13,56] Beginning the UMHS process with small-scale pilot administrations, for example, conducted with just one grade level (e.g., all fifth graders) or at important transition points (e.g., ninth grade), allows schools to trial their procedures and obtain valuable feedback.[13] 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.[56]

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.[30] 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.[25,52] 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.[30,44,62] School building administrators most often endorsed screening for the domains of social skills, behavioral risk, self-esteem, depression, anxiety, and misconduct.[63] 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.[52]

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.[45] 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.[13] 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.[64] 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.[56] Optimal screeners will be brief but informative.[56]

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[65] 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[66] 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 brief on Assessing Social Influencers of Health and Education[67] 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.

Deciding Who Will Screen Students

Decisions regarding who will complete the screeners should also center on the goals for screening and the 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 (kindergarten through second grade) typically relies on teacher informants. In the late elementary years (third through sixth grade), student self-reporting becomes increasingly reliable when student reading levels improve. Finally, self-reporting is often the preferred method for secondary grade students (seventh through 12th grades).[56,61] When deciding which informant(s) to use during screening, schools and districts should consider the strengths and potential limitations to screening 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.[30,68] Additionally, research suggests that as children age, their responses on self-report screeners become more useful and accurate.[25,56] Older students may have better insight into their feelings and/or other internal aspects (i.e., internalizing behaviors) than their teachers or parents.[30,52,55,66,69] 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.[30] 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.[52] 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.[55,56] 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.[52,55,70,71]

Timing and Frequency

Timing

Experts recommend that screening be conducted toward the beginning of the year and during important periods throughout the academic year.[56] 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.[25,55] Younger students may need more time to adjust than older students.[25] 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.[55] 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.[56]

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.[25,55,72] 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%).[61] To evaluate the impact of universal Tier 1 programming, Romer et al. recommend that screeners be administered at least twice yearly.[25]

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.[25,45] 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[45,52] (see Romer et al. for example forms[25]). 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.[45,73] 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.[22,74] 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.[62] 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.[13] Students should also be allowed to not participate in the screening.[13,25]

The implementation guide Romer and colleagues developed outlines important legal considerations regarding consent procedures for UMHS.[25] Relevant federal legislation includes the Individuals with Disabilities Education Improvement Act (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). 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.[25] 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.[75] 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.[25] 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.[25] 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.[25] Notably, when UMHS is conducted as has been outlined in this review, it does not fulfill the legal "child find" requirements under IDEA.[13] 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.[25] As discussed above, resource mapping can help identify what resources are available at each MTSS tier as well as what additional resources can be put into place as needed.[45,55] Screening data may be used to determine the focus and goal of universal or targeted (Tier 2) interventions.[27] 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.[15]

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 to identify population-level needs and trends. Data can be aggregated on various characteristics to identify trends in the strengths and needs of the whole school as well as the needs of specific grade levels and classrooms.[45] 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 before 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 consistent with their screening goals. UMHS can play a critical role in school-based prevention, but only if the data can be used to implement interventions.[76,77]

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.[36,78]

Although sharing results with parents is essential for linking students to services, parents may decline further interventions even when mental health challenges are identified.[75] 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.[79] To promote effective communication, school staff should discuss the warning signs and potential risks observed through UMHS with parents as well as the limitations of screening.[13] 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.[61] 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.[61] 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.[61] 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 plan for data use and storage before screening, including where data will be stored and who will have access.[25,55] 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).[13]

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.[80] However, most schools are not considered HIPAA-covered entities, 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 access records and if data can be shared with other school staff or officials. UMHS consent forms or information releases for UMHS data should clearly follow the policy-informed data storage, use, and protection practices established by the school.[55]

3. Equity-Centered UMHS

UMHS to Improve Equity

Coupled with urgent calls to address the mental health of our nation's youth[6,81] is an increasing awareness that social determinants shape young people's mental health experiences and outcomes.[45,82,83] 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."[45] 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.[68,84] 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.[45,85] Thus, there is an urgent need to move toward equity-centered approaches to support student mental health.

However, the most used identification processes for students with mental health, social, emotional, or behavioral needs – teacher nomination and office discipline referrals[86] – are reactive and pose a risk of further marginalizing REM students.[30] 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.[30] 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.[30,45,62] Systematic and proactive identification of students' mental health needs via UMHS may reduce the disproportionality present in the special education referral process.[87] 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.[30,55] To effectively break down barriers to mental health equity, UMHS practices must be equity-centered.[45] 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.,[45] Kiperman et al.,[88] and Miller.[30]

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.[30,45] Fundamentally, equity-centered screening requires a shift in focus from individual and risk-focused screening to holistic, systems-focused, and contextually appropriate screening.[30,45] That is, an equitable approach to screening begins with the assumption that malleable environmental factors – 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.[30] This approach further prioritizes the identification of student and community strengths in addition to their needs.[45] Finally, to realize the larger goal of addressing mental health inequities, equitable UMHS must be implemented with a comprehensive and equity-centered MTSS.[30,89] 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.[90] 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.[13,45] 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.[30,44,55,91] Failing to consider these ecological factors when selecting a screener can perpetuate inequities by incorrectly characterizing students.[92] 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.[62] 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.[45] Recommendations include rewording questions or selecting another screening tool with a better contextual fit to increase validity.[89]

Second, school-community partnerships and collaboration are essential in an equity-focused screening approach.[30] 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 in understanding contextual factors contributing to students' strengths and needs. Involving students and families can also help school teams to understand better differing cultural perspectives and beliefs regarding mental health and screening practices.[89] 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. caution that "mental health screening" could "convey the idea of mental illness to some, which may carry stigma."[30] 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.[84] 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 school community's needs and benefit students and schools.[84]

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 must understand that REM families may distrust screening and/or school processes, especially when UMHS priorities are misaligned with their culture or values.[55,62] Strong partnerships can support relationship building, develop trust, and combat stigma.[45] Robust school-community partnerships can support student and family buy-in and facilitate more equitable and socially just screening efforts.[56,84,89,93] 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.[30,85] 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.[45] 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 promote contextually and culturally

relevant skills or assets and build affirming, healing-centered school environments.[45,94] 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.[45] Content and procedural adaptations can further be made to improve the relevance of targeted Tier 2 interventions.[83] Importantly, partnerships maintained through the screening process can support these follow-up processes.

Screening should ultimately benefit students screened.[30] Universal screening, when conducted in alignment with the recommendations for equity-centered UMHS summarized above and detailed in the literature,[30,45,83,84,85] 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.[13] Research on the costs of implementing screening, however, is limited,[95] with heterogeneity in methods across schools challenging accurate estimates and forecasting of expenses.

There are several ways of evaluating the cost of education programs.[96] 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.[97] Reviews of screening instruments have provided information about the estimated cost of various tools.[47,56,98] 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 the purchase of scoring software or a user's manual.[47,56] Technical adequacy, including reliability, validity, and classification accuracy, may also factor into cost-effectiveness evaluations of screeners.[74] 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.[99]

Two studies examined the cost-effectiveness of universal emotional health screening and follow up processes during the transition to middle school in Seattle.[37,100] The costs included in Vander Stoep and colleagues' examination were for printing and scoring questionnaires, hiring translators, recruitment mailings, personnel, and incentives for staff.[101] 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).[101] 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.[37] 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.[37] 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[93] found only one study that analyzed the cost-effectiveness of different identification approaches. Ahern et. al 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.[101] 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.[102] 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 $13 per student from Kuo et. al[37] as their universal screening cost and found that combining 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 the effectiveness of 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 many 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%[84] to 13%[14] of schools or districts across the U.S. are implementing screening.[30] 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.[61] 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.[73] Twenty-two percent indicated that screenings were conducted in certain grade levels, whereas only 10% reported screening in every grade level.[73] Across studies, discrepancies were identified concerning (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.[61,73] The lack of consensus in practice calls for additional investigation concerning best practices in implementing social, emotional, and behavioral screening, risk identification, and intervention.

Briesch et al. articulated the inconsistencies in screening policies and practices between state contexts.[16] 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.[16] 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".[16] 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.[16] 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.[16,103] The state defines 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.[16,96] 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.[96] 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.[96] 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."[96] 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.[96]

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[16]). 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."[104] MTSS-B documentation provides comparative guidance on selecting and implementing various screeners, including the BASC-3 BESS, SAEBRS, SRSS-IE, and others.[105] Screeners and informants are free to vary depending on the school or district context; the Department of Education provides significant support over implementation programs.[97] 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.[97,106] 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.[97]

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.[16] 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.[16,107] Thus, specific screening practices and culturally responsive screening approaches within Utah are quite unspecified and vague in terms of 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. found that Washington state specifically focused on behavioral and mental health components within their MTSS structure.[16] 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.[108] 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."[109] 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.[110] 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.[111] Additional state documentation provides thorough information about various national student and parental consent laws in relation to UMHS to help local school districts form their own procedures for screening.[112] Although there are no policies that require UMHS, ample documentation and resources are provided by the Department of Public Instruction.

Michigan

Michigan conducts universal screening under a MTSS framework, including 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.[113] 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."[107] In addition, it provides insight into 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.[114]

Colorado

Like 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 an MTSS system component that emphasizes shared leadership, layered support, evidence-based instruction, and community partnering.[115] 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.[116] 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 the allocation of $475,278 for public schools with grades 6-12 to provide mental health screening and referrals.[117] 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.[73]

Country Level Descriptions

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

Australia

While research is being done to create screening tools for UMHS and evaluate feasibility, no policies are 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.[118] In a survey of 169 school psychologists, only 15% worked at schools that used UMHS.[22] 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.[119,120] One study highlights that UMHS is not widely adopted in Australia, but should be "seriously considered in any package of preventive health interventions."[113]

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.[121] However, there is no requirement for schools to implement screening. Documentation for guidance highlights both the effective use of data and the effective "pastoral system" (school staff team) as key factors in identifying students.[115] 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.[122]

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.[123] 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.[124] 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.[125] Again, there is no language surrounding universal screening. Ontario uses an 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.[126] Overall, there is a lack of policy and research surrounding UMHS in Canada.

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