National School Mental Health Learning Collaborative
Virtual Learning Session Transcript

This transcript corresponds to one of five recorded Virtual Learning Sessions, part of the MHTTC National School Mental Health Learning Collaborative. The recorded Virtual Learning Sessions took place between April and August 2019. Each Virtual Learning Session is about 75 minutes long and includes a deeper dive into some of the content from the MHTTC National School Mental Health Curriculum, which focuses on core components of comprehensive school mental health.

Okay everyone, we are going to get started. My name is Jessica Gonzalez, I am the Project Associate at the Mental Health Technology Transfer Center Network Coordinating Office. Welcome to Virtual Learning Session 4, part of the National School Mental Health Learning Collaborative. This is being co-facilitated by the Mental Health Technology Transfer Center Network and National Center for School Mental Health. Today's session will focus on screening and if you have not done so already, please click on the link in the chat box to sign in. We are going to start with a few reminders.

Slide 2

The first one is really important; if you are using audio through a telephone line, please mute yourself. You can go ahead and unmute using *6. If you are using computer audio, you can unmute yourself by clicking on the microphone icon to the right of your name on the participant list. If you have any questions during the presentation, please enter them in the chat box and we'll do our best to answer them before we close out today. And lastly, we do have an evaluation at the end of this session; we'll be posting the link to the evaluation in the chat box in the last five minutes of the session and we really do appreciate you taking the time to provide feedback.

Slide 3

We have just a couple of quick announcements. We did send out an email blast earlier this week announcing that the National School Mental Health Curriculum is now available on the MHTTC website. For those of you who are new to our learning collaborative, this curriculum was developed by the MHTTC Network and the National Center for School Mental Health to help states, districts, and schools across the United States understand the core components of comprehensive school mental health. The curriculum is intended to be used with district teams that can influence, develop and oversee school mental health systems at the school district and building levels. The curriculum contains trainer and participant manuals and slide decks. We will also continue to upload recordings of these virtual learning sessions which are intended to be a deeper dive into some of the curriculum content. Also, to access the curriculum you can visit our website; you'll see the link there on the slide and I'll also be adding it to the chat box in a little bit.

Slide 4
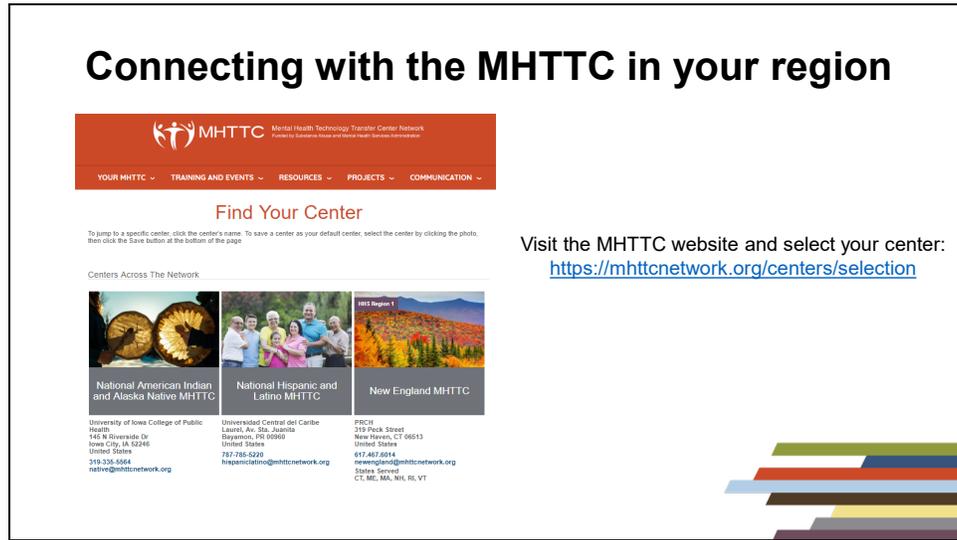
We understand we have some new folks who have not yet had the opportunity to connect with the MHTTC in their region so you can visit our website and select your center at the link that's displayed on the screen. We'll also add that to the chat box in a bit. And that's just a way to get connected with the MHTTC in your region if you have any questions related to school mental health products or resources that MHTTC offers or any questions in regards to utilizing the curriculum that we just rolled out, please feel free to connect with your center. Once again, we do thank you all for joining in today and we will now pass it on to the National Center for School Mental Health to start today's presentation on screening.

Wonderful! My name is Jill Bohnenkamp, I am an assistant professor at the National Center for School Mental Health. I met many of you at our in-person meeting and I'm thrilled to be joining you today as we talk more in depth and detail about screening.

Slide 5

Agenda

- Screening in an MTSS
- Key Pre-Planning Considerations
- District Example-Methuen Public Schools
- Screening for Mental Health and Well-being
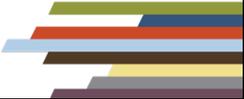
National School Mental Health Curriculum

We'll be talking in brief detail about screening as a bigger part of a multi-tiered system of support system in schools and touching on some key pre-planning considerations. We're thrilled to have an in-depth district example from John Crocker, director of School Mental Health and Behavioral Services at Methuen Public Schools, and we'll also be hearing a wonderful presentation from Michael Furlong, professor at UC Santa Barbara about screening for mental health and well-being in schools.
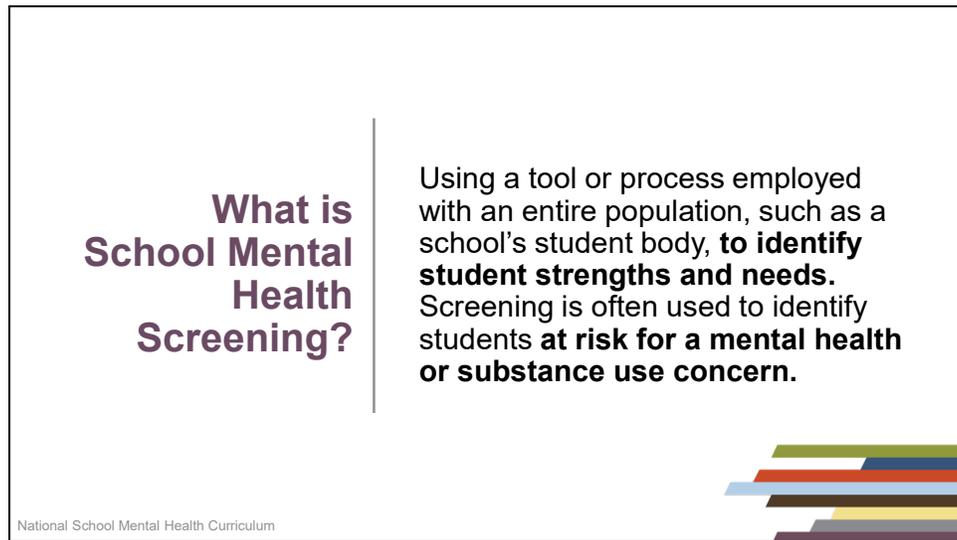
What is School Mental Health Screening?

Using a tool or process employed with an entire population, such as a school's student body, **to identify student strengths and needs.** Screening is often used to identify students **at risk for a mental health or substance use concern.**

National School Mental Health Curriculum

As we kick off our screening webinar today, I just wanted to include our definition about school mental health screening; that this is 'using a tool or process to identify student strength and needs. And that screening is used to identify students at risk for mental health concern or substance abuse.'

Slide 7

The Value of Screening

• Shift to being proactive vs. reactive
• Systematic and strategic resource allocation
• Early intervention
• Crisis prevention and school safety
• Resources to students with internalizing concerns
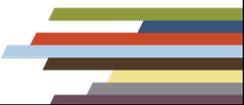
National School Mental Health Curriculum

And as we get started and before we hear a more in-depth example of what this looks like in practice, I wanted us to touch on the value of screening. We have a lot of discussion around screening, what this looks like and what this means, but one of the biggest value of mental health screening in schools and as a part of a multi-tiered system of support is that it allows us to be proactive vs being reactive. It allows us to think more systematically about our resource allocation. If we only have a limited number of school social workers, school counselors and extended school mental health clinicians and community resources, how do we make sure that our students with the highest needs are receiving those services? That we're not missing students who may in fact have high needs, and that we're thinking about tier one and tier two support that may better benefit students that are receiving tier three services. Screening allows us to do early intervention and we are able to catch and think about students who may have early risk and we can provide lower tier services to help mitigate that risk and put them on track for school success. Screening is really critical when we think about crisis prevention and school safety. When I say that, I'm very thoughtful about what I mean by that. I mean that we want to make sure we are addressing student concerns early and so that we're using that proactive approach, that we're able to meet students' needs, understand needs, make sure that we're getting students the support that they need early in the process. And that we're especially thinking about resources for students with internalizing concerns who may not show up in our more typical referral processes.

Critical considerations and pre-planning

- Multi-stakeholder planning (students and families)
- Cultural considerations
- Intentional consideration of unintentional side effects
- Start small
- What are the potential consequences of not screening?

Before we even think about what screener, what our process might be, we want to make sure we are very slow, methodical and thoughtful about this process. As you will hear from John Crocker today and many folks who are doing school mental health screening will say what was critical to their success was a multi-stakeholder planning process with students and families at the forefront of that. There was deep consideration around cultural needs and the specific needs of the student body. And a really intentional consideration of unintentional side effect that we've had discussions about and I know this came up during our meeting that we want to make sure with our screening that we are doing good and that we are not having any concerns about the screening process not being trauma informed. We want to make sure that it is trauma informed, trauma sensitive and that it's helping to support our students. And we'll have really clear examples of that and looking forward to hearing from Dr. Furlong about screening for mental health strengths and well-being and how that can support your multi-tiered systems and support. As we talk about for all quality improvement, not just in school mental health, but especially in school mental health, starting small is really critical in this intentional process. That we can very quickly see what are our strengths of our process and where we need to make improvements if we're starting with one student in one classroom and then really thinking and receiving feedback about that process. And as we are thinking about our considerations for screening or not screening and weighing those considerations, we also want to consider what are risks of not screening and making sure that is in our process as we're doing this preplanning.

Slide 9

Addressing Barriers

Identified need will exceed our capacity	Our community doesn't like the idea	Obtaining consent from parents will exceed our capacity	What will we screen for?
Set triaging data rules in advance	Involve multiple stakeholders in planning	Use passive consent and opt-out procedures	Obtain input on key focus areas to start with
Review existing resources/capacity	Use existing community and parent forums	Share a consistent message in multiple formats	Consider different measures by grade levels, schools, etc
Review surveillance data	Start by screening for resilience and strengths	Engage parents in developing your message	Use the SHAPE Screening and Assessment Library
Start small then adapt and scale up	Start small then adapt and scale up	Start small then adapt and scale up	Start small then adapt and scale up

So I quickly wanted to pull up a couple of slides, this is included in the curriculum so I won't spend a ton of time on this, but I just wanted to highlight that when we're thinking about potential barriers there are a number of strategies we may use to address those.

Slide 10

Again, this visual on the importance of starting small.

Slide 11

Screening Action Steps

Build a Foundation → Clarify Goals → Identify Resources and Logistics

Select an Appropriate Screening Tool → Determine Consent and Assent Processes → Develop Data Collection, Administration and Follow Up Processes

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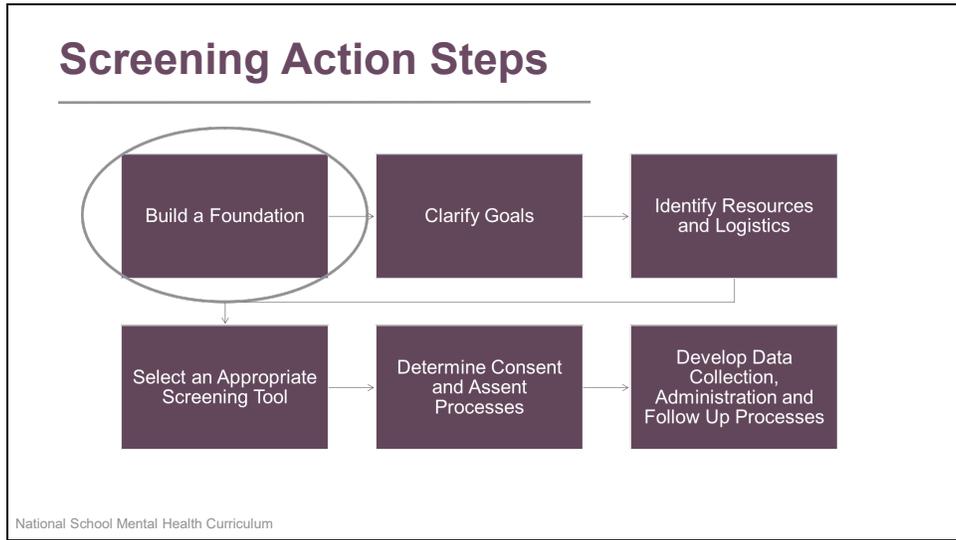
And I also wanted to draw attention to our screening action steps. That very critical is this first step of building a foundation and second step of clarifying goals and remind folks that we have a number of details in the school mental health curriculum, the national curriculum that you can reference.

Slide 12

Build a Foundation

Assemble a team:

- School Administrators and Staff
- Community
- Students
- Family
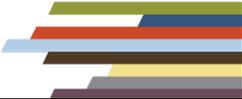
National School Mental Health Curriculum

Assembling a team is critical as part of the stakeholder process for doing your preplanning.

Slide 13

Build a Foundation

Generate Buy-In and Support

- Gather input from several groups:
  - ❿ focus groups
  - ❿parent/staff meetings
  - ❿feedback cards
- Strategize how your goals fit in with other initiatives or goals in your school/district
- Consider how students are currently being identified for MH services and the implications for service provision
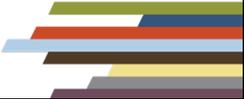
What this may look like in process is gathering input via focus groups, parent/staff meetings, feedback cards; thinking about how your goals fit with other initiatives in your district. And thinking about how students are currently being identified.

Slide 14

Build a Foundation

Cultural Considerations

- Complex stress related to poverty, immigration, language barriers
- Cultural beliefs about mental health and how concerns should be addressed
- Marginalized and underserved groups
- Screening more acceptable across cultural groups when strengths-based

"Interpreters, cultural brokers, and community liaisons should be available, utilized, and consulted with frequency in order to minimize miscommunication and improve collaboration with family members across key stakeholders."
(Bertone et al., 2018)

National School Mental Health Curriculum

Really critical for us to think about how we are making sure if we are embarking in doing school mental health screenings that we're thinking about complex stress related to poverty, immigration and language barriers, cultural beliefs about mental health and how concerns should be addressed, marginalized and underserved groups and how we want to make sure that our process is helping us to be more inclusive and thinking about that our strength based approach may be a very good approach for us. We're excited to highlight what that would look like in practice with Dr. Furlong's presentation.

Build a Foundation

Use data

- Data can support justification for mental health screening
- For example, one district used data from their screening pilot to demonstrate the value of screening:
  - *Students who scored in the moderate to severe range for depression are absent 47% more often than the average.*
  - *GPA was consistently lower for students who scored in the moderate to severe range on two different mental health screeners.*

(Crocker & Bozek, 2017)

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Getting and gathering some initial data or using data that already exists is also another way to better understand what some of the potential benefits might be for screening and what you may miss and not be able to tackle if you're not screening. So, thinking about that student who scored in that moderate to severe range for depression are absent 47% more often than average. And this is a really critical piece to understand as you're thinking about your multi-tiered system of support.

Slide 16

There's also data that exists in the public domain via surveillance data that you may want to consider as using for screening data or that you may use as a pre-step prior to screening.

Screening Action Steps

National School Mental Health Curriculum

Slide 18
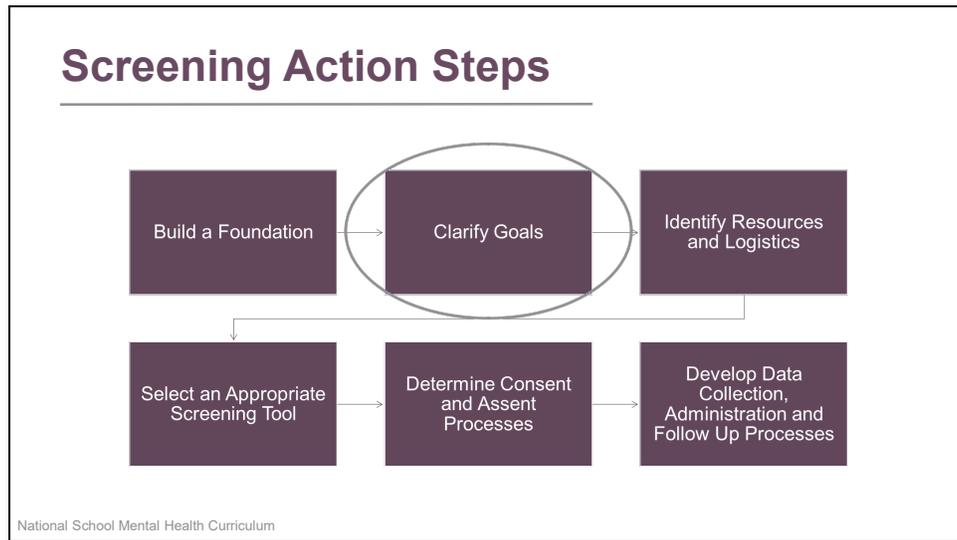
Clarify Goals

- Identify the purpose of screening and desired outcomes.
- Examples:
    - Screen **all 6th grade students in one district for anxiety** to inform who may benefit from additional support during the transition to middle school.
    - Screen **all 9th grade students in one high school for depression, including suicidal thoughts**, to improve identification of students for counseling and inform school-wide suicide prevention efforts.
    - Screen **all students in one district for school connectedness** to identify which schools have higher rates of school connectedness and learn from their efforts to improve this in other schools.

National School Mental Health Curriculum

It is very critical in your screening process to make sure you are clarifying goals. That it's not screening just for the purpose of screening but that there is a very clear purpose.

Slide 19

And then also just wanted to highlight a number of resources that are available to you. These are our newer curriculum but just wanted to highlight the school mental health screening and assessment library which is housed on the SHAPE system. It's currently live in the current format and we're excited for the SHAPE 2.0 launch in August.

Slide 20
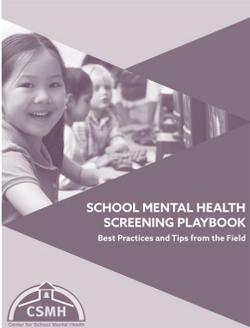
I also wanted to draw your attention to the school mental health screening playbook.

Slide 21

And then here are our quality indicators. Again, if you're looking to embark in school mental health screening processes thinking about using these quality indicators either on their own or using them via the SHAPE system to assess where you currently are to help inform your quality improvement processes.

Slide 22

Quality Indicator

To what extent did your district/school use best practices for **mental health screening planning and implementation**?

Best practices:

- Include students and families in the screening process
- Use a selection process for a screening tool that considers reliability, feasibility, cost, and fit with the goals of screening
- Share information about screening in multiple formats
- Inform students and families about screening procedures
- Roll out initial screening efforts gradually
- Respond to risk of harm to self and others immediately
- Have a process to assess screening results to triage students to appropriate services

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District-wide
Mental Health
Screening: Using
Data to Promote
Early Identification
and Quality
Services

John Crocker
Director of School Mental
Health & Behavioral Services
Methuen Public Schools

And with that, I will turn it over to John Crocker. Thank you so much for being with us today John.

Hey everyone, thank you so much. I'm really excited to be able to present on this topic. And I'll be with you for the next, I guess 30-40 minutes discussing our implementation efforts in Methuen, Massachusetts. So, we can start with the first slide.

Screening: One Piece of a Much Larger Puzzle

- Grant funded partnership with the University of Maryland's Center for School Mental Health (CSMH)
  - Methuen is 1 of 12 districts selected nationally for participation in the first cohort
  - Implementation of National Performance Measures to improve the quality and sustainability of school mental health services
  - Methuen receives ongoing support, resources, training, and assistance with implementation of project initiatives from the NCSMH
  - Communication is frequent, ongoing, and involves the reporting out of progress made toward achieving CoIIN goals (PDSA cycles)
- School Mental Health Improvement and Innovation Task Force
- National Coalition for the State Advancement of School Mental Health (NCSA-SMH)

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So, I wanted to embed this discussion in the context of what is a much larger discussion. Screening is very much a piece of a big puzzle when it comes to school mental health implementation. We were very fortunate to be able to engage with the National Center for School Mental Health about 5 years ago I believe, and we were one of 12 districts that participated in the first cohort of the national quality initiative collaborative for improvement and innovation network. And a lot of the work that we engaged in during that period of time was assessing the degree to which we were establishing the comprehensive school mental health system. We did that by using the SHAPE system and by reflecting on our engagement in practices that aligned with the national performance measures.

Comprehensive School Mental Health System (CSMHS)

"Comprehensive School Mental Health System (CSMHS) is defined as school-district-community-family partnerships that provide a continuum of evidence-based mental health services to support students, families and the school community."

- Provides a full array of tiered mental health services

- Includes a variety of collaborative partnerships

- Uses evidence-based services and supports

NCSMH
NATIONAL CENTER FOR
SCHOOL MENTAL HEALTH

This is the definition of Comprehensive School Mental Health System (CSMHS) and this was really the driving force behind our work. We wanted to establish a CSMHS so that we can really feel as though we had a multi-tiered system of social, emotional and mental health services and supports. That we had strong linkages with our community based partners, that we were being sensitive to our families and engaging with them, that we were being sensitive to all our students' needs and that the hallmark of this program that we're using evidence-based services and supports. One of the things that we notice right away when we're engaging in the SHAPE system is that our use of data was lacking. I think it's the case with a lot of districts that cycle social data, screening data, data that represents students' needs relative to mental health concerns is really far between and we wanted to address that by really attacking that head on and being able to be proactive by addressing that specific domain within SHAPE.

These are the performance measures as we were engaging with them at that time and in SHAPE 2.0 there is a revisiting of this, a reconstitution of the performance measures, but universal screening is very much alive and well in that reorganization. So that is what we are going to be focusing on today, but I do want to give a view of what we were focused on at that time in terms of really addressing different pieces of our implementation quality standpoint, implementation sustainability standpoint and as I present on screening we will be tackling pieces of the quality side but certainly on the sustainability side as well.
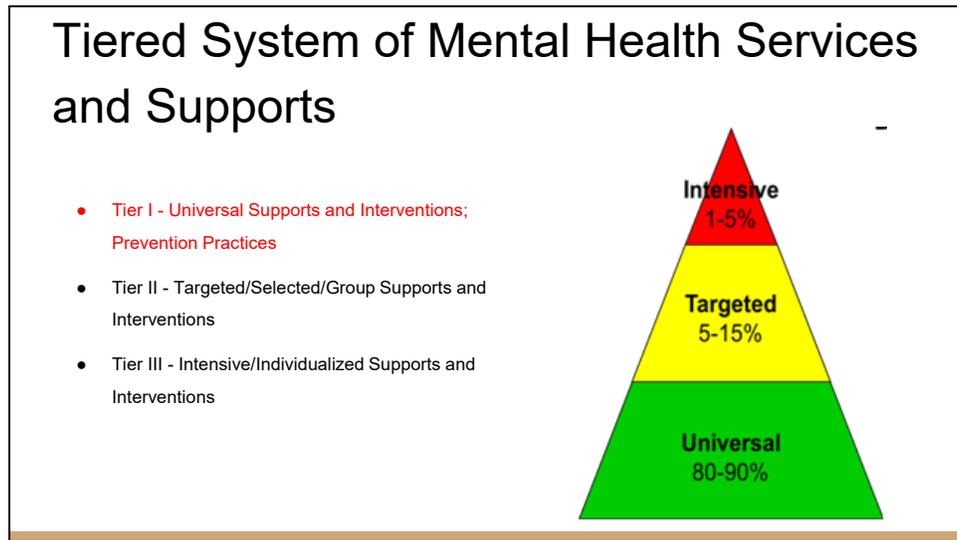
So, when we think about screening, I definitely see it as a universal. It's when we're looking at a tiered system of support, this is one of the pieces that serves as a means to support prevention and to be able to get to students early in that we seek to screen all students it is a universal practice and allows for us to aggregate to our students' needs.
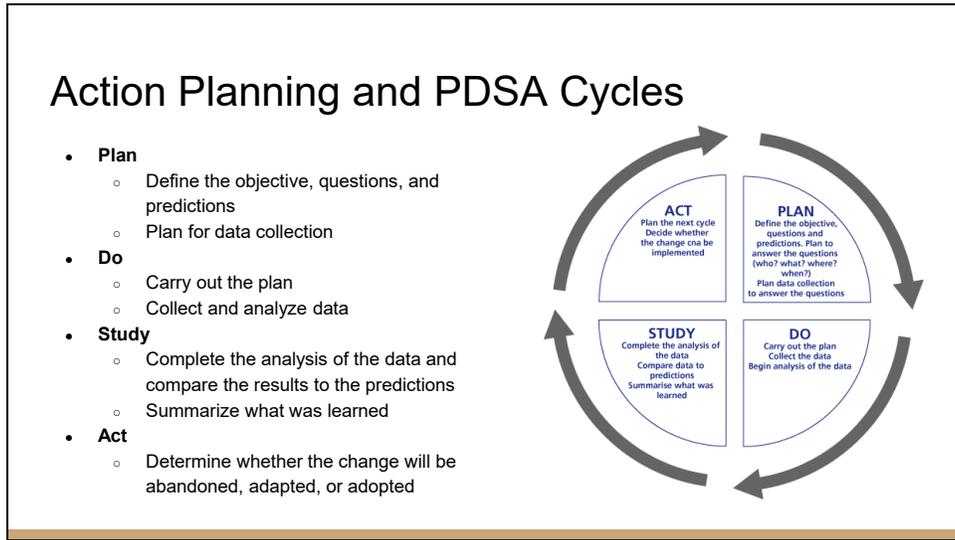
Early on in the process, we were very much focused on the quality improvement and I wanted to put this slide in the slide deck to emphasize the idea that Jodi was alluding to that we absolutely started small. That we did not go into this thinking, let's just screen the entire high school for depression and see what happens, I think that would be extremely irresponsible. We worked slowly to build up.

Slide 29
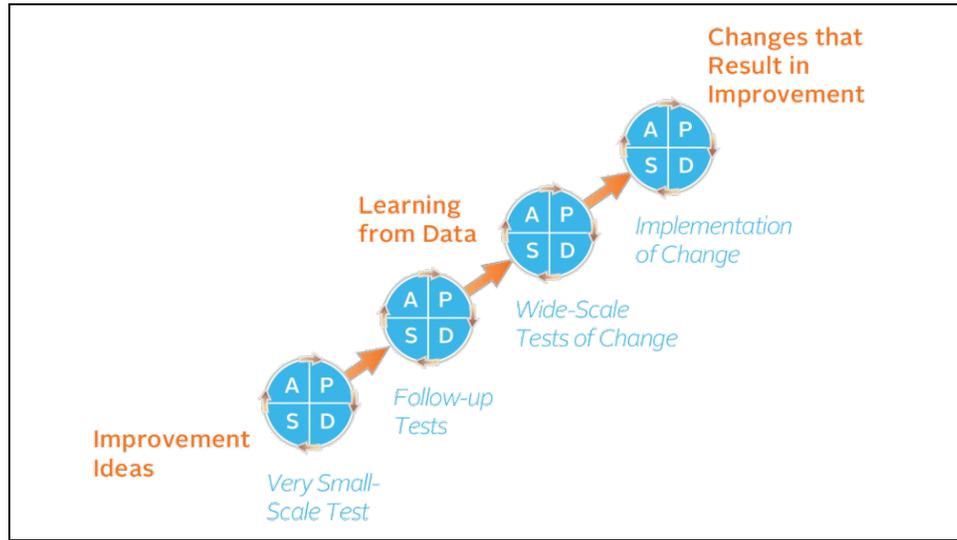
The idea behind this was that these very small steps of change would lead to larger implementation over time and I'll talk about that as we kind of move through the different phases of implementation that we experienced and improved in. I'm going to talk a little bit about the practices and how they evolved over time and then we'll talk about how the data shifted over time. So it'll be two different timelines that will make sense as we move through the presentation.

Mental Health Screening: Questions to Consider

Where do we start?

Which students should we screen?

How do we choose our screening tools?

What about consent?

What about staff readiness?

What will the parent population say?

How are we going to pay for this?

So at the onset of this, we had a lot of questions. We had not engaged in this work previously, I think that the most we had done to date was really around things like the youth risk behavior survey, which does not identify students. We had some information from surveys but again that didn't really point to any specific student, it was more just an aggregate understanding of a potential need that we could address, but it didn't allow for us to be preventative. We had questions about consent, we had questions about which screening tools we could use, where to find them, which populations we were going to look at. We had questions around sustainability, how were we going to pay for this, how were we going to train staff and how were we going to keep this program going year after year?

So, I really appreciate what was said around preparing for screening; I don't think it's something that should just be done without forethought and planning. And the piece around generating support, for us, aligned well with an initiative that we were engaged in at the same time as we sought to implement the comprehensive school mental health system. So, as we were implementing PBIS, at the very same time we were seeking to establish CSMHS. And the district really took notice of the fact that we were putting a lot of time and energy into supporting students comprehensively. We heard from our teaching staff and administrators that students' needs were not being met in a way that was effective and that in order to get to a point where we could feel as though we could get to the academic piece, we needed to first address students' needs. One of the mantras that was really developed at that time and has really persisted over the years that we've implemented is that if you don't provide students with the services and supports that they need, that they really cannot achieve academically in a way that we want them to and in the way that they want to. I think that there is a campaign that has to happen, so that we can ensure that our staff, our parents, our students are all understanding what we're moving toward. The other piece that I think is worth mentioning, and I do not believe that I have a slide on this, but we did put together a mental health parent-student advisory council early on in our implementation. And screening was a big piece of the conversation at that time. We wanted our parents and students to be able to provide feedback to help guide our implementation, if we're not aligning our services and supports with their specific needs, it kind of misses the point. So that was one additional piece that I would recommend is really

leveraging your parents and students in a formal way to be able to draw upon their perspectives and also to support implementation. Because we learned a lot from our students very early on and anyone who works in schools knows that students are very vocal about what they need, often times, when you give them the form to speak up they are ready to participate.

I think that this constitutes one of the most important pieces, in terms of screening, but also in terms of school mental health in general; is ensuring that we are preparing our staff to be able to engage in screening, engage in evidence-based therapeutics and support, engage in the types of practices that we hold dear and that we are thinking of when we are thinking of school mental health. So, we did provide a fair amount of professional development and there definitely was a shift in terms of what we were asking our staff members to do and I think that shift very much aligns with the evolving roles of mental health staff. And it would not be accurate for me to say that everyone just bought in right away. I think that we needed to really commit to this, we needed to be able to have explanations for why these things were important. But when we were ready to talk about this, when we were able to say, 'well if you do this work well and you provide this opportunity for students to access services earlier and we engage in things like screening, then you're going to have less time providing crisis counseling, you're going to have less critical incidents to deal with, you'll be able to address needs of students more readily. That resonated with staff and allowed us to do the work in a way that everyone was moving in the same direction.

Implementing Universal Screening: Starting Small

- Rapidly testing at the micro-level allowed the team to:
    - Identify areas to improve
    - Establish systems to make screening efficient and sustainable
    - Build off of successes to ensure sustainability after scaling up

- Ad hoc screening with individual students
    - Allowed the team to assess the utility of various measures
    - Small tests of change + High confidence in success = Low cost of failure

- Active consent
    - Written consent secured during the initial phase of screening
    - What were the drawbacks?
    - How can we build the capacity to screen students more readily?

So, I want to start to talk about what things look like at the very beginning, when we made the decision that screening was going to happen. So, I feel like I'm glossing over quite a bit in terms of the build up to screening, but suffice to say that teaming was a big piece of it, a comprehensive move toward supporting students holistically was a piece of this, that we definitely engage with our stakeholders and ensure that we were providing them info with why we wanted to do this. So, once that was really well established we began to rapidly test at the micro level. And this is going back to why I wanted to include a couple slides on PDSA cycles, just to be able to provide a little bit of prompting around this. This does need to start small, but also with intention. So that we are putting these tests into play, analyzing them and making decisions from cycle to cycle around how we can improve. So, we really started with just one student and we screened that student, we secured active consent, we selected a tool that we believed matched up with our populations' needs and we took that data and sat with it. I remember meeting with our mental health team and saying, "Alright what can we do with this data? How will this inform our practice? Is this something that we could use on a broader scale? When I'm meeting with this student, will I be better prepared to support this student? And how can we use this data at the aggregate level? If we were to screen 5, 10, 15, a classroom full of students what will this data tell us about our services and supports?" So, the PDSA cycle approach where we were rapidly testing, analyzing that information, making decisions to scale up, that was a really huge part of our process. And I remember conducting PDSA cycles every month and every month we had one on screening to be able to advance that practice. Because

we did move from one student, to a classroom, to a grade level, school, and now a district and I'll talk about that journey as we go through these slides. We did start with active consent, because it seemed like the quickest way to ensure that we were doing right at the time, but we very quickly realized that active consent would pose a barrier to advancing this practice on a large scale. And I'll talk about the evolving practices as we move forward.

So, let's talk a little bit about how we selected screening measures. One of the ways in which we, or one of the first tasks that we were posed with was: Why are we screening? What's the purpose behind our screening program? Do we want to identify students with needs? Do we want to be able to point to strengths that our students have? How are we going to select measures that are free, ideally, that are quality measures and what are we going to do with this data? How are these data going to inform our practice?

Rationale for Using a Problem-Specific Screener

- Needs assessments
  - Counseling log analysis (2013-2015)
  - Prevalence survey administered to all mental health staff
    - What are the most prevalent presenting problems that mental health staff are addressing across all tiers?
    - What are students reporting to be the most pressing issues related to their mental health?
  - Youth risk behavior survey

- Global vs. specific screening
  - Efficiency of screening
  - Obtaining actionable data
  - Using multiple specific screeners to piece together a richer and more comprehensive view of the student population

Ultimately, we decided to use Problem-Specific Screening tools and I will mention a few of these throughout the presentation. The justification for use of problem-specific screeners was that we had a lot of information from some of these services that I've mentioned; the youth risk behavior survey, we had counselors collecting data through a counseling log and a lot of the data indicated, not surprisingly, that anxiety, depression and trauma were issues that students faced, and I don't think that that would be foreign to anyone on this webinar. I think that probably everyone on this webinar is living or working in a district where anxiety and depression tends to be a problem for some of our populations. So, we felt like we were addressing the problem directly by using the screening tools that directly measured the degree to which anxiety and depression were problems for our students. We also felt like we would be able to get a very rich data set by using multiple different problem-specific screeners and bringing those data sets together so that we can understand the specific depressive symptoms and anxiety symptoms, we can understand the global scale, subscales that we use, and bring all of that together to be able to really paint the picture of the students' comprehensive needs. We felt like that that was a much better way to be able to develop actionable data sets.

Making Mental Health Screening a Sustainable Practice

- Electronic screening using Google forms
  - Efficient
  - Allows for easy data analysis
  - Movement from screening to coordinated follow-up in 20 minutes
- Parent notification and opt-out process established in advance of the screenings to secure passive consent
- Administration during the school's advisory block and/or classroom-based (grammar schools)

So, I think it is important for us to talk about kind of where we started with one student and then as we kind of progressed through this, we realized that there were ways where we can be more efficient and there were ways were we could produce data that was more actionable and we could develop systems that could ease the burden of screening. And this is something that I hear a lot when I talk about this with districts is that there's a concern that screening is going to be a burden, that it's going to be difficult to actually implement because there's so many steps, and I will agree that there are a number of steps that you need to take but you can also find ways to be very efficient, so I'll talk about that.

We'll talk about consent first and wrap up with where we moved from our initial stages to our later stages of screening. So, consent is something that we definitely had questions about and as I stated previously, active consent was what we went with initially, and for those of you who, let's define this for those of you who perhaps aren't super familiar-with active consent we are sending out consent forms, we are actively engaging parents and students in saying you must sign off that we can do this. With passive consent, which is ultimately what we have gone with, we are sending notices to parents and students and indicating that we are going to be conducting a screening, 'if you do not want us to conduct screening with your child, please contact us, here are the opt out procedures'.

We post this regularly, we send it out through our all-call system, we ensure that every parent is aware of the message that we send out in terms of, 'if you don't want to be a part of this, please don't, that's okay.' And I do not believe that the goal of screening, I don't think it is realistic to say that we are going to get every single student to screen, but I do think the vast majority of students actually do engage in screening. When we put the passive consent system in place, we had less than 1% of parents opt-out of screening. And because it was such a small number, I took it upon myself to call these parents and ask them, 'why are you not engaging in this screening process?' And a lot of times, it was a misunderstanding in that they didn't know what it was for, they didn't really listen to the message, they just opted-out and once I explained it, they were like 'oh well, that's actually something that I'm okay with, please can you put my son or daughter back on the list?' There were a couple instances in which there were parents indicated that, 'you know my son or daughter has already been identified for services, I don't feel as though including them in this is going to yield anything that we don't already know.' So, I think that the very small number of parents who opted out either opted out because they had already bought into the process in some way shape or form outside of our screening program or they really didn't understand what they were really opting out of. So, this is the passive consent message that we send out regularly. We actually read a version of this to students right before we screen because we allow for parents and students to opt out. And if a student wants to opt-out in real time that is absolutely okay with us, we don't want to cause discomfort to students,

we don't want them to engage in anything that is going to cause them to feel as though they are not safe in school.

The other piece, as we talk about this evolving practice of screening, we did start out with paper and pencil screening and it looked very much like the image on the left, and I think it was a huge draw on time. We are Google schools, we ultimately used Google tools to be able to build up these screening tools with Google forms and what that did is that it created a database for us very readily, where we could filter on and sort by scores and move from screening to follow up in less than 20 minutes. For those who are on the call now, who have perhaps engaged in screening in the past and weren't able to leverage these kinds of tools, I think you'll probably remember how difficult it was to move through literally hundreds of thousands of paper screening tools, and the math is easy but doing it a thousand or two thousand times takes quite a bit of time and does not lend itself to an efficient system.
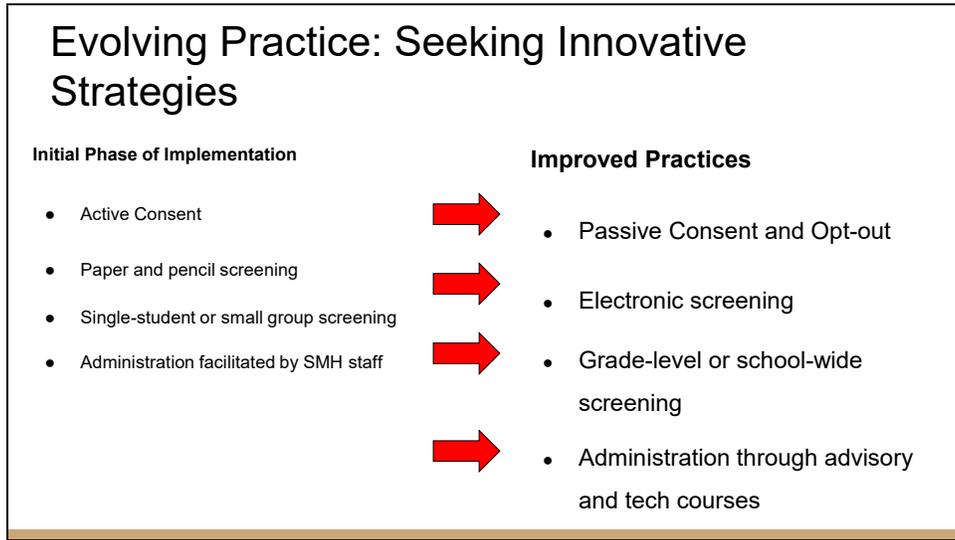
So this is what I was alluding to before; this shift in practice from active to passive consent with opt-out procedures which allowed us to be really efficient in terms of not waiting for those consent forms to come back. Sending the message that this was important and just as important as all the things we were already screening for like vision and hearing. Paper and pencil screening went away and we went with a digital format in which the students where using either their iPads, or their phones, or computers in the school to be able to engage in the screening. We went from single student to small group screening to grade-level or school-wide and district-wide screening. We ultimately leveraged our entire faculty to be able to administer screening. And let me clarify that teachers and administrators outside of the school mental health staff do not see the result, they don't engage with the results, but they are reading the opt-out procedures to the students, they are pointing the students to the link to be able to take the screening tool and we have our school mental health team that are waiting to receive that data and follow up with students. So, it allows for the people who need to work on that data to be free to do so instead of actually administering the screening.

Post-Screening: Coordinated Follow-up

- Data review and coordinated follow-up planned for all screenings
- Mental health staff receive the data within twenty minutes of the completed screening, allowing for immediate follow-up to be conducted with students who had elevated scores
  - Parent/guardian follow-up
  - Follow-up procedural guide developed and data rules established prior to screening to identify the population receiving follow-up
  - Clinical interview professional development
- Mental health staff can then make an informed decision about whether or not to offer services: in-school group or individual therapy, outside referral, etc.

So, this is a huge piece and perhaps the most important piece of screening that you actually follow-up, so you aren't screening for the sake of screening. So, you do review the data immediately following all our screening windows. Like I said, in twenty minutes the data is prepared and ready. The follow-up that is conducted is with the students' specific school mental health staff member. Those students (who staff members are assigned to) may be called down and we ensure that there are many many reasons to come down to the counseling office. It is not the case that post-screening, everyone who is leaving a classroom is identified as a student who scored in the moderate to severe range; we also make it a point to call students down for other reasons during that time period, so it's just, it doesn't lend itself to any kind of concern on behalf of the student to come down and talk to a counselor. So, clinical interviews conducted for those students that we are concerned about and we have some decision-making tools and data tools that really point us to, 'this student perhaps is presenting with an elevated score that is telling us that they need something more', but I'll say this, any data point is not worth a lot unless it is validated, unless we actually have a conversation with the student and ensure what that result indicated is confirmed and can then be moved to decisions about service.

Post-Screening: Other Considerations

- 100% of students who required follow-up received it within 7 days of the screening

- Students who indicated any degree of suicidal ideation or intent to self-harm received follow-up within 24 hours (same day)

- Crisis teams were placed on call in advance of all screenings and local community mental health partners were informed of the screenings

RESPONSE TIME

So, a huge consideration in terms of following up with students, 100% of students who need follow-up and those are students in the moderate to severe range, have that follow-up meeting with the school mental health staff member within 7 days. Any student who indicate any degree suicidal ideation or intent of self-harm received same day follow-up. We, at the beginning, were not entirely sure what we were going to look at in terms of referrals, so we kind of went all in in school crisis teams to be able to be on-call community-based partners. So, we said listen, 'you'll likely receive some calls today, please have staff available' and we planned with them ahead of time. The good news is that we ultimately did not need them and we had the internal capacity to address the needs of our students without calling any crisis teams, but I would strongly recommend having that continual plan in place just so that you aren't painting yourself into a corner.

2015-2016: Testing Practices on a Large Scale

- Using specific screeners to match our population's needs
  - GAD-7 - Generalized Anxiety Disorder, 7-question anxiety screener
  - PHQ-9 - Patient Health Questionnaire, 9-question depression screener
  - RCADS - Revised Child Anxiety and Depression Scale, 47-question anxiety and depression screener
- Two large scale screenings at Methuen High School
  - Grades 9-12 - GAD-7 (January 2016)
  - Grades 9-12 - PHQ-9 (April 2016)
- Piloting screening at the grammar schools
  - Grade 5 - RCADS anxiety/internalizing screener (March 2016)
  - Grade 4 - RCADS (May 2016)

So, I want to talk about the practices; we talked about consent and selecting tools and building the capacity for screening to happen and how it's delivered and how we analyze results, but I do want to talk about the specific tools that we used over time and what that resulted in, in terms of data. So, the specific screening tools that we used in the 15-16 school year, when we started to test these practices on a larger scale after going through several PDSA cycles. The GAD-7 is an anxiety screener, the PHQ-9 9-question depression screener, which I see in a ton of doctors' offices really all the time now. Now that we've implemented screening, people will come up to us around Methuen Middle School and they'll say 'well, isn't that the screening tool that my daughter or son took', and we'll say 'yea these are valid, reliable tools and that's why we're using them, because we feel we can trust them.' RCADS is a longer screening tool and the reason behind that is that this is a tool that we use for our students in grade 5 and 8, and there are not as many opportunities to screen at that level in our district so we wanted to use a little bit more comprehensive, internalized tool to be able to get the most bang for our buck. During that year, we conducted two large scale screenings at the high school and we piloted some screenings at the grammar schools.

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Screening for Anxiety (January 2016)

- GAD-7 administered electronically
- 839 responses (approx. 45% of the high school pop.)
- 85 students scored in the severe range (10.1% of respondents)
- 104 students scored in the moderate range (12.4% of respondents)

GAD-7 15-16	Student Population	%
Sample	839	100.00
No Concern	443	52.80
Mild Anxiety	207	24.67
Moderate Anxiety	104	**12.40**
Severe Anxiety	85	**10.13**

Ultimately, this is the kind of data that was produced when we were conducting those initial tests at a large-scale level and we found that about 22% of our students that we screened scored in the moderate to severe range and that's the kind of data that at the aggregate level, I think will really resonate with administrators and stakeholders to be able to show that this is an area of concern, this is something that we need to address, we know that anxiety and depression and other specific mental health problems have a negative impact on academic performance. When we're able to show that and show the number of students that show the degree to which it is a problem, I think it really speaks to how important it is to implement school mental health services and supports.

Screening for Depression (April 2016)

- PHQ-9 administered electronically
- 852 responses (approx. 45% of the high school pop.)
- 69 students scored in the severe range (8.1% of respondents)
- 102 students scored in the moderate range (12.0% of respondents)

PHQ-9 15-16	Student Population	%
Sample	852	100.00
No Concern	494	57.98
Mild	187	21.95
Moderate	102	11.97
Moderately Severe	36	4.23
Severe	33	3.87

And what we see here, similar in terms of results, about 20% of students scoring in the moderate to severe range for depression.

Going into the 2016-2017 school year, we decided to add a global scale into the mix and to be able to understand some of the other problems that perhaps our students are faced with, all students in grades 9-12 to take the strengths and difficulties questionnaire. One of the things I like about this was that it had a pro-social sub-scale that allowed for us to understand students' strengths to a degree. And in grades 3 and 4, we wanted to pilot a multi-gated approach to screening, where the teacher would select a small number of students, 3-5 students who they perceive to be at risk and then complete the strengths and difficulties questionnaire-the teacher report version on behalf of those students to be able to get some data to be able to inform the interventions for those students. That year we also piloted substance use screening, some of you may be familiar with SBIRT (Screening, Brief Intervention, and Referral to Treatment) it is an evidence-based substance abuse intervention model using the CRAFT screener. We screened two grade-levels, grades 9 and 7 and then we did scale up RCADS screening to all students in grades 5-8, the 16-17 school year.

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Screening for Substance Use (SBIRT)

- 580 students were screened using the CRAFFT II

- 2.2% of students screened positive and received follow up using a motivational interviewing approach and the option for continued services

- 6.4% of students received follow up to address the fact that they had ridden in a car with an individual under the influence of drugs or alcohol

- Building rapport with students and identifying the protective factors associated with not using a substance were the highest reported benefits of this screening

For SBIRT, we found that really, I'll just say quickly about SBIRT, I did not find that the process really lent itself to a ton of referrals. We did receive some and those students did receive some quality care afterward, we were able to intervene on behalf of them early, but the more important piece was that it built a tremendous amount of rapport with the school mental health staff that we were approaching a really serious topic with these students, they were seeing that they could be safe talking about this kind of a topic with one of our staff members and that they could trust that we would maintain confidentiality. So, following screening, they came back with a lot of other issues that did not relate to substance use, but they were important to address, nonetheless.

Slide 48
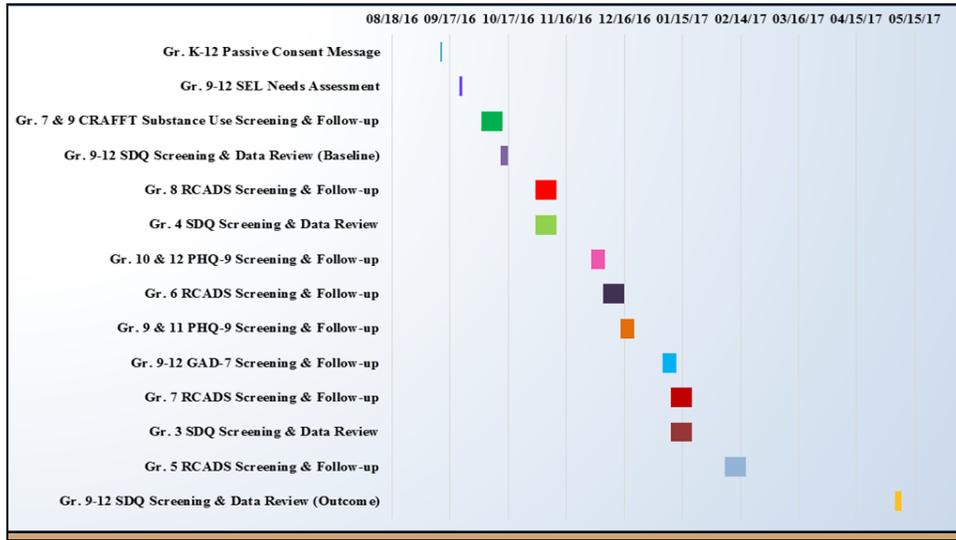
This is a brief breakdown. It kind of shows the calendar screening; we tried to ensure that our screening happens mostly in the front-end of the year.

Screening by Area of Concern

Grade	Anxiety	Depression	Substance Use	Global Scale		
3				🟥		
4				🟥		
5	🟧	🟧				GAD-7
6	🟧	🟧				PHQ-9
7	🟧	🟧	🟨			CRAFFT
8	🟧	🟧				RCADS
9	🟦	🟩	🟨	🟥		SDQ
10	🟦	🟩		🟥		
11	🟦	🟩		🟥		
12	🟦	🟩		🟥		

And then screening by area of concern; this is kind of a visual of what we screen for at which grade level.

We are using the Student Engagement Instrument, over the past year, year and a half. This is a tool we wanted to include as a means of understanding, as we address students' mental health concerns, are we seeing an increase in student engagement. And I think that that is going to be one of the ways in which we can point to a pro-social outcome for screening. We are also embedding screening practices into the tiered support process to ensure that our students receive screening when there are initial signs of concern. And I do want to point out the shape system, the online repository of screening and progress monitoring tools, that has been really beneficial to us and I've made some recommendations for sure to districts in Massachusetts that these things are, that for the vast majority of these tools, they are free. So, when we talk about sustainability, it's really critical from a funding standpoint to find some stuff that are reliable and also free.

Slide 51

Identifying Students and Increasing Services

Increasing proactive service delivery for students who require mental health services.

- Identification of individual students who may require mental health services and supports
  - Proactive identification and referral for services serves to reduce the overall impact of mental health problems on students
  - The reduction of crises through preventative care improves the overall functioning of a mental health system and decreases the larger impact of crises on the school as a whole.

63% increase in identification of students who require mental health services following implementation of mental health screening in 16-17.

So, I want to talk a little bit about why screening? What's the purpose of this? And I think the idea behind it is 1., the obvious one, we identify students, and we identify them early, that proactive identification piece allows for us to get services in place before crisis happens, because otherwise we're really just reacting to crisis, waiting for things to happen that are much harder to address. When we first implemented screening on a large scale, we saw 63% increase in the identification of students who require mental health services. And I look at a figure like that and I think, we were identifying students, it wasn't that screening was the only means by which we identified students, but without screenings we were missing a lot of students and we were missing them for quite some time. So, that I think that number in particular really speaks, for me, to how important this practice is from an identification standpoint.

So, the other piece of this is that the use of this aggregated psychosocial data can do so much for your school mental health program. If this ongoing needs-assessment that helps you understand your population's needs over time can help inform curriculum design and delivery, it can help inform the design of Tier 2 interventions. And one thing I didn't mention but that is really important is that our group therapy program at the high school is now entirely driven by our practice of screening; so that when we conduct a screening we are immediately able to make referrals to our group therapy program. And for anyone who's tried to establish a group program, I think one of the things that I notice often is the fact that the referral process tends to be this nebulous piece where you have one or two referrals here or one or two referrals there, but then getting to a point where you can kind of get a cluster of students that makes sense for a group, it's very difficult without a strong referral procedure. So, tying it to screening ensure that we are getting a cluster of students immediately following screening that we can then follow-up with and determine whether or not they are appropriate for that service.

17-18 Depression Screening - PHQ-9

PHQ-9 17-18	Student Population	%
Sample	1161	100.00
No Concern	757	65.20
Mild	240	20.67
Moderate	105	9.04
Moderately Severe	41	3.53
Severe	18	1.55

Approximately 14% of students reported moderate to severe symptoms of depression.

I think that we'll go through, I do want to belabor this data too much, but suffice to say that we continue to collect data related to depression and anxiety and across all those other scales.

17-18 Anxiety Screening - GAD-7

GAD-7 17-18	Student Population	%
Sample	1029	100.00
No Concern	649	63.07
Mild Anxiety	238	23.13
Moderate Anxiety	95	**9.23**
Severe Anxiety	47	**4.57**

Approximately 14% of students reported moderate to severe symptoms of anxiety.

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RCADS (17-18)	Student Population	%	Total % Elevated Scores (At-Risk + Clinical)	
Total Sample	2155	100.00		**13.36 percent of students in grades 5-8 scored in the moderate to severe ranges** for internalizing issues (depression, anxiety, etc.) *Methuen Public Schools (2018)*
Grade 5	552	25.62		
No Concern	469	84.97		
At-Risk	30	5.43	15.03	
Clinical Concern	53	9.60		
Grade 6	530	24.59		
No Concern	448	84.53		
At-Risk	22	4.15	15.47	
Clinical Concern	60	11.32		
Grade 7	523	24.27		
No Concern	462	88.34		
At-Risk	15	2.87	11.66	
Clinical Concern	46	8.79		
Grade 8	550	25.52		
No Concern	488	88.73		
At-Risk	18	3.27	11.27	

This in particular was something that we were able to pick up and very much turn heads in our district when we were able to say, 'you know, grades 5-8 13.36 percent of students scored in the moderate to severe range,' that's the kind of data that I think really allows for us to put at the forefront of what people think we need, it makes mental health, school mental health in particular something that is seen as incredibly valuable and necessary.

Slide 56

Progress Monitoring and System Evaluation

In addition to being used to identify students who may require services, psychosocial data is also used to:

- Gauge the efficacy of mental health services and supports
- Monitor the progress of individual students receiving services
- Accountability measure for service providers

I'll talk briefly about progress monitoring; we can kind of jump right into it.

We used the same data or the same screening tools to monitor progress over time. I think that one of the things that I always ask districts that we meet with is, 'how do you know that your therapeutic interventions work, what data are you using?' and a lot of the times I think that we're looking at secondary or tertiary outcomes that don't directly relate to the services we provide. So, I want to really ensure that we're using psychosocial data to determine whether or not our interventions work.

The Importance of Progress Monitoring

- Gauge the efficacy of the therapeutic approach - Determine what is working and what is not
- Adjustment to practice - Change the treatment / intervention plan if the student is not responding to the therapeutic approach
- Improves:
  - Student engagement in services
  - Quality of services
  - Consistency of therapy sessions
  - SMH staff self-assessment

What Are We Measuring?

- Symptom presentation
- Emotional regulation
- Specific behaviors
- Engagement
- Self-concept
- Overall functioning

Consider multiple measures of progress to gain a more complete picture of the impact of the intervention.

So, when we talk about psychosocial progress monitoring, we're talking about symptom presentation, emotional regulation, which I would define as symptom presentation over time, specific behaviors that we want to monitor, engagement, we can use a student engagement instrument or a teacher completed student engagement instrument. At the end of the day, these are things that directly relate to the services that we provide.

- Individual student run charts are used for students receiving Tier III services.
- Use of psychosocial, academic, and behavioral data is encouraged to improve our understanding of the impact of mental health services on academic outcomes.
- This method of data collection represents a shift away from a reliance on strictly qualitative measures of the effectiveness of mental health services and supports.

Here, just some examples of graphical representations of the data we have been working with over the past few years. This is a student I have worked with for I believe 6-8 months and when I'm able to graphically represent the changes in symptom presentation over time, I think it provides a much more accessible view into why our services are important.
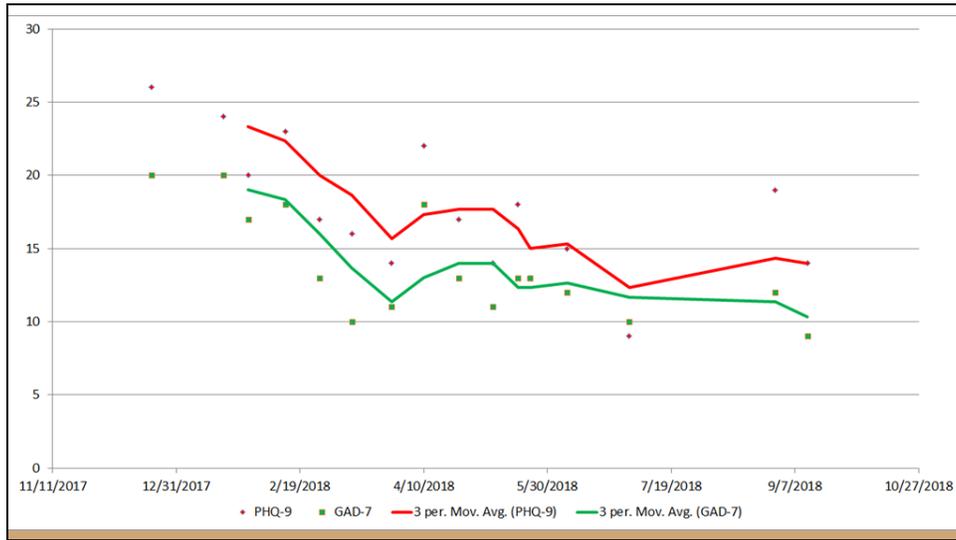
Then we continually get fancy with our graphs and we're able to paint a picture of students' symptom presentation over time. But this, for individuals who attend the IEP meetings, for individuals who are trying to justify that termination is a hugely important piece of the therapeutic process, to be able to say that this is the change that has happened over time and we are approaching a point where we need to either fade or terminate services, because the student is showing incredible progress.

Slide 62

Sample Progress Monitoring Chart

- Progress monitoring intervals of two weeks (GAD-7, PHQ-9, and SDQ subscales)
- Graphical history of the student's response to treatment
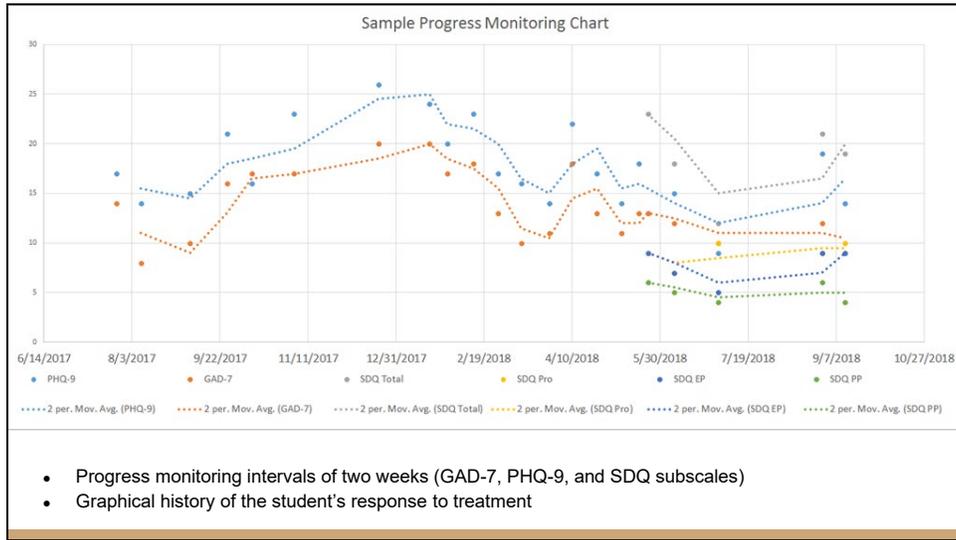
Just one last graphical representation. This is with a lot of different measures on there.

Slide 63

Post-Group Data/Group Evaluation

Average GAD-7 Score

Students' GAD-7 Scores By Session

Average GAD-7 score pre-group: 15.22
Average GAD-7 score post-group: 8.42

Indicates ~7 point average decrease on the GAD-7 (mild anxiety)
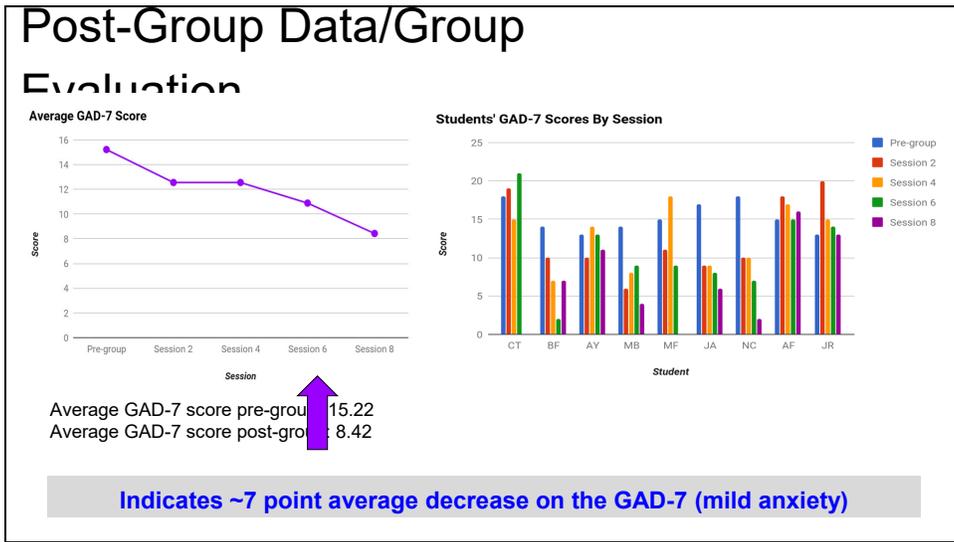
We also conducted this with group, so that when our group therapy program was engaged in providing services, we were ensuring that those services were monitored throughout the process.
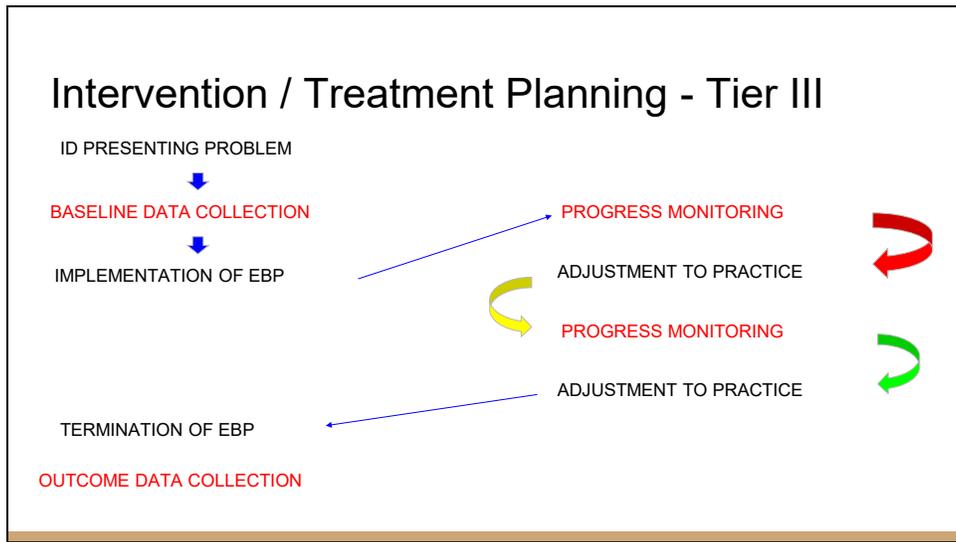
I won't belabor this, just really a nice way of understanding intervention and treatment planning in Tiers II and III.

3-Year Depression Screening Comparison Data

PHQ-9 - Annual Prevalence Rate Comparison

16.7 percent of students score in the moderate to severe range for depression, on average

**5.95% decrease in students scoring in the moderate to severe ranges** for depression between the 15-16 and 17-18 school years.

7.22% increase in students scoring in the "No Concern" range for depression between the 15-16 and 17-18 school years.

This is something we're really proud of. We used our aggregated screening data to be able to understand the changed year to year. We've seen a 7.22 increase in students scoring in the "No Concern" range, about a 6% decrease in students scoring in the moderate to severe range, and this is all information that we put into an accountability report that allows for us to speak to our stakeholders around 'this is the impact of our work'.
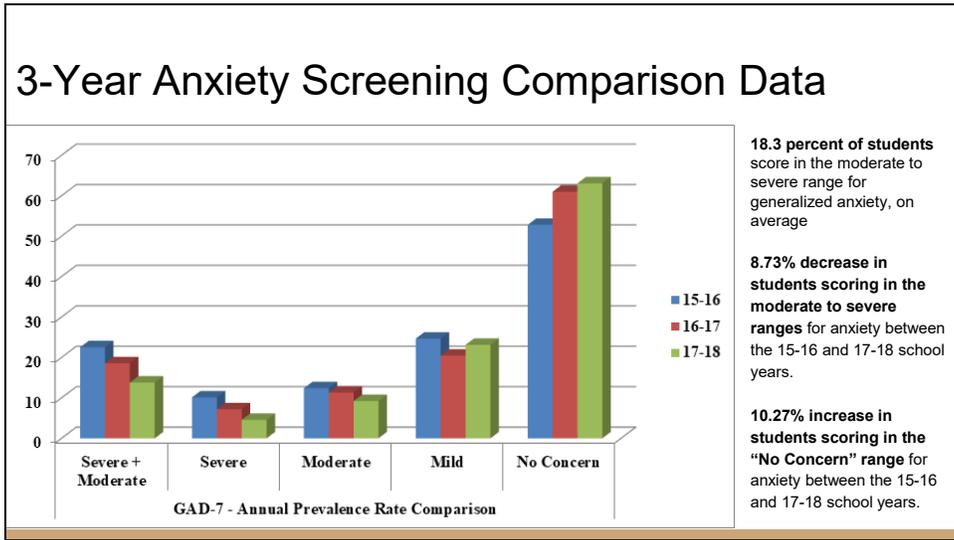
Similar graph but with a little bit of a larger positive outcome in terms of our impact on anxiety.
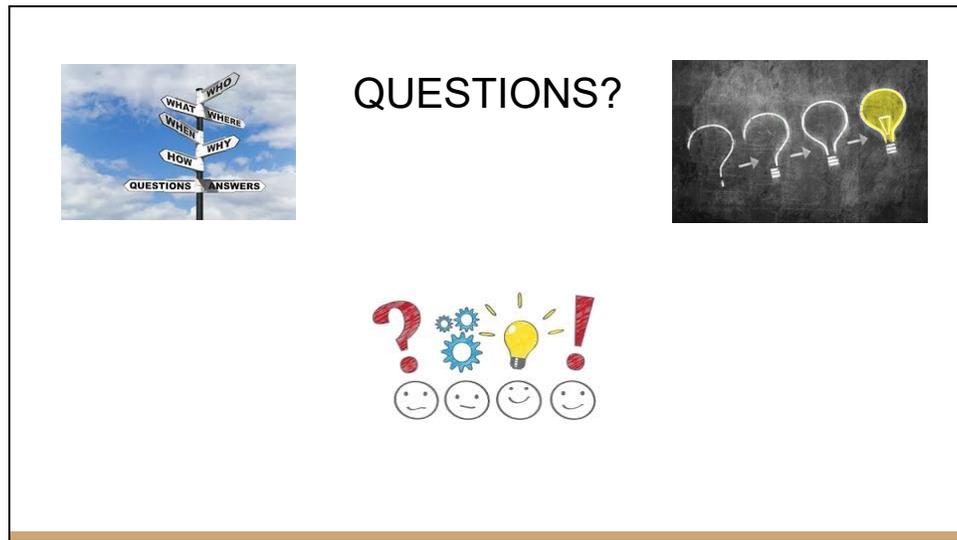
So, I know that we were moving at an incredibly alarming rate. I am thrilled to get question, this is normally and hour to an hour and a half presentation so I want to make sure to be sensitive to whatever other presentations you have. So, thank you so much.

Thank you so much John. This is a wealth of information, thank you for talking us through the process. I think we'll hold questions until the end to make sure we have enough time to get through Dr. Furlong's presentation as well.

Slide 68

So, we'll switch gears and turn it over to Dr. Furlong. Thank you. We'll go ahead and ask questions to John and Michael at the end.

Okay! So, welcome everybody and thank you for the opportunity to speak with you today and to learn from the seminar. And I'll be brief, I know we don't have much more time so I'll be happy to talk with any of you later if you think it might be helpful, I want to recognize my wonderful colleagues Erin Dowdy and Karen Nylund-Gibson. Also, the screening considerations that John just talked about are totally consistent with the approach we've taken, I think very comprehensive approach. I was very impressed. A couple of distinctions, in our approach we actually don't use the word screening, we just refer to it as monitoring as John was referring to later in his part of the presentation. And we are saying that this is not a one-off which screening sometimes has that connotation. But we're trying to think of it, we're wanting to keep track of students' wellness if they are healthy and if they're thriving and that is the general approach that we think about when we take it. The context, I realized I've added this in is this approach and the measures we use in here were developed out of our participation and evaluation of two state school healthy student projects here in Santa Barbara county a few years back. So, these measures were generated out of interest of this school to try to measure and monitor students, other aspects of students' wellness and strengths in addition to being expressing concern about any emotional distress that they might be experiencing.

Slide 69

So, just to start off. If you take a look at this particular slide, you'll see there is an item up there. This is an item that is from Scott Huebner's Life Satisfaction Scale. So this statement is one, that is 'My life is going well' and the students are asked to respond to this item using this 6-pt Likert scale. So, in considering this statement, how would we want our own children to answer this, our grandchildren, our mentees, the students that we work with? Certainly, I think we would agree that we want them to at least respond in some degree of agreement with this item, most preferably we would want them to answer 'moderately or strongly agree'. But we infrequently include such wellness items in our screening or monitoring surveys and should we? So, just briefly I want to give you a sense of yes I think we should.
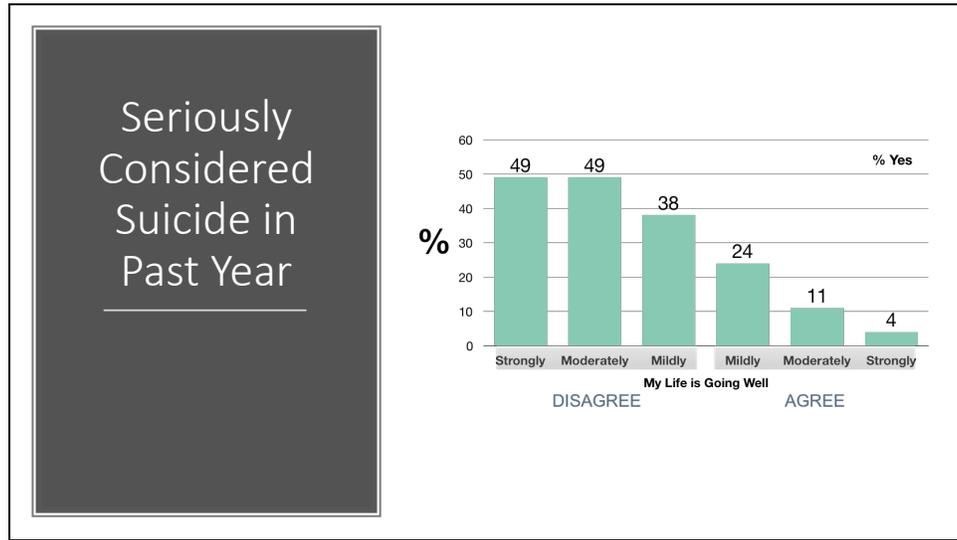
So, as this slide shows here, we have included this item. We have a study that I'll be mentioning briefly, it is called the California Student Wellness Study and it is to illustrate that of course ill-being and well-being and related to one another. So, however, our students' responses to this well-being item related to other items that we might be interested in in terms of student self-report of any emotional challenges they may be experiencing. So, in this case we asked the item, the students responded to the item from the Youth Risk Behavior Survey which is the question that asked them if they thought about suicide in the past couple of months. And as you can see, yes, student responses to ill-being and well-being items are related to one another; students who do not feel their life is going well, the left side of that slide, 49%, are substantially more likely to report that they've had suicidal thoughts in the last year.
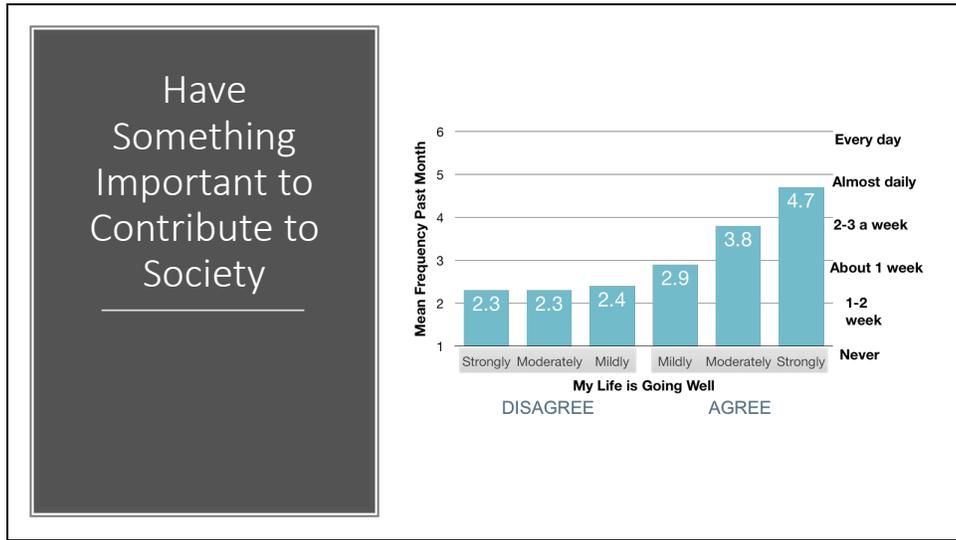
And to take a different perspective, this also illustrates another approach that we take. This chart shows the association between Huebner's Life Satisfaction Item and an item from Keyes' Mental Health Continuum short form, which is another measure that we use. This is an item that assesses social well-being. So, the students who disagree with the satisfaction item, report feeling that they contributed, made a contribution, in significant ways only one or two times a month, you can see that their average response on that Likert scale is only 2.3 as opposed to 4.7 for students who strongly agreed with the item that 'My Life is Going Well'. So, for example our partner schools do not ask items in the general universal screening on suicide items, our assessments tend to focus exclusively on whether students are doing well.

So, these are some resources; if you are going to engage in some strength-based positive assessment as part of your screening monitoring process, these are some of the go-to resources. Center for Social Emotional Learning (CASEL), there is another study that is going on that is called the Children's World: International study of Children's Well-Being study, the Office of Economic Development Study on Social Emotional Skills is developing a very comprehensive strength-based measure that is based on the Big Five Personality Inventory, and the RAND corporation has put together an online resource where you can search for and look for measures that relate to social, emotional learning and academic competencies.

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On our website, if you look under there you'll see 'research' under that research option there is a submenu that says 'presentations', I have posted on there a document, document #4 in that list, which provides you a description of each of those resources I've just mentioned from the previous slide, and then provide you with the hyperlink index to those resources- so you can find out more there. Of course, in our context today, I am going to talk a little bit more about Project CoVitality, summarize the work that we are doing on this website, under the research link there's links to the many studies that we've done to validate the measures that we've been using. And you also know I won't go into great depth obviously but there are strategies that also provide access to resources that counselors and psychologists and teachers can use to support their interest to support the social/emotional development of students.
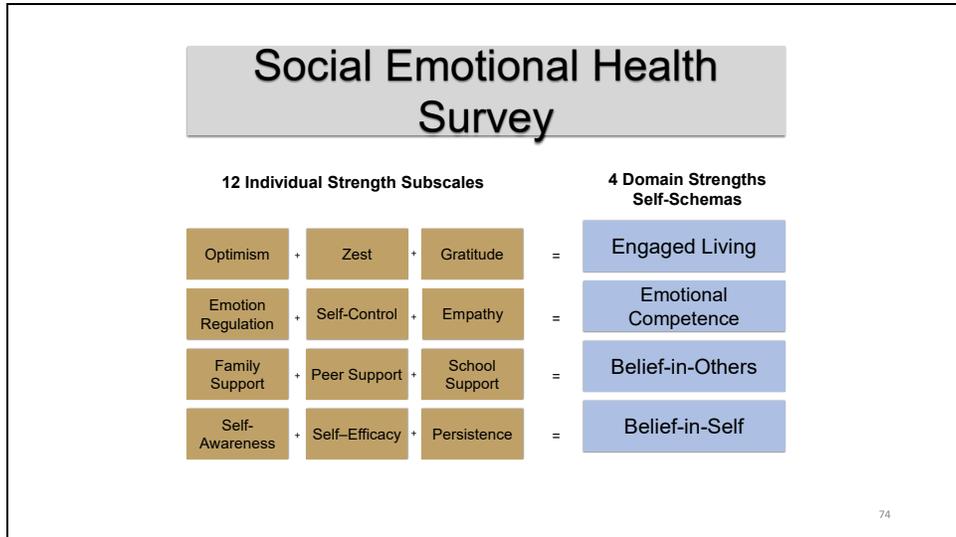
I won't go into this in great depth, but this is a core measure that we've developed, the Social Emotional Health Survey. I'm sharing this with you now just so you get the sense of some of the positive psychological mindsets that are included in this measure such as optimism, zest, gratitude, emotion regulation, as John has mentioned. So, this is a measure we have been developing and using in our studies.

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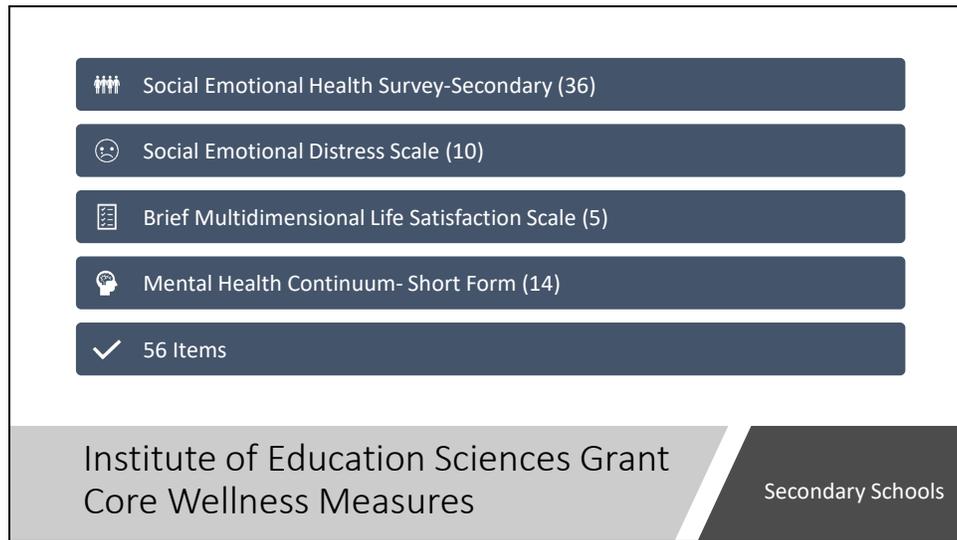
The measures here represent what would be the core measures that are used in our universal screening with our partner schools, which I graciously acknowledge, because we are doing this as a resource for the schools to monitor and support their students, but also because this is integrated into our research activities here at the university. So, we couldn't do it without the support of the schools, which we appreciate. Just to mention briefly, we have also used other measures, the Add Health School Connectedness Measure, the Psychological sense of school membership measure. Other times, we have piloted use of the DASS21, the depression, anxiety, and stress scale. We use another instrument, the Me and My School Scale, which is an emotional distress scale which is specifically for students 8-12 years old, we've used the DASDIS, PAMIS, HQ-9, and the SDQ, so we've had experience with those instruments too.
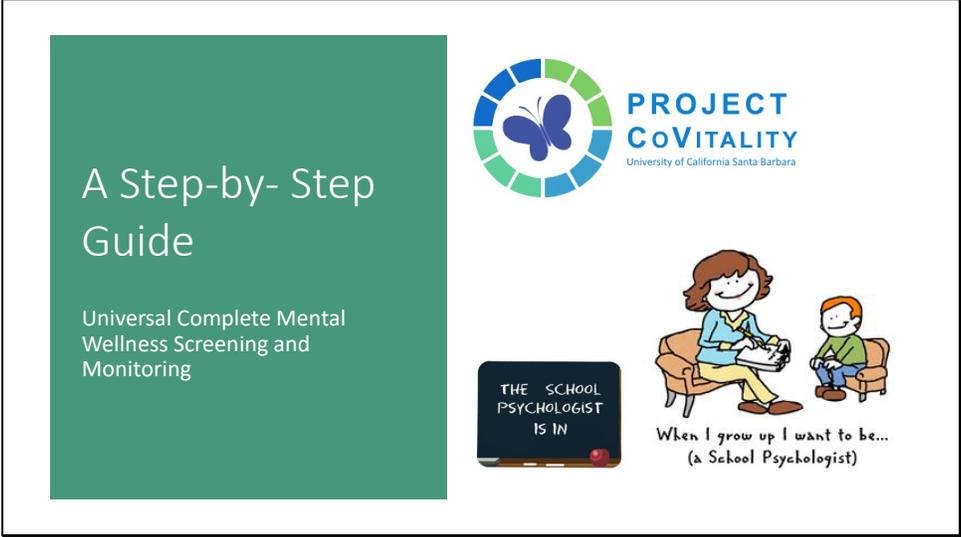
We also follow a step-by-step guide.

Of course, the presentation that John had was exemplary; there's great information on there on the steps to follow. I found what I would do here today is just briefly mention that all steps are important but not equally resource demanding. So, survey administration is an example, it's easier said than done as John alluded to, because this is more than just distributing papers or getting parental consent. Just to focus briefly on that to give you a sense of what we do with our schools, when we administer the surveys we set them up on Qualtrics, each school gets their own unique link. Depending on the school's resources, the students at schools now often have tablets, those schools administer this survey, they're able to do it in 20-25 minutes and schools with 2,000 students are able to complete it in one morning. Others might have tablets or carts that they have to move from classroom to classroom or use computer labs. We have developed reports in the Qualtrics format and we show from year to year, so the reports are now developed, the school gets the report back the next day. Given that we're using this for research purposes also, when the students at the schools do the survey, they do provide an ID number after we get that information, the data is exported to a SPS file and we use wellness and distress response items to help the care team evaluate student and individual needs and prioritize their follow-up support and efforts.
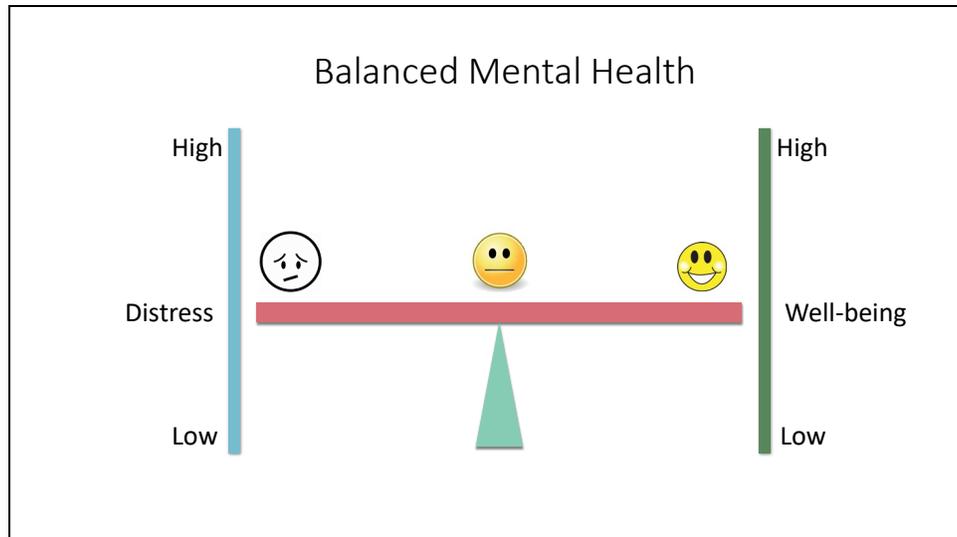
So, we employ in our process to evaluate the needs of students what has been called a dual factor or dual continuum and bi-dimensional model. So, you see it's really two continua, related continua, so there's one with distress, students reporting on some measure of distress and then some measures on well-being, so you look at the combination of the two.
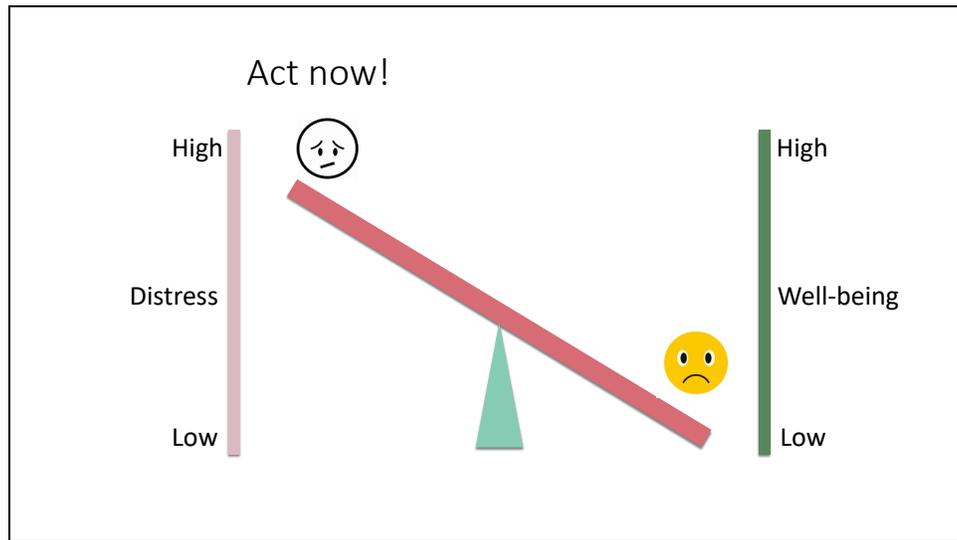
So, if we think of doing screening or monitoring, students who are particularly low on well-being and high on distress measures, looking at the combination of the two then identifies the students that this school identifies wanting to follow up-on.

What is Complete Mental Wellness?
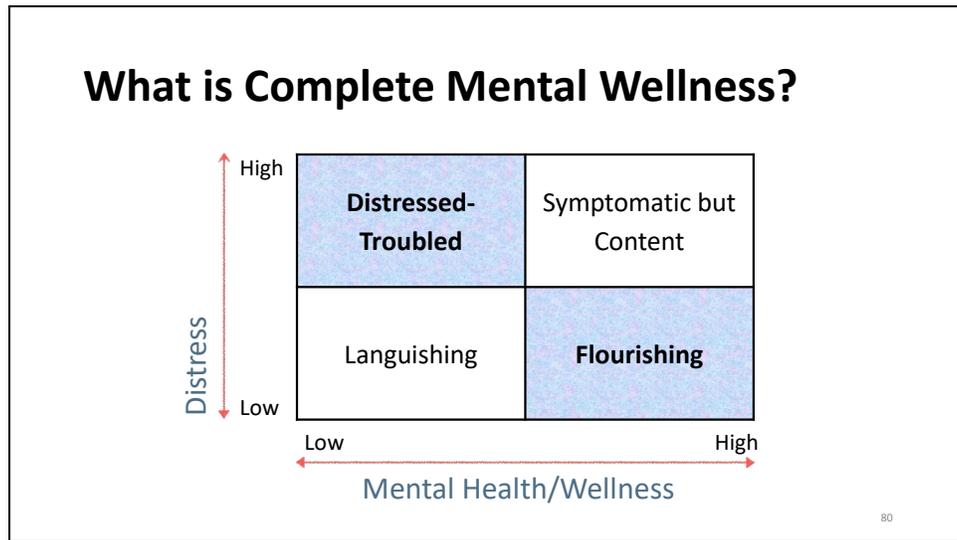
And this is just another way of thinking about complete mental health. Clearly, our goal is for all students to be in the Flourishing range of development and our particular concerns are for students who might be distressed. Now, the advantage of doing the dual factor or dual bi-dimensional approach is that if we just do screening just for student distress, we would only identify students with distress and not that lower left quadrant of students; students who some have called 'languishing', these are students who are not reporting substantial emotional concerns at the moment, but they're also very low on personal strengths and assets. And these are student who might be vulnerable to some more substantial mental health problems in the future if they're not given a certain type of support.

Bi-dimensional Approach: Cut Points
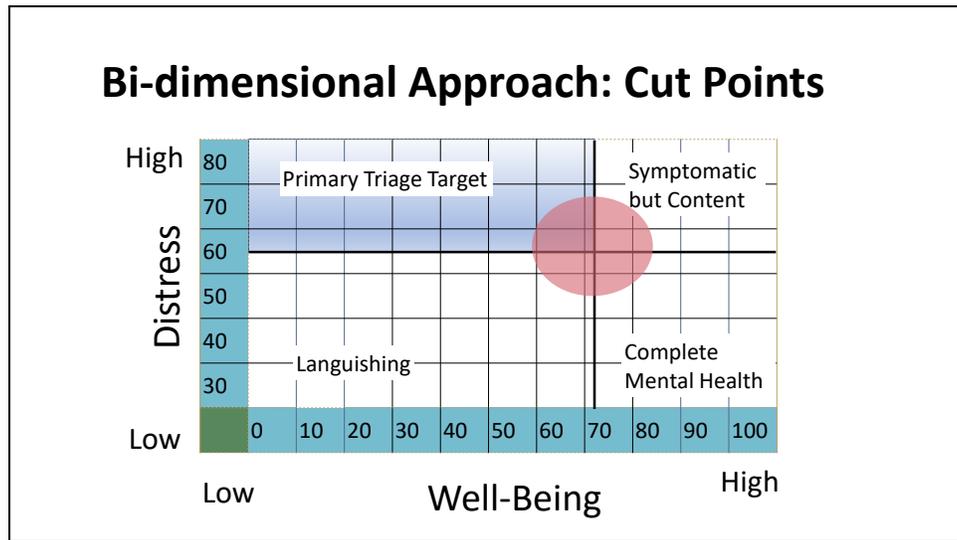
So, of course again this is easier suggested than done because when we are using any screening measure one still needs to consider cut-scores. So, on this chart for example if you look on the left Y axis, if you considered using the BASIS as a distress screener and if that was used, a cut score or decision score could be a score of 65 as shown here and this is what the best manual suggests. But one would also need to simultaneously administer and consider some wellness index, in this example here, I use a simple one item global life satisfaction rating scale that goes from 0-100, it's an option in Qualtrics for having students respond to the question. So, the median here, which is shown as 72 you see you have two cut scores to decide, 'who are we going to follow-up with?' in this dual factor model, that's actually the average of responses we have gotten from 120,00 students in grades 7-12. In other words, at some point you have to have some criterion for deciding where is the critical point, and the same would be true whether you are doing a distress focused screening approach or using a dot bi-dimensional approach. Of course, my point here is to recognize that when we're doing this, decisions about where we put the cut points have direct implications for the number of students we identify and made a follow-up with. And there's also error.

One issue that is often not addressed when we talk about screening is whether or not these measures are co-normed with one another, they are usually not. So, distributions may not be the same for both measures, they're not derived form the same sample. Rarely are any of the samples we're using actually been based on large normative samples. One option is to develop local norms and of course the combination of which measures to use is always a question that still needs to be addressed. In our case, what we feel fortunate to have to opportunity to do is just this past month, we completed data collection on the California Student Wellness Study and the students, and we're already preparing documents that present validation information for this approach to school based mental health screening. You can see there that we have a sample of 120,000 students, 290 schools, we also have a subsample of students that we've been following 3-years during their high school years and this information is also going to be integrated with the California Healthy Kids Survey, which is a Youth Risk Behavior Surveillance type survey that our schools use. I want to note that the large data set is anonymous and again when we are working with partner schools after getting appropriate parental permission, student consent, students provide an ID number which provides the Care Teams at the school the information they need to follow up on with them.

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Primary Schools	Social Emotional Health Survey-Primary (20)
	Me and My Schools (16)
	Adapted Psychological Sense of School Membership (9)
	45 Items
	Tyler Renshaw's Scales (http://tyrenshaw.org/measures)

And just as an FYI, we don't leave the young children out. This shows the three measures that we use when we're trying to measure wellness with elementary school students so we have a junior version of the Social Emotional Health Survey, we have Me and My Schools measure which is specifically to asses distress in students 8-12 years old and we've adapted a version of the Psychological Sense of School Membership that looks at the sense of students' connections to schools. Another excellent resource that you'll want to look at is Tyler Renshaw's, a UCSB graduate, and Tyler has a website and has access to many assessment tools that can be used to monitor wellness among elementary school students.
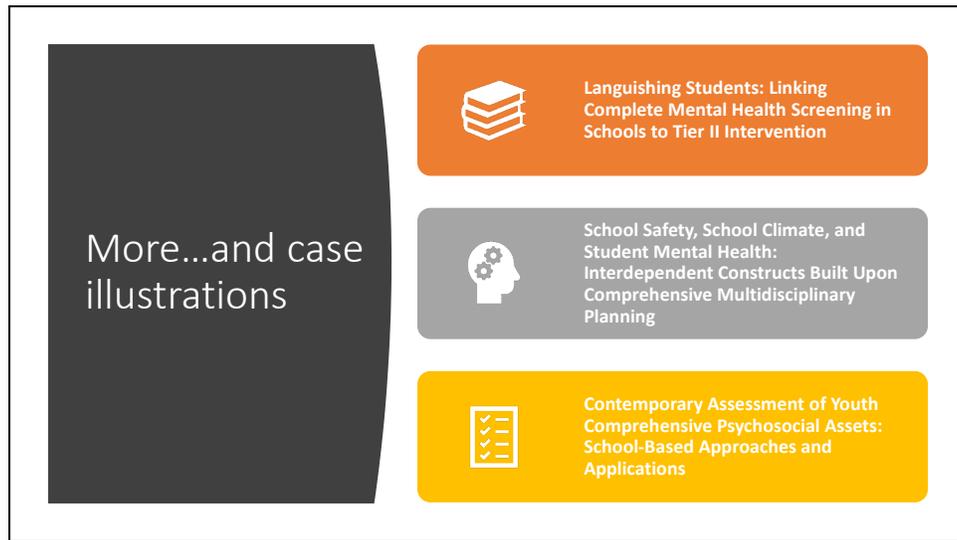
All of what I've talked about here, in our approach doing screening is described in three documents that we've prepared and they are posted on the website. The one at the top shows our approach doing screening at the universal and interfacing with a Tier II follow-up. The second document there provides a way of thinking about integrating multiple aspects of data needs in school which relate to school safety, school climate, and school mental health. And the last one provides descriptions of some other instruments that you might be interested in pursuing. One of which is what they call the Positive Youth Development Questionnaire and their Five C's, where they look at competence, confidence, connection, character, and caring youth and it has a measure based on human flourishing model called PERMA, which looks at engagement, perseverance, optimism, connectedness, and happiness. Those latter two documents include illustrations and examples of how some local educational agencies have been implementing these assessments in their schools and these summaries where written by the personnel with the school who were implementing them.
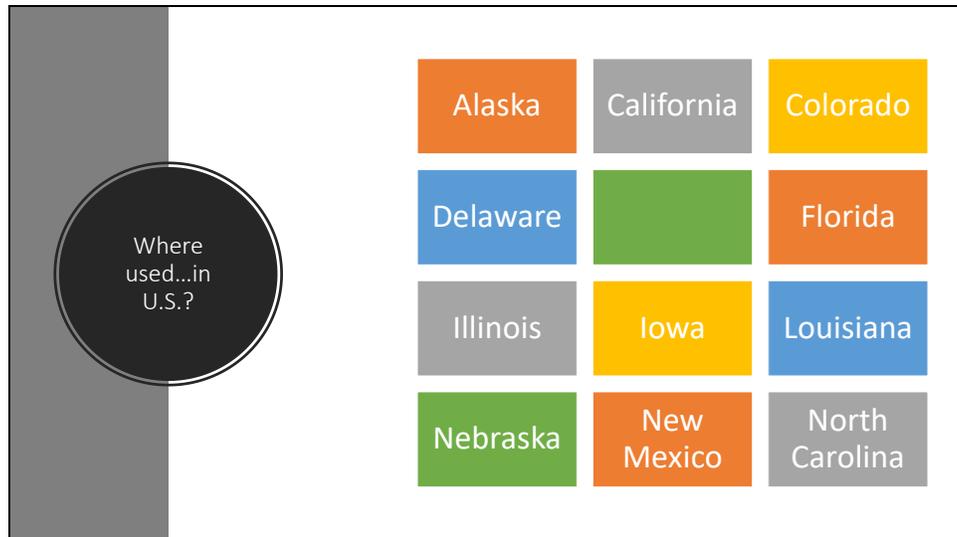
So, just real briefly, I know you are from many places, as far as I can tell I know there are at least one school in each of these states that have been using these measures as part of their school-wide assessment.

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And we're also just very grateful that in fact these measures have been and are starting to be implemented in various places all around the world.

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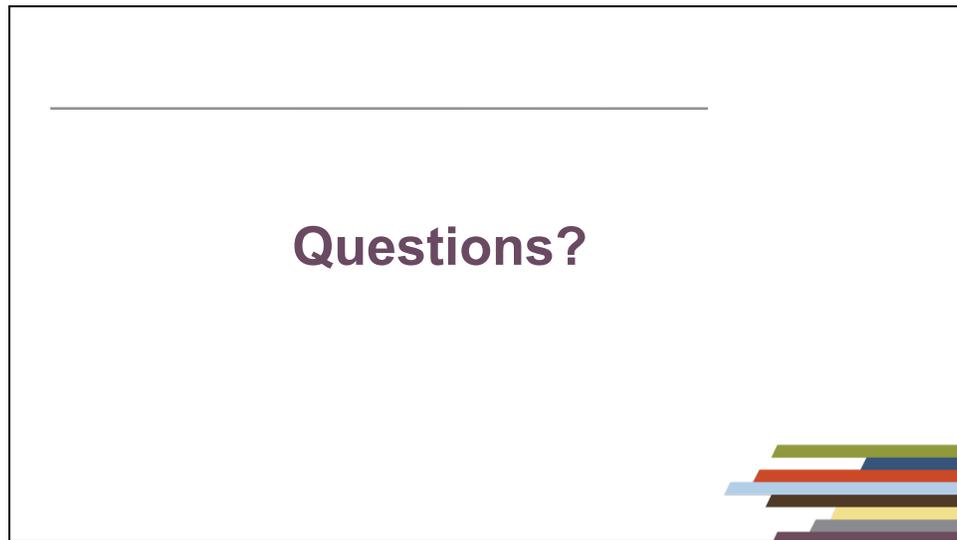
Questions?

So, I thank you for the opportunity to speak with you today and I'm happy to follow-up as might be helpful for you all. Thank you.

Wonderful, Thank you Dr. Furlong and thank you again John. So, I'm glad we have some time left over to open it up to questions. I know we have a couple that are in the chat. But I'll open up if anyone wants to ask those out loud.

So, while folks are thinking and getting those out, I'll ask these first few from Dr. Hoover. Is this measure available in the public domain? And why should I screen for distressing moments?

Okay, Scott Huebner, he's at the University of South Carolina and he posts these measures online and these are measures that have been around for many years. They are available and you can use them and the second part of the question, I'm sorry, was?

So, the question is: If a district asks why should I screen for distress and wellness instead of just psychopathology, what would your response be?

Honestly, we say we don't screen for psychopathology; we think it scares people away from doing screening. We say our interest is that all children 100% would be well and we want to do measures that are relevant to all students, and that's where we're thinking a multi-tiered system

of support. If we're doing this, we should have a coordination with the counselors, social workers, psychologists, others at school who follow-up systematically with students and make sure if there are any other deeper psychological needs that there, that they address them. So, that's what we say. Our approach is to say, we're trying to assess student wellness as opposed to assess student psychopathology directly.

Great, Thank you.

But, we need to have a balanced approach.

I'll be quite to open it up, if anyone wants to ask a question out loud.

You're also welcome to put those in the chat, any questions of course for John as well. I'm seeing one in the chat, 'How do you report findings to students and families?'

So, we in Methuen, you know after we've conducted our coordinated follow-up with students, we definitely want to be sensitive to confidentiality and I know that that is definitely going to look different depending on which grade level you're in and I know it's a huge topic in schools in general, but at the end of the day students are made aware of their results as a function of the follow-up that is conducted with the school mental health staff. And we do encourage students to engage with their families around what they are needing at that moment too.

We can follow up with John if there's additional information. Dr. Furlong and Mr.Crocker's information are both in the chat. I'm sure they would welcome additional questions. We are at the top of our time. We want to thank them so much for their time and expertise and lots of resources and knowledge; thank you so much for joining us today as we talk about this topic. We look forward to our additional virtual learning sessions. Please don't forget to complete and give feedback on today's session and we look forward to talking with everyone at our next virtual learning session. Have a wonderful afternoon.

Thank you for your participation today!

Please click on the link in the chat: http://bit.ly/VLS4-eval
to provide feedback on today's virtual learning session.

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Acknowledgements

This work is supported by grant SM081726 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Module content was developed by the National Center for School Mental Health in partnership with the MHTTC Network Coordinating Office.

National School Mental Health Curriculum