COMMONWEALTH OF VIRGINIA

UNIVERSAL MENTAL HEALTH SCREENING: A PRIMER

Conceptual Overview & Review of Current Best Practices

For the School Health Services Committee

INTRODUCTION

This document is intended to serve as a primer on universal mental health screening [UMHS] for the purpose of informing a foundational understanding of mental health screening both (i) in concept, including what UMHS is, key characteristics of effective UMHS, the UMHS process, and the purpose, benefits, and role of UMHS in supporting school multi-tiered systems of support and youth mental health, and (ii) in practice, including best practices, recommendations, and essential considerations for implementing, administering, and sustaining effective UMHS in public schools. This primer is not intended to serve as a complete or exclusive source of information on UMHS or UMHS best practices. Rather, this primer is intended to inform a foundational understanding sufficient to guide and supplement decision-making and planning relating to UMHS implementation and administration.

This primer draws from a wide range of relevant and current guidance on UMHS from a variety of sources, including reports developed by governmental agencies, academic articles authored by mental health professionals, and guidance documents published by organizations specializing in youth mental health for the purpose of guiding the implementation of UMHS.

A complete list of sources with full citations can be found at the end of the document.

Julia Bergamini, Attorney, Division of Legislative Services *Sept. 2026*

PRIMER OUTLINE

I. CONCEPTUAL OVERVIEW: UNIVERSAL MENTAL HEALTH SCREENING.

A. What is Universal Mental Health Screening?

Defining universal mental health screening & identifying key characteristics of effective universal mental health screening.

1. Universal Mental Health Screening, Defined.

Universal Mental Health Screening [UMHS] can be defined as:

(i) An *evidence-based*, *proactive*, and *systematic* method of assessing students for indicators of risk for mental health concerns and risks as well as indicators of strengths and wellbeing;

(ii) Whereby screening is:

(1) Conducted using a *systematic tool or process;* and

(2) Administered to *an entire student population* (*e.g., classroom, grade-level, group of grade-levels, school wide*), regardless of risk-status;[1]

(iii) For the purpose of:

(1) Facilitating and improving the efficacy of *early identification* and *early intervention* through increasing opportunities for identifying students showing early signs of being at risk for mental health concerns & informing the selection and provision of interventions to address such concerns; and

(2) Monitoring s*chool-wide needs, strengths, and trends* and *the efficacy of universal [Tier 1] supports* to better understand school-wide and population-level needs and strengths, inform decisions relating to school-wide programming, and improve overall student outcomes.[2]

Data—School-Based Mental Health Screening in the Commonwealth:

A 2025 survey on rates of mental health screening use by school divisions in the Commonwealth found significant regional variation, finding that:

- Overall, 35% of school divisions in the Commonwealth conduct screening using a "systematic process," while, regionally, rates range from 37% of divisions in Northern VA to 25% or fewer divisions in Southside & SW VA; &
- Rates of mental health screening use in general range from 50% in urban & suburban divisions to 28% in rural divisions.

VDOE, *LEA Survey* (2025), at 18.

[1] Nat'l Ctr. for Sch. Mental Health, *School Mental Health Quality Guide: Screening*, U. of Md. Sch. of Medicine & Nat'l Ctr. for Sch. Mental Health (2023), https://www.schoolmentalhealth.org/media/som/microsites/ncsmh/documents/quality-guides/Screening.pdf, at 1.

[2] *Ready, Set, Go, Review: Screening for Behavioral Risk in Schools*, Substance Abuse & Mental Health Services Administration (SAMHSA) (2019), https://www.samhsa.gov/sites/default/files/ready-set-go-review-mh-screening-schools.pdf, at 5; *Universal Screening Guidance*, Rhode Island Dep't of Educ. (Dec. 17, 2021), https://ride.ri.gov/sites/g/files/xkgbur806/files/Portals/0/Uploads/Documents/Students-and-Families-Great-Schools/Health-Safety/Mental-Wellness/Universal-Screening-Guidance.pdf?ver=2021-12-20-120814-030, at 6; *Counting what Counts: Opportunities for school-based universal behavioral health screening*, Cal. Comm'n for Behavioral Health (2025), https://bhsoac.ca.gov/wp-content/uploads/CBH_SUBHS_Report_Digital.pdf, at 98; Brandon J. Wood, et al., *Universal Mental*

2. Key characteristics of effective UMHS.

Effective, "fully implemented" UMHS is: [3]

(i) "Meaningfully integrated into a school's MTSS" [multi-tiered support system];

(ii) Conducted:

a) Using a psychometrically defensible screening tool;
b) Such that student data are identifiable; and
c) Using a *holistic & comprehensive screening approach* (approach measures indicators of mental health risks and needs as well as indicators of strengths and well-being);

(iii) Administered:

a) *Universally*: to an entire student population (e.g., class-, grade-, or school-wide);
b) At least two times per school year;
c) To obtain *valid* and *reliable* data on:
    a. School-wide and population-level patterns, trends, and needs; and
    b. Mental health risks and intervention needs of individual students;
d) For the purpose of:
    a. Informing decisions relating to improving, expanding, or modifying school-wide programming and universal [Tier 1] supports; and
    b. Facilitating the early identification of and the provision of proactive, early interventions to students at risk for mental health concerns.

***Conceptual Overview—Mental Health*:**

"A state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life."

"Mental health is not simply the absence of mental illness but also encompasses social, emotional, and behavioral health and ability to cope with life's challenges."

Universal Screening Guidance, Rhode Island Dept' of Educ., at 4; Colorado WARE, at 1.

Health Screening in Schools: A Primer for Principals, J. of Educ. Leadership & Pol'y Studies (2021), https://files.eric.ed.gov/fulltext/EJ1308530.pdf, at 2.

[3] Comprehensive Ctr. Network, *Choosing and Using Screeners and Assessments*, Mich. DOE (Oct. 2023), https://www.michiganassessmentconsortium.org/wp-content/uploads/Choosing-and-Using-Screeners-and-Assessments.pdf, at 1; Romer, N. & von der Embse N., et al., *Best Practices in Universal Social, Emotional, and Behavioral Screening: An Implementation Guide (Version 2.0)*, SMBH Collaborative (2020), https://smhcollaborative.org/wp-content/uploads/2019/11/universalscreening.pdf, at 9 (suggesting that "fully implemented" UMHS means the collection of data for "at least 90% of the target (universal) population").

B. UMHS: Purpose & Benefits.

Describing several purposes of UMHS data, including the collection and analysis of UMHS data and appropriate uses and limitations of such data, and the benefits of UMHS to individual students, schools, and society.

1. UMHS Data.

A significant purpose of UMHS is the generation and analysis of data on individual student, population-level, and school-wide needs, concerns, trends, and outcomes, and the efficacy of school programs, services, and supports.

This data can inform better identification of student needs, the provision of appropriate interventions, and the improvement of school programs and student outcomes as a whole. However, the data generated by screening is limited in scope and the value of implementing and administering UMHS is in large part dependent on understanding the appropriate uses and limitations of the data obtained from screening.

(a) Generally. Screening data "is versatile in its ability to describe school-wide trends while also identifying individual student needs" and should be used as a part of a school's "multi-tiered support system (MTSS) ensure students receive appropriate help at the right time" and "make informed decisions to help each student achieve personal and academic success."[4]

Overview—Screening Data:

Screening can collect data on indicators of:

- **Externalized behaviors** (*e.g., self-injury, aggression, hyperactivity, noncompliance, and disruptive behavior*);
- **Internalized behaviors** (*e.g., anxiety, depression, withdrawal, and isolation*);
- **Positive indicators of strengths and resiliency** (*e.g., social and emotional skills, coping strategies, mental wellbeing*);
- **Social determinants of mental health** (*e.g., economic hardship, parental/familial matters, presence of responsible, consistent adult at home, etc.*)

Ill. State Bd. of Educ, Lessons Learned, at 9; Moore, et al., at 167; Wood, et al., at 3.

(b) Uses and Limitations of UMHS Data:

Appropriate uses - Screening data may be used to:

- Inform "further assessment and intervention planning for students with identified needs;"[5]
- Analyze and identify individual student-level, "population"-level, and school-wide needs and trends, including:[6]
    - "[T]he proportion or distribution of students at the various risk levels in relevant groups (e.g., grade-level, school-level, and other relevant categories);"
    - "[T]he prevalence of specific needs in the whole school;"
    - "[T]he distribution of at-risk students across grades;" and
    - "[I[dentifying common indicators or characteristics of students with elevated potential of being vulnerable to poor outcomes/risk."
- Inform the school needs assessment;

[4] Comm'n for Behavioral Health, *Counting What Counts*, at 109; *id.*, at 4, 11.
[5] AWARE, *Mental Health Screening Guide*, TX Educ. Agency (July 2021), https://schoolmentalhealthtx.org/wp-content/uploads/2021/09/MentalHealthScreeningGuideTool.pdf, at 4.
[6] Comm'n for Behavioral Health, *Counting What Counts*, at 110; AWARE, *Guide*, at 14.

- Monitor progress on addressing needs and reducing risks; and
- Serve as a part of an "early warning system."[7]

Limitations - Screening data:

- Is not diagnostic: Screening data "may detect the presence of a problem" but do not "necessarily indicate a root cause."[8] Rather, "[t]he goal . . . . is to provide the option for further assessment. Such identification [of a student with a possible mental health problem] does not involve reaching a diagnosis of a condition. . . . Neither action signs nor screening tools provide sufficient information to reach a diagnoses."[9]
- Does *not* fulfill child find, screening, or evaluation requirements under IDEA;
- Is not "an in-depth analysis of the standards or individual strengths and needs;"[10]
- Should not be used as a sole source of information or in making high stakes decisions.[11]

2. Roles & Benefits in Supporting Student Mental Health.

(a) UMHS is a fundamental part of an effective multi-tiered systems of support [MTSS] framework:

The effectiveness of an MTSS framework "is dependent on the ability of schools to determine the strengths and needs of their students early and to evaluate if students are responding to . . . supports and intervention."[12] As such, UMHS is "one essential process within" such framework,[13] particularly through:

(i) Increasing opportunities for "the early identification of student mental health strengths and needs and, subsequently, support[ing] intervention delivery within MTSS and access to needed mental health supports."[14]

CONCEPTUAL OVERVIEW—MTSS:

A "prevention-based framework that emphasizes" data-based problem solving and decision-making to inform and evaluate a "full continuum of prevention, early intervention, and intensive services," including "family, school, and community partnerships," across three "tiers" of supports:

Tier 1. Universal/School-wide prevention & wellness promotion: Supports provided to the entire student population to promote mental-health wellness and improve overall student outcomes.

***Tier 2. Early intervention and supports for at-risk youth*:** Targeted, individualized services and supports for students identified as at risk for mental health concerns to prevent problems from progressing; needed by ~5–10% of students.

Tier 3. Specialized, individual services for acute needs: individualized, intensive evidence-based interventions provided by school-based or community-based mental health professionals for students with more serious concerns/intensive needs; needed by ~1–5% of students.

(ii) Generating "valuable information" on school-wide strengths and concerns that serve as an "additional data point" that can be used to:

[7] Comm'n for Behavioral Health, *Counting What Counts*, at 109.
[8] SAMHSA, *Ready, Set, Go, Review*, at 6; *Mental Health Screening Resource Guide*, Wisconsin Dep't of Public Instruction (Dec. 2018), https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/mental_health_screening_guide_web.pdf, at 2.
[9] SAMHSA, *Ready, Set, Go, Review*, at 6.
[10] Rhode Island Dep't of Educ., *Guidance*, at 6.
[11] Rhode Island Dep't of Educ., *Guidance*, at 7.
[12] Romer, et al., *Implementation Guide (Version 2.0)*, at 5; SAMHSA, *Ready, Set, Go, Review*, at 3; Sharon Hoover & Jeff Q. Bostic, *Best Practices and Considerations for Student Mental Health Screening in Schools*, 68 J. of Adolescent Health 225-226 (2021), https://www.jahonline.org/article/S1054-139X(20)30657-1/pdf.; *Reaching the Kids Before the Crisis: Leveraging Universal School-Based Mental Health Screenings*, Colorado Health Instit. (Mar. 2023), https://www.coloradohealthinstitute.org/sites/default/files/2023-04/MH%20in%20Schools%20%281%29.pdf, at 5 ("Universal mental health screenings in schools are one element of a school-based behavioral health care framework — a multi-tiered system of supports to appropriately serve students and meet their behavioral health needs").
[13] Romer, et al., *Implementation Guide (Version 2.0)*, at 5.
[14] Comm'n for Behavioral Health, *Counting What Counts*, at 102; Brandon J. Wood, et al., at 3.

- 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 difficulties);"[15] and
- Evaluate and inform decisions relating to the improvement of "the quality of comprehensive school-based health systems at the universal [Tier 1], targeted [Tier 2], and intensive [Tier 3] levels of service delivery."[16]

(b) UMHS is a proactive & preventative method:

UMHS systematically assesses an entire population of students, not just those already identified as potentially at-risk, shifting "the focus from a reactive, wait-to-fail model to a ***proactive system*** *in which needs are* ***identified early*** *and* ***interventions are delivered efficiently*** *to the level of need demonstrated by the student,"[17] thereby:*

- Decreasing "the likelihood that schools will overlook a student in need of support and intervention;"[18] and
- Increasing opportunities to detect "the onset of challenges early," enabling more effective early identification and early intervention before concerns escalate and "become less amenable to treatment;"[19]

> ***"Overarching goal" of UMHS:***
>
> The "proactive identification and subsequent treatment/intervention of at-risk students, especially those who would otherwise go undetected, with or presenting characteristics of mental health disorders using diagnostically reliable and developmentally appropriate screening tools."
>
> Brandon J. Wood, et al., at 3.

(c) UMHS is holistic & comprehensive:

UMHS measures both indicators of strengths and of need, allowing for a "broad evaluation" of student needs and outcomes on an individual and school-wide level,[20] which allows schools to better:

- Identify and assess school-wide, population-level, and individual student needs and patterns;
- Identify and address social determinants of health that tend to drive "mental health and academic disparities;[21]
- Inform decision-making and engage in "continuous problem solving" relating to the "appropriate development, maintenance, and accessibility of" universal/school-wide, population-level, and individualized supports and programs , including:[22]
    - Assessing the "overall effectiveness of universal . . . practices and supports;"[23] &

[15] Comm'n for Behavioral Health, *Counting What Counts*, at 12; Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 2 ("When school systematically ask students about indicators of well-being and social-emotional distress, they gather information that enables them to implement targeted prevention and intervention strategies that can address the unique needs of a school or community."); Ill. State Bd. of Educ, *Lessons Learned*, at 9.
[16] Connors, et al., at 3; Wisc. Dep't of Public Instruction, *Screening Resource Guide*, at 1-2.
[17] SAMHSA, *Ready, Set, Go, Review*, at 7.
[18] SAMHSA, *Ready, Set, Go, Review*, at 7.
[19] Wood, et al., at 3.
[20] Connors, et al., at 4 (Allows for "results from initial implementation . . . to be used as baseline data" and "each subsequent screening utilized to monitor schoolwide and individual trends."); Rhode Island Dep't of Educ., *Guidance*, at 7; Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 2; VDOE, *LEA Survey*, at 28 (results in collection of data which "helps schools tailor their mental health programs and interventions to the specific needs of their student population.").
[21] Comm'n for Behavioral Health, *Counting What Counts*, at 21 (noting that UMHS provides schools a "strategic opportunity" to identify and address social determinants of health, allowing disparities to be mitigated at an early stage).
[22] Romer, et al., at 5, 8 ("Identifying problems early coupled with monitoring strengths and competencies" allows for "opportunities to build on the assets and resources of the school community," and informs continuous problem solving" for individual students and student outcomes as a whole"); VDOE, *LEA Survey*, at 18; Rhode Island Dep't of Educ., *Guidance*, at 8.
[23] Ctr. for Sch. *Mental Health, Playbook*, at 1.

- Informing decision-making relating to necessary "adjustments in programming and resource allocation"[24] by improving the ability to identify, advocate for, and develop strategies to "obtain[] additional resources, strategic planning and school improvement efforts."[25]

(d) UMHS helps increase mental health awareness & decrease stigma:

Through increasing opportunities for schools, families, and community members to learn and talk about mental health, UMHS can help increase awareness and reduce social stigma around mental health.[26]

(e) UMHS improves accessibility & availability of supports & services:

UMHS helps improve the accessibility and availability of supports and services by increasing opportunities for and better enabling schools to connect students in need with access to school- and community-based services to which many students otherwise may not have been able to access.

Facts—Youth Mental Health:

Data shows that significantly more students require services than are currently receiving them:

- ~70% of children do not receive the mental health treatment they need; &
- Only 20–45% of youth with mental health difficulties receive timely mental health services.

Moore, et al., at 166 (citing CDC data); Connors, et al., at 2.

- Research indicates that many barriers to accessing mental health services faced by students and families "can be avoided by identifying and supporting students in school;"[27] &
- "Children and adolescents are much more likely to initiate and continue mental health care in school than in other community settings."[28]

(f) UMHS is cost-efficient for schools and families and reduces societal downstream costs:

"A recent national review identified school-based screening and intervention as the most cost-effective strategy for preventing mental illness."[29] *Specifically, UMHS is more cost-efficient for:*

(i) Schools/School Divisions: UMHS enables schools to more efficiently allocate resources through screening all students periodically, not just those exhibiting observable signs of high risk, thus allowing for more effective data tracking and analysis to better inform schools on student needs, the efficacy of existing supports at all levels, and efficient allocations of resources relating to programs, supports, and services.[30]

(ii) Families: UMHS is more cost-effective for families through facilitating access to and "connect[ing] students and families to cost-effective services such as individual and group outpatient mental health services and support groups."[31]

(iii) Society: UMHS reduces overall mental health service costs and reduces societal downstream costs through increasing opportunities for mental health concerns to be identified and addressed before they become

[24] VDOE, *LEA Survey*, at 28.
[25] Ill. State Bd. of Educ, *Lessons Learned*, at 9.
[26] Wood, et al., at 3.
[27] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 3.
[28] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 3.
[29] Comm'n for Behavioral Health, *Counting What Counts*, at 98.
[30] Moore, et al., at 167 (UMHS "does not require waiting until teachers, parents, or other caregivers notice significant symptoms of distress and then refer them for individualized assessment services which can be resource intensive.").
[31] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 3.

severe and require long-term, more intensive interventions and services, which are significantly more costly than early interventions,[32] thus reducing the long-term societal costs of untreated or inadequately treat mental health crises and care, including by:

- Improving overall student outcomes that contribute to higher graduation rates and post-graduate success for students as members of society;[33] and
- Reducing the "[w]idespread consequences and societal costs of unaddressed mental health, such as homelessness, addiction, incarceration, and suicide."[34]

(g) UMHS is more effective than traditional methods of early identification & intervention:

UMHS has "been associated with a lower false-positive rate and higher positive predictive value for significant mental health problems and a lower false-negative rate than"[35] traditional referral methods, such as teacher, office/administration, and disciplinary referrals and high rates of absenteeism.

<u>*Traditional Methods*</u>*:* Primarily base identification of at-risk students on observable, "externalizing" behaviors or symptoms, [36] and are therefore *reactive*, resulting in:

- *Under-identification and fewer early interventions:* While "students with externalizing behavior make themselves known,"[37] traditional methods tend to under-identify students who exhibit primarily internalizing symptoms or behaviors, such as those associated with anxiety or depression,[38] resulting in "missed opportunities or significant delays in [such] students accessing treatment/intervention."[39]

- *Over-identification of certain student populations, contributing to bias and disparities:* Traditional methods tend to over-identify male students and Black students, contributing to:
    - Disparities in provision of interventions, particularly disproportionate placements in "restrictive service settings" instead of more appropriate intervention; and
    - Bias in perceptions of symptoms of mental health concerns as "disruptive" behavior necessitating a disciplinary response.[40]

- *Overreliance on disciplinary and behavioral interventions:* Traditional methods tend to result in an "overreliance on behavioral referrals" and "unnecessary disciplinary actions and/or special education referrals in lieu of mental health supports."[41]

<u>*UMHS*</u>*:* Screening all students for both externalizing and internalizing indicators of risk/needs much more effectively identifies "students who experience or have symptoms of internalizing mental health disorders . . . who

[32] Comm'n for Behavioral Health, *Counting What Counts*, at 22; Connors, et al., at 4 ("[S]creening will ultimately save schools money, as early identification of social, emotional, or behavioral difficulties and early intervention is less costly than long-term or more intensive care.").
[33] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 3.
[34] Comm'n for Behavioral Health, *Counting What Counts*, at 22.
[35] Moore, et al., at 167.
[36] Wood, et al., at 3; Comm'n for Behavioral Health, *Counting What Counts*, at 21.
[37] Ill. State Bd. of Educ, *Lessons Learned*, at 9.
[38] Wisc. Dep't of Public Instruction, *Screening Resource Guide*, at 2.
[39] Wood, et al., at 3.
[40] Comm'n for Behavioral Health, *Counting What Counts*, at 21 ("Traditional methods for identifying students with behavioral or mental health needs . . . 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"); Moore, et al., at 167.
[41]Comm'n for Behavioral Health, *Counting What Counts*, at 21.

are less disruptive and detectable by adult caregivers and overwhelmingly underserved in K-12 school settings,"[42] thus:

- Significantly reducing under-identification of such students;
- Improving early, proactive intervention for students at risk for or exhibiting early symptoms of mental health difficulties;[43] and
- "[R]educe[ing] the need for punitive strategies and special education resources, while also addressing mental health and academic inequities among historically marginalized youth."[44]

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[42] Ill. State Bd. of Educ, *Lessons Learned*, at 9; Moore, et al., at 167 ("UMHS identifies more students with mental health needs and is more effective in identifying students with internalizing symptoms who may otherwise go unidentified."); Wood, et al., at 3.
[43] Ill. State Bd. of Educ, *Lessons Learned*, at 9; Comm'n for Behavioral Health, *Counting What Counts*, at 101 ("UMHS "can proactively provide information about students' mental health that informs wellness promotion, prevention, and early intervention supports.").
[44] Comm'n for Behavioral Health, *Counting What Counts*, at 21.

II. PRELIMINARY PLANNING & COMMUNITY ENGAGEMENT

Prior to implementing or administering universal mental health screening, best practices recommend a number of preparatory actions that should be initiated and completed prior to implementation, beginning at the earliest planning stages with: (i) organizing a team to plan, coordinate, and oversee the implementation and administration of UMHS; (ii) developing a communication plan to build stakeholder support for the UMHS initiative and ensure families, school staff, and community members are informed of and offered opportunities to engage in and offer input on the UMHS initiative; and (iii) identifying, inventorying, and developing strategies to address resource capacity and needs relating to UMHS implementation, administration, and maintenance.

A. Assembling a Team.

Best practices recommend schools use an existing school-based behavioral health team for planning, coordinating, and overseeing the implementation and administration of UMHS. However, if a school/school division does not have such an existing team or elects not to use it, an equivalent or similar existing team may be utilized or a team may be created specifically for such purposes.

This subsection addresses best practices and recommendations for establishing such team, including its membership composition, essential roles and responsibilities, and other activities.

Conceptual Overview—School-Based Mental Health Team (SBMHT):

"A multidisciplinary group of school and community stakeholders who work collaboratively within a school or district" that "meet[s] regularly and use[s] data-based decision making to support student mental health, including improving school climate, promoting student and staff well-being, and addressing individual student strengths and needs."

VDOE, *LEA Survey*, at 25; SAMHSA, *Ready, Set, Go, Review*, at 15-16.

1. Membership Composition.

Generally, the team should consist of key "family-school-community stakeholders"[45] who:
(i) Are selected from a variety of "roles and backgrounds"[46] that are "reflective of the community;"[47]

(ii) Are "leaders who will help plan, implement[,] and evaluate the screening process through collaboration and feedback;"[48]

> ***Best Practice:***
>
> Teams should identify an individuals to serve as interpreters and "cultural liaisons" for the team in community and parental engagement/outreach to "facilitate[e] communication . . . and ensur[e] that the programs developed are culturally relevant and acceptable."
>
> Comm'n for Behavioral Health, Counting What Counts, at 105.

(iii) Include the following ***"essential members":***[49]

- School administrators;
- School staff, including:
    - Specialized student support staff (e.g., school psychologists, social workers, counselors, & paraprofessionals, school nurses);[50]
    - General education and special education instructional personnel;
    - Staff with expertise in technology and data security/systems;[51]
- School and community mental health professionals with expertise and training in youth mental health who are "competent in identifying mental health symptomology, conducting assessment, and implementing intervention" as well as "data-based decision-making and assessment;"[52]
- Representatives from school/school division finance, human resources, & professional development departments;
- Community-based mental health and behavioral health providers;
- Parents, guardians, and caregivers; and
- Students, where appropriate.

2. Roles and Responsibilities.

The team should be responsible for planning, coordinating, and overseeing the UMHS implementation, administration, and follow-up processes.[53] Unless otherwise stated, the majority of the best practices for UMHS implementation and administration set forth throughout this document should be the responsibility of this team. A high level overview of the team's essential responsibilities include:

(i) Planning, overseeing, and coordinating UMHS implementation and administration, including:

- Identifying and clearly defining the purpose and objectives of screening;

[45] Ctr. for Sch. Mental Health, *Playbook*, at 2.
[46] Comm'n for Behavioral Health, *Counting What Counts*, at 105; AWARE, *Screening Guide*, at 1.
[47] Colorado WARE, *Screening Toolkit*, at 16.
[48] SAMHSA, *Ready, Set, Go, Review*, at 5.
[49] Rhode Island Dep't of Educ., *Guidance*, at 9.
[50] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 7; Comm'n for Behavioral Health, *Counting What Counts*, at 105.
[51] Colorado WARE, *Screening Toolkit*, at 16.
[52] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 7; Comm'n for Behavioral Health, *Counting What Counts*, at 105.
[53] Comm'n for Behavioral Health, *Counting What Counts*, at 105.

- Evaluating and inventorying the school/school division's current capacity and resources, identifying the resources and capacity needed to successfully implement, administer, and maintain UMHS, and developing strategies to address any identified gaps between current and needed capacity;
- Discussing and making decisions relating to screening logistics, including: [54]
    - The administration timeline, frequency, and location;
    - Selecting the screening tool, student target population for screening, and the screening informant;
    - Data management and infrastructure; and
    - Budgetary matters.
- Developing policies and procedures necessary for UMHS implementation and administration, including procedures for protecting student privacy and confidentiality and obtaining informed consent; screening response and follow-up; and school staff roles, responsibilities, and training.

Best Practice:

A school psychologist or other school mental health professional should serve a leadership role on the team.

Nat'l Ctr. for Sch. Mental Health, Quality Guide: Screening, at 7.

(ii) Overseeing and coordinating the UMHS administration process, including:

- Overseeing the scoring and interpretation of screening results;
- Coordinating follow-up after screening; and
- Engaging in ongoing evaluation and improvement of the UMHS process.

(iii) Working effectively as a team, including by:

- Establishing "consistent and clear" meeting structures, schedules, and procedures, including procedures for documenting the team's activities and defining the roles and responsibilities of all members; [55]
- Meeting "regularly to ensure that screening efforts are planned for, implemented[,] and monitored effectively;"[56]
- Using " data-based decision making and continuous improvement processes;"[57] and
- Prioritizing community and family engagement, communication, and feedback.[58]

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[54] Wood, et al., at 5.
[55] Rhode Island Dep't of Educ., *Guidance*, at 9; AWARE, *Screening Guide*, at 1.
[56] SAMHSA, *Ready, Set, Go, Review*, at 5.
[57] Rhode Island Dep't of Educ., *Guidance*, at 9.
[58] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 7; Comm'n for Behavioral Health, *Counting What Counts*, at 105 (To this end, many sources emphasize the importance of ensuring all members are "capable of collaborating with and obtaining feedback from a variety of school community members and partners.").

B. Community Engagement & Outreach.

Ensuring key stakeholders, namely, families, community members, and students are informed of and offered opportunities to participate in and offer input on the UMHS initiative as early in the planning process as possible is an important part of the "strategic planning" for UMHS implementation and is essential to garnering support and building trust among stakeholders and "maximiz[ing] the effectiveness of the process."[59]

Generally, best practices recommend developing a communication plan for informing, facilitating the engagement of, and soliciting feedback from key stakeholders, including families, students, community members, and school staff, on the UMHS initiative.

Specifically, best practices recommend that such communication plan include:

1. A clear "written procedure for communicating with families and communities"[60] that:

(i) Is designed to ensure transparency, strengthen trust, and "promote common, open dialogue around mental health to help reduce stigma and provide a sense of empowerment to students, families, and staff;"[61]

(ii) Includes strategies for ensuring all communication, engagement, and outreach is clear, understandable, and respectful;[62]

(iii) Includes strategies and objectives for providing clear, consistent, and understandable information relating to:

- The purpose, objectives, and process of UMHS;[63]
- The roles of all parties involved in the screening implementation and administration process, including students, families, school personnel, and community providers;
- Common parental concerns, including the protection of the confidentiality and privacy of student information;[64] and
- Mental health resources, including available school-based and community-based free or low-cost services, supports, trainings, and other relevant programs.[65]

Best Practice:

In introducing parents, families, and community members to UMHS, consider comparing it to other, familiar forms of universal student screenings already conducted in schools, namely, vision and hearing screenings.

AWARE, Screening Best Practices.

2. A plan for communicating with and informing students:

As the "subjects" of UMHS, ensuring students are adequately informed of UMHS and soliciting their feedback on the UMHS initiative is particularly important for the "effective implementation of screening tools and supportive interventions."[66] Such plan should:

[59] SAMHSA, *Ready, Set, Go, Review*, at 23.
[60] VDOE, *Lessons Learned* at 24.
[61] Rhode Island Dep't of Educ., *Guidance*, at 12.
[62] SAMHSA, *Ready, Set, Go, Review*, at 23.
[63] Col. WARE, *Screening Toolkit*, at 29; AWARE, *Screening Best Practices*.
[64] AWARE, *Screening Guide*, at 2.
[65] SAMHSA, *Ready, Set, Go, Review*, at 23; VDOE, *Lessons Learned*, at 28.
[66] SAMHSA, *Ready, Set, Go, Review*, at 8.

- "[E]mphasize the importance of creating space for students to advise and support decision making through the stages of development, implementation, and evaluation of screening activities;"[67] and

- Explain "the purpose and intended use of screening tools to students, in language they can understand."[68]

3. Plans for providing frequent opportunities beginning early in the UMHS planning process to educate, engage, and solicit feedback from key stakeholders on UMHS:

Namely, plans and strategies for:
(i) Engaging and soliciting feedback from key stakeholders across a variety of perspectives and cultures in the school and surrounding community to identify prevalent beliefs, attitudes, concerns, and thoughts relating to mental health and screening.[69]

(ii) *Engaging, involving, and soliciting feedback from parents, caregivers, and family early & often:* Encouraging frequent and early opportunities for education, engagement, and soliciting feedback from parents, guardians, and caregivers is crucial to increasing parental trust, support, and willingness to allow their children to participate in UMHS and ensuring parents do not feel as though it is "happening behind their backs."[70] Therefore, it is strongly recommend teams develop plans for:

- Encouraging parents to participate in the process of setting goals for a screening initiative;"[71] and
- Frequent opportunities to facilitate the ability of parents, caregivers, and families to share feedback, concerns, and preferences relating to UMHS in order to identify and address concerns early and inform the development of UMHS policies and procedures, particularly on the most common areas of parental concern such as privacy, confidentiality, and consent.[72]

4. Strategies, guidance, and plans for culturally responsive communication:

Different cultures have different attitudes, beliefs, and concerns relating to mental health. Research demonstrates that this has a significant impact on the successful implementation and maintenance of UMHS in schools."[73] Best practices for culturally responsive communication recommend teams:

(i) Consider the cultural composition of the community and ensure awareness of of "[t]he significant variation across cultural beliefs and practices in what is considered normal development[,] developmentally appropriate parenting," and mental health;[74]

- In doing so, teams should determine the prevalence of (i) different cultural and historically marginally or

Best Practice:

Research indicates that framing discussions around UMHS and mental health from a strengths-based rather than deficit-focused perspective is "more acceptable across cultural groups" and leads to higher support for UMHS across cultural backgrounds.

Col. WARE, Screening Toolkit, at 15.

[67] SAMHSA, *Ready, Set, Go, Review*, at 8-9.
[68] SAMHSA, *Ready, Set, Go, Review*, at 23.
[69] SAMHSA, *Ready, Set, Go, Review*, at 23.
[70] SAMHSA, *Ready, Set, Go, Review*, at 8; Ill. State Bd. of Educ., *Lessons Learned*, at 24.
[71] SAMHSA, *Ready, Set, Go, Review*, at 23.
[72] Hoover & Bostic; Ill. State Bd. of Educ., *Lessons Learned*, at 24.
[73] Ill. State Bd. of Educ., *Lessons Learned*, at 11.
[74] SAMHSA, *Ready, Set, Go, Review*, at 20.

underserved groups in the community; and (ii) "[c]omplex stress factors related to poverty, immigration, [and] language barriers;"[75]

(ii) Develop culturally responsive strategies to address and mitigate "fear, shame, hesitancy, and stigma" surrounding mental health;[76]and

(iii) Consider the involvement, when feasible, of community members to serves as cultural liaisons in navigating cultural attitudes toward mental health.

- Several sources recommend involving or consulting with clergy, finding that some cultures are more responsive and receptive to discussions relating to mental health.[77]

5. Strategies, guidance, and plans for ensuring linguistically accessible communication:

Ensuring parents, students, and community members from all linguistic backgrounds, including those with limited English proficiency, can adequately access, understand, and participate in community engagement opportunities and resources is critical to ensuring parental trust and support in the UMHS implementation and administration phases. Best practices for ensuring linguistically accessible communication recommend that teams:

(i) Consider the linguistic composition of the community and determine the:

- (i) Relative rates of community members with limited English proficiency; and
- (ii) Most common languages spoken other than English;[78]

(ii) Ensure that all communication, resources, and engagement opportunities are adequately available, accessible, and understandable to all members of the community, including:

- Making all resources and communications available in multiple formats, including translations to the most prevalent languages other than English spoken in the community.[79]
- Considering the involvement, when feasible, of community members to serve as translators/interpreters at in-person or live engagement/outreach activities.

6. Plans for engaging, informing, and encouraging active participation of school staff:

"Involving [teachers and other school staff] in the development of a screening process and communicating the intent and outcomes will facilitate 'buy in' and cooperation."[80] Teams should:

(i) Provide ample opportunities for and methods of informing school staff on UMHS, including through developing and/or making available informational materials and resources and providing access to professional development or training opportunities on:

- The purpose, process, and procedures of UMHS;
- Youth mental health, including:
    - Means of supporting " the mental health culture and climate in schools and reducing stigma;"[81]
    - Understanding and recognizing mental health risk factors, symptoms, and outcomes; and

[75] SAMHSA, *Ready, Set, Go, Review*, at 20; Col. WARE, *Screening Toolkit*, at 15.
[76] Ill. State Bd. of Educ, *Lessons Learned*, at 11; Hoover & Bostic.
[77] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 7.
[78] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 9.
[79] SAMHSA, *Ready, Set, Go, Review*, at 23.
[80] SAMHSA, *Ready, Set, Go, Review*, at 24.
[81] Ill. State Bd. of Educ., *Lessons Learned*, at 28.

- Understanding methods and types of interventions and services in a school-based and community-based setting.

(ii) Encourage school staff to share input, preferences, and concerns on UMHS to help inform the effective development and implementation of a sustainable UMHS program;

- In particular, teams should identify areas for which teacher input is critical to ensuring UMHS is implemented and administered in a manner acceptable to school staff *and* sustainable in the school environment.
    - *e.g.*, input on "how to minimize disruptions of class instruction and approaches to training teachers in screening procedures."[82]

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[82]AWARE, *Screening Guide*, at 1.

C. Evaluating Capacity.

It is essential to carefully consider and evaluate the capacity necessary—or "the full range of knowledge, skills, materials, and resources that will be required"—to implement, administer, and maintain an effective UMHS program.[83]

> *Schools and school divisions have an "**ethical responsibility**" to ensure, prior to implementation of UMHS, that they have the capacity to "act upon the results of any screening program in a way that is **timely, meaningful, and defensible**."*
>
> Comm'n for Behavioral Health, Counting What Counts, at 105.

Best practices strongly recommend that, prior to implementation, teams engage in a thorough, comprehensive process of evaluating, inventorying, and defining its capacity to effectively implement, administer, and carry out all steps of the UMHS process through:

(i) Resource mapping;

(ii) Conducting a needs assessment; and

(iii) Ensuring processes are in place for ongoing inventorying and management of resources the school or school division already "has in place to support students identified as needing intervention" as well as other resources essential for the overall screening process.[84]

1. Resource Mapping.

Best practices recommend using resource mapping to identify the resources already available to support student needs "that may be identified through UMHS."[85]

Resource mapping is a process whereby the team *identifies* and *visually depicts* the resources that are available within the school/school division and surrounding community in order to "analyze the strengths, challenges, and gaps in the resources, services, and programs available" and "understand what type of support can be provided at each tier of an MTSS and what additional supports may be necessary to complete the continuum."[86]

> ***Conceptual Overview— Resource Mapping:***
>
> "A process to identify, visually represent, and share information about school-based and community-based "mental health services, supports, and resources available to students and families within a school or division, as well as in the surrounding community."
>
> VDOE, Survey), at 27; SHAPE, *Guide*, at 2

Resource mapping helps:

- Reduce duplicative or otherwise inefficient uses of resources and services;
- Improve awareness and access to services; and
- Enhance communication and collaboration between schools and community partners.[87]

[83] Comm'n for Behavioral Health, *Counting What Counts*, at 104.
[84] Wood, et al., at 5.
[85] Comm'n for Behavioral Health, *Counting What Counts*, at 105.
[86] Comm'n for Behavioral Health, *Counting What Counts*, at 105.
[87] *School Mental Health Quality Guide: Needs Assessment & Resource Mapping*, SHAPE (2023), at 2.

2. Needs Assessment.

Best practices also recommend conducting a *needs assessment* in evaluating capacity. In conducting the needs assessment, teams should:

(i) Identify the "full range of knowledge, skills, materials, and resources that will be required"[88] to establish, administer, and sustain UMHS, including: the resources needed to respond to all screening results, including those requiring immediate response;

(ii) Estimate the school/school division's current capacity to "establish, administer, and sustain UMHS with existing resources."[89] Resource mapping should be used in this step. This should include an estimate of:

- The capacity to respond to any and all results of any screening administered, including capacity for immediate response; and
- The maximum number of at-risk student identifications to which the school/school division would have the capacity to adequately, timely, and meaningfully respond during any given screening administration;[90] and

> ***Conceptual Overview—Needs Assessment:***
>
> A process used by a system such as a school or school division to identify strengths and gaps, clarify priorities, inform quality improvement, and advance action planning, including to:
>
> - Identify and address mental health needs that are the most pressing.
> - Understand how well existing services and supports are meeting student needs.
> - Identify and leverage system strengths.
> - Inform priorities and actions for school mental health programming.
>
> *School Mental Health Quality Guide: Needs Assessment & Resource Mapping*, SHAPE (2023), at 2.

(iii) Identify with specificity any areas in which the school/school division has insufficient capacity and develop strategies for addressing such gaps. Best practices recommend that teams should develop such strategies with a goal of ensuring there are "effective universal supports in place to sufficiently support approximately 80% of the students and provide the environment to support the success of students who required targeted or intensive support as they learn and practice new skills."[91]

[88] Comm'n for Behavioral Health, *Counting What Counts*, at 105.
[89] Comm'n for Behavioral Health, *Counting What Counts*, at 105.
[90] Comm'n for Behavioral Health, *Counting What Counts*, at 106.
[91] SAMHSA, *Ready, Set, Go, Review*, at 39.

III. SCREENING SPECIFICS: PURPOSE, OBJECTIVES, APPROACHES, TOOLS, & LOGISTICS.

This section discusses best practices and key considerations relating to the implementation and administration of UMHS, namely determining:

A. Why UMHS is being implemented & administered.

The purpose & objectives of the UMHS initiative.

B. Screening of Whom, by Whom.

(1) The Target student population: the subject of the screening; &

(2)The Informant: by whom the screening will be completed.

C. What screening will measure.

The screening approach: for what indicators will the screening measure & what data will be obtained.

D. When screening will be administered.

(1) How frequently UMHS will be administered per school year; &

(2) When screening will be administered: at what points in the school year & when in the school day.

E. Where screening will be administered.

The location in which UMHS will be administered and completed.

F. How Screening will be administered & completed.

The screening tool to be used to administer & complete the screening.

A. Screening Purpose & Objectives:
Why UMHS is being implemented and administered.

Best practices recommend that teams clearly identify and define "a purpose, intentional goals, and strategies to avoid duplication and promote efficiency" in developing and implementing UMHS[92] through establishing a UMHS "mission statement," or a written statement clearly identifying and defining:

(i) The overall purpose of UMHS and how this purpose relates to the broader vision and mission of the school or school division in terms of student wellbeing and outcomes; and

(ii) The specific objectives of implementing the screening: namely,

- (a) What information/data is sought as a result of the screening;[93]
    - These may include:
        - Assessing general indicators of positive well-being or risk;
        - Identifying concerns for a specific subgroup of students, such as a classroom or grade-level concern;
        - Identifying individual students with high needs/at-risk[94]
        - Supporting the existing MTSS framework;
        - Informing mental health promotion and prevention strategies; or
        - Expanding access to mental health services and supports.

- (b) How the identified objectives:
    - Serve the identified purpose of UMHS;
    - Relate to the broader vision of the school or school division's educational and student wellbeing goals and MTSS Framework/student mental health support system; and
    - Serve to "to address an identified need or gap"[95]: e.g., How the identified objectives will address any gaps, difficulties, or areas for improvement in the school's or school division's current resources, systems, and practices for identifying and addressing student needs;[96]
        - This may include identifying any areas in which current resources, systems, or practices may contribute to over- or under-identification of mental health problems or inefficiencies, inaccessibility, or inadequate availability of intervention/support resources, and how the screening objectives will help address these issues.

[92] Rhode Island Dep't of Educ., *Guidance*, at 9.
[93] Wood, et al., at 5.
[94] Col. WARE, *Screening Toolkit*, at 16.
[95] Romer, et al., *Implementation Guide (Version 2.0)*, at 9; AWARE, *Screening Guide*, at 1.
[96] Ctr. for Sch. Mental Health, *Playbook*, at 2.

B. Determination of Target Population and Informant: *Screening of Whom, by Whom.*

This subsection discusses best practices and key considerations for selecting (1) the student target population, or the specific population of students being screened and (2) the screening informant, or the individual who will actually be completing the screening. The selection of student target population and informant impact several other logistical considerations and decisions relevant to planning and implementing UMHS. Therefore, it is important that these decisions be made early in the planning process.

1. Screening of Whom: Selecting Target Student Population.

The team will have to select the student target population or the student population that will be the *subject of the screening*. To be "*universal*," mental health screening must screen all students in a given population, regardless of whether such students have ever been identified as at-risk or potentially at-risk.

Options for student target population include:

(i) Grade-wide or class-wide screening (e.g., screening of one specific grade or one class);
(ii) Screening of a group of grades or school levels (e.g., grades six through 12 or all students in middle school); or
(iii) All students in a given school division (e.g., K-12).

Best Practice: Instead of fully implementing UMHS from the outset, it is recommended that schools/school divisions begin with a *pilot implementation* or "*phase-in*" *implementation approach* to "ensure the effectiveness of all processes before scaling out."[97]

- *Rationale*: Beginning with a small-scale implementation for only a specific subset of the student population increases opportunities to collect "valuable feedback on" and make necessary improvements to UMHS processes while the initiative is still at a "manageable scale."[98]
- Teams should consider developing a strategy or procedure for utilizing the data from the pilot/phase implementation for "measuring capacity and readiness" whereby pilot/phased implementation data relating to capacity needs is used to estimate projected capacity needs for larger scale to full implementation.[99]

2. Selecting Screening Informant: Screening by Whom.

[97] Rhode Island Dep't of Educ., *Guidance*, at 11; Ctr. for Sch. Mental Health, *Playbook*, at 4 (recommending beginning with "[p]ilot screening procedures with small groups of students . . . to test procedures before administering to an entire grade or school."); AWARE, *Screening Best Practices*.
[98] Comm'n for Behavioral Health, *Counting What Counts*, at 108; SAMHSA, *Ready, Set, Go, Review*, at 36; Rhode Island Dep't of Educ., *Guidance*, at 11.
[99] Rhode Island Dep't of Educ., *Guidance*, at 11; Ill. State Bd. of Educ., *Lessons Learned*, at 26.

The team will be responsible for determining who the informant will be for UMHS, or the individual who will actually be completing the screening.

The options for informant include (i) classroom teachers, (ii) parents, (iii) students, or (iv) multi-informant whereby the screening would be completed by a combination of those individuals.

There are a number of considerations and factors unique to each particular informant that should be taken into account in making this selection, including (a) the purpose and objectives of the screening and (b) the student target population.

Overview—Selection of Informant:

The informant should be selected based on a determination of which informant could provide "the most relevant and valuable data to inform evidence-based intervention" & best advance the defined purpose & objectives of UMHS.

In making this determination, consider for each potential informant:

1. The limitations & strengths, including in terms of:

(a) Ability to understand & appropriately complete the screening;

(b) The age(s) & characteristics of the target student population; &

(c) The defined purpose & objectives of UMHS; &

2. The impact of selecting that informant on the accuracy, reliability, & consistency of screening results.

Romer, et al., Implementation Guide (Version 2,0), at 10; Comm'n for Behavioral Health, Counting What Counts, at 106.

(i) Teacher-as-Informant/"Teacher Report": When the teacher is selected as the informant, each classroom teacher of students in the student target population will complete the screening measures for all students in that teacher's classroom.[100] In deciding whether to select teachers as the informant, the following considerations apply:

The student target population: Typically, teacher-as-informant is *recommended* when the student target population is limited to elementary school students, particularly students in kindergarten through grade three.[101]

- Tends to be particularly accurate, reliable, and informative for screening students in kindergarten through grade three because students at those grade levels:
    - (i) Typically "spend the majority of their school day in one classroom" with one teacher; and
    - (ii) Are more limited in their ability to independently complete screening due to lower literacy levels and ability to understand what they are being asked to do and how to properly do it.[102]

The screening objectives: Evidence suggests that teacher-as-informant may be *appropriate across grade levels* when the objective of the screening is primarily understanding and identifying risk for *externalizing behaviors* because such behaviors are generally identified through observation of students in the school environment.

[100] Comm'n for Behavioral Health, *Counting What Counts*, at 106.
[101] Connors, et al., at 2.
[102] Romer, et al., *Implementation Guide (Version 2.0)*, at 10.

- Additionally, evidence consistently indicates that even among younger grade levels, teachers are more reliable informants in identifying externalizing behaviors than parent informants.[103]

Professional development/training needs: When teachers are the informants, research indicates that the accuracy and consistency of screening results is strongly impacted by the provision of adequate professional development/training on accurately completing and understanding the screening.[104] Thus, when considering selecting teachers as the informant, professional development/training capacity and needs must also be taken into account.

> Regardless of the informant(s) selected, research indicates that the accuracy of screening depends on the extent to which the informant "understands the purpose of the screening, what they are being asked to do, []how the information will be used," and how to appropriately complete the screening. AWARE, Screening Guide; Wood, et al., at 8.

(ii) Parent-as-Informant/"Parent Report": When the parent is selected as the informant, the parent of each student being screened completes the screening measures for their student. In deciding whether to select parents as the informant, the following considerations apply:

The student target population: Parent-as-informant is typically *only* recommended if the student target population falls within the early childhood category (e.g., pre-kindergarten or younger). It is *not* recommended for students in secondary school grade levels.

- Research indicates that at the middle or high school level, students tend to spend less time and share less with their parents and that parents tend to overestimate the accuracy with which they can complete a screening for their child.[105]

(iii) Student-as-Informant/"Self Report": When the student completes the screening measures for him or herself. In deciding whether to select students as the informant, the following considerations apply:

The student target population: Student self-report/students-as-informants is considered *most effective* when the target student population includes students in *grades four through 12*.[106]

- Where the target student population is limited to secondary school grade levels, students are "**more accurate informants** of their own behavior and can reliably assess their own functioning."[107]

[103] Wood, et al., at 8.
[104] Romer et al., *Implementation Guide (Version 2.0)*, at 10.
[105]
[106] Connors et al., at 2.
[107] Romer et al., *Implementation Guide (Version 2.0)*, at 10.

- *However*, research indicates that student informants/self-report ***can be valuable at any grade level***, so long as the particular screening tool is developmentally appropriate for the particular target population.[108]
    - "[R]esearch has demonstrated that student self-report, even in early grades, can contribute unique and valuable information that is distinct from teacher ratings."[109]

Recommendation:

If students are selected as informants, options for "electronic screening" or "e-screening" should be considered because research indicates that students tend to prefer completing screening electronically and that e-screening has "potential to facilitate" "increased rates of student self-disclosure."

Wood, et al., at 8; Martel, et al., Implementing the Routine Use of Electronic Mental Health Screening for Youth in Primary Care, at 7.

The screening objectives: Student self-report has been found consistently more effective in measuring and identifying "risk for *internalizing symptoms*," or issues not easily observable by others, such as anxiety or depression. [110] Thus, student self-report is recommended if the screening objectives are focused on measuring and identifying internalizing symptoms.

(iv) Multi-Informant: *A* team may also select more than one informant to complete the screening. Best practices recommend that if multiple informants are selected, to ensure the most accurate and reliable results, ***students should serve as at least one of the informants***.[111]

[108] Wood, et al., at 8.
[109] Romer et al., *Implementation Guide (Version 2.0)*, at 10.
[110] Wood, et al., at 8; Romer et al., *Implementation Guide (Version 2.0)*, at 10.
[111] Wood, et al., at 8.

C. Screening Approaches:
What indicators the screening will measure & what data the screening will generate.

There are several different approaches to UMHS. Teams should identify and define the screening approach to be utilized based on the purpose and objectives of the screening and the needs, characteristics, and common concerns of the student target population.

General Considerations:

The selection of screening approach and content should be guided by:

1. The purpose & objectives of screening, namely:

(i) The indicators for which the team wishes to screen; &

(ii) The data/information the team seeks to obtain from the screening; &

2. The needs, characteristics, & common concerns of the target student population.

Mich. DOE, Screeners and Assessments, at 1; Wisc. Dep't of Public Instruction, Screening Resource Guide, at 4.

Generally: There are a number of different approaches to UMHS, including multiple gating procedures, brief behavior rating scales, and reliance on extant behavior data (disciplinary referrals, attendance data, etc.).[112] Best practices recommend selecting a "*holistic approach*" or an approach which screens for both indicators of strengths and wellbeing *and* indicators of need and risks.

Holistic approaches ensure screening focuses on strengths as well as risks and "direct[] attention to student competencies, assets, and positive emotions that are also highly relevant to a complete mental health status" and valuable to informing intervention decisions.[113]

Screening solely for indicators of risk, such as indicators of risk for mental health concerns, is *not* recommended as such approaches have been found to result in an "undue focus on student weaknesses, risk factors, and/or emphasize problem severity as determining the need for intervention."[114]

Specifically: The most common screening approaches include:

(a) ***Multi-gated approach:*** Often considered the *traditional approach*, through this approach:

- Classroom teachers are asked to identify students with internalizing and externalizing behaviors in the classroom and then rank each student in the classroom based on the extent to which the teacher identifies signs of the internalizing or externalizing behaviors. Using the ranked listed made by the teacher, a small number of students (typically three to five) ranked in the top of each category are identified as at a higher

[112] Romer, et al., *Implementation Guide (Version 2.0)*, at 9.
[113] Romer, et al., *Implementation Guide (Version 2.0)*, at 7.
[114] Romer, et al., *Implementation Guide (Version 2.0)*, at 7.

risk and in need of further screening/evaluation (e.g., classroom observations, behavior rating scales, and other relevant data). The results of that further screening/evaluation are then used to guide effective intervention and support decisions."[115]

(b) ***Consideration of base-rates:*** This is an approach whereby, after universal mental health screening is conducted, school teams evaluate "serviceable base rates of risk," or the percentage of students whose needs can be met with adequate supports by school personnel. Those "serviceable base rates" are then used to guide intervention decision-making considerations in the context of the screening data.[116]

(c) ***Multiple-measure approach:*** This is a *holistic approach* and, as such, is generally the preferred approach. It consists of more than one measure, of which at least one measure is focused on measuring (i) "symptoms of distress" (indicators of mental health concerns/needs for intervention) and (ii) "strength indicators" (indicators of strengths and wellbeing).[117]

- Through allowing simultaneous identification of students indicating a risk for mental health concerns/need for intervention and student strengths/wellbeing, this approach tends to better:
    - Inform the selection of interventions and help students more effectively address the indicators of problems;[118] and
    - "[S]upport 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."[119]

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[115] Wisc. Dep't of Public Instruction, *Screening Resource Guide*, at 4; Romer, et al., *Implementation Guide (Version 2.0)*, at 9.
[116] Romer et al., *Implementation Guide (Version 2.0)*, at 4.
[117] Romer, et al., *Implementation Guide (Version 2.0)*, at 10; Wood, et al., at 3.
[118] Romer, et al., *Implementation Guide (Version 2.0)*, at 10.
[119] Comm'n for Behavioral Health, *Counting What Counts*, at 11.

D. Screening Frequency & Timeline:
How often and when screening will be administered.

Teams must determine the screening (a) frequency, or how many times per school year UMHS will be administered, and (b) timeline, or at what point in the school year and at what time during the school day UMHS will be administered.

Frequency Considerations:

In selecting a UMHS frequency and timeline, teams should consider:

1. How the frequency & timeline may impact the ability to ensure students receive timely access to needed interventions to promote success & wellbeing throughout the school year; &

2. How to strike a balance between the burdens & benefits of the timeline & frequency, namely:

a) The impact on the workload/administrative burdens of school staff & disruptions to instructional time; &

b) The impact on the overall value and usability of screening results.

1. Screening Frequency.

There is no definite consensus on exactly how many times per school year screening should be administered.[120] Additionally, some screening tools include guidance on how frequently the tool should be utilized and, in such case, the guidance that came with the particular screening tool should be followed.[121]

However, research shows that administering UMHS *at least twice each school year* is most effective for "determining a baseline" and evaluating the impact and efficacy of universal, Tier 1 interventions and evaluating the needs and progress of individual students.[122]

Therefore, ***best practices recommend administering UMHS at least two times per school year but, ideally, three times per school year***.[123]

[120] Col. WARE, *Screening Toolkit*, at 26.
[121] SAMHSA, *Ready, Set, Go, Review*, at 59.
[122] Col. WARE, *Screening Toolkit*, at 26; Romer, et al., *Implementation Guide (Version 2.0)*, at 11.
[123] AWARE, *Screening Best Practices*; Wood, et al., at 9.

2. Screening Timeline.

Teams must also decide the points in the school year during which each UMHS administration window should be scheduled and at what time during the school day UMHS should be administered.

(i) At what point in the school year during which each UMHS administration window will be scheduled: There are various factors that should be taken into consideration in establishing the screening timeline and the timeline may vary depending on whether the screening frequency is two or three times per school year. However, regardless of whether the selected screening frequency is two or three times per school year, best practices recommend the following general timeline for the first and second/final screening administration of the school year: [124]

First Screening: At least four to six weeks after the beginning of the school year.[125]

- Screening at the beginning of the school year allows for a "current assessment of the student and school-population needs."[126]
- It also contributes to the accuracy and reliability of screening where the informant is:
    - *Teacher:* Ensures sufficient time for the teachers to become familiar with their students, reducing the risk of under- or over representing students at-risk; or
    - *Student:* Ensures sufficient time to readjust to the school schedule and environment;[127]

Final Screening: Four to six weeks prior to the end of the school year.[128]

- *Rationale*: Conducting the final screening at least four weeks before the end of the school year is most effective for the purpose of comparing the data obtained through the final screening to that of the initial screening data to "identify trends and patterns in student and school-level needs over time" and evaluate individual student progress and changes in overall student outcomes.[129]

**Second Screening Administration [if screening three times per school year]:* Mid-year, in either December or January. [130]

(ii) At what point in the school day UMHS will be administered: Ideally, screening should be administered during non-instructional time to minimize disruptions. [131] Best practices recommend making this this decision in close consultation with teachers and administrators.

Overview - Best Practices for Frequency & Timeline:

1. Frequency: *At least* ***two times****, ideally* ***three times*** *per school year.*

2. Timeline:
(a) Initial screening: 4-6 weeks after beginning of the school year;
(b) Second screening (if applicable): December or January;
(c) Final screening: 4-6 weeks before the end of the school year;

3. Time of day: *Ideally, non-instructional time; determined in consultation with instructional personnel.*

[124] Col. WARE, *Screening Toolkit*, at 26; Comm'n for Behavioral Health, *Counting What Counts*, at 106.
[125] AWARE, *Screening Guide*, at 2.
[126] Comm'n for Behavioral Health, *Counting What Counts*, at 106.
[127] Romer, et al., *Implementation Guide (Version 2.0)*, at 9.
[128] AWARE, *Screening Guide*, at 2.
[129] Comm'n for Behavioral Health, *Counting What Counts*, at 106.
[130] AWARE, *Screening Guide*, at 2.
[131] Col. WARE, *Screening Toolkit*, at 26.

E. Screening Location:
Where screening will be administered.

Teams must identify the location at which UMHS will be administered. In selecting the location, teams should consider the informant selected and the impact of the location on the informant's real and perceived privacy and confidentiality in completing the screening.

In selecting the screening location, the "[p]rivacy of respondents when answering is of the utmost important and may have an impact on informant responses and validity."[132]

Students as Informants: Where students are selected as informants, privacy is particularly important in terms of both the student's *actual privacy and perceived* privacy. Thus, teams should consider the extent to which each potential location affords each student sufficient privacy to feel comfortable to honestly complete screening.[133]

Best practice: "If groups of student informants are completing screeners simultaneously, private places and appropriate social distancing between respondents can help protect against breaches of confidentiality."[134]

[132] SAMHSA, *Ready, Set, Go, Review,* at 44.
[133] SAMHSA, *Ready, Set, Go, Review,* at 46.
[134] Wood, et al., at 7.

F. Selecting a Screening Tool:
How UMHS will be administered and completed.

The screening team will be responsible for selecting the particular screening tool or the actual instrument/system through which UMHS is administered to and the screening measures (or questions designed to measure the specific indicator/domains for the target population) are completed by the informant. The screening tool may be electronic or physical.

The selection of a screening tool is important because screening tools, "when selected and used appropriately, can supplement professional judgment, boost credibility of referrals, and support staff and families in understanding developmentally appropriate behaviors."[135]

Overview—Screening Tool Selection:

The selection of screening tool should be based primarily on evaluation of the tool's:

1. Appropriateness across three categories:

a. Contextual appropriateness: alignment with identified needs and objectives;

b. Developmental appropriateness: whether it is designed to be administered to the age(s) and developmental level(s) of the target student population; and

c. Cultural appropriateness: alignment with the cultural and linguistic composition of the target student population and school community;

2. Technical Adequacy evaluated based on evidence of the tool's:

a. Reliability; &

b. Validity

3. Feasibility & Usability; &

4. Required Costs & Resources.

1. Generally.

Screening tools, (sometimes called screening measures, screening instruments, or simply "screeners") typically involve a brief list of questions relating to a student's behavior, thoughts, and feelings, and based on data generated from responses, can yield (i) positive findings (i.e., indication that student may be in need of additional interventions) and (ii) negative findings (i.e., indication that a student is not in need of additional interventions).[136]

Screening tools can vary in several ways, including based on the format of the screening, the indicators/symptoms (or "domains") the tools measure, the data they generate, and various features included with the tool (such as data analysis/visualization capabilities, adaptations for accessibility or translations, etc.).[137]

A general overview of screening tool varieties based on the indicators being measured include:

[135] Wisc. Dep't of Public Instruction, *Screening Resource Guide*, at 1.
[136] SAMHSA, *Ready, Set, Go, Review*, at 17.
[137] Comm'n for Behavioral Health, *Counting What Counts*, at 106..

- (a) *Broadband tools*: measure indicators of both externalizing and internalizing problems;
- (b) *Narrowband tools*: measure only indicators of internalizing problems;[138] and
- (c) Screening tools that measure domains/indicators beyond mental health and wellbeing indicators, such as indicators of the social determinants of health.[139]

***Best Practice**:*

The variety of and options for screening tools has rapidly proliferated in recent years. As such, best practices recommend "individual research studies" as one of the best sources of evidence to consider in selecting a specific screening tool.

Comm'n for Behavioral Health, *Counting What*, at 103.

2. Selecting a Screening Tool.

There are a number of critical, specific considerations that go into selecting a screening tool. Generally, however, best practices recommend that the selection of a screening tool be guided primarily by evaluation of the *appropriateness, technical adequacy, and feasibility and usability of the screening tool*.

(a) Appropriateness of Screening Tool.

A screening tool should be *appropriate* or aligned with the identified purpose, objectives, initiatives, and needs of the target student population and school or school division. In determining the *appropriateness* of a screening tool, teams should evaluate whether there is evidence of the tool's appropriateness across *three categories*:

Conceptual Overview—Categories of Screening Tool Appropriateness:

1. Contextually Appropriate.

Aligned with (consistent with and relevant to) the defined purpose & objectives of UMHS, the broader initiatives of the school/school division, and intended use of the screening data.

2. Developmentally Appropriate.

Designed to be administered to the age(s) & developmental level(s) of the target student population.

3. Culturally Appropriate.

Aligned with & responsive to the cultural & linguistic demographic composition of the target student population & school community.

[138] Comm'n for Behavioral Health, *Counting What Counts*, at 103.
[139] Rhode Island Dep't of Educ., *Guidance*, at 12.

(i) Contextually Appropriate: A screening tool is "*contextually appropriate*" if it is aligned with the defined purpose and objectives of UMHS, the intended use of screening data, the broader goals and initiatives of the school/school division, and the needs of the student target population and overall school community.[140]

To determine whether a screening tool is *contextually appropriate*, the primary consideration is whether the constructs measured and data obtained by the tool are aligned with—or *consistent with and relevant to*—the identified purpose and objectives for UMHS, or whether the tool is:

- *Designed to measure the specific indicators of student risks, challenges, needs, strengths, or wellbeing that the school/school division "seeks to identify*."[141] In other words, whether the screening tool measure indicators and generates data *relevant to and consistent with* the identified objectives for what the school/school division seeks to learn and accomplish through the screening;
- *Designed to measure more relevant data than duplicative data.* Evaluating the relevancy of data generated is necessary to avoid redundant or duplicative data collection. Teams should evaluate the specific data that the tool is designed to generate in comparison to already-existing data to which the school/school division already has access to ensure that the tool collects primarily the necessary and desired data.[142]
- *Contextually aligned with and able to support the structure, capacity, and resources of the school or school division's existing MTSS framework/comprehensive service delivery system*.[143]

(ii) Developmentally Appropriate: A screening tool is *developmentally appropriate* if it is designed to be administered to students of the age(s) and developmental level(s) of the student target population. In considering whether a tool is developmentally appropriate, the primary consideration is whether there is evidence that the tool was designed and evaluated for students of the age and developmental range of the student target population.

(iii) Culturally Appropriate: A screening tool is *culturally appropriate* if it is aligned with and responsive to the cultural and linguistic composition of the student target population and the broader school community.[144] In determining whether a screening tool is culturally appropriate, teams should:

> *The cultural appropriateness of a screening tool is important because cultural various in beliefs relating to mental health and child development can impact the accuracy of screening results by "show[ing] up as problems if the screening tool has not been normed for or informed by such variations."*
>
> SAMHSA, *Ready, Set, Go, Review*, at 20.

(a) Identify the demographic, linguistic, and other characteristics and needs of the target student population, the school, and the surrounding community, including:

- The current needs of the student target population, the overall student population, and the community, including:
    - The areas of greatest needs in the community and student population;[145]
    - The degree of literacy of the student population being screened and whether the screening tool has "been tested for a range of literacy levels,"[146] and

[140] Comm'n for Behavioral Health, *Counting What Counts*, at 103, 106.
[141] AWARE, *Screening Guide*.
[142] Wisc. Dep't of Public Instruction, *Screening Resource Guide*; Romer, et al., *Implementation Guide (Version 2.0)*, at 16.
[143] Romer, et al., *Implementation Guide (Version 2.0)*, at 16.
[144] Comm'n for Behavioral Health, *Counting What Counts*, at 103.
[145] AWARE, *Screening Best Practices*.
[146] SAMHSA, *Ready, Set, Go, Review*, at 20.

    - Whether the tool has evidence of being trauma-informed.[147]
- The cultural and linguistic backgrounds of the target student population and the broader school community, including rates of limited English proficiency and the most common languages spoken other than English.

(b) Evaluate whether there is evidence that the tool was "validated or normed on a sample similar to the population being evaluated;"[148]

(c) Considering whether the tool is linguistically appropriate and accessible.[149] This involves considering whether the tool has available accommodations or adaptations that are aligned with the needs of LEP students, including:

- (i) Whether the screening tool includes translations or is otherwise capable of being administered in the most prevalent languages other than English spoken by the student population; and
- (ii) If the available translations are *adequate*, or the translations are accurate and easily understood by the participating population. Ideally, this would be considered in consultation with a translator/interpreter or school staff with expertise in limited English proficiency students and/or the specific language.[150]

(b) Technical Adequacy.

The technical adequacy of a screening tool is primarily determined by evaluating **psychometric evidence** of the screening tool's **reliability** and **validity—**or evidence that "the screener can accurately and reliably identify both population and individual student needs to inform data-based decision-making processes."[151]

***Overview—Technical Adequacy**:*

Evaluation of psychometric evidence of the screening tool's:

*1. **Reliability**: Ability of the tool generate consistent, comparable scores each time it is used;*
&

*2. **Validity**: Degree to which the tool measures the constructs & indicators it is intended to measure.*

(i) Reliability: The *reliability* of a screening tool is *the degree to which the screening tool generates comparable scores each time it is used*[152]and should be evaluated based on evidence of:

- *Consistency* of scores generated by the screening tool across three measures:[153]
    - *Internal Consistency*: evidence of consistency of scores across items within a measure;
    - *Test-retest Consistency*: evidence of consistency of scores across subsequent administrations; and
    - *Inter-rater Consistency*: evidence of consistency across informant ratings.

[147] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 13.
[148] SAMHSA, *Ready, Set, Go, Review*, at 16.
[149] Comm'n for Behavioral Health, *Counting What Counts*, at 106.
[150]
[151] Comm'n for Behavioral Health, *Counting What Counts*, at 103, 106.
[152] SAMHSA, *Ready, Set, Go, Review*, at 18.
[153] Romer, et al., *Implementation Guide (Version 2.0)*, at 14.

- *Diagnostic Accuracy* or the reliability with which the tool differentiates between at-risk students and students not at risk. This is often considered one of the most important reliability considerations and should be considered based on evaluating evidence of the tool's:[154]
    - *Sensitivity:* the tool's capacity to identify at-risk students or yield "true positives"; and
    - *Specificity:* the tool's capacity to rule out students not at-risk or yield "true negatives".

- *Recommendation*: Many sources recommend also taking into account "how the tool was normed and what populations were included in the norming sample."[155]

(ii) Validity: The *validity* of the screening tool is *the degree to which the chosen screening tool measures the constructs and indicators that it is intended to measure*,[156] should be determined based on evaluation of evidence of the tool's:[157]

- *Construct Validity*: "[T]he extent to which the measurement estimates of the latent constructs align with preordained theory or prior knowledge-based expectation";

- *Predictive Validity*: A type of criterion validity measuring the extent to which the screening tool can accurately identify which students are at-risk or have unmet mental health needs and may be in need of intervention or support;

- *Consequential Validity:* The capacity of the screening tool to promote "positive intervention outcomes;" and

Best Practice:

Consider selecting a screening tool that results in valid cut scores is because valid cut scores "help reduce false positives and false negatives and assure that students are receiving the services they need."

SAMHSA, Ready, Set, Go, Review, at 18.

- *"Test Fairness":* The extent to which the screening tool "performs similarly across various subgroups, including those defined by gender, race/ethnicity, language, geographic region, and sexual orientation."[158]

[154] Romer, et al., *Implementation Guide (Version 2.0)*, at 14; AWARE, *Screening Guide*.
[155] Rhode Island Dep't of Educ., *Guidance*.
[156] SAMHSA, *Ready, Set, Go, Review*, at 18.
[157] Romer, et al., *Implementation Guide (Version 2.0)*, at 14.
[158] Romer et al., *Implementation Guide (Version 2.0)*, at 14.

(c) Usability & Feasibility.

The usability and feasibility of a screening tool can be best be understood as the extent to which the screening tool would be perceived by teachers and other staff who would be administering the tool/interpreting its results as acceptable—that is, easily usable and feasible—within the unique context and limitations of the school environment.

Overview—Usability & Feasibility as Acceptability:

Teachers & staff involved in the screening process are more likely to perceive a screening tool as acceptably usable & feasible if they feel that:

(i) The screening process as a whole is sufficiently efficient to ensure minimum disruption to instructional time & core academic activities;

(ii) The tool makes the data available quickly & in a format aligned with "educator understanding of the classroom;"

(iii) The data obtained & results generated adequately inform decision-making in all tiers of the MTSS framework; and

(iv) The overall costs in terms of staff time and resources do not outweigh the perceived benefits associated with screening.

Comm'n for Behavioral Health, Counting What Counts, at 103; Romer et al., Implementation Guide (Version 2,0), at 15.

***(i) Usability*:** The *usability* of a screening tool refers to the extent to which users can easily access, use, and understand the screening tool and the results obtained from the screening tool,[159] or the extent to which (i) the format and means for administering and scoring the screening is "user friendly" and easily understandable and (ii) the tool generates and presents screening results in an easily understandable manner that facilitates meaningful and effective decision-making relating to student needs and interventions. In determining the *usability* of a screening tool, consider:

(a) *The ease and accessibility of administering the tool and interpreting the results:* Or whether the screening tool would be "user friendly" and "readily available" to those tasked with administering it or interpreting screening results, meaning accessible to use as intended. This includes considering:

- How quickly screening results are available after completing screening;
- The availability and accessibility of supported accommodations, including:[160]
    - Translations for limited English proficiency students; and
    - Tech support during screening administration or scoring.

(b) *The accessibility and comprehensibility of screening*: Or whether the results generated by the screening tool for teachers and other applicable staff are sufficiently accessible and understandable as to effectively and meaningfully inform decision-making, including whether:

[159] Romer et al., *Implementation Guide (Version 2.0)*, at 14.
[160] Comm'n for Behavioral Health, *Counting What Counts*, at 16.

- There is evidence of *treatment utility* or evidence of the tool's ability to effectively guide decisions relating to intervention;[161] and
- The results:
    - Are easily understood in the context of what results mean for student needs; and
    - Can be used to meaningfully and effectively "inform intervention and follow-up procedures."[162]

(c) *The training needs & accessibility:* Or the training needs for teachers and school staff to appropriately administer the tool and interpret the screening results and the accessibility of the necessary training, including:

- The amount of training teachers and relevant school staff would need in order to administer the screening tool appropriately, interpret screening results, and understand how to use the results to meaningfully and effectively guide decisions relating to student needs and interventions; and
- Whether the tool comes with or provides access to any or all of such training.[163]

(ii) Feasibility: The *feasibility* of a screening tool refers to the extent to which data generated from screening can be "collected, analyzed, interpreted, and used" within the specific parameters, limitations, and contexts of the educational environment. The *feasibility* of a screening tool should be based on an evaluation of:

> ***Best Practice:***
>
> *The selected screening tool should consist of fewer than 25 items and, ideally, fewer than 20 items.*
>
> *Romer et al., Implementation Guide (Version 2,0), at 14.*

(a) *The costs of administering the screening tool and the scoring results*, in terms of the time, resources and effort necessary, including:

- The allocation of time necessary to administer and score the screening, and the potential degree of interruption to instructional time, educational activities, and staff time (e.g., instructional planning time, time for administrative tasks);[164] and
- The resources and effort needed from teachers and relevant school staff to administer and complete the screening.

(b) *The benefits as perceived by teachers and relevant school staff:* The perceptions of teachers and other relevant staff as to the extent to which the time, effort, and resources necessary to administer and complete UMHS using the tool outweighs the benefits associated with it;[165] and

(c) *Whether the costs outweigh the benefits for teachers and school staff:* Evaluate the identified costs in comparison to the identified benefits to ensure that the screening tool does "not require a prohibitive amount of time, effort, or educational resources" relative to the benefits of conducting.[166]

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[161] Comm'n for Behavioral Health, *Counting What Counts*, at 16.
[162] Romer et al., *Implementation Guide (Version 2.0)*, at 14; Comm'n for Behavioral Health, *Counting What Counts*, at 16.
[163] Romer et al., *Implementation Guide (Version 2.0)*, at 14.
[164] Rhode Island Dep't of Educ., *Guidance*, at 10.
[165] Comm'n for Behavioral Health, *Counting What Counts*, at 103.
[166] Romer et al., *Implementation Guide (Version 2.0)*, at 14.

(d) Other Considerations: Costs & Resources.

Finally, in selecting a screening tool it is critical to carefully evaluate both the initial and ongoing financial costs and resources associated with implementing, administering, and utilizing the screening tool to ensure that the costs of the screening tool do not outweigh the benefits obtained as a result of the process,[167] including:

(a) *Financial costs*: Whether the tool is financially feasible to procure *and* sustain.[168] This includes considering:

- Whether the screening tools is available at low-cost or no-cost or the general pricing model;
- What, if any, programs or services are included in the cost, including:[169]
    - Professional development and training;
    - Ongoing technical assistance, including real-time technical support to assist during screening administration;
    - Access to a web-based platform or data management system; and
    - A progress-monitoring tool.
- Any additional technical support costs associated with initial implementation and ongoing maintenance of the screening tool.

(b) *Time:* The amount of time and effort the screening tool requires throughout the entire process, including the time needed to:[170]

- Administer and complete screening;
- Manage screening data and results, including:
    - Collect and aggregate screening data; and
    - Manage, access, review, store, and communicate screening data and results.

(c) *Staffing/Administrative Requirements:* The amount of additional requirements for staff, including:[171]

- The amount of training required to adequately and effectively administer and complete the screening process, including the time and effort required of staff to complete such training; and
- The amount of time and effort required of staff to complete or perform duties relating to specific aspects of the screening process and the extent to which it would disrupt or impede instructional time and staff time outside of instructional time, including instructional planning time.

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[167] SAMHSA, *Ready, Set, Go, Review*, at 17.
[168] Col. WARE, *Screening Toolkit*, at 18.
[169] Rhode Island Dep't of Educ., *Guidance*, at 10.
[170] Rhode Island Dep't of Educ., *Guidance*, at 10; SAMHSA, *Ready, Set, Go, Review*, at 17.
[171] SAMHSA, *Ready, Set, Go, Review*, at 17.

IV. POLICIES AND PROCEDURES FOR IMPLEMENTATION & ADMINISTRATION.

This section addresses best practices and key considerations for developing plans, processes, and procedures for all aspects of UMHS implementation and administration, including: (i) legal and ethical considerations, such as privacy, confidentiality, and parental consent; (ii) screening data infrastructure, management, interpretation, and use; (iii) screening result response, referral, and follow-up; (iv) follow-up and communication with parents, students, and appropriate staff; (v) staff roles, responsibilities, and professional development; and (vi) ongoing evaluation and improvement of the UMHS program.

Best practices strongly recommend that the team complete these processes prior to implementation to ensure maximum opportunities for key stakeholders to voice concerns and provide feedback and sufficient time for the team to modify and adjust policies and procedures to address those concerns, which is critical to ensuring successful implementation and maintenance of UMHS as well as stakeholder, parent, student, and teacher support and trust.

A. Legal & Ethical Considerations.

This subsection addresses key legal and ethical considerations relating to UMHS and how such considerations factor into the development of plans and procedures relating to the privacy and confidentiality of student information, parental consent, and student assent, including (i) understanding applicable laws and regulations as applied to the UMHS process; (ii) considering any existing guidelines, such as those established by the Department of Education or other similar entities, that "may help determine the legality, ethics, and typical policy of conducting universal screenings in schools;"[172] and (iii) developing plans and procedures for UMHS that are in compliance with all applicable legal and regulatory requirements and sufficiently address common or prevalent ethical considerations and concerns.

[172]SAMHSA, *Ready, Set, Go, Review*, at 25.

1. Overview of Relevant Legislation & Regulations.

(i) The Family Educational Rights and Privacy Act (FERPA) [20 U.S.C. § 1232(g)]. [173] FERPA applies to establishes certain protections and parental rights with respect to student education records, including rights and protections relating to privacy, access, inspection, and disclosure of such education records. When a student reaches 18 years of age or otherwise becomes an "eligible student" as defined by FERPA, all rights transfer from the parent to the student.

> ***FERPA—Education Records:***
>
> Those records, files, documents, and other materials which, except as provided in subsection (B):
>
> (i) Contain information directly related to a student; &
>
> (ii) Are maintained by an educational agency or institution or by a person acting on the behalf thereof.
>
> *20 U.S.C. § 1232g(a)(4)(A).*

FERPA applies to any educational agency or school that receives funds under a program administered by the U.S. Department of Education.

In general, FERPA affords the following rights and protections:

(a) Right to Access & Inspect Education Records: FERPA requires a school/local educational agency [LEA]/state educational agency [SEA] to provide the parent of any student, upon request, the opportunity to access and inspect their child's education records within a reasonable period of time not to exceed 45 calendar days following the receipt of a request.[174]

(b) Disclosure of Education Records: FERPA prohibits a school/LEA from disclosing or releasing a student's education records or any personally identifiable information contained therein (other than directory information) *without the prior written consent of that student's parent*,[175] except in the case of release/disclosure that falls under one of the enumerated exceptions, including:

- Disclosure to other school officials, including teachers within that school or LEA, who have been determined to have *legitimate educational interests* in the education records to be disclosed;[176]
- Disclosure in connection with a health or safety emergency where knowledge of the information disclosed is necessary to protect the health or safety of the student or other individuals.[177]

(ii) The Protection of Pupil Rights Amendments (PPRA) [20 U.S.C. § 1232(h)]: PPRA applies to any programs or activities of a SEA, LEA, or other entity that receives funds under a program of the U.S. Department of Education and establishes certain rights and protections for parents and students relating to participation in certain surveys and activities and uses of student information for marketing purposes.[178]

The rights afforded to parents under the PPRA transfer to the student upon the student reaching 18 years of age or status as an emancipated minor under applicable state law.

In general, the PPRA affords the following rights and protections:

(a) Right to Access & Inspect: PPRA affords parents the right to inspect:

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[173] Col. WARE, *Screening Toolkit*, at 27.
[174] 20 U.S.C. § 1232g(a)(1)(A).
[175] 20 U.S.C. § 1232g(b)(1).
[176] 20 U.S.C. § 1232g(b)(1)(A).
[177] 34 C.F.R. § 99.31(a)(10), § 99.36(a).
[178] Col. WARE, *Screening Toolkit*, at 27.

- *Instructional materials:* Including any supplementary materials that will be used in connection with any survey, analysis, or evaluation administered by an LEA/school;[179]
- *Protected information surveys:* Regardless of whether such survey is required of all students and/or funded as a part of a program administered by the U.S. Department of Education;[180] and
- *Third-party surveys, upon request:* Upon request, *any* survey created by a third party prior to the survey being administered or distributed by a school to the student.[181]

PPRA—Protected information surveys:

Surveys, evaluations, or analyses that ask for information relating to one or more of the following:

(1) Political affiliations or beliefs of the student or his parents;

(2) Mental or psychological problems of the student or his family;

(3) Sex or behavior attitudes;

(4) Illegal, anti-social, self-incriminating, or demeaning behavior;

(5) Critical appraisals of other individuals with whom the student has close family relationships;

(6) Legally recognized privileged or analogous relationships, e.g., lawyers, physicians, or ministers;

(7) Religious practices, affiliations, or beliefs of the student or his parents; or

(8) Income, other than as required by law for determining eligibility for certain programs.

20 U.S.C. § 1232h(b) & (c)(1)(B).

(b) Parental Consent: PPRA prohibits any school/LEA/SEA from *requiring* a student to participate in any *protected information* survey *that is funded as a part of a program administered by the U.S. Department of Education* [or funded by an "applicable program"] without the *prior written, informed consent of the student's parent*.[182]

(c) Rights to Notice & Opt-Out: PPRA requires each LEA to, for certain enumerated activities, provide parents (i) at least annually at the beginning of the school year, notice of the activity and the specific or approximate date on which each such activity is scheduled or expected to be scheduled,[183] and (ii) an opportunity to opt their child out of participating in such activity.[184]

The activities to which such notice and opt-out requirements apply include:

- Activities involving the collection, disclosure, or use of student personal information for the purpose of marketing or selling that information, or providing that information to others for such purpose;
- The administration of any *protected information survey* that is either:
    - (i) Not funded as a part of a program administered by the U.S. Department of Education; or
    - (ii) Funded as a part of a program administered by the U.S. Department of Education but for which the participation of each student *is not required*.[185]
- Any nonemergency, invasive physical examination or screening administered by a school that meets the specifications set forth in the act.[186]

(d) Required Policies & Procedures: PPRA requires each LEA to develop and implement policies and procedures relating to:

[179] 20 U.S.C. § 1232h(a).
[180] 20 U.S.C. § 1232h(c)(1)(B).
[181] 20 U.S.C. § 1232h(c)(1)(A).
[182] 20 U.S.C. § 1232h(b); SAMHSA, *Ready, Set, Go, Review*, at 26.
[183] 20 U.S.C. § 1232h(c)(2)(B).
[184] 20 U.S.C. § 1232h(c)(2)(A)(ii).
[185] SPPO-21-01: Protection of Pupil Rights Amendment (PPRA), Student Privacy Pol'y Office of U.S. Dep't of Educ., (2020), https://studentprivacy.ed.gov/sites/default/files/resource_document/file/20-0379.PPRA_508.pdf.
[186] 20 U.S.C. § 1232h(c)(2)(C).

- The protection of student privacy in the event of the administration or distribution of a *protected information survey*, including procedures for the right of a parent to inspect, upon request, any such survey;[187]
- The collection, disclosure, or use of personal information collected from students for the purpose of marketing or selling that information, or providing it to others for such purpose, including procedures for parental access and inspection.[188]
    - *Exception: The above provision does not apply to the collection, disclosure, or use of personal information collected for the exclusive purpose of developing, evaluating, or providing educational products or services for or to students or educational institutions, such as in the case of "tests and assessments used by elementary or secondary schools to provide cognitive, evaluative, diagnostic, clinical, aptitude, or achievement information about students (or to generate other statistically useful data for the purpose of securing such tests and assessments) and the subsequent analysis and public release of the aggregate data from such tests and assessments."[189]*
- The provision of notice to parents of the adoption or continued use of policies adopted by an LEA pursuant to the act at least annually at the beginning of the school year.[190]

(iii) The Individuals with Disabilities Education Act (IDEA) [20 U.S.C. § 1400 et seq.]: The IDEA establishes certain rights and protections for students with disabilities and their parents relating to ensuring the provision of a free appropriate public education, including requirements relating to evaluations and eligibility determinations, the development of Individualized Education Programs, and the provision of special education and related services.

For UMHS purposes, the most relevant aspect of IDEA, is that *universal mental health screening does not constitute a screening or evaluation under IDEA nor does it satisfy any requirements under IDEA relating to child find or the screening and evaluation of children with disabilities for eligibility for special education and related services*.[191] While IDEA requires written, informed parental consent for certain evaluations to determine eligibility for special education and related services, it expressly clarifies that "*the screening of a student by a teacher or specialist to determine appropriate instructional strategies for curriculum implementation*" is not considered an evaluation under the IDEA.[192]

(iv) Title IV of the Every Student Succeeds Act (ESSA) [20 U.S.C. § 4001, et seq.]: Title IV of ESSA provides that any SEA, LEA, or other entity receiving funds under that title, including funds received under Part A Student Support and Academic Enhancement Grants, *"shall obtain prior written, informed consent from the parent of each child who is under 18 years of age to participate in any mental-health assessment or service that is funded under this title and conducted in connection with an elementary or secondary school under this title."[193]*

In other words, any school or LEA seeking to use funds received under Title IV, Part A for universal mental health screening would be *required* to obtain prior written, informed parental consent from the parent of each child in order for that child to participate in the screening.

(v) The Health Insurance Portability and Accountability Act of 1996 (HIPAA) [42 U.S.C. § 1320d et seq.; 45 C.F.R. Parts 160 through 164]: HIPAA requires any health care provider that is a *covered entity* to protect

[187] 20 U.S.C. § 1232h(c)(1)(B).
[188] 20 U.S.C. § 1232h(1)(E)-(F).
[189] 20 U.S.C. § 1232h(c)(4)(A)(iv).
[190] 20 U.S.C. § 1232h(2)(A).
[191] SAMHSA, *Ready, Set, Go, Review*, at 25.
[192] 20 U.S.C. § 1414(a)(1)(E); 34 C.F.R. § 300.303.
[193] 20 U.S.C. § 4001(a)(1).

individuals' health records and other personal health information that such entity maintains or transmits.[194] Under HIPAA, *covered entities* include health care providers that transmit health information in electronic form in connection with covered transactions.[195]

The applicability of HIPAA to schools in the context of UMHS is limited to highly specific situations and it is relatively unlikely that HIPAA would apply. However, it is important to understand when HIPAA would apply in order to consider whether it applies with respect to a specific school/LEA in implementing and administering UMHS.

> ***HIPAA—Protected Health Information:***
>
> Excludes individually identifiable health information:
>
> (i) In education records covered by the FERPA; &
>
> (ii) "Treatment records" described in FERPA: records on a student who is at least 18 years old or enrolled in an institution of postsecondary education which are made or maintained by a medical professional in connection with the provision of treatment to the student.
>
> *45 C.F.R. § 160.103; 20 U.S.C. § 1232g(a)(4)(B)(iv)*

The relevant provisions of HIPAA apply to *any health care provider* that is a *covered entity.* A public school could, in limited situations, be deemed a *health care provider*. A public school would be deemed a *covered entity* under HIPAA if it (i) meets the definition of a *health care provider* AND (ii) transmits any personal health information electronically in connection with a transaction "for which HHS has adopted a transaction standard."[196] However, *even if a public school is considered a covered entity under HIPAA, the relevant provisions of HIPAA relating to protected health information still may not apply.* HIPAA's definition of *protected health information* expressly excludes those *education records* and *treatment records* subject to FERPA. Thus, a school that is a *covered entity* would nevertheless not be subject to HIPAA if the school's only health records constitute "education records" or "treatment records" under FERPA.[197]

In other words, HIPAA would only apply to a public school that (i) is a *health care provider,* (ii) is a *covered entity* or that transmits any personal health information electronically in connection with a transaction "for which HHS has adopted a transaction standard," *and* (iii) has health records other than those considered "education records" or "treatment records" under FERPA.

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[194] *Joint Guidance on the Application of the Family Education Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to Student Health Records*, USDHHS & US DOE (Dec. 2019 update), https://www.hhs.gov/sites/default/files/2019-hipaa-ferpa-joint-guidance.pdf, at 5.
[195] 45 C.F.R. § 160.103.
[196] *Joint Guidance*, at 7.
[197] 45 C.F.R. § 160.103; *Joint Guidance*, at 7.

	Overview of Most Pertinent Legal Requirements		
	FERPA **(20 U.S.C. § 1232g)**	**PPRA** **(20 U.S.C. § 1232h)**	**Title IV of ESSA** **(20 U.S.C. § 4001 et seq.)**
Consent/Opt-Out	Requires written parental consent for disclosure of a student education records or any personally identifiable information contained therein, except in certain enumerated cases.	Requires ***prior written parental consent*** for any student to participate in any *protected information survey* that is <u>*both*</u> (i) required of students & (ii) funded as a part of a program administered by the U.S. Department of Education. Affords parents the right **to *opt their children out*** of certain activities, including any *protected information survey* that is <u>*either*</u> *(i) not* funded as a part of a program administered by the U.S. Department of Education or (ii) *not required* of students.	Requires any state, LEA, or other entity receiving funds under Title IV to obtain ***prior written, informed consent*** from the parent of any student who is under 18 years of age for such student to participate in any *mental-health assessment that is funded under Title IV*, (including Part A of Title IV, Student Support and Academic Enrichment Grants).
Right to Inspect	Requires LEA's to allow parents, upon request, to access and inspect their child's educational records.	Requires LEA's to allow parents, upon request, to access and inspect: 1) All instructional materials, including supplementary material used in connection with a survey; 2) Any *protected information survey*; & 3) Any survey created by a third party.	
Notice		Requires notice, at least once at the beginning of each school year, of the specific or approximate dates on which certain activities are scheduled, including any *protected information survey.*	

2. Confidentiality & Privacy.

It is critical to carefully consider and develop clear, consistent plans and procedures relating to the confidentiality and privacy of student data in the screening process to ensure that such plans and procedures are (i) consistent with all applicable state and federal laws and regulations and (ii) responsive, to the extent feasible, to the most common concerns of parents, guardians, and caregivers.

Specifically, these plans and procedures should:

- Be in compliance with all applicable laws and regulations;
- Ensure data is securely collected and not accessible to others;
- Be developed in consultation with:
    - Parents and other stakeholders to solicit feedback relating to and address common concerns; and
    - Information security personnel to identify a secure electronic file format that can be limited to only those parties responsible for coordinating data collecting and intended parties;[198]
- Identify "specific circumstances" in which information obtained from screening "will be shared with other service providers;"[199] and
- Identify who will be responsible for gathering data and organizing it for review by appropriate staff members.

[198] AWARE, *Screening Guide*, at 3.
[199] SAMHSA, *Ready, Set, Go, Review*, at 28.

3. Parental Consent.

The development of clear, consistent written procedures relating to parental notice and consent that are consistent with all applicable federal and state laws and sufficiently responsive to common parental concerns is essential to facilitating parental support and trust for the UMHS initiative, encouraging student participation in UMHS, and successfully implementing and sustaining an effective UMHS program:[200]

(a) ***Forms of Consent:*** Teams will need to select what form of consent will be required for screening. In making this decision, teams must consider all applicable state and federal laws and regulations, common parental concerns, and ethical considerations relating to how consent and notice procedures affect perceptions of transparency, trust, and support in the school and the UMHS program. The *forms* of consent that must be considered are *active consent* and *passive consent*.

(i) *Active consent:* Requires the school to obtain prior written, informed consent of the parent of a student for that student to participate in the screening. Only those students whose parents provided prior written consent would participate in UMHS. Any student whose parent did not response to the request for consent or refused to provide consent would not be permitted to participate in the screening.

(ii) *Passive consent*: Commonly known as an "opt-out" consent model, requires the school/school division to provide to each parent of a student who will be asked to complete UMHS reasonable notice of the screening and an opportunity to opt their student out of participation. Only those students whose parents elected to opt-out of participation in the screening would be excluded from participation—all other students would participate in the UMHS.

(b) ***Consent Considerations.*** In deciding which form of consent to require for students to participate in UMHS, teams should consider:

(i) *Legal & Regulatory Requirements*. The most relevant federal law for consent purposes is PPRA. Generally, UMHS does *not* fall under the category of surveys/activities for which PPRA requires *prior, written parental consent* (*active consent*) because, while UMHS measures will involve one or more of the categories of *protected information* enumerated therein, they are typically not *both* (i) funded as a part of a program administered by the U.S. Department of Education *and* (ii) required for all students.[201]

Thus, in most cases, it would be permissible for schools and school divisions to adopt a *passive consent* model, whereby they would notify the parent of each student at the beginning of the year of (a) the UMHS screening initiative, (b) the specific or approximate dates of each administration window, (c) the right of each parent to *opt their child out of participation*, and (d) the process and deadline for opting their child out of participation.

However, teams should also consider applicable state laws and regulations relating to parental consent that may be more comprehensive than or otherwise go beyond the requirements set forth in federal law and regulation.

(ii) *Ethical & Other Considerations*. There are additional considerations relating to the implications of each form of consent on *parental perceptions* of UMHS and, therefore, parental willingness to allow their child to participate. These, in part, involve *ethical* considerations about parental rights to transparency and choice with respect to what

[200] Romer et al., *Implementation Guide (Version 2.0)*, at 17.
[201] 20 U.S.C. § 1232h(c)(2)(B).

their children are asked to do by schools, particularly activities involving the collection and use of student personal information. These considerations, while they may go beyond what is required pursuant to applicable state and federal law, are important to ensuring and maintaining support for and participation in the UMHS program.

Passive consent may be permissible in most cases and research indicates that it tends to result in higher student UMHS participation rates, but it tends to contribute to parental mistrust and perceptions about lack of transparency in screening and school procedures in general.[202] This may adversely impact the ability to successfully implement *and* maintain effective UMHS.

Active consent, on the other hand, tends to reduce overall participation rates *but* contributes to higher trust between parents and schools and better parental perceptions of transparency, and may increase the willingness of parents to communicate and engage with schools in discussions about their child's mental health.[203]

(d) Consent Procedures: Regardless of the form of consent selected, teams must adopt clear, consistent, and understandable policies and procedures relating to the consent process. These procedures should, at a minimum:

- Detail specific consent/opt-out procedures, including how parents and students will be informed of the procedures and deadlines for providing consent or opting their child out of participating in UMHS;
- Require any consent/notification materials to include pertinent information about UMHS, including a description of the process and goals, information about the screening tool, and contact information for those with further questions or concerns;[204]
- Ensure all consent forms and related information are available in multiple formats, including various languages prevalent in the school community;[205] and
- Include procedures for providing parents, upon request, the opportunity to access and inspect UMHS measures/instrument within a reasonable time period, consistent with applicable state and federal laws and regulations.

4. Assent.

<u>Assent</u> is the "*willing agreement to participate in an activity for which the purpose and process has been explained and any alternatives have been discussed*."[206] While minors cannot provide legal consent and, therefore, their consent need not be obtained prior to asking them to participate in UMHS, best practices recommend seeking and obtaining informed, voluntary assent from students to complete screening.[207]

Requiring informed student assent to participate in UMHS has been found to improve student willingness to "participate openly" and, thus, helps ensure "useful results" are obtained from the screening.[208] If teams adopt procedures requiring student assent prior to participating in UMHS, best practices recommend such procedures:

- Require documentation of informed student assent through signed assent forms;[209] and
- Include requirements ensuring that, prior to asking for student assent, students are adequately informed of and understand:

[202] Comm'n for Behavioral Health, *Counting What Counts*; Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 13.
[203] Comm'n for Behavioral Health, *Counting What Counts*; Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 13.
[204] Comm'n for Behavioral Health, *Counting What Counts*, at 108-109.
[205] Comm'n for Behavioral Health, *Counting What Counts*, at 107.
[206] SAMHSA, *Ready, Set, Go, Review*, at 30.
[207] SAMHSA, *Ready, Set, Go, Review*, at 30.
[208] SAMHSA, *Ready, Set, Go, Review*, at 30.
[209] SAMHSA, *Ready, Set, Go, Review*, at 30.

- The screening process, purpose, and objectives;
- How data obtained from the screening will be used and the circumstances in which students may be identified as at-risk or referred for further evaluation or intervention or a student's parents will be contacted; and
- The rights of students to refuse to participate in the screening entirely or decide not to complete the screening at any time, even if the parent of such student provided formal consent to the student's participation or failed to opt the student out of participation.[210]

5. Additional Ethical Considerations.

"Identifying a student's needs without having the capacity to provide support could be harmful."[211] Therefore, schools and school divisions have an *ethical duty* to ensure prior to implementing UMHS that they have the ability and capacity to adequately, promptly, and meaningfully carry out all aspect of the UMHS process.[212]

Capacity as an Ethical Consideration - the Data:

Research indicates that when more than 20% of students in a school demonstrate elevated risk, the necessary individual supports are "likely to outstrip [the school's] response capacity."

Col. WARE, Screening Toolkit, at 21.

Thus, teams have an ethical duty to:

- *Ensure sufficient response capacity*: ensuring (i) access to and availability of sufficient school-based and community-based resources and interventions to adequately and meaningfully address any and all student needs identified through screening, and (ii) that "[a]ppropriate resources [are] allocated to ensure that school personnel and other key stakeholders have the capacity to perform the necessary follow up;"[213]
- Ensure school staff have the capacity and proper training to participate in or complete appropriate aspects of the UMHS process; and
- Ultimately, "*be honest about their capacity limitations for responding to positive screens.*"[214]

[210] SAMHSA, *Ready, Set, Go, Review*, at 30; Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 15.
[211] Comm'n for Behavioral Health, *Counting What Counts*, at 19.
[212] Wisc. Dep't of Public Instruction, *Screening Resource Guide*, at 2.
[213] Wisc. Dep't of Public Instruction, *Screening Resource Guide*, at 2; Mich. DOE, *Screeners and Assessments*.
[214] Comm'n for Behavioral Health, *Counting What Counts*, at 19.

B. Screening Data:
Data Infrastructure & Systems, Data Management, & Data Interpretation & Use.

Teams must carefully consider and develop plans and procedures relating to (i) data infrastructure and systems necessary for effectively managing, analyzing, and using UMHS data; (ii) the collection, storage, access, and management of UMHS data; and (iii) the interpretation and use of UMHS data for data-based decision making.

1. Data Infrastructure.

Teams must carefully consider the data infrastructure and system capacity, capabilities, and features necessary to facilitate efficient and timely collection, access, interpretation, and use of data obtained through UMHS, consider the extent to which existing data infrastructure or systems could be leveraged, identify any inadequacies in the capacity or capabilities of existing data infrastructure and systems, and develop strategies for addressing any inadequacies and needs prior to UMHS implementation. Specifically, teams should consider:

(i) Data infrastructure and system capacity and capabilities necessary for the effective management of UMHS data: Assess the specific data infrastructure and system capacity, capabilities, and features needed to ensure the effective ongoing management of UMHS data from the initial data collection process to data interpretation, follow-up, and progress monitoring, including:

(a) *Data conversion and visualization capabilities* (e.g., how the data will be presented and summarized);

- Consider "to what extent [the tool, e.g., screener, platform, system, etc.] will allow data analysis consistent with screening goals."[215]

(b) *Data retention & removal*: Assess the capabilities/means for handling and removing data obtained from inadvertent screening (e.g., parent did not consent and student participated anyway).[216]

(c) *Data linkage capabilities*: Evaluate capabilities for linking screening data to existing data systems,[217] including:

- Capability to connect screening data to:
    - (i) Decision-making processes relating to supports, services, and interventions, and
    - (ii) Follow-up tracking;[218]
- Means of integrating screening data with existing student information systems (SIS) and whether existing SIS have the requisite consents and processes "that explain how the data would be stored, who would have access, and how it would be used to include it in the data system;"[219] and
- Means of tracking student screening data and the efficacy of supports and interventions,"[220] as well as the progress and results of such assessments and interventions.

[215] Comm'n for Behavioral Health, *Counting What Counts*, at 110.
[216] Col. WARE, *Screening Toolkit*, at 30.
[217] Romer, et al., *Implementation Guide (Version 2.0)*, at 11 ("[M]any . . . screening tools are part of larger electronic data platforms and can often be linked to other student data (e.g., attendance, discipline, grades, and test scores) informing databased decision making.").
[218] Col. WARE, *Screening Toolkit*, at 30.
[219] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 11; Col. WARE, *Screening Toolkit*, at 29.
[220] SAMHSA, *Ready, Set, Go, Review*, at 55.

(d) *The adequacy of data privacy and access controls:* Data infrastructure and systems must have and "maintain adequate privacy controls" that limit access to certain student data, consistent with applicable law and regulation;[221] Teams should consider the means/capabilities for controlling and facilitating data access, including whether the infrastructure/system:

- Has sufficient means/measures for controlling who is granted access to what levels/type of data;[222]
- While still facilitating (i) "prompt analysis of results at multiple levels," (ii) ease of integration "with other district data collection systems" and sources of data (e.g., student well-being, various levels of intervention), and (iii) simple means of accessing data for team members and qualified school staff.[223]

Importance of Data Linkage:

Reviewing screening data alongside other data sources is essential to "ensure the validity of findings."

Col. WARE, *Screening Toolkit*, at 30.

(e) *Initial & ongoing financial costs and technical support needs*: Evaluate the *initial and ongoing*

- Financial costs of implementing/obtaining/leveraging, using, and maintaining the necessary data infrastructure and systems; and
- Technical support needs: consider
    - The technical support that will be necessary for the initial implementation and ongoing use and maintenance of data infrastructure and systems, as well as for periodic troubleshooting during UMHS administration or data analysis/review processes;
    - Whether the screening tool or data infrastructure or systems provide access to some form of technical support; and
    - Initial and ongoing financial costs of procuring or obtaining the necessary technical support.

Best Practice:

In evaluating data systems, teams should "prioritize accuracy, safety, and follow-through" and ensure the selected system "promote[s] communication to those making decisions while protecting student and family privacy."

Hoover & Bostic.

(ii) The suitability of existing data infrastructure and systems: Evaluate the extent to which the school/school division's existing data infrastructure and systems have adequate capacity and capabilities to be utilized or leveraged for the management of UMHS data, as compared to the necessary capacity and capabilities identified in consideration ***(i)***, including:

- The possibility/means of integrating screening data with existing student information systems (SIS);[224]
    - *Recommendation:* if considering using an existing SIS, it is essential to assess whether it has the requisite consents and processes "that explain how the data would be stored, who would have access, and how it would be used to include it in the data system."[225]
- Whether the particular screening tool selected includes or provides access to a means of data collection, storage, and conversion;[226]

[221] Romer, et al., *Implementation Guide (Version 2.0)*, at 11.
[222] Col. WARE, *Screening Toolkit*, at 30.
[223] Col. WARE, *Screening Toolkit*, at 30.
[224] Col. WARE, *Screening Toolkit*, at 29.
[225] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 11.
[226] Col. WARE, *Screening Toolkit*, at 29.

- "[M]any . . . screening tools are part of larger electronic data platforms and can often be linked to other student data (e.g., attendance, discipline, grades, and test scores) informing databased decision making."[227]

2. Data Management: Data Collection, Storage, & Access.

Teams must develop clear, transparent, and consistent plans and procedures relating to screening data collection, storage, management, and access that are designed to protect the confidentiality and privacy of student data and ensure the effective, meaningful, and timely collection, storage, management, & access of data throughout the UMHS process. Such plans and procedures should, at a minimum, include:

(i) A Data Collection Process: Defining, at a minimum, when and how data will be collected after screening is administered, including a timeline ensuring prompt collection of data after UMHS administration, including:

- Who will be responsible for data collection; and
- What supports need to be in place to collect data.[228]

(ii) Data Storage & Retention Protocols: Which, at a minimum, should identify where and how data will be stored[229] and include:

- Protections for confidentiality, privacy, and integrity of data that are consistent with, but may be more comprehensive than, all applicable laws and regulations and are designed to ensure that "the storage system is secure and that only authorized personnel have access to the data;"[230] and
- Procedures for data retention, including for how long data is retained, under what circumstances data may need to be reviewed, and processes for removing individual student data based on circumstances such as graduation, transfer, or parental request. [231]

(iii) Data Access Protocols: Which, at a minimum, should:

- Define how to access screening data, who may access screening data, and the forms in which the data will be returned to individuals granted access;[232] and
- Ensure adequate protection of data privacy, confidentiality, and integrity, consistent with applicable law and regulation.

3. Screening Data Review, Interpretation, & Use.

Teams must develop and implement procedures for the review, interpretation, and use of screening data in identifying student needs and concerns and informing decisions relating to interventions and school programming, including procedures for:

(a) ***A Data Review & Analysis Timeline***. The timeline should ensure individuals responsible for data analysis receive, review, and analyze screening data as soon as possible after completion of UMHS administration.

[227] Romer, et al., *Implementation Guide (Version 2.0)*, at 11.
[228] Ctr. for Sch. Mental Health, *Playbook*, at 2.
[229] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 16.
[230] Ill. State Bd. of Educ, *Lessons Learned*, at 24.
[231] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 16.
[232] Comm'n for Behavioral Health, *Counting What Counts*, at 109-110.

- Ideally, screening data should be received as soon as possible, on the day of screening completion, if feasible,[233] and data review should occur within a reasonable timeframe, ideally within one week of screening being conducted and no more than three weeks of screening being conducted.[234]

(b) ***Screening Data Review.*** Procedures for the review of screening data for "data quality, including potentially removing invalid data . . ., identifying duplicate responses, and examining missing data trends" help avoid duplication of data, expenditure of additional resources and staff time, and the over- or under-identification of students at risk.[235] Data review procedures should:

- Identify the groups or individuals who will be responsible for reviewing screening data.
    - *Best practice*: Data review personnel/groups should include student support personnel as well as school administrators and classroom teachers.[236]
- Outline how data will be returned to those responsible for reviewing it, including the format in which the data will be returned and "what level of analysis will be possible;"[237] and
- Include protocols for identifying and "potentially removing invalid data" and "duplicate responses," and "examining missing data trends."[238]

(c) ***Data Analysis & Interpretation.*** Procedures for data analysis and interpretation should be designed to ensure that the analysis and interpretation of screening data and decisions made on the basis thereof are "defensible and consistent with the intended and validated purpose of the" screening tool.[239] Such procedures should, at a minimum:

(i) *Define the appropriate uses & limitations of screening data:* Define and include guidance for staff responsible for reviewing, analyzing, and interpreting screening data on the appropriate uses and limitations of screening data in its capacity to inform decision-making on the individual student and school-wide level.[240]

(ii) *Include systematic protocols for identifying student needs and risks:* Protocols for analyzing and interpreting student screening results/data to identify student needs, identify students who are potentially at-risk, and determine the severity of risks and immediacy of response needed, and that identify and define:

General Categories of Risk:

1. *Positive for Risk*: Students should receive prompt follow-up in the form of evaluation to determine the exact level of risk and type of intervention needed. Includes:

a. *High Risk*: Students identified as at risk of harming self or others; immediate/same-day response/intervention;

b. *Some risk*: Students with some identified risk indicators should receive prompt follow-up (within a week);

2. *Negative for risk*: No response needed/communication of negative results.

SAMHSA, *Ready, Set, Go, Review*, at 50-51.

[233] Ctr. for Sch. Mental Health, *Playbook*.
[234] Comm'n for Behavioral Health, *Counting What Counts*, at 109.
[235] Romer et al., *Implementation Guide (Version 2.0)*, at 11; SAMHSA, *Ready, Set, Go, Review*, at 13.
[236] N. Romer, et al., *Best Practices in Universal Screening for Social, Emotional & Behavioral Outcomes, An Implementation Guide, 2026 Version*, Sch. Mental Health Collaborative (2026), https://usf.app.box.com/s/hhxbt97jqjbek3xwkoflqkutlld2ir6x, at 12.
[237] SAMHSA, *Ready, Set, Go, Review*, at 36.
[238] Romer et al., *Implementation Guide (Version 2.0)*, at 11.
[239] Romer, et al., *Implementation Guide (Version 2.0)*, at 17.
[240] Comm'n for Behavioral Health, *Counting What Counts*, at 109; *id.*, at 4, 11.

- What screening scores will be used, (*e.g., the use of a total risk score or subscale scores*);[241]
- The categories/levels of risk that will be used when identifying students who are at-risk and determining the applicable risk level;
- An estimated threshold for how many students can be supported at various levels of need based on available resources;[242] and
- The specific cut-off scores at which students will be identified as potentially at-risk[243] and at which parents will be notified of the student's results.[244]

(iii) Include data validation protocols: While students *may* be identified as at-risk based on cut-off scores alone, there is strong consensus that the best practice is to treat cut-off scores as an indication of risk and use additional data review to validate the screening data and scores.[245] Data validation protocols should:

- Define the number and types of additional data sources that should be reviewed, which may include:
    - Attendance records;
    - Grades and curriculum-based measures;
    - Disciplinary referrals or behavioral records; or
    - Interviews/discussions with teachers, school psychologists, school counselors, and other appropriate staff. [246]
- Clarify how to request or otherwise access such additional data;
- Require consideration of the validity and accuracy of outliers in relation to "other indicators of the student's mental health to ensure reliable interpretation;"[247] and
- Ensure such protocols and requirements do not require such extensive additional data review as to (i) result in delays in students receiving timely intervention or (ii) increase the difficulty of identifying students in need of intervention.[248]

> ***Best Practice:***
>
> *Data validation protocols should require at least two additional sources of data be used to validate screening data/scores identifying a student as at-risk.*
>
> *SAMHSA, Ready, Set, Go, Review, at 49.*

(iv) Include a process for using screening data to analyze population-level and school-wide needs and trends: Such process should establish how to interpret and use screening data at multiple levels to identify and analyze student needs, outcomes, and trends and guide decisions relating to the development, implementation, and improvement of interventions at all levels of the MTSS framework/comprehensive student support system.[249] Such process should, at a minimum:

- Define how to use and interpret screening data:

> ***Best Practice:***
>
> *Screening data should first be used to evaluate the effectiveness of "core instructional, universal practices and interventions" (e.g., school-wide, Tier 1), then to identify students that may be in need of targeted, individualized Tier 2 or 3 assessments or services.*
>
> *Rhode Island Dep't of Educ., Guidance, at 13.*

[241] Romer et al., *Implementation Guide (Version 2.0)*, at 12.
[242] Romer et al., *Implementation Guide (2026 Version*), at 12.
[243] Wisc. Dep't of Public Instruction, *Screening Resource Guide*, at 6.
[244] Romer et al., *Implementation Guide (2026 Version)*, at 13.
[245] Romer et al., *Implementation Guide (2026 Version)*, at 12.
[246] SAMHSA, *Ready, Set, Go, Review*, at 49.
[247] Romer et al., *Implementation Guide (Version 2.0)*, at 11.
[248] Romer et al., *Implementation Guide (Version 2.0)*, at 12.
[249] Romer et al., *Implementation Guide (Version 2.0)*, at 12; Rhode Island Dep't of Educ., *Guidance*, at 14.

- *At the school-wide level* to:
  - Identify school-wide student needs, outcomes, and patterns;
  - Determine progress toward meeting school/division goals and how screening data aligns with other relevant performance indicators; and
  - Evaluate the effectiveness of, monitor, and guide the implementation, maintenance, and improvement of school-wide/universal [Tier 1] programs and supports.
- *At the grade- or classroom-levels*: to identify and inform decisions relating to trends in needs and outcomes for a specific grade level or range of grade levels, classes, or teachers, including to identify specific groups of students in need of additional support, including provision of intervention or additional professional development to help teachers meet such support needs; and
- *Across subgroups of students* (e.g., gender, ethnicity, IEP status, LEP status, etc.): to identify trends in needs and outcomes across specific subgroups of students with similar needs or risk-factors.

- Define how screening results (e.g., total scores, subscale scores) and extant data (e.g., office discipline referrals, attendance) will be used to guide the development of evidence-based interventions,"[250] at all levels of the MTSS framework, including decisions relating to school-wide/universal (Tier 1) supports and programming.

- Include a process for sharing screening data with school administrators, staff, and relevant stakeholders, including:
  - *Aggregated Data:* Best practices recommend establishing a process for periodically compiling and sharing such aggregated data with school administrators, school staff, and other appropriate stakeholders to (i) demonstrate how screening is informing school programming and improving student outcomes; (ii) guide administrators and staff in decisions relating to school programming and the implementation of certain supports and services; and (iii) assist administrators in advocating for and leveraging stakeholder support, funding opportunities, and means to secure needed resources.[251]
    - Such process should be carefully established to ensure data is presented in a manner designed to prevent misinterpretation of results and ensure the protection of any personally identifiable student data.
  - *Other data relevant to school instructional personal and other appropriate staff*: including summaries of:
    - Overall screening results;
    - Information on student progress and system effectiveness over time;
    - The lessons or considerations staff can take away from the screening process and results to inform professional responsibilities.[252]

[250] Romer et al., *Implementation Guide (Version 2.0)*, at 12.
[251] Romer, et al., *Implementation Guide (Version 2.0)*, at 12.
[252] Col. WARE, *Screening Toolkit*, at 28.

C. UMHS Response Plans:
Responding to Screening Results, Referral Pathways, & Progress Monitoring.

Prior to implementation of UMHS, teams must carefully consider and develop a response plan that is designed to ensure teams and schools are prepared to act upon screening results in a manner that is "timely, meaningful, and defensible."[253] Such response plan should include:

1. A Follow-up Timeline.

Response plans should include a timeline for action after screening administration and following the data review that is designed to ensure that follow-up with students and parents, as well as discussion and provision of additional assessment or support/interventions, occurs in a "timely manner" based on the immediacy of need/risk identified for the individual student.[254]

2. Referral Pathways.

Referral pathways are critical to ensuring the ability to adequately, timely, and meaningfully respond to any and all screening results and that all interventions "are provided in a timely manner and that any student who may be a danger to self or others is further assessed immediately to ensure safety."[255] In developing an effective referral pathway, teams should:

(i) Evaluate response capacity. Teams should first evaluate school and community response capacity, including by:

- Identifying availability of school-based and community-based interventions within the school and community;[256] and
- Evaluating the extent to which existing response systems and supports can be leveraged, including:[257]
    - Existing threat assessment or suicide assessment processes;
    - Referral systems already in place; and
    - Community-based supports/services with which the school/school division may already have MOU's/partnerships.

Conceptual Overview–Referral Pathway:

The series of actions or steps taken after identifying a student with a potential mental and/or substance use issue.

Effective referral pathways include a continuum of school-based and community-based supports and services capable of addressing potential needs at all levels.

SAMHSA, *Ready, Set, Go, Review*, at 40.

(ii) Include a continuum of school- and community-based supports and services across all levels of need: *An essential characteristic of an effective referral pathway is the inclusion of a continuum of school- and community-*

[253] Romer et al., *Implementation Guide (Version 2.0)*, at 18.
[254] Comm'n for Behavioral Health, *Counting What Counts*, at 110.
[255] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*; Col. WARE, *Screening Toolkit*, at 20.
[256] Col. WARE, *Screening Toolkit*, at 18.
[257] Col. WARE, *Screening Toolkit*, at 20.

based supports and services capable of addressing potential student needs at all levels of risk and severity. [258] *This continuum should include:*

- School-based mental health services and professionals (e.g., school psychologists, social workers, and counselors);
- Partnerships with community-based services and providers (e.g., local community mental health centers and health centers, private practitioners,);
- "Non-clinical" community members/supports, such as:
    - Interpreters and clergy for "consultation and referral to programs that may be more accessible and acceptable" to parents across various cultures, backgrounds, and circumstances;[259] and
    - Mentoring opportunities.[260]
- Partners encompassing multiple levels of response that may be needed, including: [261]
    - Long-term or short-term resources/supports;
    - School-wide/universal supports and services, [262] and grade-wide, classroom-wide, and individual student level response options; and
    - Responses/interventions based on degree and immediacy of individual student need, including:
        - Students who require immediate response; and
        - Students who are "not responsive to intervention or at significant risk."[263]

> ***Best Practice****:*
>
> *Referral pathways should focus on resources and supports that "complete and leverage existing partnerships."*
>
> *Ill. State Bd. of Educ, Lessons Learned, at 27.*

(iii) Include plans and procedures for selection of and referral to interventions: *The second essential characteristic of an effective referral pathway is the inclusion of plans and procedures clearly detailing the steps and processes for responding to any and all student screening results. Such plans and procedures should include:*

(a) *A clearly defined referral process*: that defines:

- How referrals will be made and managed;
- The roles and responsibilities of all parties involved in the referral process, including who can make referrals;
- Processes for sharing information within and between various referral partners; and
- Progress monitoring and follow-up protocols to evaluate the effectiveness and progress of particular interventions provided by all partners within pathway.

(b) *Decision-making procedures:* Procedures for making decisions relating to interventions to ensure:

- Decisions are made collaboratively based on what is best for students and their families and with appropriate consideration of:
    - The availability and accessibility of resources in school and community;

[258] SAMHSA, *Ready, Set, Go, Review*, at 39.
[259] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 7.
[260] SAMHSA, *Ready, Set, Go, Review*, at 52.
[261] Col. WARE, *Screening Toolkit*, at 20.
[262] Wisc. Dep't of Public Instruction, *Screening Resource Guide*, at 2.

    - The needs of the student, as indicated by the level of risk severity indicated by the screening, further assessment, and review of additional data; and
- Interventions are implemented through a tiered approach "at the universal, targeted, and intensive levels within a MTSS framework."[264]

(c) *Procedures for ensuring appropriate and, if necessary, immediate response:* Procedures for ensuring any student with a positive screening result receives appropriate intervention as promptly as necessary, including procedures:[265]

- Defining the process for referrals for further assessment/evaluation, including:
    - Determining when referral for further assessment/evaluation is necessary to determine need for targeted, individualized, or specialized intervention;"[266]
    - Referring a student for further assessment/evaluation and ensuring informed parental consent is obtained prior to referral;[267]
- For ensuring immediate response can be provided for students identified at high levels of risk;[268] and
- Determining whether the student identified as at-risk is already receiving services and ensuring, upon such determination, the student's parents and the individuals/group responsible for coordinating and providing the existing services are promptly notified of the screening results to evaluate whether modification to the existing interventions/supports is needed;
    - *E.g., If a student who receives special education pursuant to an IEP is identified as at-risk/in need of intervention based on screening results, procedures should ensure the student's parents and IEP Team are promptly contacted so they can determine if the IEP needs to be modified to include additional services.*[269]

Best Practice—Preparing for Immediate Response:

In developing referral pathways, consider including procedures for partnering with a local crisis team or other community-based service to notify them of the date & time of each UMHS administration window to ensure they are:

1. Prepared to provide students and families access to supports in a timely manner; &

2. Are on-call &, if feasible, physically present on school property during administration in the event a student is identified as in need of immediate response.

AWARE, *Screning Best Practices*; Nat'l Ctr. for Sch. Mental Health, *Quality Guide*, at 18.

3. Communication Plans: Follow-up & Discussing Screening Results with Parents & Students.

Teams must develop clear, written plans for communicating with parents & students about UMHS screening results and intervention needs in an understandable, appropriate, and meaningful manner and that should include:

(i) Procedures & Guidance for Communicating Parents, Guardians, & Caregivers: Communication plans should include procedures and guidelines for communicating with parents, guardians, and caregivers about their children's' screening results, next steps, and intervention needs, in a manner which is adequately timely, understandable, and appropriate. Such communication plans should include:

[264] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 18.
[265] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 18.
[266] Rhode Island Dep't of Educ., *Guidance*, at 7.
[267] AWARE, *Screening Guide*.
[268] AWARE, *Screening Guide*.
[269] Romer, et al., *Implementation Guide (Version 2.0)*, at 12.

(a) *Communication protocols* that:

- Identify the school staff members responsible for communication screening results and mental health concerns and interventions with parents. Ideally, this role should be assigned to "properly trained" staff members who are specifically "trained to discuss students' mental health;"[270] and
- Establish timelines and procedures for ensuring parents are contacted as promptly as necessary based on the screening results, by telephone or in person; [271]
    - This should include protocols for prioritizing the notification of the parents of any student whose screening results indicate risk/high-risk or an otherwise urgent situation.[272]

(b) *Guidance on effective, appropriate, linguistically accessible, and culturally-responsive, communication*: including guidance and strategies for:[273]

- Addressing concerns while reducing stigma and encouraging productive problem-solving;
- Framing discussions of student screening results in a strength-based and resilience-focused manner;[274]
- Ensuring parents understand the meaning and limitations of screening results,[275] including by:
    - Providing concrete examples and avoiding generalities and labels;
    - Explaining that screening results do not indicate a clinical diagnosis; [276] and
- Recognizing and responding to parent's concerns, reactions, or decisions regarding treatment "without displaying pity, shame, or blame;"[277] and
- Communicating with parents with limited English proficiency to ensure they clearly understand the implications of screening data and next steps, including ensuring the availability of translators or interpreters.[278]

(c) *Follow-up/check-in procedures:* procedures and guidance for ensuring parents receive timely follow-up about next steps and "[k]now the procedure and plan for after screening is administered,"[279] including procedures for:

- Ensuring parents receive information and resources about screening follow-up and interventions, including:
    - Current, accessible, and clear contacts and resources for follow-up questions and concerns about next steps and follow-up procedures; and
    - Resources for support and information about mental health concerns, interventions, and services.
- Following-up with parents to inquire about and help address any difficulties in accessing services or making arrangements for needed assessments/evaluations or other services, [280] including through:
    - Providing them with information on who to contact if they need assistance in making arrangements;[281]
    - Connecting them with school-based services; and
    - Encouraging ongoing communication and collaboration through clearly communicating a willingness to continue to assists the parent with accessing resources or supports and otherwise addressing their child's needs. [282]

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[270] SAMHSA, *Ready, Set, Go, Review*, at 47; Ill. State Bd. of Educ, *Lessons Learned*, at 25.
[271] SAMHSA, *Ready, Set, Go, Review*, at 47.
[272] SAMHSA, *Ready, Set, Go, Review*, at 49
[273] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 18.
[274] Rhode Island Dep't of Educ., *Guidance*, at 12.
[275] Comm'n for Behavioral Health, *Counting What Counts*, at 110.
[276] SAMHSA, *Ready, Set, Go, Review*, at 47.
[277] SAMHSA, *Ready, Set, Go, Review*, at 47.
[278] Comm'n for Behavioral Health, *Counting What Counts*, at 110.
[279] Ill. State Bd. of Educ, *Lessons Learned*, at 25.
[280] Ill. State Bd. of Educ, *Lessons Learned*, at 25.
[281] Col. WARE, *Screening Toolkit*, at 28.
[282] Ill. State Bd. of Educ, *Lessons Learned*, at 25; SAMHSA, *Ready, Set, Go, Review*, at 47-48..

(ii) Procedures & Guidance for Communicating with Students: Communication plans should include procedures and guidance for discussing screening results and follow-up with students that ensure all such communication: [283]

- Is appropriate, clear, and understandable, taking into consideration the student's age and developmental level and ability to understand what is being communicated;
- Includes open, honest, and direct explanations of:
    - The screening process and purposes and the range and intended use of screening results;
    - The individual student's screening results, taking particular care to ensure the student understands that the screening results are not a diagnosis, but an indication of potential risk factors; and
    - The follow-up procedures based on the student's screening results, including any necessary further assessments/evaluations and how decisions are made relating to the provision of supports/services/interventions.
- Occurs in a comfortable, private setting, individually with the student.

4. Progress Monitoring Procedures.

Effective progress monitoring procedures are essential to ensuring effective early intervention. Procedures for progress monitoring, or monitoring the response of an individual student to a specific intervention provided on the basis of screening results, should include procedures for:

(i) The ongoing evaluation and progress monitoring of the MTSS framework at the school, classroom, and individual student level, including:

- Evaluating/monitoring the general student population screened to determine the efficacy of universal/Tier 1 supports on overall student outcomes;

(ii) Monitoring the progress of individual students identified as at-risk and connected with interventions through UMHS For tracking the efficacy of the interventions/supports provided to such students, including procedures:[284]

(a) For evaluating data in monitoring student progress, including:

- Reviewing "baseline data regarding student responses for the sake of comparison to screening later in the school year;"[285]
    - *Best practice:* An individual student's progress "should be measured to examine whether the intervention is effective for that student" and "should be based on a discrete and operationally defined behavior or construct;"[286]
- Identifying the types of data/information that should be evaluated in monitoring student progress, which may include:[287]
    - Provision of behavior supports;
    - Records of disciplinary referrals;
    - Grades/academic records;

Conceptual Overview—Progress Monitoring:

"The frequent repeated measurement of a specific and clearly defined behavior or construct" which serves as an "essential component for the evaluation of student needs and response to individualized interventions."

SAMHSA, *Ready, Set, Go, Review*, at 54-55.

[283] SAMHSA, *Ready, Set, Go, Review*, at 48.
[284] SAMHSA, *Ready, Set, Go, Review*, at 57.
[285] SAMHSA, *Ready, Set, Go, Review*, at 54.
[286] SAMHSA, *Ready, Set, Go, Review*, at 57.
[287] SAMHSA, *Ready, Set, Go, Review*, at 57.

    - Attendance records; or
    - Other individualized measures.
- Using progress monitoring data to determine when the type of support/intervention a student is receiving should be maintained, modified, or terminated, including protocols for:
    - Determining whether there is a need for a moral formal intervention or support, such as a Section 504 Plan or IEP and protocols for initiating the requisite processes for this;
    - Identifying whether a student already has a formal intervention in place, such as a Section 504 Plan, IEP, or other formal documentation of needed services and determining if the monitoring indicates a need to amend such plan.[288]

(iii) Follow-Up & Data-Sharing across Referral Partners, Interventions, and Other Personnel: Procedures for facilitating progress monitoring across school-based and community-based services, including:

- Data-sharing procedures to ensure access to timely, reliable information necessary to track and evaluate the progress of students referred to community-based services; and
- Conducting periodic follow-up with relevant teachers and other appropriate school personnel, parents, and students, to discuss student progress.[289]

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[288] Col. WARE, *Screening Toolkit*, at 21.
[289] SAMHSA, *Ready, Set, Go, Review*, at 47.

D. School Staff:
Roles & Responsibilities.

Teams should (i) develop clear procedures identifying and defining the roles and responsibilities of school staff in the screening process; (ii) develop policies, procedures, and guidance for communicating with, educating, and training school staff on all aspects of UMHS; and (iii) establish plans for ensuring school staff receive the appropriate professional development.

1. Roles & Responsibilities.

Procedures should be developed for defining the roles and responsibilities of school staff in the screening process and ensuring the effective, successful implementation, administration, and maintenance of UMHS. Such procedures should:

(i) ***Identify and define the roles and responsibilities of screening support personnel:*** including: [290]

- *Screening Proctors:* such procedures should identify who will serve as the screening proctors, define the role of the proctors, and include a written script for proctors to read to student prior to UMHS administration.[291] Proctor scripts should:
    - Include, at a minimum (i) guidance on addressing any questions that may arise during administration; (ii) a brief overview of the purpose of the screening process, confidentiality of results, and relevance to students;[292] and
    - To the extent feasible, be available in translations to languages other than English for the administration of screening to a subgroup or category of students with a high prevalence of LEP students.[293]
- "A site-based professional responsible for leading the screening process, who will be available and accessible to address any potential issues that may arise;"[294] and
- If screening is being done electronically/technologically a "district technology specialist available to help with technology issues."[295]

(ii) ***Include guidance for all school staff on general matters relating to screening:*** Procedures should include guidance and plans designed to ensure all staff have an adequate understanding of UMHS, including:

- The informant;
- The screening process and procedures;
- The purpose and function of universal mental health screening and the appropriate use of the particular screening tool, including:
    - The rationale for the screening process;
    - An overview of the screening tool, including an overview defining the function of the questions asked; and

[290] SAMHSA, *Ready, Set, Go, Review*, at at 37.
[291] Ctr. for Sch. Mental Health, *Playbook*, at 4.
[292] Nat'l Ctr. Sch. Mental Health, *Quality Guide: Screening*, at 17.
[293] Nat'l Ctr. Sch. Mental Health, *Quality Guide: Screening*, at 17.
[294] SAMHSA, *Ready, Set, Go, Review*, at 44.
[295] SAMHSA, *Ready, Set, Go, Review*, at 44.

- How the results from screening will be used.[296]

(iii) Include guidance and plans for all teachers and school staff involved with, assisting with, or supervising UMHS administration: Including

(a) Clear written and oral instructions for staff relating to UMHS administration: Written instructions for all staff involved in UMHS administration, including classroom teachers supervising administration or support staff present for administration, should articulate:[297]

- (a) The date and time/point of the school day during which screening will occur; and
- (b) Who is responsible for distributing surveys and proctoring.

(b) A Written Script for Classroom Teachers: For classroom teachers to use to inform students of UMHS administration and communicate critical information relevant to the process prior to the administration windows that:

- Is designed to ensure students "understand why they are being asked to complete the screening and feel comfortable" responding "openly and honestly;"[298]
- Includes explanations of:
  - (i) The screening process and purpose;
  - (ii) The importance of students completing the screening honestly;
  - (iii) The expectations and requirements relating to the student's participation in screening, including that:
    - (a) Students can choose not to participate in the screening at all or choose to stop completing the screener at any point during screening administration; and
    - (b) Choosing not to participate in or not to complete UMHS will not result in adverse academic or disciplinary consequences; and
  - (iv) The circumstances in which parents will be contacted based upon screening results.[299]

(c) Guidance and protocols for addressing circumstances that may arise during screening: including procedures for:

- *Students who are not participating*: (either due to parent not consenting/electing to opt-out the student or student refusal) that include options for the provision of of alternative activities for any students not participating in screening[300]
- *Students who were late/ absent on administration date*: Students who arrive late to or were absent from school on the date of the initial screening administration;
- *Student in need of accommodations/support*: Guidance and protocols for supporting students who may need accommodations to complete the screening (e.g., pursuant to an IEP or Section 504 Plan), should include:
  - Guidance on ensuring the student receives the appropriate accommodations;
  - Relating to students who need assistance from an adult to complete the screening, that:
    - Focus on ensuring the student feels comfortable answering honestly (as opposed to trying to please the staff);
    - Include guidance for staff on how to best protect the student's confidentiality;[301] and

[296] SAMHSA, *Ready, Set, Go, Review*, at 44.
[297] Nat'l Ctr. for Sch. Mental Health, *Quality Guide: Screening*, at 17.
[298] SAMHSA, *Ready, Set, Go, Review*, at 44.
[299] SAMHSA, *Ready, Set, Go, Review*, at 46.
[300] Col. WARE, *Screening Toolkit*, at 28; Nat'l Ctr. Sch. Mental Health, *Quality Guide: Screening*, at 17; SAMHSA, *Ready, Set, Go, Review*, at 44.
[301] SAMHSA, *Ready, Set, Go, Review*, at 46.

- Allow the student, in consultation with the student's IEP Team or other designated support personnel, to identify a staff member *with whom they feel the most comfortable to assist them in completing the screening.*[302]

- *Students who become distressed during administration:* Identifying and responding to students who become distressed while completing screening in an appropriate manner, including when to direct the student to appropriate supportive staff.[303]

2. Professional Development & Training.

Teams should establish plans and procedures for ensuring that all school staff have access to and complete appropriate professional development and training on UMHS, including ensuring:

(i) All Staff: Receive training on

- Student mental health, including (i) understanding and recognizing the signs and symptoms of mental health difficulties, including "both internalizing and externalizing emotional problems;"[304] and (ii) how and to whom they should refer students exhibiting such indicators to relevant support services within the school or through community-based partnerships;
- The purpose, objectives, and general features of UMHS; and
- UMHS policies and procedures relating to data confidentiality and privacy, including training on compliance with pertinent laws and regulations.[305]

(ii) Staff Responsible for Scoring/Interpreting Screening Results or Implementing Interventions: Receive training and professional development on:

- Data-based decision making, including:
  - The appropriate uses of screening data, including the "value of . . . screening data within a comprehensive, multi-tiered system;"[306]
  - The limitations of screening data;
  - The data interpretation process, including understanding how screening data are "collected, analyzed, communicated, and used to inform intervention decisions" and "match interventions to problems and using evidence-based interventions;"[307]
- Interpreting data in a culturally responsive manner, including:
  - Using "knowledge and understanding of cultural values" to inform or guide the analysis and interpretation of screening results; and
  - Understanding how "cultural differences in child rearing may result in very different interpretations of a student's behavior."[308]
- Understanding policies and procedures relating to data confidentiality and privacy protections and compliance with applicable laws and regulations;[309]
- The use of "prevention and intervention strategies;"[310] and

[302] AWARE, *Screening Guide*, at 4.
[303] AWARE, *Screening Guide*, at 4.
[304] SAMHSA, *Ready, Set, Go, Review*, at 17.
[305] Ill. State Bd. of Educ, *Lessons Learned*, at 24.
[306] Romer et al., *Implementation Guide (Version 2.0)*, at 11.
[307]
[308] SAMHSA, *Ready, Set, Go, Review*, at 22.
[309] Ill. State Bd. of Educ, *Lessons Learned*, at 24.
[310] SAMHSA, *Ready, Set, Go, Review*, at 53-54.

- Communicating mental health matters with parents in a trauma-informed, culturally responsive, and understandable manner.[311]

(iii) Staff Administering or Proctoring screening: including training on responsibilities and procedures designed to ensure standardized, consistent administration across classrooms.

E. Continuous Evaluation & Improvement of UMHS Program.

In order to maintain and sustain an effective UMHS Program, teams must ensure there are procedures in place for continuously evaluating the UMHS program, identifying areas of success and areas in which improvement may be needed, and developing strategies for addressing necessary improvements.

Specifically, such procedures should:

- Define a process for "evaluat[ing] the screening process to determine what worked well and potential areas for improvement or change;"[312]
- Include procedures for evaluating "[f]idelity data collected during the screening . . . to examine potential patterns of low fidelity;"
- Provide for the collection and review of "[f]eedback from anyone involved with the screening process"[313] on what worked and what needed improvement; and
- Ensure that follow-up and actions to address issues and make improvements "involve[s] work with [screening] implementers to address any issues and help reinforce the importance of implementing the screener as" intended.[314]

[311] SAMHSA, *Ready, Set, Go, Review*, at 22.
[312] SAMHSA, *Ready, Set, Go, Review*, at 59.
[313] SAMHSA, *Ready, Set, Go, Review*, at 59.
[314] SAMHSA, *Ready, Set, Go, Review*, at 59.

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