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**Enhancing School-Based Mental Health Services with a Preventive and Promotive
Approach to Universal Screening for Complete Mental Health**

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Abstract

Universal screening for complete mental health is proposed as a key step in service delivery reform to move psychological services from the back of the service delivery system to the front in order to focus on prevention, early intervention, and thriving mental health promotion. In the fall of 2012, a sample of 2,240 high school students participated in a school-wide universal screening designed to identify both behavioral and emotional distress, as well as personal strengths. School psychologists utilized these screening data as the primary step to engage in a collaborative consultation model with administration to make decisions regarding the refinement and expansion of mental health service-delivery options. Prevention activities were tailored according to the needs identified through the screening data. The roles of the school psychologist, site administrators, and district personnel are discussed as critical components to service delivery change. Implications for future consultation research, practice, and training are provided.

Keywords: screening, dual continua, consultation

Enhancing School-Based Mental Health Services with a Preventive and Promotive Approach to Universal Screening for Complete Mental Health

In the aftermath of the Sandy Hook shootings there has been increased recognition of the need to expand mental health services to America's youth (e.g., Cowan & Vallincourt, 2013; Interdisciplinary Group on Preventing School and Community Violence, 2013). Yet, the high incidence of children with unmet mental health needs, coupled with the limited resources available to provide assistance (Nastasi, 2004), has been a long-recognized unresolved issue (Kataoka, Zhang, & Wells, 2002) associated with the Children's Mental Health Services System of Care cross-agency model (Stroul, Blau, & Friedman, 2010). Despite substantial federally-funded efforts over the past 20 years, there has been surprisingly limited progress made to increase the continuum of mental health services for youth (Kutash, Duchnowski, & Lynn, 2006), which, in our view, necessitates a change in the paradigm that organizes how mental health services are provided, particularly in school settings.

A crucial step in service delivery reform is to move psychological services from the back of the service delivery system, where students are provided services after significant symptoms of distress are present, to the front of the service delivery system where all students are screened and provided access to a range of prevention or early intervention services (Dowdy, Ritchey, & Kamphaus, 2010). Drawing upon an ongoing school-based mental health consultation program, this article describes how school psychologists are utilizing universal screening data in collaboration with administrators to direct mental health services to students demonstrating the greatest need. They are meeting this need while engaging in a process that is bringing about systems-level reform by recognizing that many students on campus are not in urgent distress, but are also not thriving—psychologically they are just “getting by.” This universal screening

program to assess complete mental health gathers information on students' personal strengths and psychological distress with the goal of promoting optimal development for every student.

Service-Delivery Reform through Universal Screening

Historically, the provision of school psychological services has been based on the medical model paradigm with services primarily focused on the remediation of individual problems, rather than population-based and preventive services (Gutkin, 2012). Such a reactionary approach to service delivery is not sustainable, particularly when resource-restricted economic conditions prevail. A remediation-based model is also inconsistent with current prevention and multitiered models of service delivery (Kutash et al., 2006; Radcliff & Cooper, 2013), whereby all students are provided with some level of support based on identified need, and with the expanded goal of supporting all students' optimal development and mental "health."

Population-based service delivery models, including multitiered systems of support (MTSS) and response-to-intervention (RTI), rely on data to inform prevention and intervention activities to promote the psychological well-being of all students (Doll & Cummings, 2008). However, the data currently collected in the majority of schools are insufficient to accomplish this goal. For example, the individual assessment data that are gathered for eligibility into special education are insufficient to monitor the well-being of an entire student population. Furthermore, current population-based surveys, such as the *California Healthy Kids Survey* (California Department of Education, 2010; <http://chks.wested.org/about>) or the *Youth Risk Behavior Surveillance Survey* (Centers for Disease Control and Prevention, 2010), are insufficient because of the anonymity of respondents, providing no information on which specific students need additional supports.

Universal screening is a contemporary, alternative approach to collecting data that are easily incorporated into existing population-based service delivery frameworks. In this approach, *all* students are screened and provided with the same opportunity for potential early identification and service provision (Dowdy, Kamphaus, Twyford, & Dever, 2013). Universal screening is an essential first step to mobilize school-level resources while also identifying which students might benefit from preventive or early intervention services (Severson, Walker, Hope-Doolittle, Kratochwill, & Gresham, 2007). The principle behind universal screening is straightforward: it is impossible to proactively help individual students unless school personnel take the time to ask the students how they appraise both the negative and positive aspects of their life experiences; that is, they have to watch, care, ask, and respond in support of students. Moving away from a referral practice heavily reliant on teacher nomination (Gerber & Semmel, 1984), the students themselves have the opportunity to disclose information about their life experiences. This is critical as the students who might benefit from support services are not just those who are obvious to teachers or those who are experiencing significant mental distress.

The practice of universal screening for behavioral and emotional health is gaining traction in schools due to (a) increased recognition of the importance of prevention and early intervention (Glover & Albers, 2007); (b) advancements in the availability of time- and cost-efficient screeners, including self-report screeners (Levitt, Saka, Romanelli, & Hoagwood,

2007); and (c) educational legislation that recommends screening and early identification practices (Ikeeda, Neessen, & Witt, 2008; U.S. Department of Education, 2006). Additionally, a solid body of evidence supports the benefits of prevention and early intervention programs following universal screening to determine who is in need of services that boost social-emotional competence (Durlak, 2009). However, school-based screening practices have been incomplete in that they include few mental health items (Zima et al., 2013) or they do not include items that assess *complete* mental health (Keyes, 2005), as the majority of screening programs focus exclusively on risk factors or symptoms of mental distress (e.g., Husky et al., 2011).

Current risk or disorder-based screening measures are designed so that about 15-20% of students, those experiencing significant symptoms of distress or risk, will endorse them. This proactive practice of screening for risk or disorder is a significant improvement upon reactive approaches, but outside of population-based planning efforts (e.g., Guhn et al., 2012), this leads to the expenditure of resources that are predominately applicable to few students. Including strengths-based information in the assessments expands the appeal of universal screening as *all* students, regardless of their level of impairment or risk, have significant strengths that can be utilized and built upon to achieve more optimal developmental pathways.

This *complete* mental health screening approach is consistent with what have been called “dual-factor” (Suldo & Shaffer, 2008) or “two-continua” (Keyes, 2009) models of mental health, which argue that complete mental health is composed of two distinct dimensions. One involves the experience of symptoms of psychological distress, whereas the other dimension involves the experience of positive affective experiences and a generalized satisfaction with life. Specifically, mental illness and mental wellness are not considered to exist along a single continuum, with illness at one end and wellness at the other end; instead, they are complementary, but separate continua (Keyes, 2005). In the words of Provencher and Keyes (2011), “... this line of research has demonstrated the independence of mental illness and positive mental health, representing two separate continua rather than the opposite ends of a single continuum. This implies that experiencing less mental illness does not necessarily equate with experiencing better positive mental health and also highlights the possibility of achieving a high level of positive mental health despite the presence of enduring psychiatric symptoms and deficits” (p. 57). For example, Ryan, Hills, Huebner, and McQuillan (2012) found four distinct groups of adolescents in their study examining a dual-continua model of mental health. Sixty-four percent of the sample were identified as flourishing due to high subjective well-being (SWB) and low psychopathology, approximately 20% of the participants were identified as symptomatic but content due to average-to-high SWB in spite of also having high psychopathology, 8% of the sample were identified as vulnerable with low levels of psychopathology and low SWB, and a final 8% were labeled troubled due to low SWB and high psychopathology.

Through universal screening efforts, school site student care teams need to know which specific youth are in need of immediate services because they are experiencing mental distress and which youth are not experiencing thriving or flourishing mental health—both are necessary to implement a complete school-based mental health program. Researchers have recently

suggested that strengths-focused definitions of mental health might provide a pathway toward more balanced school-based mental health screening. Keyes (2002) suggested looking at social and psychological well-being because some youth do not present mental health symptoms, but are languishing—not reaching their potential.

Systems-Level Reform

The practice of complete mental health screening has the potential to lead to systems-level reform by monitoring and promoting the psychological well-being of all students because the screening process focuses on understanding and promoting student health and is much more than a search for illness or disorder. The first step in systems-level reform is to consider prevention of mental health problems instead of reactive approaches focused solely on remediation. The next step, beyond prevention of severe mental health problems, is to consider the broader goal of enhancement of each youth's development. This is a more encompassing goal that if pursued has the potential to change the organizational dialogue about mental health issues. Potentially, such an approach can provoke schools to reexamine their priorities and the types of questions they ask. Recognizing that a sole focus on deficits is problematic and insufficient, changes can be made in the type of data that are collected and used to evaluate individual student progress, as well as reaching institutional goals, for example, related to school climate. Although school-based mental health services should always consider and respond to the needs of students who experience significant psychological disorders, it is also apparent that only focusing on severe psychopathology falls short of the more universal, aspirational goal of moving students along a developmental trajectory toward complete, positive mental health.

Through universal screening for complete mental health, all students with needs are identified and a shift towards prevention takes place. Additionally and importantly, data are provided at the school level, which allows for a focus on population-based service delivery. School-level data provide population level, public health information about the prevailing needs in the student body. With school-level data, administrators are provided the opportunity to engage in population-based planning efforts and to reevaluate their overall school-level priorities, with a focus towards thriving mental health and optimal development, in addition to prevention and early intervention goals. School-level data are then used to evaluate systems progress and to consider the need for additional focused programs and services. Systems-level reform is part of this process of refocusing on more positive student outcomes and the dialogue that occurs when moving towards these goals. Complete mental health screening data can be used to engage in this consultative work to shift school level priorities and evaluate progress.

School Psychologists as Systems-Level Consultants

In order for school-level reform to take place, there must be a shift away from the previously emphasized role of the school psychologist as that of a psychometrician or gatekeeper to special education. The primary focus of the school psychologist has been on using standardized instruments to make judgments on student ability and potential *after* the student has demonstrated behavioral or academic difficulty. Similarly, school psychologists have been used inefficiently to provide services only to individuals at the highest level of risk (Kleiver & Cash,

2005). This limited depiction of school psychologists ignores their capacity to function as consultants, collaborating with school care teams, administration, teachers, parents, and students (Splett, Fowler, Weist, McDaniel, & Dvorsky, 2013). The movement from a reactionary to a preventive and comprehensive method of student identification and support provides an avenue for more complete and efficient use of the skills of the school psychologist.

The practice of universal screening has the potential to change service delivery models and lead to systems-level reform. However, the consultation skills of the school psychologist are paramount to reform occurring. Collecting new data, without the oversight and understanding of its worth, will undoubtedly lead to stagnation and continued standard of practice. School psychologists have the potential to be change-agents if they act as universal screening consultants, devoting their resources and knowledge to prevention, intervention, and promotion of complete mental health. Specifically, school psychologists have the specialized training and expertise to gather stakeholders (e.g., school and district level administrators, teachers, counselors, parents), collect and analyze data, work with school care teams to identify next best steps, and provide varying levels of consultation throughout the universal screening process. School psychologists are well positioned to lead and organize screening efforts, consulting with stakeholders at every step of the intervention (Powers, Hagans, & Busse, 2008). With school psychologists acting as universal screening consultants, the core school-based mental health system paradigm can change from reactionary to preventive and promotive.

School psychologists are trained to provide insight into strategies designed to improve student performance and lead efforts to implement interventions to promote positive behavioral and emotional functioning (Reschly, 1976). Due to the psychological nature of the data gathered when screening, school psychologists are seen as essential resources to interpret data, follow-up with students identified as needing additional services, and consult regarding school and systems wide changes needed to reach the goal of optimal student development. The role of the school psychologist as behavioral consultant in this reformation is a natural fit (Splett et al., 2013). As a consultant, the school psychologist is able to work with the school administration to coordinate screening, triage the students who demonstrate behavioral and emotional risk, and assist with intervention development/implementation *before* the student demonstrates substantial impairment. As consultants, school psychologists are also poised to effectively share the findings of universal screening with parents and students, connecting them with community resources. Furthermore, school psychologists can use their consultation skills to engage teachers, administrators, and students in the dialogue needed to transition towards a focus on optimal student development.

The universal screening consultation model also leans heavily on the support of school administrators and educators. It is crucial that school administrations value this proactive model, have a strong desire to allocate resources to students *before* they demonstrate overwhelming educational need instead of after, and see the importance of focusing on thriving student development in addition to the prevention of mental distress symptoms. School administrators

take a lead in the universal screening consultation model, as they are able to influence perspectives on district allocation of funding and personnel that make this reform possible.

Administrators must also be aware that committing to this model of school reform may be initially challenging. Often in the early stages of universal screening, school systems may feel burdened by the number of students requiring support or those identified as psychologically just “getting by” (Dever, Raines, & Barclay 2012; Husky et al., 2009). While a larger number of students might be identified at the onset of universal screening, these students will ultimately require fewer resources and have a better overall trajectory as a result of early intervention and a focus on optimal development (Jones et al., 2002). School administrators must be committed to this model knowing that when implemented over time, they will see a positive shift in student performance as a result of early intervention and refocusing on complete mental health.

Complete Mental Health Screening Illustration

Implementing a systematic approach to complete mental health screening requires service delivery reform. Systems-level changes are required to change the focus to a population-based, preventive, and promotive model of service delivery. To assist school-based practitioners and researchers, we offer a description of an implementation of the universal screening consultation model including an assessment of student strengths and personal assets in addition to risks as it was implemented in two large, urban high schools. Specifically, we will discuss the systems-level changes that were needed to implement the reform.

Initially, university-based personnel and school-district personnel met to discuss the aims of the screening program. Recognizing that a systems-level change would be difficult from a solely top-down approach whereby the district mandates change leading to resistance or a bottom-up approach wherein change would need to occur at a school by school level, a hybrid approach was chosen to employ strategies from both a top-down and bottom-up perspective. University, district, and school-based personnel were involved in the implementation process to capitalize on the strengths of each person involved. Working within a program-centered administrative consultation framework (Caplan & Caplan, 1993), we identified the overall goals of the program. Initially, we were interested in identifying which students were in need of additional supports in a timely fashion. We recognized that there were students with unmet mental health needs and our first priority was to determine how to identify and serve those students. We were also interested in gathering an overall “picture” of the complete mental health functioning of the students in each school so that school-wide services could be appropriately tailored. More broadly, district personnel were interested in ways to improve school-based mental health programming.

District personnel identified a few potential schools with interest in piloting a program to demonstrate the viability of this approach prior to implementing broader district-wide change. These schools were identified as having excellent leadership and a mission consistent with the program’s focus on early identification, prevention, and complete mental health. Our hope was that by being successful at a few schools initially, we would learn about the key steps needed to implement the reform and then expand the program in an efficient manner.

Consultation Context

Two public comprehensive high schools serving students in Grades 9-12 were chosen for inclusion. As mentioned, the schools were chosen purposefully by district personnel due to the strong leadership of the site administrators and their schools' alignment with the program's goals. All students at two schools were invited to participate ($N = 2,240$, 46.9% female). The average age of students was 15.5 years ($SD = 1.2$). As screening was conducted universally, for all students in these grades, ethnicity data were collected at the school, rather than the individual student, level. Demographic information for School 1 is as follows: 87.8% Latino, 5.6% White, 4.2% African American, 1.3% Asian or Pacific Islander, and the remaining Filipino or American Indian/Alaskan Native. Demographic information for School 2 is similar: 92.7% Latino, 3.9% White, 2.4% African American, and the remaining Asian, Filipino or Alaskan American.

Universal Screening Instruments

In order to screen for complete mental health consistent with a dual continua approach to assessment, two self-report forms were chosen for inclusion in the screening program to assess for behavioral and emotional risks and personal strengths. Neither form requires any training and both were available in Spanish and English. All youth completed the forms in English.

Behavior Assessment System for Children-2 Behavioral and Emotional Screening System student self-report form (BESS Student). The BESS is 30-item behavior rating scale designed to measure risk for behavioral and emotional problems in students in Grades 3 through 12 (Kamphaus & Reynolds, 2007). Students report on their behavioral and emotional functioning using a four-point response scale (*never, sometimes, often, almost always*). A total T -score is provided, in which higher scores reflect more problems. Students are placed into one of three risk categories: normal, elevated, or extremely elevated. Factor analytic work suggests that the BESS is measuring inattention, internalizing problems, school problems, and personal adjustment (Dowdy, Twyford, Chin, Kamphaus, & Mays, 2011). The manual provides extensive information on the psychometric properties of the BESS Student (Kamphaus & Reynolds, 2007).

Social Emotional Health Survey (SEHS). The SEHS is a modification and extension of the Resilience Youth Development Module (RYDM) in the suite of assessments included in the California Healthy Kids Survey (Furlong, Ritchey, & O'Brennan, 2009; Hanson & Kim, 2007). It is a 36-item measure designed to assess positive psychological well-building blocks (Furlong et al., 2013). Based on confirmatory factor analyses and multigroup invariance testing (Furlong et al., 2013), support has been found for a measurement model that includes its 12 subscales, with three items per subscale, which load onto four second-order traits, which all load onto a single higher-order latent trait called CoVitality. The 12 subscales and their four second order traits are as follows: Belief-in-Self (*self-awareness, persistence, self-efficacy*); Belief-in-Others (*school support, family coherence, peer support*); Emotional Competence (*empathy, self-control, delay of gratification*); and Engaged Living (*gratitude, zest, and optimism*). For 10 of the subscales (excluding gratitude and zest), students report on their functioning using a four-point response scale (*not at all true of me, a little true of me, pretty much true of me, and very much true of me*). For the gratitude and zest subscales, a five-point response scale is used (*not at all,*

very little, somewhat, quite a lot, extremely). See Furlong et al., 2013 for additional development and psychometric information on the SEHS.

Universal Screening Procedure

In the Fall of 2012, following district and university-approved procedures, a letter was sent home to the parents of all students enrolled in the two participating high schools. The letter informed the parents of the screening program and offered them the option to withdraw their children from participating in the screening (i.e., passive consent forms). Parents who returned opt-out forms received a personal phone call to confirm receipt and exclusion from the screening. Students who did not return opt-out forms were eligible for inclusion in the screening.

In the first month of the academic school year, during one hour of the regular school day, members of the school and research team visited each classroom to administer the assessments. All students who were present in the classrooms were provided with a brief explanation about the screening and were informed that they were not required to participate. All students who chose to participate completed the SEHS and the BESS. Forms were returned for approximately 83% of the enrolled student population.

Survey responses for the BESS were recorded on scannable forms and processed using the BASC-2 BESS Assist Plus Software. An overall *T*-score was provided and based on these scores each student was placed into one of three categories that describe students' general level of risk: normal, elevated, and extremely elevated, per standard BESS procedures. Responses for the SEHS were recorded on the form and scored by a research assistant. Based on previous research showing that the sum of the 36 SEHS items was approximately normally distributed (Furlong et al., 2013), students were categorized as having low strengths ($< 1 SD$), low average strengths ($1 SD$ to $0 SD$), high average strengths ($> 0 SD$ to $1 SD$), or high strengths ($> 1 SD$) scores. Additionally, based on evidence in support of a two-continua model of mental health (Keyes, 2005), responses to both the BESS and the SEHS were combined. Students were placed into one of the following nine categories: Highest Risk (extremely elevated BESS, low or low average SEHS), Moderate Risk (elevated BESS, low SEHS), Lower Risk (elevated BESS, low average SEHS), Languishing (normal BESS, low SEHS), Getting By (normal BESS, low average SEHS), Moderate Thriving (normal BESS; high average SEHS), High Thriving (normal BESS, high SEHS), and Inconsistent (elevated or extremely elevated BESS and high average or high SEHS).

Universal Screening Data as a Catalyst to Engage in the Consultation Process

The initial and primary objective to identify youth in need of additional services was met. Individual student level reports, organized by level of risk, were provided to school personnel to begin the process of determining who was in need of additional supports. Screening data acted as a catalyst for engaging in the consultation process. Specifically, school psychologists engaged with other members of the student care team and administrators to explain and evaluate the data collected and the importance of following up with individual students identified as at risk. Based on SEHS and BESS data, a triage process was developed to determine the priority of needs, as resources were insufficient to see all students immediately. Initially, the lists of students in each

of the nine dual continua groups were examined to determine who was identified but already receiving services. Then, starting with the Highest Risk group, school personnel began to follow-up with the students reporting both significant distress and low levels of personal strengths. Administrators, recognizing the significant needs of some of the students in the school, began to identify resources and referrals to help meet the needs.

School-wide results were also provided to school personnel. Results describing the school's overall picture of mental health functioning were presented to school administrators and staff, and data were used to facilitate consultation and discussion regarding school-wide needs. At School 1, results indicated that 12.9% ($n = 221$) of the students reported symptoms of behavioral and emotional risk as measured by the BESS, with ninth graders reporting the lowest levels of personal adjustment. At School 2, results indicated that 14.0% ($n = 110$) of the students screened were identified as at an elevated (11.7%) or extremely elevated (2.3%) level of risk for emotional and behavioral problems. The largest group of students at both schools reported having 7-8 out of a total of 12 personal strengths as measured by the SEHS, with task persistence and peer support identified as the focal areas of school-wide concern. Graphs depicting the percent of students with low, middle, and high scores for the 12 personal strengths were provided (see example in Figure 1). Additionally, results from the BESS and SEHS were combined (see Figure 2) placing students into one of nine categories describing their overall mental health functioning inclusive of both psychological distress and strengths.

The screening data were the primary tools used to engage in a collaborative consultation model with school professionals. After explaining the data, school psychologists used the data to engage in consultation regarding the needs of the student population and the additional resources or trainings that would be helpful to promote optimal development for the entire student body. Overall, the combination of information on both strengths and risk factors allowed for richer information regarding the functioning of each student and the school population as a whole. The detailed information regarding the overall profile of each school's student population was used for prevention and early intervention planning. Through the consultation process, school personnel began to understand the value of building capacities in students, as opposed to solely focusing on remediation of deficits. For example, school personnel discussed strategies to increase peer support and academic persistence, instead of solely focusing on individual strategies to support students with symptoms of anxiety, depression, or inattention. Additionally, due to the finding of overall low levels of gratitude amongst students at one school, administration provided professional development tools to teachers regarding strategies to further enhance gratitude among the students and faculty. In line with expectations that "what gets measured gets done" (Knopf, Park, Brindis, Mulye, & Irwin, 2007, p. 335), the proposed interventions were concerned with both how to remediate risk factors while also fostering the social and emotional health of all students within the school.

Implications and Conclusions

The universal screening consultation model used to gather information on complete mental health provided a unique and valuable opportunity to move away from reactive service

delivery models towards preventive and promotive approaches. However, such approaches alone do not inform school-based mental health professionals about the specific needs of individual students, or how to prioritize responses to those students in greatest need. Similarly, universal screening data should not be used as a sole determinant of need. It is critical that school personnel be alert to other signs of distress, particularly when screening does not capture every student, such as in the current study where only 83% of the student population participated.

A fully implemented universal screening consultation model requires a planned response to screening data, the integration of data with school site student care teams, a protocol stating intervention needs based on screening profiles, and the school psychologist's awareness of how to best consult with various constituents. Additional research is needed to determine the best practices regarding complete mental health screening including which screening tools are optimal under which circumstances and with which specific student populations (e.g., transient, English Language Learner). In addition, in the example shown in Figure 1 there were not many youth whose responses were inconsistent (2.3%). That is, the BESS responses suggested that they were experiencing some psychological distress, but their SEHS responses were above average on psychological strengths. This relative small group has consistently been found in previous dual continua research (e.g., Antaramian, Huebner, Hills, & Valois, 2010) and more research is needed about this group of students and their mental health status and needs; for example, it could be that these students have core psychological strengths and are experiencing acute and not chronic mental distress. Finally, the optimal schedule or timing of complete mental health screening is also unknown, as prevention and promotion activities might be more or less effective at certain developmental time periods. Research further exploring assessment and intervention within a dual continua approach is warranted.

Future consultation research is needed to further explicate the specific processes and required steps of this universal screening consultation model. This will be critical as training programs seek guidance on how to prepare future school psychologists for their role as consultants seeking reform. As the practice of universal screening grows, and with an increased awareness that interventions are often chosen based on available data, it will also be necessary to link universal screening assessment data to empirically-based interventions. A systems-level reform increasingly focused on thriving mental health and optimal development might not be sufficiently powerful without evidence-based tools to enhance students' development.

The production of this manuscript was a part of this collaborative effort to move psychological services to the front of the service delivery system by engaging in a universal screening consultation model; however, it is not the end of our work together. We continue to work as a partnership to advance the science of screening and wrestle with the associated practicalities of implementation and scale-up for additional schools and districts. We plan to co-present our findings at local and national conferences and work together to identify funding resources to support our continued collaborative work. Complete mental health screening data have already been used as a part of internal grant applications to document the need for additional services. Most importantly, however, this process has served students in need that

may not have otherwise been noticed while also solidifying our partnership and collaboration to further enhance and promote optimal development for all students.

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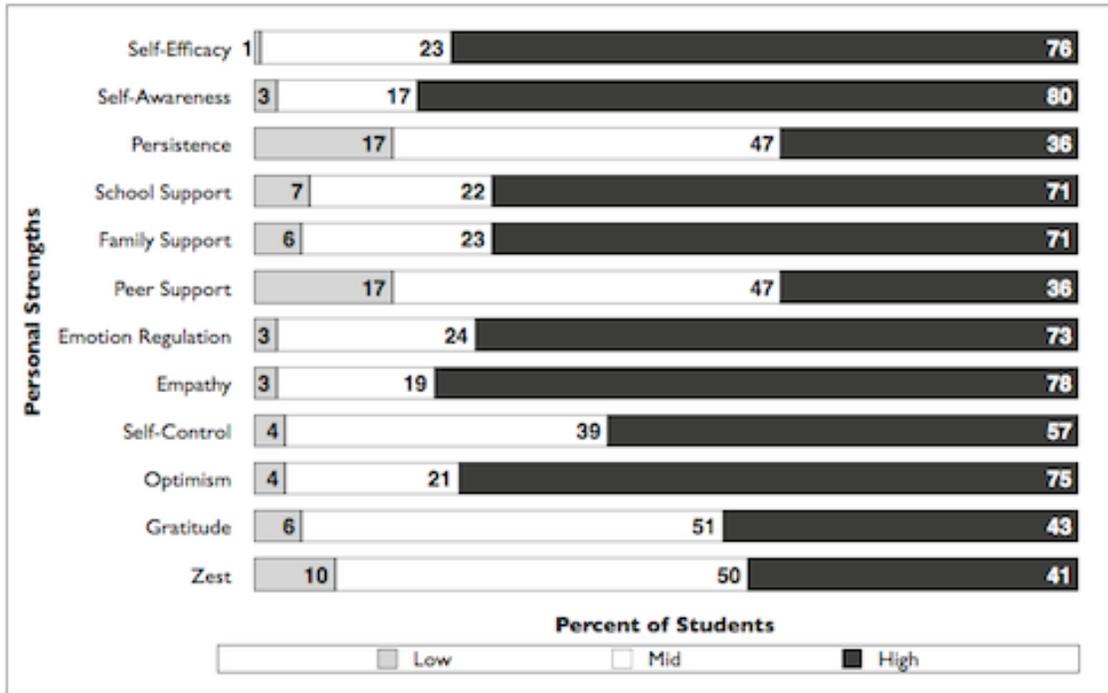


Figure 1. Example of schoolwide students' strengths profile.

BESS Risk Groups SEHS Strength Groups	BESS Normal ($T \leq 60$)	BESS Elevated ($T = 61-70$)	BESS Very Elevated ($T \geq 71$)
Low SEHS Strengths ($z < -1 SD$)	4. Languishing ($N = 122$)	2. Moderate Risk ($N = 61$)	1. Highest Risk ($N = 25$)
Low Average SEHS Strengths ($z = -1 SD - 0 SD$)	5. Getting By ($N = 398$)	3. Lower Risk ($N = 56$)	
High Average SEHS Strengths ($z = 0 SD - 1 SD$)	6. Moderate Thriving ($N = 504$)	9. Inconsistent ($N = 31$)	8. Inconsistent ($N = 3$)
High SEHS Strengths ($z > 1 SD$)	7. High Thriving ($N = 248$)		

Figure 2. Example of the results of using a two-continua complete mental health screening process to identify and prioritize universal and targeted mental health services (N = number of students in each risk by strength grouping, which are actual data from one high school).