Commission *for* Behavioral Health

# Counting what Counts

## Opportunities for school-based universal mental health screening (SUMHS)

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

Commission for Behavioral Health

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# Executive Summary

## California's commitment to youth behavioral health

Most mental health challenges emerge before adulthood, and currently afflict as many as one in three Californians under the age of 18. Unaddressed mental health challenges are one of the largest obstacles to a young person's ability to learn and thrive, yet children's mental 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 mental health screening (SUMHS) is a proactive assessment of all students' mental and behavioral health risks and strengths.

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

SUMHS 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 SUMHS has more to do with the implementation process. For SUMHS 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 mental health labels, and the need for adequate follow-up services have raised questions about how to implement SUMHS 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 mental 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 SUMHS in support of California's broader goals and investments for youth mental and 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 SUMHS implementation.

# Findings and recommendations

## Finding 1: Evidence supports the use of SUMHS 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 SUMHS, but practices vary. Many of those not implementing SUMHS 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 SUMHS practices and impact across California's school districts.

## Finding 2: Myths are driving the narrative around SUMHS, reinforcing stigma, fears, and mistrust that hinder progress for school-based mental health.

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

For students and parents/caregivers, concerns around labeling and discrimination about mental 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 mental health screening and services.

Meanwhile, confusion about what SUMHS is and how it is used only reinforces negative perceptions about SUMHS. Definitions and language used to describe SUMHS 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 SUMHS.

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 SUMHS.

## Finding 3. Capacity barriers are outweighing the benefits of SUMHS. Schools need resources and technical support to use SUMHS effectively and responsibly.

The majority of school representatives engaged by the Commission expressed broad support for the use of SUMHS. Yet, many schools are already stretched thin and worry that they do not have the capacity to implement SUMHS. Capacity barriers underlie many of the ethical and legal concerns about implementing SUHMS, 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' mental 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 SUMHS.

## Recommendation 2: To ensure success of its school-based behavioral health strategy California must do more to improve the mental health culture and climate in schools and diminish the stigma and fear associated with screening and seeking mental health support.

As part of this effort, the State must invest more in supporting the mental 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 mental health standards, including mental health screening.**

The State should provide incentives and resources to support the planning, testing, and scaling of effective SUMHS practices in California, as well as infrastructure and resources to support implementation of SUMHS 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 SUMHS fits within the broader youth behavioral health ecosystem, and this report is intended to guide that work.

# Introduction

## The youth mental health crisis puts a spotlight on schools

Half of mental 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 mental 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 mental 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 mental 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]

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

**1 million** K-12 students are at risk of developing a mental health challenge.
**42%** of 11th graders report chronic sadness and hopelessness.
**65%** of youth mental health challenges are not supported.
**3 in 20** secondary students seriously considered suicide in the past 12 months.
**527** California youth died by suicide in 2020.
**1 in 4** K-12 students were chronically absent during the 2022-2023 school year.

The COVID-19 pandemic exacerbated what was already a steady decline in youth mental health. Between 2011 and 2021 alone, U.S. high school students reporting poor mental health increased from 28 to 42 percent.[7, 8]

California high schoolers in a focus group said that today's young generation is struggling to stay mentally healthy 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 mental health, sometimes among their peers and sometimes in their homes.

**Families are desperate for mental health support in schools.** In the U.S., 87 percent of parents and caregivers of school-aged children say they support mental health services in school.[9] In a 2023 survey, mental health was the number one reason parents decide to switch their student to a new school, ranking higher than academic concerns.[10] 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' mental health needs.

**Educators and school staff have also felt the consequences of unaddressed mental 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.[11] 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.[12] 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.[13] 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' mental 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 mental 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 mental 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 mental health needs early, which is crucial to improving outcomes. [18]

Although mental 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.[20] Unlike clinical settings which are often not equipped to address contextual risk factors impacting students' mental health (e.g., food insecurity, housing instability), schools possess the infrastructure and partnerships to provide and/or facilitate access to preventive services.[21]

## 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.[22] 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 mental health within this broader ecosystem.[23]

As California evolves its capacity for school-based mental 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 mental health screening (SUMHS)***.[24]

# The SUMHS 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 mental health screening policies and practices in school settings, with attention on data, tools, and costs for implementation.[25]

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, the Commission 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 SUMHS;
- Summarize findings from public engagement activities and a statewide school survey to describe current SUMHS 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 SUMHS as part of California's broader youth behavioral health care ecosystem.

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# A Primer on School-based Universal Mental Health Screening

## SUMHS defined

**School-based universal mental health screening (SUMHS) is the proactive assessment of all students' mental, behavioral, and relational health risks and strengths.**[26]

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

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.[27]

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 mental health screening. A child's ability to thrive and learn is hampered when they are experiencing a mental health challenge.[28] Teachers alone cannot be expected to notice all the small – and sometimes invisible – signs of a child's mental health needs. [29]

By focusing on both risks and strengths, SUMHS helps schools support a range of student needs by informing school-wide policies and programs that promote mental wellbeing and address environmental factors that put students at risk for various mental health problems.[30]

### What is youth mental health?

Mental health encompasses a person's emotional, psychological, and social wellbeing. It affects how they think, feel, learn, and act, and is an essential component of their overall health.

For children, good mental health helps them cope with difficulties, build friendships, and make positive choices. Conversely, poor mental health in children and youth can lead to issues like anxiety, depression, and behavior challenges, affecting their growth, learning, and relationships.

**"Mental health is a "springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem."**

– U.S. Surgeon General's Report on Mental Health, 1999

## Common questions about SUMHS

### What are schools screening for?

SUMHS tools can be used to screen an array of behaviors, risks, and strengths, depending on the student's age and purpose of screening.[31]

Mental health behaviors and risk examples:

- Externalized behaviors (e.g., self-injury and aggression)
- Internalized behaviors (e.g., anxiety, depression, withdrawal, and isolation)
- Contextual or situational risk factors (e.g., economic hardships, abuse, divorce of a parent, or extreme loss)

Mental health strength examples:

- Resiliency traits: (e.g., social and emotional skills, coping strategies, subjective wellbeing)
- 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 student mental and behavioral health assessment and intervention. In addition to mental 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. [32]

### 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. [33]

### 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.[34] 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 SUMHS

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

## SUMHS is NOT:

**Diagnostic**: SUMHS is not used to diagnose or make high-stakes decisions, such as for crisis intervention or special education services. SUMHS can flag students at risk who may benefit from additional assessment or support.

**Redundant**: SUMHS does not replace other types of assessments but is part of a continuum of strategies to identify and support a range of students' needs.

**Stigmatizing**: SUMHS does not result in in excessive "labeling" or put children "in a box." Instead, screening ALL students helps normalize mental health needs and help-seeking behavior.

**Burdensome**: SUMHS is not overly time consuming or difficult to administer. SUMHS can be an asset to educators and administrators by supporting MTSS.

**Stand-alone**: SUMHS should never be used alone. Schools must first establish a visible and timely referral pathway to respond to a positive screen.

## SUMHS IS:

**Preventive**: SUMHS assesses students' risks and strengths to inform prevention and early intervention programming to improve student wellbeing, behaviors, and learning.

**Versatile**: SUMHS data can be used to describe trends across classrooms, grade levels, schools, and districts while also identifying individual student's needs.

**Precise**: SUMHS data is objective, contextual, and representative of all students, rather the behaviors of a select few.

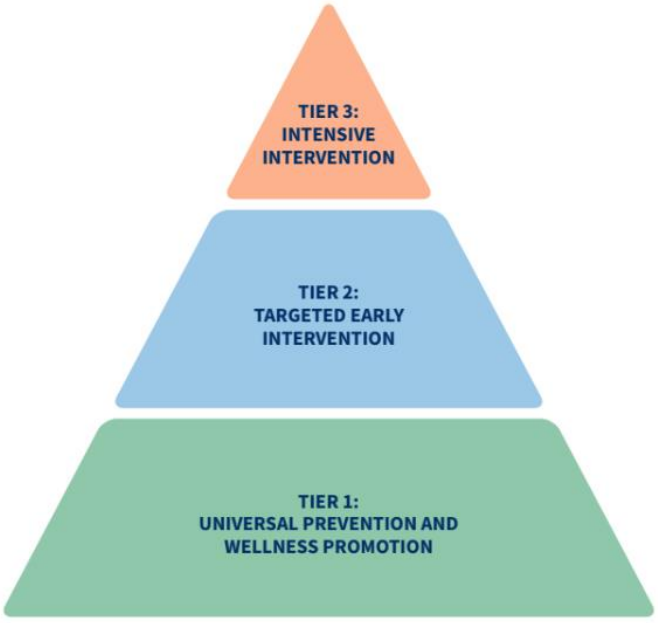
**Equitable**: By improving precision and inclusion, SUMHS prevents students from slipping through the cracks and reduces disparities among historically underserved populations.

**Confidential and Consensual**: SUMHS adheres to strict and transparent policies and laws protecting students' and families' rights to consent, confidentiality, and protection of health and academic information.

# SUMHS promotes equity-centered multi-tiered systems of support

School-based universal mental health screening can inform schools' **multi-tiered systems of support (MTSS)**.[35] The MTSS framework involves research-based strategies to meet the needs of all students, including academic AND social, emotional, and behavioral needs. [36] Many schools and districts across the U.S. and California are already using MTSS.[37]

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




**Tier 3 – Specialized, individual services for acute needs**

**Tier 2 - Early intervention and support for at risk youth**

**Tier 1 - Prevention and wellness promotion**

In a well-implemented MTSS, most students would benefit from Tier 1, universal school-wide and classroom-based wellness promotion and mental 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.[38]

## SUMHS 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.[39] 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 SUMHS Application.

**Table 1: Data-informed multi-tiered systems of support**

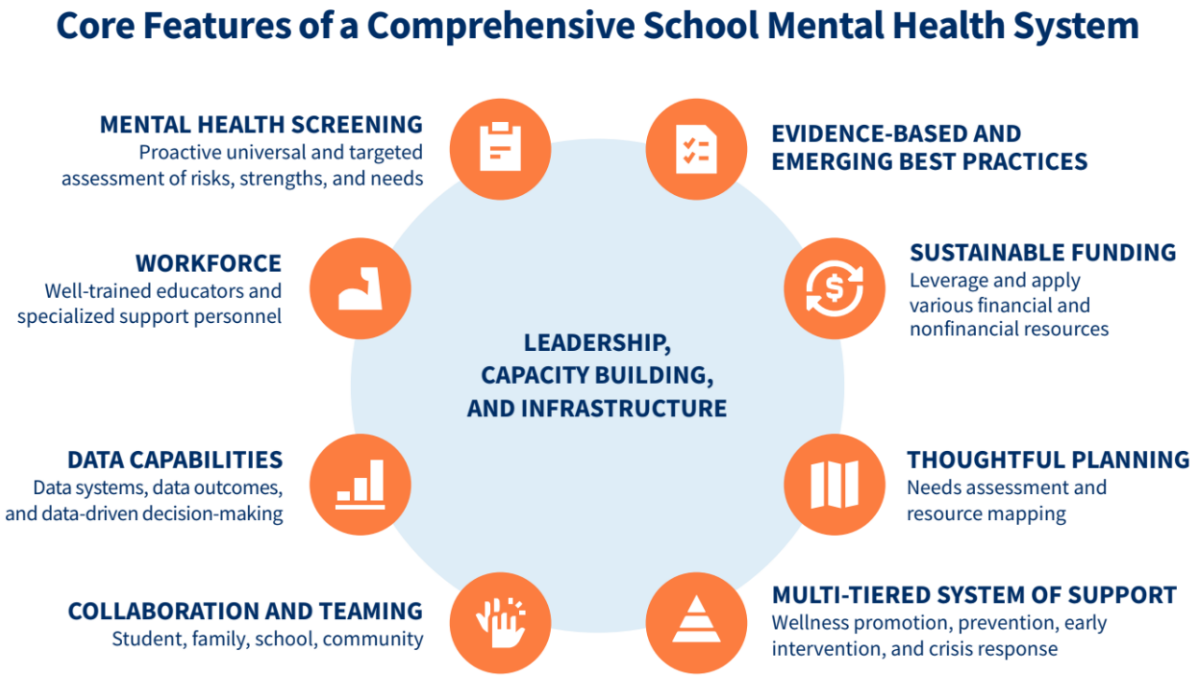
| | Data type | MTSS service |
|---|---|---|
| 1 | **Universal screening data**<br>Data is used to assess and respond to trends and patterns (positive and negative) across the school population or specific subpopulations (e.g., grade level, single classroom, learning cohort).[40] | **Universal prevention and wellness promotion**<br>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**<br>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. [41] | **Targeted support and early intervention**<br>Individual or group-based supports or skill-building activities provided to students at risk of or showing early signs of developing a mental health challenge. |
| 3 | **Clinical evaluation or assessment data**<br>Specialized assessments administered and interpreted by a licensed professional to determine the presence and severity of a diagnosis and inform individualized services.[42] | **Intensive, specialized services**<br>Specialized services provided by a licensed professional to the students with the most intensive or acute needs. |

# Implementing SUMHS as part of a comprehensive school mental health system

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

A comprehensive school mental 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 mental health and wellbeing, while reducing the prevalence and severity of mental illness.[43] This involves the integration of education, behavioral health, family, and community partners into a single, efficient, and equitable service delivery system.[44]

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




In practice, comprehensive school mental health systems work when each of its core components are in place and integrated. In other words, **SUMHS is not only a part of a comprehensive school mental health system but is dependent on that system to be effective**.[45] For this reason, implementing SUMHS must be considered within this framework.

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

**Table 2: SUMHS implementation aligned with a comprehensive school mental health system[46,47]**

| Comprehensive school mental health component | SUMHS Implementation |
|---|---|
| **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. (See page 20 more information) |
| **Workforce** | • Secure a network of highly skilled and adequately paid professionals (licensed and non-licensed) to conduct mental 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.<br>• Establish trust, buy-in, and collaboration with families, students, and teachers. |
| **Mental 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.<br>• 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.<br>• 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 SUMHS.<br>• Reliable financial and/or non-financial resources are necessary to secure staffing, MTSS infrastructure, and data systems to support SUMHS. |

## Considerations for effective, ethical, and equitable screening

Implementing SUMHS effectively and responsibly involves proactive and ongoing efforts to address what can, at times, be complex considerations.[48] Despite the potential benefits of SUMHS, some schools may determine they are not ready for the commitment. Before implementing SUMHS, 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 SUMHS, 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.[49] 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 SUMHS. 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 mental health screening and services can undermine the screening process, which is why care must be taken to build awareness and trust.[50]

### Consent and data privacy

Planning and implementing SUMHS should involve ongoing collaboration with legal experts to ensure SUMHS practices adhere to legal guidelines regarding consent and data management.[51]

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. [52]

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.[53] 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.[54]

### 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: [55]

- 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 SUMHS, school are encouraged to start "slow" or "small".[56] 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.[57] Starting SUMHS 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 SUMHS more widely.[58]

# Benefits of SUMHS

Proactively identifying and responding to student mental and behavioral health needs through a systematic universal screening process has multiple advantages. When implemented as part of an equity-centered MTSS, SUMHS supports early individual identification[59] and population-level (e.g., school, district, county-wide) monitoring, reduces bias and stigma, and promotes more positive and equitable outcomes,[60] ultimately saving lives and dollars.[61]

### Removes bias

Traditional methods for identifying students with behavioral or mental 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).[62] In contrast, the systematic and proactive nature of SUMHS processes can reduce bias in the identification process[63] and help schools support students much earlier – *before* problem behaviors occur – thereby reducing disparities in youth behavioral health care access and outcomes. [64]

### 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 mental health supports.[65] 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.[66] Proactively assessing and supporting students' needs via SUMHS may reduce the need for punitive strategies[67] and special education resources, while also addressing mental health and academic inequities among historically marginalized youth.[68]

### Comprehensive and holistic

Mental 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.[69] Educators often see the academic and behavioral challenges associated with these factors, but may not recognize the underlying causes.[70] Implementing SUMHS provides a strategic opportunity for schools to identify contextual factors contributing to a student's mental 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.[71]

### Cost effective

While dollar-for-dollar comparisons between SUMHS and other referral strategies (e.g., teacher referral) are limited, those that exist point SUMHS cost-effectiveness over other identification methods.[72] For example, studies suggest that implementing SUMHS 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.[73]

By promoting prevention and early identification, SUMHS has the potential to stop mental health challenges from becoming severe and disabling[74] and, thereby, reduce overall mental health service costs. When used within a school's MTSS, this can translate to downstream benefits,[75] such as fewer referrals for special education, reduced need for intensive psychiatric care, and fewer mental health crises.[76] In the long run, prevention and early intervention services help reduce the widespread consequences and societal costs of unaddressed mental health needs such as homelessness, addiction, incarceration, and suicide.[77] A 2022 global analysis[78] revealed a $24 return for every $1 invested in mental 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.[79]

"...it is imperative to re-envision how we approach mental health screening in schools to center equity. […] Equity-focused mental 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 mental health outcomes for minoritized youth..."
– Excerpt from A Roadmap to Equitable School Mental Health Screening [80]

# The California Landscape

As California evolves its capacity for school-based mental health services, there is a need to understand if and how school-based universal mental health screening (SUMHS) fits within its broader behavioral health strategy. Guided by the Legislature, this section provides findings from a landscape analysis of existing SUMHS 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 SUMHS 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 SUMHS 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 (LEA) 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 SUMHS 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 mental 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 mental health screening for all children from birth through age 21, and the U.S. Preventive Services Task Force recommends that universal mental 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 mental health screening has been recommended by major U.S. education and health authorities to support school-based mental health support systems.[81]

Although SUMHS has shown great promise, implementation has been limited the U.S. When schools are conducting SUMHS, research shows wide variability in implementation practices and policies.[82] In California, there are no existing policies or standards for implementing or monitoring SUMHS in K-12 settings, which makes it challenging to describe statewide practices. The following is a preliminary summary of SUMHS practices assessed through a statewide survey and follow-up interviews with local education agencies (LEAs).

## Schools implementing SUMHS

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

During follow-up interviews, LEA survey respondents described why their schools/districts are implementing SUMHS. 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 SUMHS "to use data to identify students who need more assistance" and "to better direct and support mental health resources."

School survey highlight

**Screening vs. not screening**

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

**43%** are implementing SUMHS

**43%** are not implementing SUMHS

### Screening procedures

#### Who is being screened

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

### 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.

## School survey highlight

**SUMHS 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)

While most (58 percent) of screening tools were evidence-based, a surprising 18 percent of schools currently implementing SUHMS 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 SUMHS, most (66 percent) reported that students completed the screening tool, 38 percent reported that teachers completed the tool, 16 percent were completed by mental health professionals, and 11 percent were completed by parents/caregivers.

### Equity practices

Most respondents who were conducting universal mental 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.

### Costs and funding

Only 16 respondents said they were familiar with the costs of implementing SUMHS 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 SUMHS.

### SUMHS within MTSS

Many LEAs are intentionally integrating SUMHS into their MTSS. For example, one LEA representative described how their district mental health team – which includes their school psychologist, mental 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 mental 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 SUMHS

Among the 443 LEA representatives who responded to the School Survey, 43 percent said their school/district was not implementing SUMHS. When asked what they are currently doing to identify students who need mental health supports, 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 SUMHS had been implemented in their schools/districts, and several LEAs who reported using SUMHS were actually using screening practices that did not meet the survey definition of SUMHS.

### School survey highlight

**Implementation needs**

LEA representatives identified what schools needed to implement SUMHS.

**65%** Technical assistance for planning and implementation

**55%** Direction from district leadership

**43%** State-level policy requiring screening

**43%** State-level policy providing standards

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# 2. Awareness, perceptions, and buy-in

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

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

## School survey highlight

**SUMHS 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 SUMHS – agree that implementing SUMHS would benefit students, staff, and school communities.

LEAs that were not conducting SUMHS 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 SUMHS

## Promotes early intervention

SUMHS 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

SUMHS 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 SUMHS 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 mental health needs and help destigmatize support-seeking behavior. Staff who were interviewed also highlighted the potential of SUMHS in helping to raise awareness about mental 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 [mental] 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 mental 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 SUMHS is that the primary goal is to identify, diagnose, and treat a mental health condition. While SUMHS can identify "red flags" that may warrant additional assessment and intervention, SUMHS are not designed to diagnose and treat all students. Assumptions that SUMHS are diagnostic are not only inaccurate, but cause schools to inflate the perceived resource burden and liability of administering and responding to SUMHS.

### Stigma

According to students, many young people feel fear or shame that keeps them from opening up about their mental 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 SUMHS 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 mental health services, but they also want to maintain their right to make decisions related to their child's health.[83] 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 SUMHS 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.

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# 3. Capacity barriers and resource needs

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

While schools overwhelmingly acknowledged the benefits of SUMHS, they also emphasized the need for more resources – both within schools and their surrounding community – for schools to be able to effectively meet students' mental 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 SUMHS 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

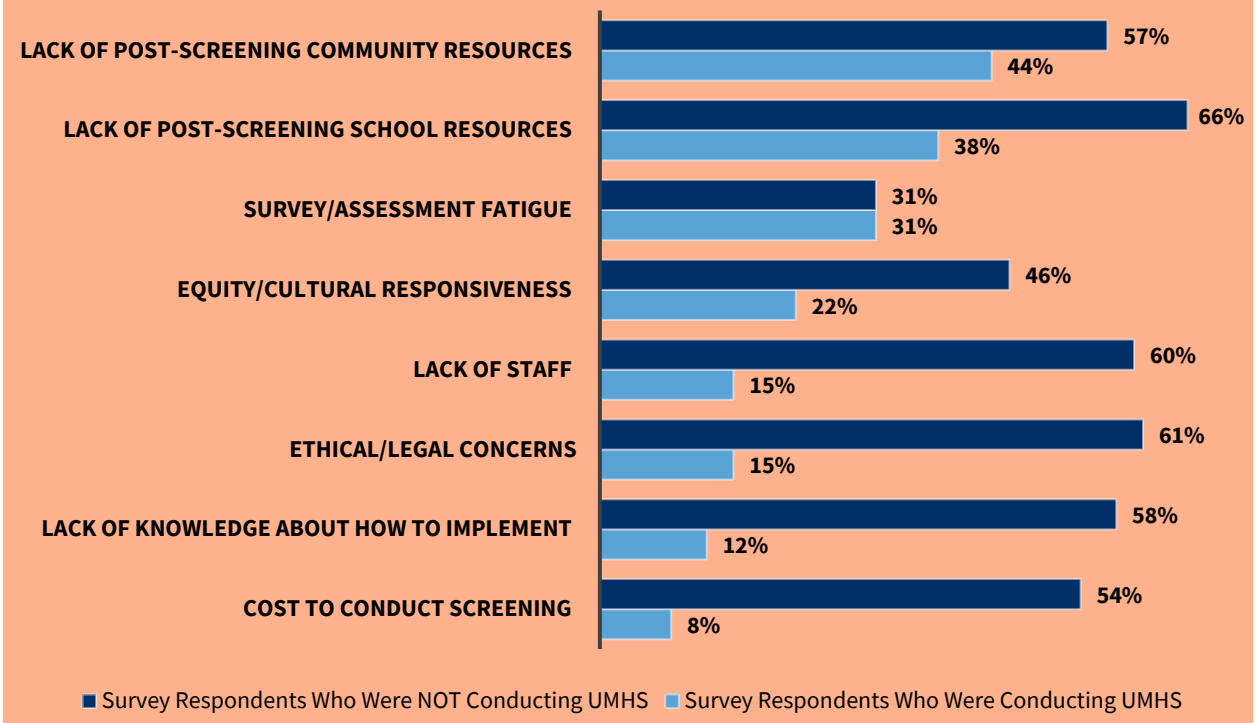
# Barriers to implementing SUMHS

**Limited resources are the number one barrier to implementing SUMHS.**

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 SUMHS. Overall, respondents whose 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 SUMHS.

## School survey highlight

### Barriers to implementing SUMHS




### Staffing

Shortages of both school-employed and community-based mental 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 SUMHS – 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 mental health or SUMHS 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 SUMHS and related mental health 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 mental health incentive funds, like the Mental Health Student Services Act 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 SUHMS. 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."

# 5. Opportunities within California's youth behavioral health ecosystem

A keystone moment in addressing California's youth behavioral health crisis was Governor Gavin Newsom's office release of the Master Plan for Kids' Mental[84] 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 mental health systems and can be leveraged to support SUMHS implementation in California's K-12 settings. (Some of these opportunities are highlighted below (See Table 3).

**Table 3: California initiatives supporting SUMHS implementation**

| SUMHS Implementation | California initiative example |
|---|---|
| **Sustainable funding** | • CYBHI Fee Schedule Program<br>• BHSA Population-based Prevention |
| **Workforce** | • Youth Mental Health Academy<br>• CYBHI Certified Wellness Coaches<br>• Healthcare Provider Training and eConsult<br>• CYBHI Safe Spaces: trauma-informed Training for Education and Early Care settings |
| **School-community collaboration** | • Mental Health Student Services Act Partnership Grants<br>• California Community Schools Partnership Program |
| **Thoughtful planning** | • School-Linked Partnerships and Capacity Grants<br>• BHSSA Universal Screening Planning Grant |
| **Multi-tiered system of support** | • CYBHI Mindfulness, Resilience, and Wellbeing Supports<br>• Project Cal-Well |
| **Evidence-based and emerging best practices** | • CYBHI Evidence-Based and Community-Defined Evidence Practices Grants<br>• Youth Suicide Crisis Response Pilots<br>• Youth Peer-to-Peer Support Program Pilots |
| **Mental health screening** | • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medi-Cal benefit<br>• BHSSA Universal Screening Planning Grant<br>• Multi-Payer Fee Schedule (screening and assessment reimbursement) |
| **Data systems** | • CYBHI Data Sharing and Privacy Workgroup and Guidelines<br>• California's Data Exchange Framework<br>• Semi-Statewide Electronic Health Record (CalMHSA) |

# Comprehensive school mental health system feature: Sustainable funding

Building and sustaining comprehensive school mental 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.[85]

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[86] 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.[87]

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[88] strategy to connect youth and families to essential services allocation of Mental Health Student Services Act

While progress has been made, many of these investments are short-term and are 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[89] 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.[90]

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 mental health system feature: Workforce

A comprehensive school mental 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 mental 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.[91]

When it comes to SUMHS, the availability of school-employed and community-based mental health providers impacts schools' ability to respond in a timely way to screening data.[92] As such, workforce concerns are one of the primary reasons schools are not implementing SUMHS 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 emotional, mental and 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. [93]

**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 mental 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 mental health careers but also envisions a future with high-quality mental 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.[94]

# Comprehensive school mental health system feature: Family-school-community collaboration

Supporting student mental health requires codified relationships and strong coordination between schools, mental 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. [95]

## 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.[96] A community school model involves districts and schools working closely with teachers, students, families, and community partners to organize school and community resources, including mental 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.[97] 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 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.[98]

# Comprehensive school mental health system feature: Thoughtful planning

Before implementing SUMHS, schools must conduct a robust planning process led by a multidisciplinary assessment and asset mapping to inform screening goals and procedures.[99] 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 mental health screening.

## Mental Health Student Services Act – Universal Screening Planning Grants

The Behavioral Health Student Services Act (BHSSA)[100] provides grants for partnerships between county behavioral health departments and local education agencies (LEAs) to deliver school-based mental 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 SUMHS 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 SUMHS. Using their plans, grantees will pilot a SUMHS program, and through a learning cohort, compile lessons learned into a "road map" to support SUMHS planning and implementation in California schools.[101]

# Comprehensive school mental 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.[102] 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 mental and behavioral health services over time.[103]

## 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. [104] 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.[105]

## 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 mental health, expand access to school and community-based mental health services for youth and families, and create sustainable student mental health infrastructure through leveraged resources.[106]

# Comprehensive school mental 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 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 mental health services. [107]

### CYBHI Youth Peer-to-Peer Support Pilot Program

Peer support in California high schools is a key strategy for promoting mental 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 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.[108]

### 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 healthcare 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.[109]

## Comprehensive school mental health system feature: Mental health screening

Early identification and intervention lead to better outcomes for children. Mental health screening, including assessment of the social determinants of mental 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.[110]

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

By law, under the EPSDT benefit healthcare providers are required to provide routine developmental, social, behavioral, and mental health screening and intervention to all Medi-Cal beneficiaries beginning at birth through age of 21.[111] 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.[112]

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. The Department of Health Care Services (DHCS) has is taking this concern seriously and is developing a standardized provider training on Medi-Cal for Kids & Teens.

# Comprehensive school mental health system feature: Data systems

Data about student and school needs obtained through SUMHS 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 SUMHS data in a reasonable timeframe. A timely response is more likely when universal mental health screening data are readily accessible, and results are interpretable to those on the screening/response team.[113]

### 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. [114]

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 HIPAA, 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[115]) 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.

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.

# Recommendations for Implementing SUMHS

Findings about the benefits and barriers to implementing school-based universal mental health screening (SUMHS) reinforce the importance of conducting SUMHS within comprehensive school mental 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 SUMHS 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 mental 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 mental and behavioral health, including SUMHS

California should establish a leadership structure to coordinate and align state and local partners and workstreams and build on the progress of its current efforts towards a long-term strategy for youth behavioral health. That strategy should establish standards, guidance, and build capacity for implementing comprehensive school mental health systems in California's public education system.

That strategy should prioritize strengthening education and behavioral health partnerships at the state and local level through policy, incentives, and infrastructure that promotes cohesive planning, service coordination, and data sharing for youth behavioral health services.

The states strategy should also establish clear standards and guidance to support successful implementation of SUMHS K-12 settings. This should be informed by a robust participatory process to achieve the following:

- Establishing a statutory definition of SUMHS with quality standards and metrics consistent with evidence-based best practice guidelines for planning, implementing, and monitoring SUMHS within K-12 systems.
    - Standards and metrics should be tied to a broader accountability framework for statewide comprehensive school-based mental health systems.
- Providing guidance, tools, and technical assistance to help local education agencies (LEAs) implement SUMHS 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 mental health screening and services.
    - Braiding existing funding streams and resources to support SUMHS 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 mental health culture and climate in schools and reducing the stigma related to screening, referral, and participation in mental health services. This should include:

- Investing in the mental health of teachers and school staff through programs and practices aligned with California's standards for workplace mental health.
- Establishing resources, consultation, training, and curriculum requirements to improve mental 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 SUMHS through incentives, resources, and scaled approaches.

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 mental health standards. This should include investments in infrastructure, incentives, and resources to support the planning, testing, and scaling of SUMHS practices in California schools. This may include:

- Funding the planning, development, and piloting of SUMHS practices in California schools.
- Leveraging research to practice and multi-county learning models to refine and scale best practices for implementing equity-centered SUMHS.
- 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.

# Conclusion

In summary, SUMHS is a critical step in advancing comprehensive school mental health systems. With thoughtful planning and preparation, SUMHS has the potential to identify mental 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 SUMHS within its broader youth behavioral health care ecosystem, California can pave the way to a brighter future for children and youth.

# Appendices

# Appendix I: SUMHS Resources

## Guidance Documents and Toolkits for Implementing SUMHS

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

- 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 SUMHS 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 mental health. After creating a free SHAPE System account, users can search by focus area, assessment purpose, student age, language, informant, and cost. One-page summaries, which include direct links to measures, administration instructions, and information about scoring and interpretation, are provided for each measure.
- The *Mental Health, Social-Emotional, and Behavioral Screening and Evaluation Compendium* (2nd Edition; Center for School-Based Mental Health Programs, Ohio Mental Health Network for School Success, 2022) provides information on select no-cost and at-cost screening and evaluation tools. Information includes a description of the tool, target population, informant, logistics for use, and sample technical properties.

- The Center for Health and Health Care in Schools, School-Based Health Alliance, and NCSMH (2021) brief on *Assessing Social Influencers of Health and Education* reviews screening and surveillance practices for social influences of health and education and provides an overview of several measures that may be used for each purpose.

# Fictional Examples of SUMHS Application

This appendix contains fictional examples of how schools at different grade levels conduct SUMHS 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 mental health supports, improve Positive Behavioral Interventions and Supports implementation, and increase mental 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 mental health efforts regularly reviews data and last year identified the need for a universal mental health screening system to monitor the impact of their school-wide interventions and support the early identification of student mental 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 SUMHS 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 mental health screening processes and screeners, and how these aligned with the goals of their mental health and wellness programming. The workgroup also conducted listening sessions with parents, teachers, and students. The listening sessions revealed that parents generally supported school mental health and SUMHS, but wanted to better understand what universal mental health screening would mean for their children. They wanted to be assured that the SUMHS would provide information about their children's strengths – not just searching for mental health problems. They also expressed concerns about family privacy being protected and that participating in SUMHS would be a choice. Educators generally felt SUMHS 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 UMHS.

The workgroup wrote an article describing the SUMHS 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 mental health clubs at the middle and high schools. After a year of planning, UMHS screener selection, and co-designing a SUMHS process, the workgroup decided to pilot a UMHS 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 mental health.

Mr. Xu is a member of the COST and is responsible for coordinating the SUMHS process. Mr. Xu participates in ongoing district-led professional development and quarterly meetings to monitor and improve SUMHS 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 SUMHS and other data indicating that over 80percent 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 mental 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 SUMHS. 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*.]

## Highschool – 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 SUMHS to inform decision-making within their MTSS. This year, they're piloting their SUMHS process in Emilio's high school.

During new student enrollment, Emilio's mother receives an opt-out consent form for SUMHS 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 mental 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, the University of California, Riverside, and WestED to conduct a Landscape Analysis of existing school-based universal mental health screening (SUMHS) 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 SUMHS policies and practices in schools, including evidence to support SUMHS for mental health processes; 2) best practices in equitable UMHS; 3) commonly used SUMHS models, including those in California, other states, and/or countries, including information on who is doing the screening, what mental health needs they are screening for, and what happens with the results; 4) information published on guiding principles and standards for SUMHS 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 SUMHS for children and youth. (The Literature Review Report and methodology is available at *https://bhsoac.ca.gov/wp-content/uploads/MHSOAC_UMHS-Phase-1-Report-Lit-Review_Final.pdf*.

## 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 SUMHS 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 mental 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 SUMHS and 55 representatives who were not sure if their LEAs were conducting SUMHS.

The UCSF team identified survey respondents who were and were not implementing SUMHS 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 mental 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, mental 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 SUMHS 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 – Anticipated delivery date December 2024

# 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 mental health support.

During the visit, teachers and administrators described the ways students' unaddressed mental 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 mental 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 mental 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 mental 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 mental health screening pilot program.

Trauma can have profound and lifelong effects on a person's physical and mental 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 mental 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 mental 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 mental 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 Mental 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 mental 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 mental 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 Mental 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 mental/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' mental 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 TOPPS team was gaining trust and buy-in from parents. Stigma and misunderstandings about mental 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 mental 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 TOPPS 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.

Commission for Behavioral Health

# Appendix IV: Survey, Listening Session, and Interview Findings

## SUMHS Statewide School Survey Findings

### Overview

To understand the current landscape of universal mental health screening (UMHS) in California schools, the 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 SUMHS, 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 mental 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.[1] While the sample sizes are small and not representative of schools or districts statewide, they provide insights into the current landscape of SUMHS 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 SUMHS implementation, including barriers and facilitators, for those who were and were not conducting SUMHS. 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 SUMHS.

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

> *"'Universal mental 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.*

[1] Missing data are excluded from all percentage calculations.

*Universal mental 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 SUMHS in recent years. Out of 443 total respondents, 43% (n=192) reported that their LEAs had conducted SUMHS, 43% (n=191) said their LEAs were not conducting SUMHS, and 14% (n=60) were not sure.

## Counties Represented

Among respondents who were at LEAs that had conducted SUMHS, 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 SUMHS, most were from Los Angeles (12% and 17% respectively; Table 1).[2]

Table 1: 2024 SUMHS Survey Respondents, Percentage of Total Respondents by County

| County | Conducting SUMHS (n=192) | Not Conducting SUMHS (n=191) | Not Sure if Conducting SUMHS (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% |

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

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

Table 2: 2024 SUMHS 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 SUMHS (n=188) | Not Conducting SUMHS (n=188) | Not Sure if Conducting SUMHS (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 SUMHS Survey Respondents, by Type of Educational Agency *(Respondents could choose multiple options)*

| In which type of educational agency do you work? | Conducting SUMHS (n=187) | Not Conducting SUMHS (n=187) | Not Sure if Conducting SUMHS (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).[3]

Table 4: 2024 SUMHS Survey Respondents, by LEA County Urbanicity

| | Conducting SUMHS (n=192) | Not Conducting SUMHS (n=191) | Not Sure if Conducting SUMHS (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) |

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

[3] 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.

Table 5: 2024 SUMHS Survey Respondents, by Primary Role

| What is your primary role? | Conducting SUMHS (n=191) | Not Conducting SUMHS (n=190) | Not Sure if Conducting SUMHS (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 mental health specialist, mental health clinician) | 18% (35) | 15% (29) | 30% (18) | 19% (82) |

## LEA Mental Health Resources across All Respondents

Over one-half of the LEAs that were and were not conducting SUMHS were using the California Healthy Kids Survey to identify students' mental 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 SUMHS, which was asked in a different question only of respondents whose LEAs were conducting SUMHS.*

Table 6: 2024 SUMHS Survey, Surveys Currently Used to Identify Students' Mental Health Needs *(Respondents could choose multiple options)*

| Are you using any of the following surveys to identify students' mental health needs? | Conducting SUMHS (n=158) | Not Conducting SUMHS (n=173) | Not Sure if Conducting SUMHS (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 SUMHS 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' mental health needs. This differed across LEAs that were and were not conducting SUMHS, as seen in the table below.

Table 7: 2024 SUMHS Survey, Perceptions of SUMHS and Available Resources to Support Students' Needs

| Participants who responded "Agree" or "Strongly Agree" to the following statements: | Conducting SUMHS (n=158) | Not Conducting SUMHS (n=171-174) | Not Sure if Conducting SUMHS (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' mental health needs. | 56% (89) | 29% (50) | 32% (14) | 41% (153) |

When asked whether their LEAs had organizations they could refer students to for mental 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 SUMHS reporting this than those from LEAs that were (Table 8).

Table 8: 2024 SUMHS Survey, Availability of Community-Based Mental Health Services

| Does your district or school have organizations you can refer students to for mental health services in the community (off-campus)? | Conducting SUMHS (n=158) | Not Conducting SUMHS (n=173) | Not Sure if Conducting SUMHS (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 SUMHS

Among the survey respondents from LEAs that had conducted SUMHS, most reported they had conducted SUMHS in the current 2023-24 school year (79%), with 11% reporting that they conducted SUMHS in the 2022-23 school year, 4% in 2021-22 or earlier, and 6% were not sure when they conducted SUMHS. Most respondents reported using Local Control Funding Formula (52%) and/or grant/foundation (27%) funds to support their SUMHS 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 SUMHS

When asked why they decided to conduct SUMHS, 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 mental 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 mental 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 mental 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 SUMHS

Among those who reported conducting SUMHS, most reported that students complete the screening tool (70%); 39% reported that teachers complete the tool, 11% parents/caregivers, and 16% mental 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 SUMHS Survey, Screening Tool Focus Areas *(Respondents could choose multiple options)*

| Which of the following did you screen for? | LEAs Conducting SUMHS (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 SUMHS 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 SUMHS Survey, Which Students Are Screened

| Which students were screened? Indicate the largest relevant group. | LEAs Conducting SUMHS (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) |

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 SUMHS, 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 SUMHS Survey, Screening Tools Used *(Respondents could choose multiple options)*

| Which tool(s) were used in your universal mental health screening process? *Please note, we are not endorsing any of these tools.* | LEAs Conducting SUMHS (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 mental health needs through the SUMHS process, including referring students to a mental health professional in the school (53%) and/or to a problem-solving team (38%; Table 12).

Table 12: 2024 SUMHS Survey, Next Steps after Students Are Identified as Having Mental Health Needs *(Respondents could choose multiple options)*

| What happens when a student is identified to have mental health needs through the universal mental health screening process? | LEAs Conducting SUMHS (n=167) |
|---|---|
| Students are referred to a mental 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 mental 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 SUMHS Implementation

Respondents were asked to select the challenges they faced when implementing SUMHS 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 mental 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 mental 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 mental 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 SUMHS Survey, Challenges Faced with SUMHS *(Respondents could choose multiple options)*

| What challenges do you face with your universal mental health screening efforts? | LEAs Conducting SUMHS (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."*
- *"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)."*
- *"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."*
- *"We reach out to parents and inform them that their child requires mental 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 SUMHS Implementation

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

Table 14: 2024 SUMHS Survey, Factors that Facilitate SUMHS *(Respondents could choose multiple options)*

| What factors help your universal mental health screening efforts succeed? | LEAs Conducting SUMHS (n=161) |
|---|---|
| Adequate school staff to handle referral needs | 58% (93) |
| Ongoing communication about screening and related mental 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 SUMHS

Given the importance of centering equity in SUMHS efforts, respondents were asked to indicate which strategies they used to center equity in their SUMHS 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 SUMHS Survey, Strategies Used to Center Equity in SUMHS *(Respondents could choose multiple options)*

| What strategies are you using to center equity in your SUMHS process? | LEAs Conducting SUMHS (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 SUMHS

When asked, overall, if they felt their SUMHS efforts were successful in identifying students who needed additional mental health supports and why, most respondents felt that it was successful. Yet, some shared mixed feedback, reinforcing the need to ensure that SUMHS 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 mental 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 mental health questionnaire helps to identify students struggling with mental 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 mental health screening efforts have been hugely successful in identifying students who need additional mental 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 SUMHS

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

Table 16: 2024 SUMHS Survey, Future Plans to Conduct SUMHS

| Has your site ever seriously considered conducting universal mental health screening? | LEAs Not Conducting SUMHS (n=181) | Not Sure if LEA Was Conducting SUMHS (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 Mental Health Needs

When asked what they are currently doing to identify students who need mental health supports, most respondents indicated that "school staff refer students to community partners," "school mental 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 SUMHS Survey, Methods to Identify Students with Mental Health Needs
*(Respondents could choose multiple options)*

| What are you currently doing to identify students who need mental health support? | LEAs Not Conducting SUMHS (n=175) | Not Sure if LEA Was Conducting SUMHS (n=46) |
|---|---|---|
| School mental 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 SUMHS said that current approaches to identifying students with mental 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 SUMHS (Table 18).

Table 18: 2024 SUMHS Survey, Adequacy of Approaches to Identify Students with Mental Health Needs

| Do your current approaches to identifying students with mental health needs adequately meet the needs of your school community? | LEAs Not Conducting SUMHS (n=176) | Not Sure if LEA Was Conducting SUMHS (n=46) |
|---|---|---|
| Yes | 18% (32) | 24% (11) |
| Somewhat | 73% (129) | 59% (27) |
| No | 9% (15) | 17% (8) |

## Challenges to SUMHS Implementation

Similar to LEAs that were conducting SUMHS, most survey respondents from LEAs that were not or were not sure if they were conducting SUMHS noted a lack of resources to refer students to as a factor that limits SUMHS. 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 SUMHS Survey, Factors Limiting SUMHS *(Respondents could choose multiple options)*

| What factors may limit screening efforts? | LEAs Not Conducting SUMHS (n=178) | Not Sure if LEA Was Conducting SUMHS (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 SUMHS Survey, Interest Holder Concerns Limiting SUMHS *(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 SUMHS (n=142) | Not Sure if LEA Was Conducting SUMHS (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 SUMHS

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

Table 21: 2024 SUMHS Survey, Interest Holders' Support of SUMHS

| How much do you agree or disagree that the following groups would support conducting universal mental health screening in your school community? (Percent responding "agree" or "strongly agree") | LEA Not Conducting SUMHS (n=171-173) | Not Sure if LEA Was Conducting SUMHS (n=43-44) |
|---|---|---|
| School mental 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 SUMHS

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

Table 22: 2024 SUMHS Survey, Needed Supports to Implement SUMHS *(Respondents could choose multiple options)*

| What would you need to conduct universal mental health screening? | LEAs Not Conducting SUMHS (n=183) | Not Sure if LEA Was Conducting SUMHS (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 SUMHS, more than half selected "technical assistance on how to develop and use a SUMHS process" and "direction from district leadership" (Table 23). More respondents from LEAs that were not conducting SUMHS 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 SUMHS.

Table 23: 2024 SUMHS Survey, Helpful Resources to Implement SUMHS *(Respondents could choose multiple options)*

| Would any of the following resources be helpful in implementing universal mental health screening? | LEAs Not Conducting SUMHS (n=182) | Not Sure if LEA Was Conducting SUMHS (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 Mental Health Screening

## Overview

The Behavioral health services oversight and accountability commission (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 mental health screening (SUMHS), 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 mental 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, mental 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 SUMHS. Participants were first asked to reflect on the current state of youth mental health, including contributing factors to mental health challenges, consequences of an insufficient support system, and the role of schools in identifying and connecting youth to mental health supports. Next, participants provided input on how the schools in their communities identify students with mental health concerns. In this stage of the listening sessions, participants provided their own definitions or examples of SUMHS, 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 SUMHS. For the remainder of the listening sessions, questions diverged between the two groups. Youth were asked about which school staff should be involved in SUMHS, their experiences with school staff after they were screened, and how SUMHS might improve outcomes for marginalized groups. Parents/caregivers were asked what potential challenges schools interested in conducting SUMHS may face.

These listening sessions resulted in numerous important insights into how youth and parents/caregivers conceptualize SUMHS amid the current school and cultural climates surrounding mental 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 mental health and SUMHS 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 Mental Health Struggle in Schools

Respondents felt that youth mental 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 mental 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 mental health challenges. Across youth and parent/caregiver listening sessions, participants agreed that the stigmas surrounding mental 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 mental 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 mental 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 mental 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 SUMHS. We now turn to participants' identification of challenges in the SUMHS process.

## Challenges to Effective Implementation of SUMHS to Address Mental Health

In the face of endemic mental health struggle, parents/caregivers and youth alike felt that SUMHS 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 mental health supports. Additionally, although the parent/caregiver

participants had favorable views of SUMHS, they noted that resistance to SUMHS 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 mental 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 SUMHS 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 SUMHS 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 mental 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.*

SUMHS 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 mental health services to better capitalize on SUMHS's potential and help students.

## Facilitators and Helpful Practices

Despite the challenges discussed above, SUMHS 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 mental 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 mental 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 SUMHS, 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' mental/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 SUMHS processes and democratize student mental health support. Respondents' recommendations to improve SUMHS 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 SUMHS measures and give them multiple modes for screener completion.
- Establish transparency about SUMHS implementation to address stigma among families and community members.

Youth believe in the important role their schools play in supporting their mental wellbeing, 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 SUMHS outcomes, listening session respondents offered the following points.

Youth believe that counselors and psychologists should be primarily responsible for SUMHS, as they are trained in mental health issues. However, school mental 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 SUMHS 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 mental 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 SUMHS seriously. Parents tend to think outward into their communities and how district politics and cultural climates influence the way mental health programming occurs in schools. Additionally, they are concerned with how their students, particularly students with disabilities, might interact with school mental health networks and discussed the importance of appropriate planning and resources to maximize the impact of SUMHS programs.

Although these differences in viewpoint are certainly important, parent/caregiver and youth listening sessions indicated broad alignment about contributing factors to youth mental health issues and critical issues in screening. Both sets of participants want broader, more personal access to school mental 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 mental health climate can make peers a powerful source of support and encouragement for youth. Most importantly, they tend to support the implementation of SUMHS as an effective method for both (1) identifying individual students in need of more targeted intervention and (2) gauging the overall mental wellbeing 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 local education agency (LEA) representatives to conduct semi-structured interviews with to learn more about their experiences with school-based universal mental health screening (SUMHS). Individuals were identified from the sample of respondents to the SUMHS Survey based on whether they were or were not implementing SUMHS. 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 SUMHS 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 mental 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 SUMHS screening in California.

## Implementing SUMHS

Those working in LEAs that conduct SUMHS 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 SUMHS 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 mental 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 mental 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 mental 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 SUMHS

Those who work in LEAs that conduct SUMHS 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 mental 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 mental 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 mental 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 SUMHS

Those who did not conduct SUMHS 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 mental health resources. The lack of dedicated funding for mental health services

was a significant barrier to implementing SUMHS. Participants noted that short-term grants needed to be increased to build sustainable systems. Among those who were not conducting SUMHS, 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 SUMHS 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 SUMHS shared the following thoughts on the challenges of SUMHS:

- *"I think [a benefit of SUMHS 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 mental 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 mental 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 mental 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 mental 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 SUMHS 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 SUMHS emphasized the need for state and district mandates and funding to support SUMHS, technical assistance for implementation, and greater investment in school-based mental 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 mental 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 mental 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 SUMHS 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 SUMHS 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 SUMHS in schools.

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