SMART
School Mental Health Assessment Research & Training Center

ENSURING A HEALTHY SYSTEM & CONNECTING STUDENTS WHO MAY NEED MORE SUPPORTS

Universal Screening

2024 Jeremy Bullock Safe Schools Summit Butte, Montana

LAND ACKNOWLEDGEMENT

The University of Washington
SMART center acknowledges that we learn, live, and work on the ancestral lands of the Coast Salish people who walked here before us, and those who still walk here. We are grateful to respectfully live and work on these lands with the Coast Salish and native people who call this home.

We also want to acknowledge and honor the traditional lands of the Cayuse, Umatilla, Walla Walla, Salish, and Shoshone-Bannock that we are on today.

SMART
School Mental Health Assessment
Research & Training Center

School Mental Health Assessment, Research, & Training Center

A national leader in developing and supporting implementation of evidence-based practices (EBPs) in schools, including prevention, early intervention, and intensive supports.

The overarching mission of the SMART Center is to promote high-quality, culturally-responsive programs, practices, and policies to meet the full range of social, emotional, and behavioral (SEB) needs of students in both general and special education contexts.

RESEARCH & EVALUATION

TRAINING & TECHNICAL ASSISTANCE

COMMUNITY PARTNERING & OUTREACH

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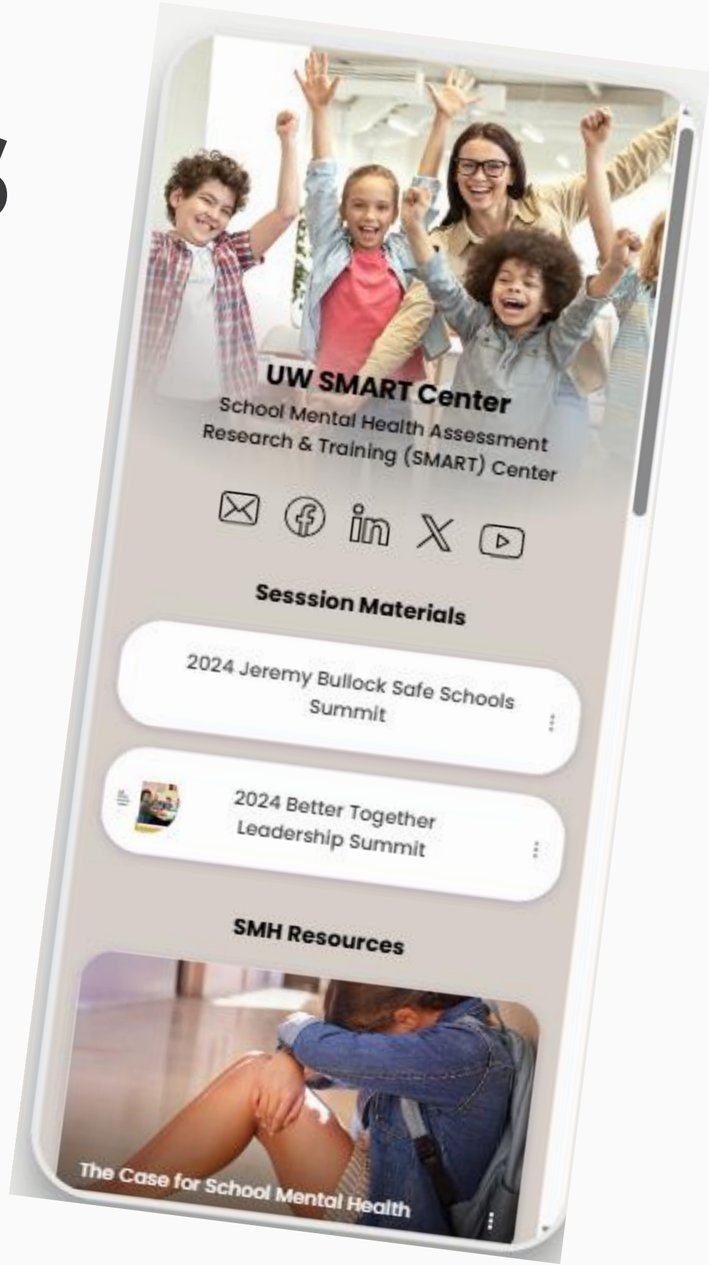
SESSION MATERIALS

SESSION MATERIALS

SCAN HERE!

linktr.ee/UWSMART



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WELCOMING INCLUSION ROUTINE

- ➔ **Safety & Predictability**
- ➔ **Contribution of ALL Voices**
- ➔ **Norms for Respectful Listening**
- ➔ **Create a Sense of Belonging**

Join at menti.com | **use code 4223 0731**

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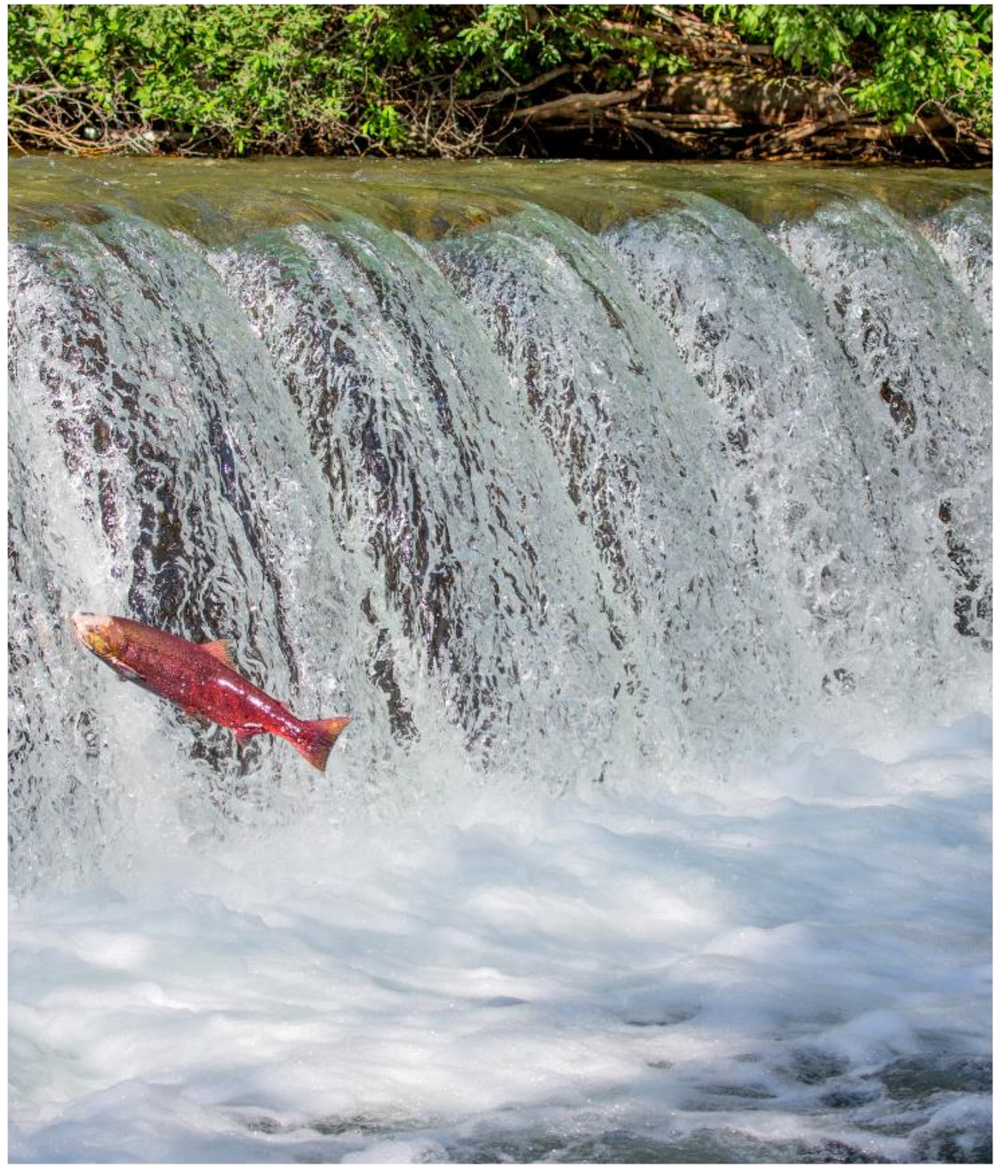
MOVING UPSTREAM

A STORY OF PREVENTION & INTERVENTION

In a small town, a group gathered down at the river.

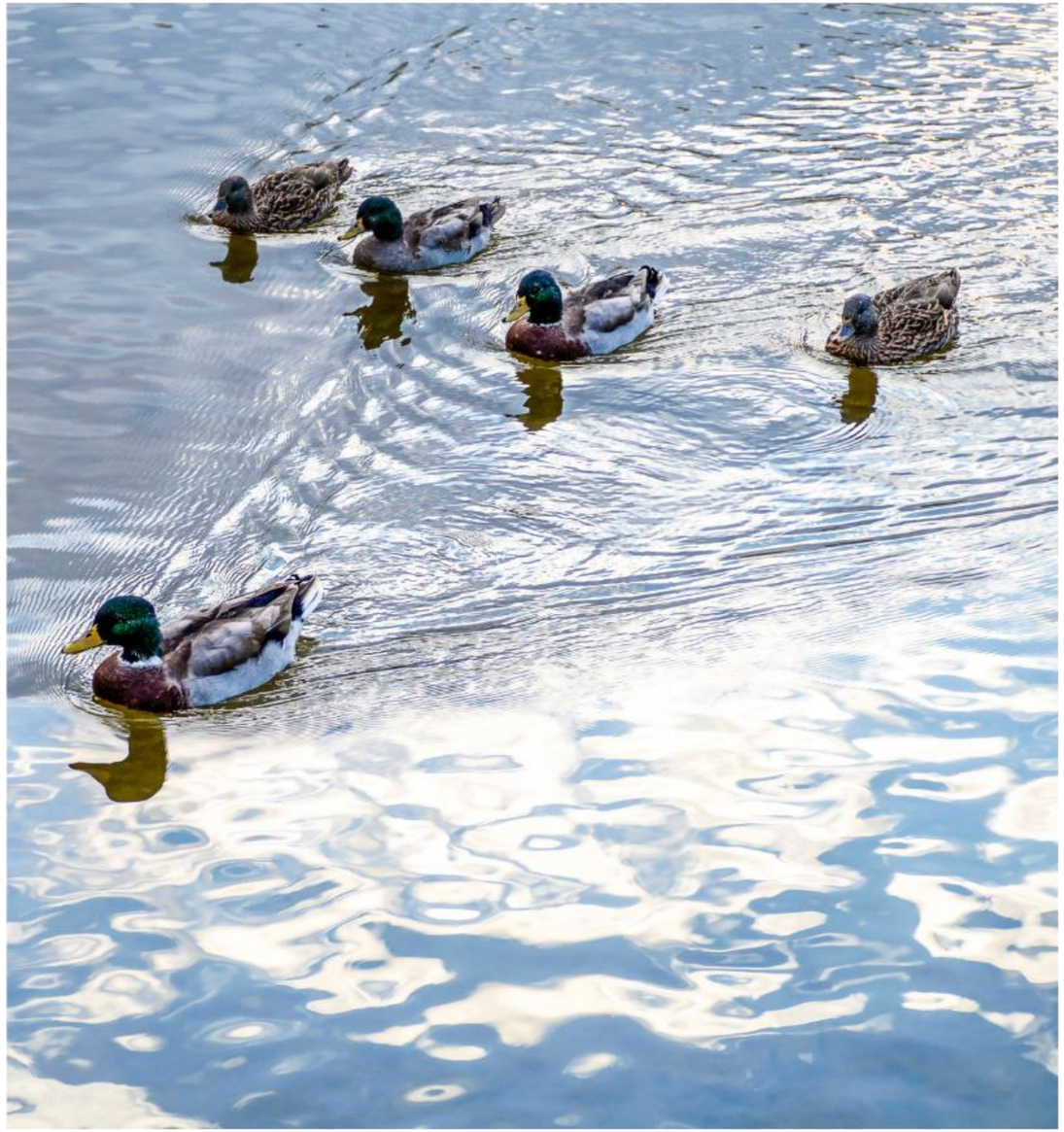
Not long after they arrived, a child came floating down the rapids calling for help.

Someone from a group on the shore quickly jumped in and pulled the child out.



Minutes later, another child came…

Then another, **AND ANOTHER**, **<u>AND THEN MANY MORE CAME</u>** floating down the river.



Soon EVERYONE was diving in the river, dragging children ashore, and then jumping back in to rescue as many as they could.

In the midst of all the frenzy, one member of the group was seen walking away...

This made others very upset! **“How could they just walk away when we have all these children to save?”**

After some time passed, and to their relief, the flow of children stopped, and they could finally catch their breath.

At that same moment, their colleague returned. They quickly turned to them and angrily shouted, **“How could you leave when we needed everyone here to save the children?”**

They replied…*“It occurred to me that someone ought to go upstream and find out why so many kids were falling in the river.”*

“What I found is that the old wooden bridge had several missing planks. Children were trying to jump over the gap, couldn’t make the leap, and were falling into the river.”

“SO I FOUND SOMEONE TO FIX THE BRIDGE.”

TURN & TALK

What prevention efforts have we tried? OR have we been overly reliant on reactionary practices?

What prevention efforts have worked?

HOW DO WE KNOW?

WHAT MADE THEM EFFECTIVE?

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DATA AHEAD

A DISCLAIMER

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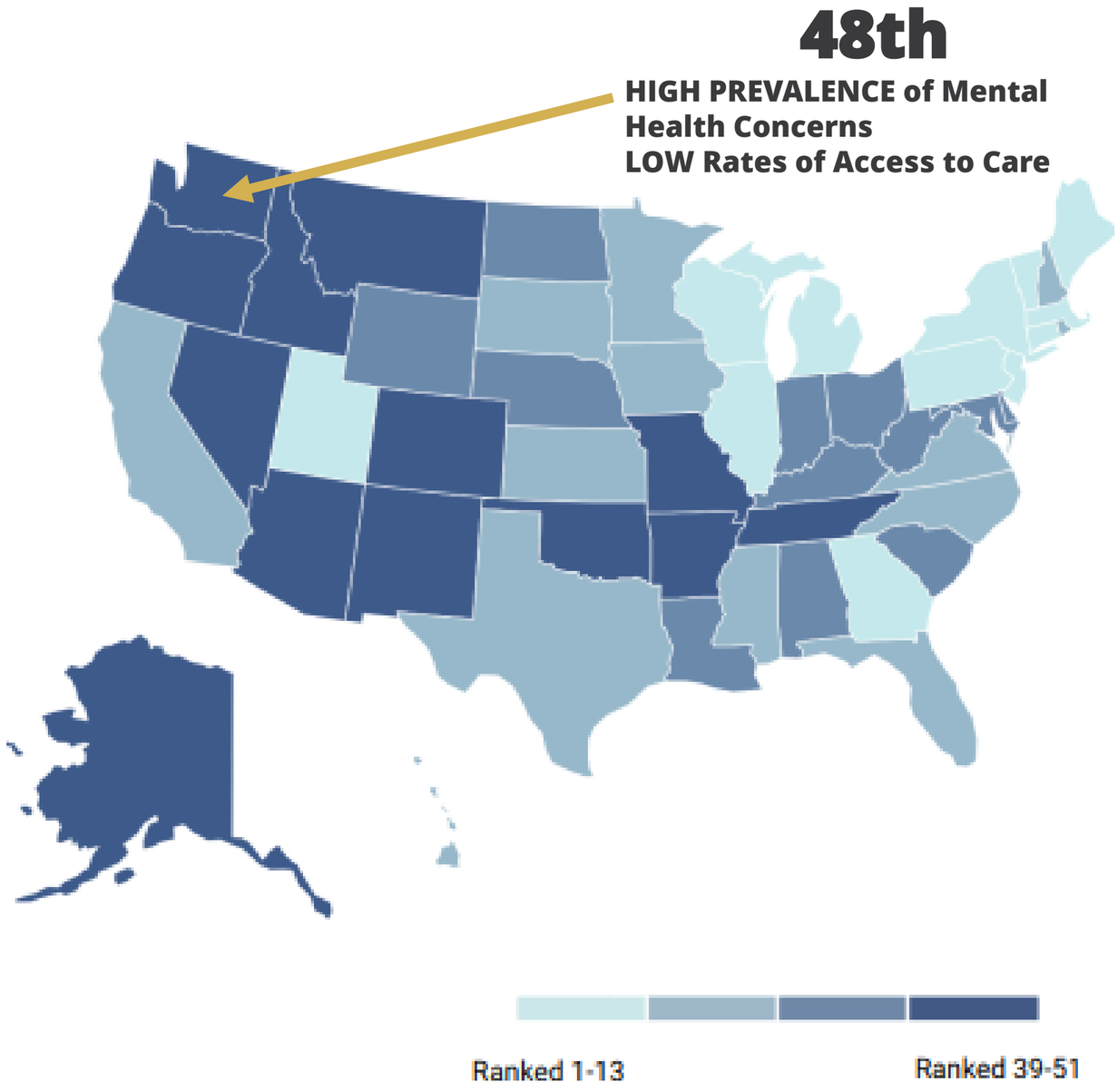
STATE RANKINGS: Youth

- Youth with at least one **major depressive episode** (MDE) in the past year
- Youth with **substance use disorder** in the past year
- Youth with **serious thoughts of suicide**
- Youth (6-17) flourishing
- Youth with MDE who **did not receive mental health services**
- Youth with **private insurance that did not cover mental or emotional problems**
- Students (K+) **identified with emotional disturbance for an Individualized Educaion Program (IEP)**

States with rankings **1-13 have lower prevalence of mental illness and higher rates of access to care for youth**. States with rankings 39-51 indicate that youth have higher prevalence of mental illness and lower rates of access to care.



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THE NATIONAL STATE OF YOUTH MENTAL HEALTH—2024 REPORT

Reinert, M, Fritze, D & Nguyen, T (July 2024). “The State of Mental Health in America 2024.” Mental Health America, Alexandria VA.

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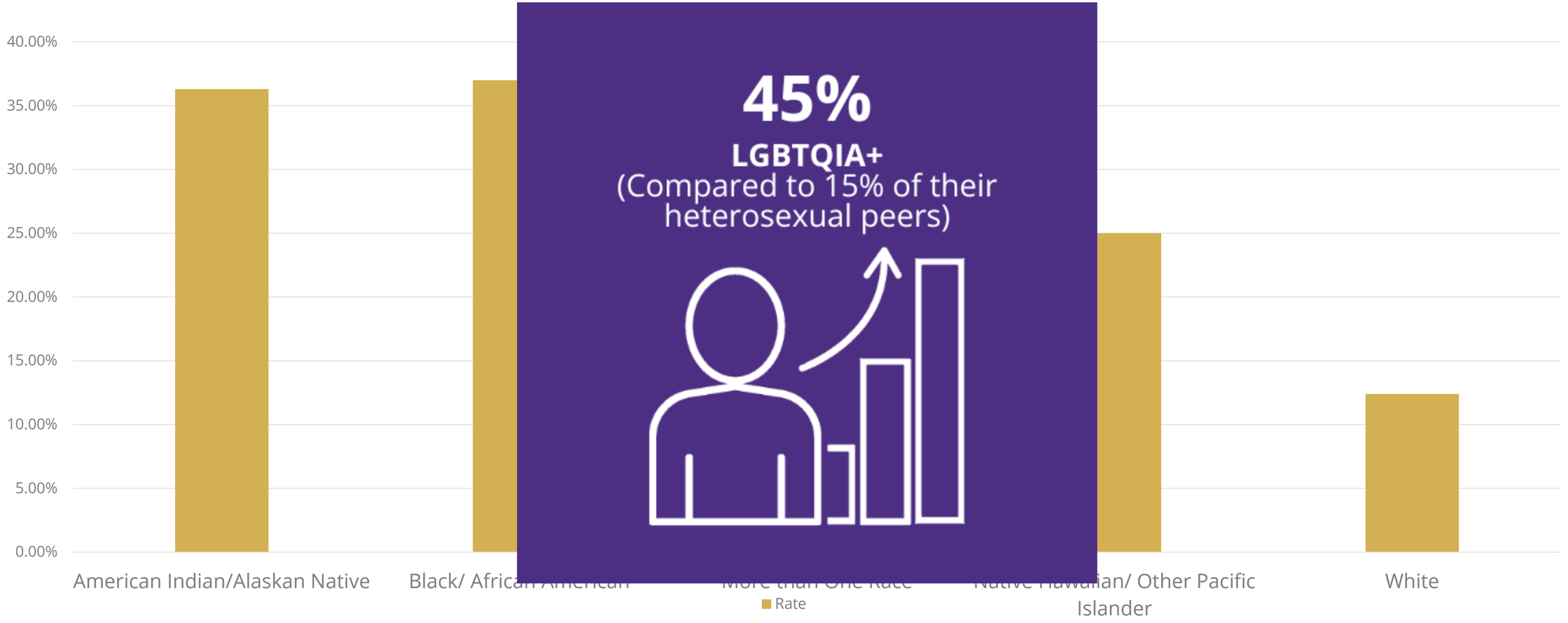
PREVALENCE & DISPROPORTIONALITY IN YOUTH SUICIDE RATES



Stone DM, Mack KA, Qualters J. *Notes from the Field:* Recent Changes in Suicide Rates, by Race and Ethnicity and Age Group — United States, 2021. MMWR Morb Mortal Wkly Rep 2023;72:160–162.
DOI: http://dx.doi.org/10.15585/mmwr.mm7206a4

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RATES OVER TIME

ANNUAL SUICIDE RATES (per 100,000) BY RACE & ETHNICITY (Ages 10-24)					
	2018	**2019**	**2020**	**2021**	**Relative Rate Change**
Total	10.7	10.2	10.5	11.0	+2.8
White					
Hispanic/ LatinX	7.3	7.5	7.9	7.9	+8.2
Asian	8.5	7.7	7.4	9.4	+10.6
Multiracial	7.2	7.2	8.0	8.2	+13.9
American Indian or Alaskan Native	31.1	29.9	33.0	36.3	+16.7
Black/ African American	8.2	8.5	9.9	1.2	+36.6
Native Hawaiian or Other Pacific Islander		16.6	18.9	16.2	NA

Stone DM, Mack KA, Qualters J. *Notes from the Field:* Recent Changes in Suicide Rates, by Race and Ethnicity and Age Group — United States, 2021. MMWR Morb Mortal Wkly Rep 2023;72:160–162. DOI: http://dx.doi.org/10.15585/mmwr.mm7206a4

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TURN & TALK

BARRIERS TO MENTAL HEALTH CARE

- Lack of **EDUCATION** and **AWA**
- **COST** of care and insurance co
- **SOCIAL STIGMATIZATION** (vis xclusion)
- **PERSONAL STIGMATIZATION** r help
- Lack of drug treatment option
- **DELAYS SEEKING CARE UNTI**
- **LANGUAGE** barriers, **CULTUR** **SE REPRESENTATION IN THE FIELD**
- **CO-OCCURRENCE OF MENTA** hich compounds existing challenges
- The COVID-19 pandemic
- **SCARCITY OF SERVICES AND** liance on emergency departments

Whitney DG, Peterson MD. US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatr. 2019 Apr 1;173(4):389-391. doi: 10.1001/jamapediatrics.2018.5399. PMID: 30742204; PMCID: PMC6450272.

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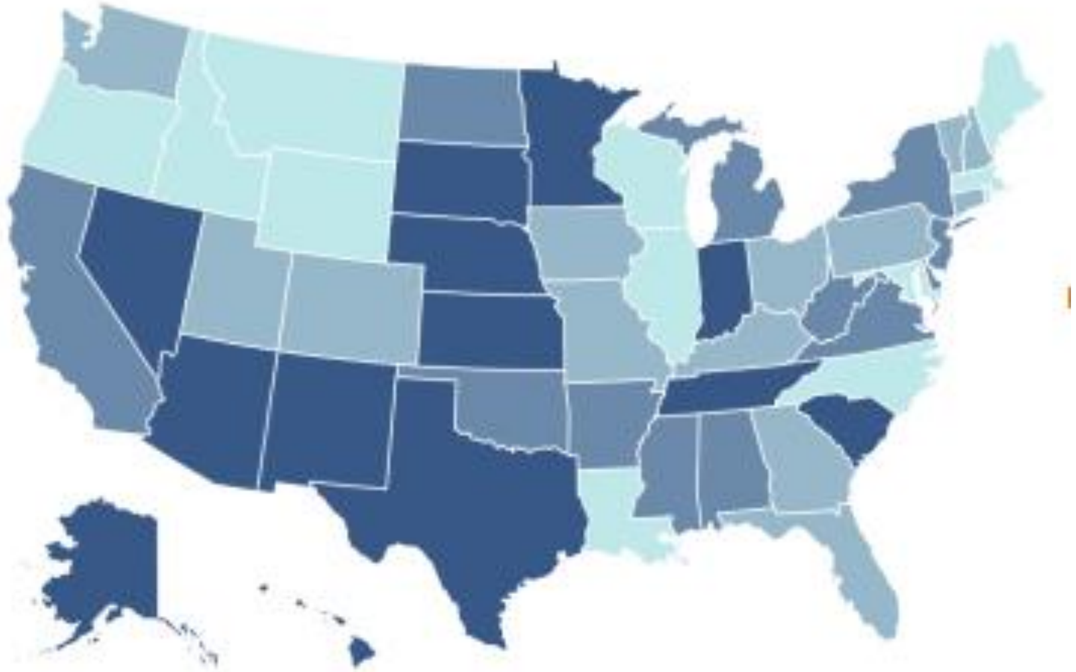
YOUTH REPORTS ON WHY

UNMET NEED

- **56.1%** of youth with MDE do not receive **ANY** mental health services
  - Should be able to handle mental health on my own (86.9%)
  - Perceived stigma (59.8%)
  - Privacy (57.8%)
  - Unsure how to access services (55.5%)



The state prevalence of untreated youth with depression ranges from:

31.50% (DC)
Ranked 1-13

82.10% (SD)
Ranked 39-51

View your state's report here:

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WHAT DO WE KNOW

- COVID-19 added to the **pre-existing challenges** that our youth faced
- Mental health is **SHAPED BY MANY FACTORS**

- WE HAVE THE ABILITY TO PROMOTE POSITIVE MENTAL HEALTH AND **MITIGATE NEGATIVE OUTCOMES**

→**SOCIETY** (economic inequalities, discrimination, racism, media/technology)
→**ENVIRONMENT** (safety, food, housing, health care)
→**COMMUNITY** (relationships with peers/teachers/mentors, school climate, academic rigor)
→**FAMILY** (relationships with caregivers, family mental health)
→**INDIVIDUAL** (genetics, race, gender, coping skills)

WHERE DO WE HAVE THE HIGHEST "CONTROL"

SOCIETAL? ENVIRONMENTAL? COMMUNITY? FAMILY? INDIVIDUAL?

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WELL-BEING RISK FACTORS | COMMUNITY

LOW Control

	SUBSTANCE USE	DELINQUENCY	TEEN PREGNANCY	SCHOOL DROPOUT	VIOLENCE	DEPRESSION & ANXIETY
Friends use drugs	X	X	X	X	x	
Favorable attitudes toward use	X	X	X	X	x	
Early initiation of drug use	X	X	X	X	x	
Perceived risk of drug use	X	x				

Hawkins JD, Catalano RF, Miller JY. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. Psychol Bull. 1992 Jul;112(1):64-105. doi: 10.1037/0033-2909.112.1.64. PMID: 1529040.

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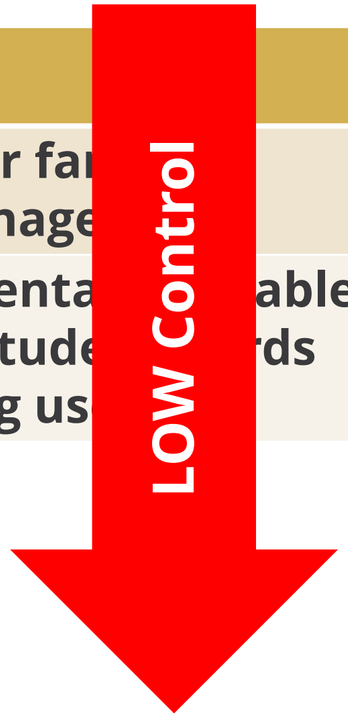
WELL-BEING RISK FACTORS | FAMILY



	SUBSTANCE USE	DELINQUENCY	TEEN PREGNANCY	SCHOOL DROPOUT	VIOLENCE	DEPRESSION & ANXIETY
Poor fa… manage…	X	X	X	X	x	X
Parenta… …able attitude… …rds drug us…	X	X			x	

Hawkins JD, Catalano RF, Miller JY. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. Psychol Bull. 1992 Jul;112(1):64-105. doi: 10.1037/0033-2909.112.1.64. PMID: 1529040.

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WELL-BEING RISK FACTORS | SCHOOL

HIGH Impact

	SUBSTANCE USE	DELINQUENCY	TEEN PREGNANCY	SCHOOL DROPOUT	VIOLENCE	DEPRESSION & ANXIETY
Acad[illegible]re	X	X	X	X	x	X
Low Co[illegible]ment to School	X	X	X	X	x	

Hawkins JD, Catalano RF, Miller JY. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. Psychol Bull. 1992 Jul;112(1):64-105. doi: 10.1037/0033-2909.112.1.64. PMID: 1529040.

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WELL-BEING RISK FACTORS | SOCIETY

LOW Control

	SUBSTANCE USE	DELINQUENCY	TEEN PREGNANCY	SCHOOL DROPOUT	VIOLENCE	DEPRESSION & ANXIETY
Perceiv ilability of drug	X				X	
Perceiv ilability of han		X			X	
Laws a ms favora drug use	X	X			X	
Low ne hood attach	X	X			X	

Hawkins JD, Catalano RF, Miller JY. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. Psychol Bull. 1992 Jul;112(1):64-105. doi: 10.1037/0033-2909.112.1.64. PMID: 1529040.

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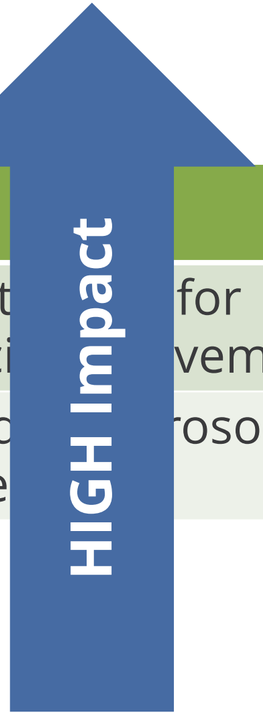
WELL-BEING PROTECTIVE FACTORS



	SUBSTANCE USE	DELINQUENCY	TEEN PREGNANCY	SCHOOL DROPOUT	VIOLENCE	DEPRESSION & ANXIETY
Opport for prosoci vement	X	X				
Reward rosocial involve	X	X			X	X

Hawkins JD, Catalano RF, Miller JY. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. Psychol Bull. 1992 Jul;112(1):64-105. doi: 10.1037/0033-2909.112.1.64. PMID: 1529040.

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When RISK factors outweigh protective factors

Youth is likely to be at a
DISADVANTAGE

When PROTECTIVE factors outweigh risk factors

Youth is likely to be
RESILIENT

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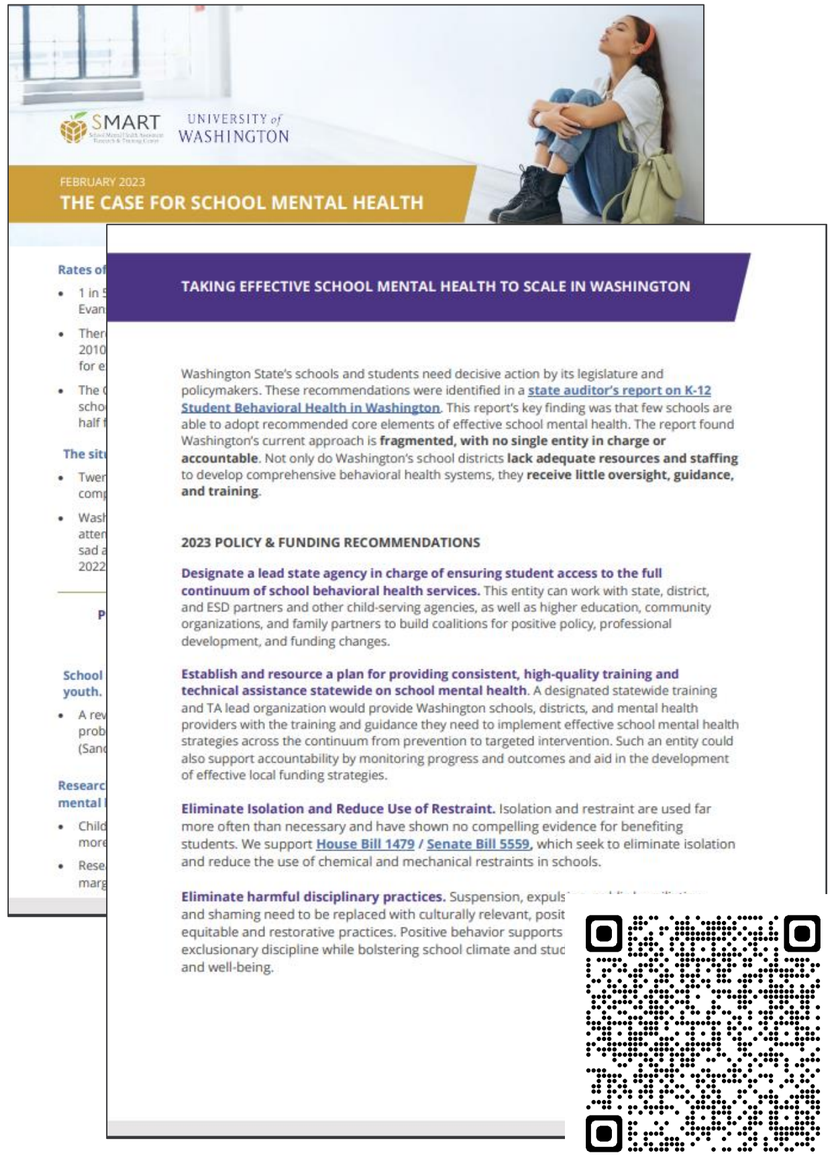
THE CASE FOR SCHOOL MENTAL HEALTH

➔There is an 11 **YEAR GAP between onset and treatment** of mental health disorders (Wang et.al., 2004)

➔Youth are **more likely to access MH services from SCHOOL** than any other settings (Duong et al., 2020)

➔School mental health is **associated with positive mental health outcomes** and decreasing mental health problems through targeted services (Sanchez et.al., 2017)

➔Research shows that school **mental health services can close gaps in access for UNDERSERVED AND MARGINALIZED POPULATIONS** (Lyon et al., 2013)



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HISTORY OF SMH IN WA

2014

Authorizing State Legislation for Recognition, Screening, and Response **RCW 28A.320.127**

2014

State Legislation for Model District Plan **RCW 28A.320.1271**

2021

K-12 Behavioral Health Audit

(1) Beginning in the 2014-15 school year, each school district must adopt a plan for **recognition, initial screening**, and **response to emotional or behavioral distress in students, including but not limited to indicators of possible substance abuse, violence, youth suicide, and** sexual abuse. The school district must provide the plan to all district staff.

(3) The plan under this section may be a separate plan or a component of another district plan required under the harassment, intimidation, and bullying prevention policy under RCW 28A.300.2851 or the comprehensive safe school plan required under RCW 28A.320.125.

The office of the superintendent of public instruction's school safety center, established in RCW 28A.300.630, **shall develop a model school district plan for initial screening, and response to behavioral distress in students, limited to indicators of possible violence, and youth suicide.**

unity organizations and agencies for referral of port services, including development of at least entity in the community or region;

rporate **research-based best actices and protocols used in districts in other states.**

ardians, including the notification

ter an incident of violence, youth suicide, or

ntact or abuse are made against a staff member, a e student, including how staff should interact with parents,

d classified staff the training on the obligation to report

must be posted by **February 1, 2014.**

safety center website, along with relevant resources and information to support school districts in developing and implementing the plan required under RCW 28A.320.127.

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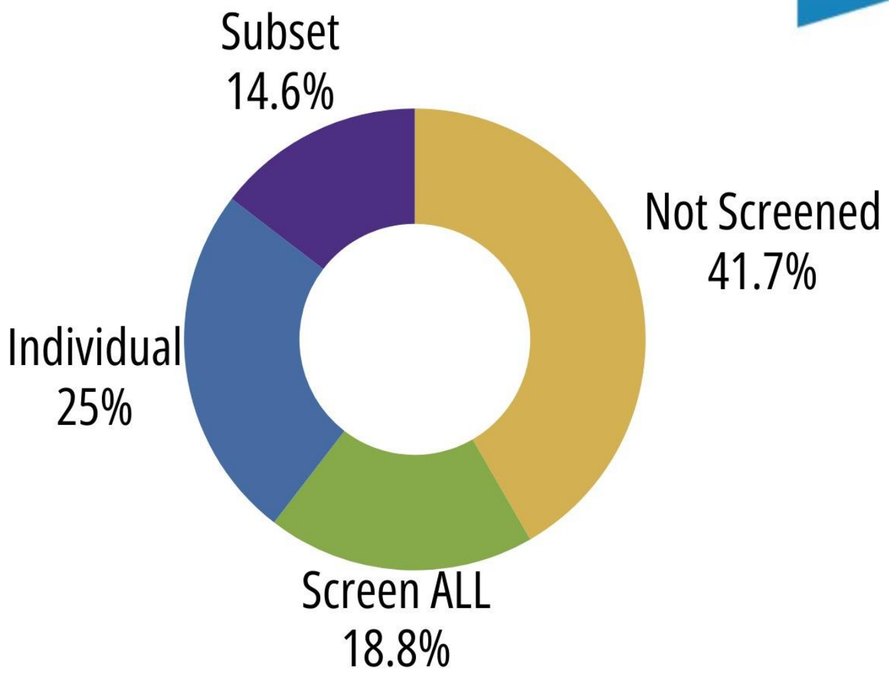
BEHAVIORAL HEALTH AUDIT

Office of the Washington State Auditor
Pat McCarthy

- **Universal screening is the BASIC FOUNDATION FOR BEHAVIORAL HEALTH SYSTEMS**, because screening identifies needs and early symptoms before they become disruptive to the students' life and harder to treat.



McCarthy, P., Frank, S., Cortines, C., Fleming, T., Cato, C., Clark, B., Patino, N., Cooper, K. (2021). K-12 Student Behavioral Health in Washington: Opportunities to improve access to needed supports and services. Office of the Washington State Auditor.

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FINDINGS

Office of the Washington State Auditor
Pat McCarthy

The state's approach to student behavioral health is **FRAGMENTED AND LACKS SUFFICIENT RESOURCES**

Behavioral health supports and services available to students **DEPEND ON WHAT SCHOOLS ARE ABLE TO PROVIDE AT THE LOCAL LEVEL**

McCarthy, P., Frank, S., Cortines, C., Fleming, T., Cato, C., Clark, B., Patino, N., Cooper, K. (2021). K-12 Student Behavioral Health in Washington: Opportunities to improve access to needed supports and services. Office of the Washington State Auditor.

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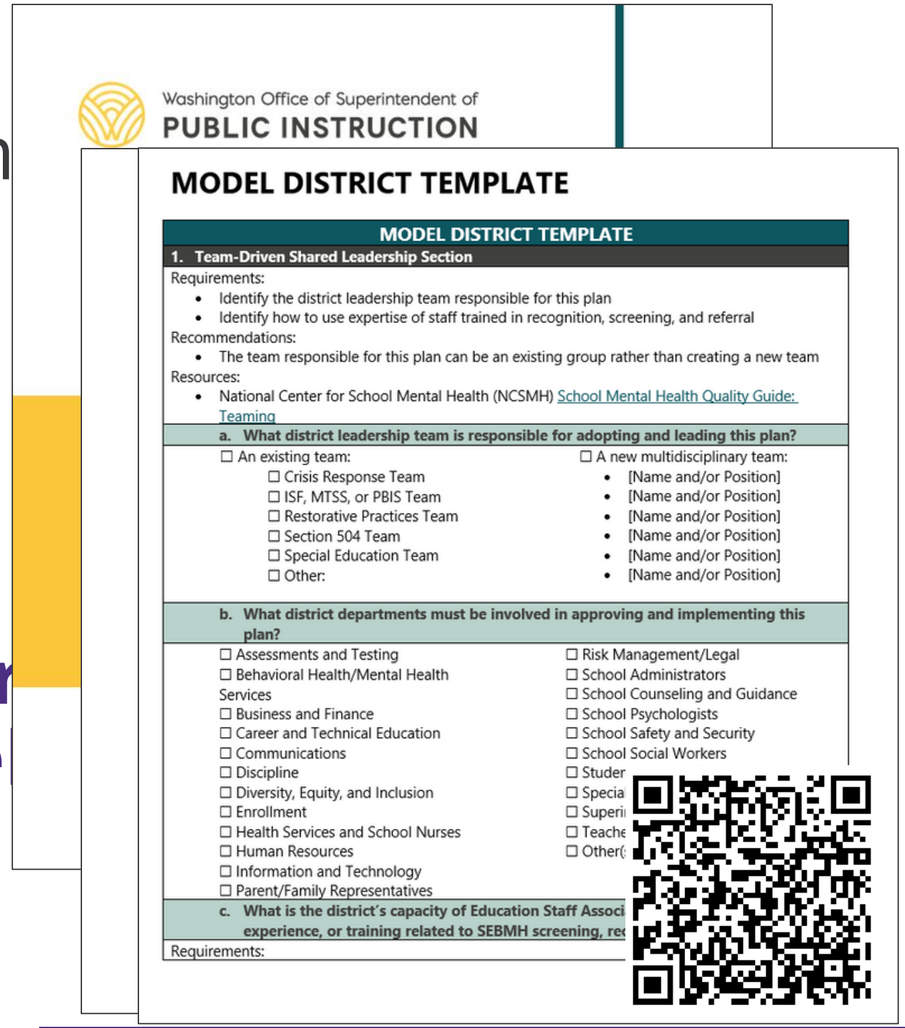
RECOMMENDATIONS FOR OSPI

- Revise the district plan template to m
  follow state requirements.
  - Training
  - How to respond to crises
  - Partnerships
  - Protocols/Procedures
- To achieve this, it should address a **br**
  understanding of "emotional or be
  distress" beyond suicidality.


Washington Office of Superintendent of
PUBLIC INSTRUCTION

MODEL DISTRICT TEMPLATE

MODEL DISTRICT TEMPLATE

1. Team-Driven Shared Leadership Section

Requirements:
- Identify the district leadership team responsible for this plan
- Identify how to use expertise of staff trained in recognition, screening, and referral

Recommendations:
- The team responsible for this plan can be an existing group rather than creating a new team

Resources:
- National Center for School Mental Health (NCSMH) School Mental Health Quality Guide: Teaming

a. What district leadership team is responsible for adopting and leading this plan?

☐ An existing team:
- ☐ Crisis Response Team
- ☐ ISF, MTSS, or PBIS Team
- ☐ Restorative Practices Team
- ☐ Section 504 Team
- ☐ Special Education Team
- ☐ Other:

☐ A new multidisciplinary team:
- [Name and/or Position]
- [Name and/or Position]
- [Name and/or Position]
- [Name and/or Position]
- [Name and/or Position]
- [Name and/or Position]

b. What district departments must be involved in approving and implementing this plan?

- ☐ Assessments and Testing
- ☐ Behavioral Health/Mental Health Services
- ☐ Business and Finance
- ☐ Career and Technical Education
- ☐ Communications
- ☐ Discipline
- ☐ Diversity, Equity, and Inclusion
- ☐ Enrollment
- ☐ Health Services and School Nurses
- ☐ Human Resources
- ☐ Information and Technology
- ☐ Parent/Family Representatives
- ☐ Risk Management/Legal
- ☐ School Administrators
- ☐ School Counseling and Guidance
- ☐ School Psychologists
- ☐ School Safety and Security
- ☐ School Social Workers
- ☐ Studer
- ☐ Specia
- ☐ Superi
- ☐ Teache
- ☐ Other(

c. What is the district's capacity of Education Staff Associ
experience, or training related to SEBMH screening, re

Requirements:

FOREFRONT SUICIDE PREVENTION

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TURN & TALK

Reflect on where you live/work….

What similar CHALLENGES do you see?

What CELEBRATIONS exist?

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CORA


REC
LIVE
2239 Cora Hoyt
21
01/25/24 08:35:57 AM
House Education
January 25, 2024, 8:00 am - House Hearing Rm A and Virtual
TVW

TURN & TALK

What's one thing that resonated with you?

In what ways do school systems measure how well ALL STUDENTS feel safe, supported, and a sense of belongingness?

How do we know who needs more?

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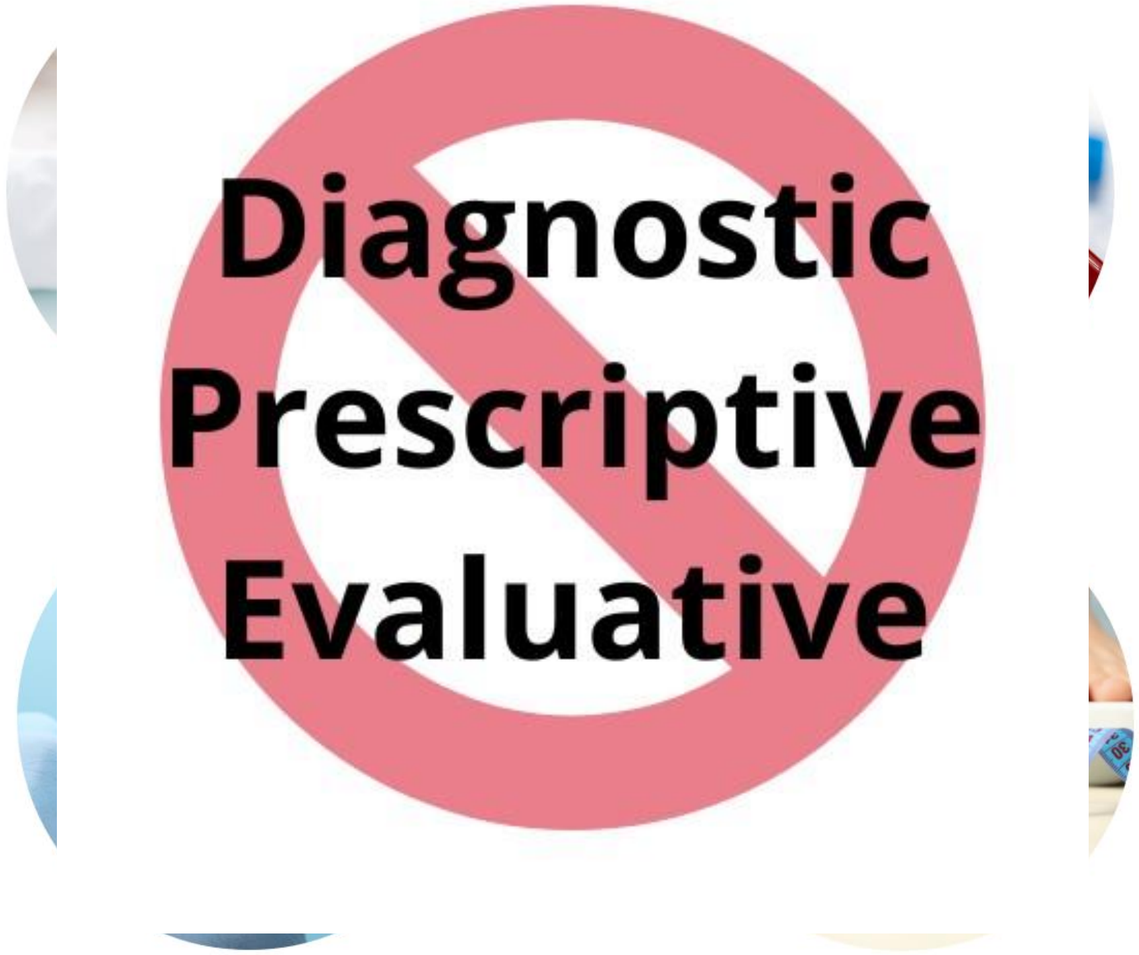
WHAT IS UNIVERSAL SCREENING?



WHAT IS UNIVERSAL SCREENING?

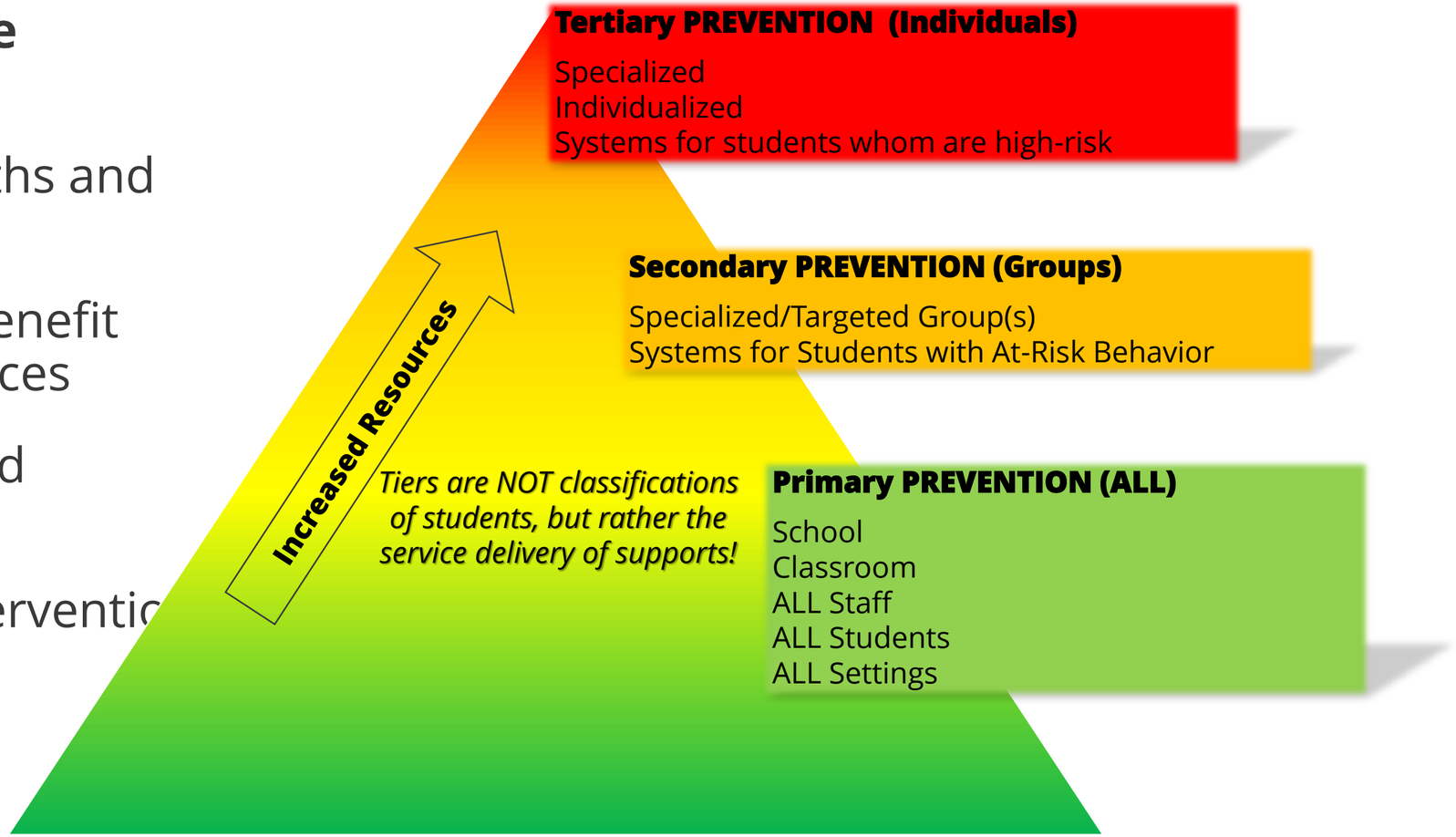
Proactive procedure for detecting students who may require supports beyond primary (tier 1) prevention efforts at the earliest signs of concern. Systematic screening involves several key features (Lane & Walker, 2015):

- **Universal:** all students attending a school are screened
- **Repeated:** fall, winter, and spring each year
- **Proactive:** used to examine overall level of students' performance (e.g, internalizing and externalizing behaviors; by district, school, grade, and class levels) and inform decisions about appropriate supports for students with relevant secondary (Tier 2) and tertiary (Tier 3) needs
- **Psychometrically sound:** reliable and valid for the intended population

Lane, K.L., Powers, L., Oakes, W.P., Buckman, M.M., Sherod, R., & Lane, K.S. (April 2020). Universal Screening – Systematic Screening to Shape Instruction: Lessons Learned & Practicalities. Eugene, OR: Center on PBIS, University of Oregon. Retrieved from www.pbis.org.

WHY SCREEN?

- Enhance **comprehensive continuums of support**
- Identify students' strengths and needs
- Improve access to and benefit from mental health services
- Make economically sound decisions
- Prevention and early interventic



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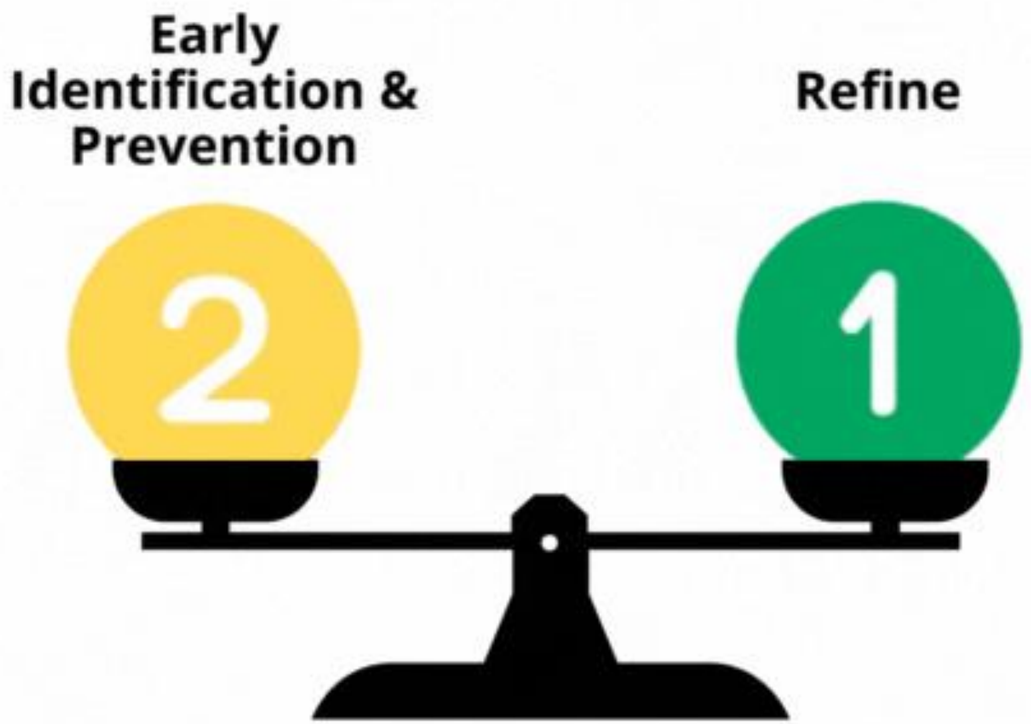
WHAT CAN WE LEARN FROM A UNIVERSAL SCREENER?



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REFLECT & POPCORN

When thinking about screening, what are some things you'd typically want to screen for?

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MENTAL HEALTH CONTINUUM

Concerning Indicators (SEB Problems)

Positive Indicators (SEB Wellness)

SYMPTOMS

Anxiety, Depression, Other Internalizing Problems

Disruptive Behaviors (defiance, rule violations, substance use)

Life Satisfaction & Happiness

Strong Social Relationships

Trauma and other environmental stressors

Thinking errors, behavioral withdrawal

Risky/Unsafe settings

Inconsistent rules and expectations across settings

Building blocks of well-being (gratitude, empathy, persistence)

Basic Needs are Met

Social Skills

Healthy Interactions (minimal bullying, high support)

Risk Factors

Protective/Promotive Factors

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MENTAL HEALTH CONTINUUM

Concerning Indicators (SEB Problems)

Anxiety, Depression, Other Internalizing Problems

- Trauma and other environmental stressors
- Thinking errors, behavioral withdrawal

Disruptive Behaviors (defiance, rule violations, substance use)

- Risky/Unsafe settings
- Inconsistent rules and expectations across settings

Risk Factors

PREVENT, REDUCE, AND MANAGE RISK FACTORS

- **Identify** students at-risk
- **Provide targeted interventions** matched to signs of risk and needs
- Provide support to youth in **crisis** or with chronic mental health needs

Positive Indicators (SEB Wellness)

Life Satisfaction & Happiness

- ilding blocks f well-being gratitude, empathy, ersistence)
- Basic Needs are Met

Strong Social Relationships

- Social Skills
- Healthy Interactions (minimal bullying, high support)

Promotive/Protective Factors

FOSTER PROTECTIVE FACTORS

- **Teach** social, emotional, and behavioral skills
- Create **safe and nurturing environments** that support well-being for ALL
- Foster resilience and increase protective factors for ALL

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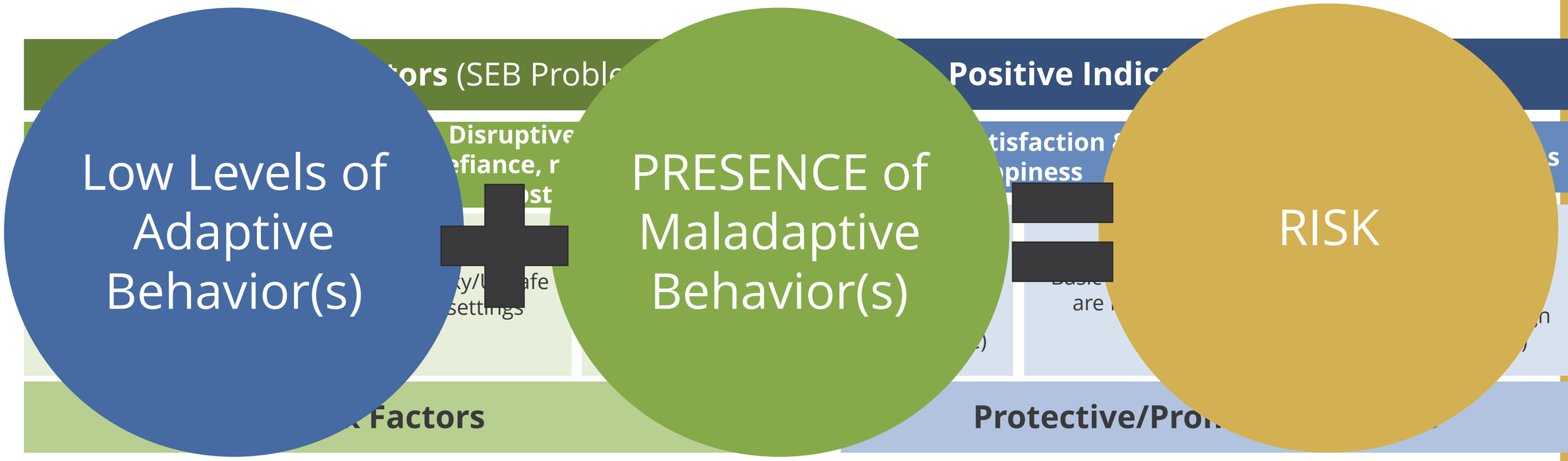
WHAT IS RISK?



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WHO COMPLETES THE SCREENER?

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W

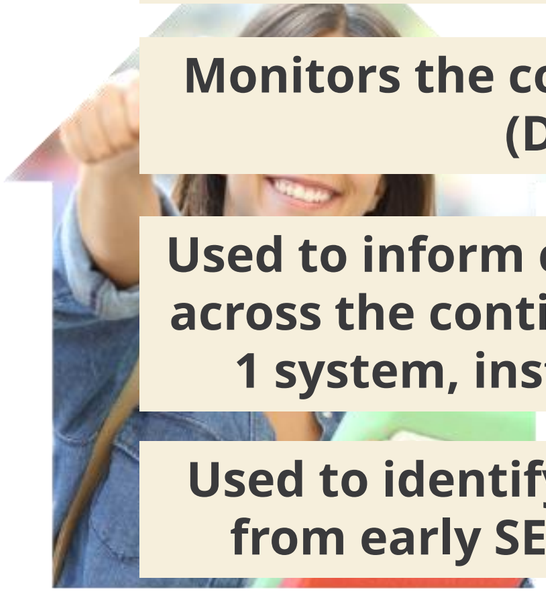
CRITICAL FEATURES

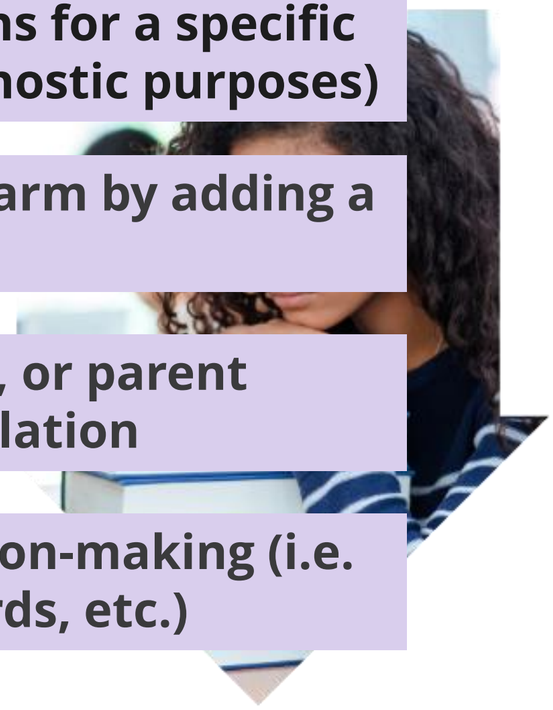
INCREASES THE LIKELIHOOD OF PROMOTING POSITIVE OUTCOMES

- Supported and informed by youth and family (MULTI-INFORMANT)
- Monitors the continuum of SEB well-being (DUAL-FACTOR)
- Used to inform continuous problem-solving across the continuum of supports (e.g., tier 1 system, instructional supports, etc.)
- Used to identify student who may benefit from early SEB interventions supports

INCREASES THE LIKELIHOOD OF HARM/ NEGATIVE IMPACT

- Selecting a tool that screens for a specific diagnosis (or using for diagnostic purposes)
- Assessing for suicide/self-harm by adding a single-item
- Uses teacher, student, or parent nomination in isolation
- Uses for high-stakes decision-making (i.e. referrals, report cards, etc.)





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KEY FEATURES OF UNIVERSAL SEBMH SCREENING

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EXAMPLES

Increase the likelihood of SEBMH screening impacting POSITIVE outcomes

- Monitors SEB health (i.e., high levels of SEB well being and low levels of SEB problems)
- Supported and informed by youth and family
- Used in conjunction with other student data to increase accuracy of decisions
- Assumes a clearly defined population such as all students within a school
- Aligned with universal programing to meet the needs of all students within the defined population
- Informs continuous problem solving (i.e., problem identification, analysis, intervention planning and evaluation) for improved SEB outcomes across continuum of supports
- Identifies students who may benefit from early SEB intervention
- Uses instruments that are psychometrically defensible and tested with populations similar to the school population
- Examines SEB constructs aligned with the vision, mission, and priorities of school mental health programming
- Individuals with mental health expertise (i.e., assessment, intervention, and relevant ethical and legal considerations) inform the SEB screening implementation and intervention decision-making processes
- Ongoing consultation with legal and data system administrators to ensure compliance with legal mandates and policies
- Data systems and follow-up procedures established and communicated prior to collecting SEB screening data

NON-EXAMPLES

Increase the likelihood of SEB screening resulting in NEGATIVE IMPACT or CAUSING HARM

- Screens for symptoms of a specific diagnosis or use of assessments developed for diagnostic purposes
- Assesses for suicide or self-harm only using single item
- Purpose is not well defined and/or communicated to youth, families, staff, and other stakeholders
- Conducted using selected items or measures without sufficient evidence
- Data collected only for some students but not others
- Limited or no follow-up following data collection
- Used to make high-stakes (e.g., change in placement) or diagnostic decisions
- Uses teacher, parent, or student nomination data in isolation
- Review of academic and behavioral data only
- Parents and youth are not well informed; appropriate consent and assent is not obtained
- Mandated rather than selected based on the strengths and needs of the population and matched to the priorities and vision of the school community

Romer, N., von der Embse, N., Eklund, K., Kilgus, S., Perales, K., Splett, J. W., Sudlo, S., Wheeler, D., (2020). Best Practices in Social, Emotional, and Behavioral Screening: An Implementation Guide. Version 2.0. Retrieved from smhcollaborative.org/universalscreening Version 2.0. Current and future versions available at smhcollaborative.org/universalscreening 1 “Parents” is a term we use broadly for all caregivers and guardians filling the parent role. ABSTRAC

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BUT HOW?

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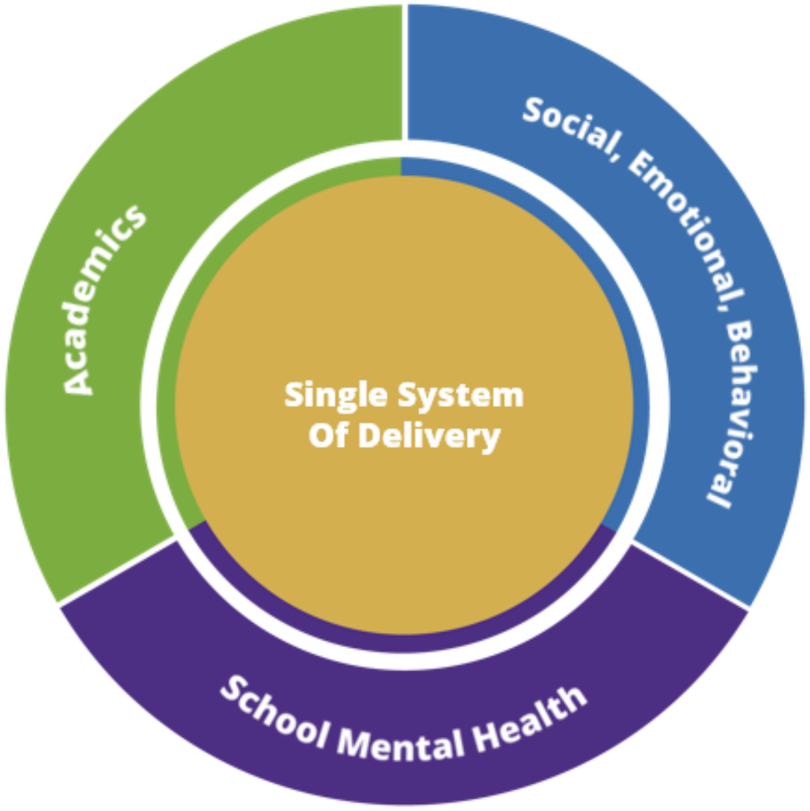
ABSTRAC

HOW DO WE MOVE BEYOND FRAGMENTED?

The state's approach to stu
behavioral health is
**FRAGMENTED AND LAC
SUFFICIENT RESOURC**



ehavioral health supports and
ervices available to students
**EPEND ON WHAT SCHOOLS
RE ABLE TO PROVIDE AT THE
LOCAL LEVEL**

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IMPLEMENTATION CASCADE

Blase, K., Fixsen, D., Jackson, K. (2015_ Cascading Logic Model. National Implementation Research Network, University of North Carolina at Chapel Hill

TEACHERS BUILDINGS

DISTRICTS

PROFESSIONAL ESA ORGANIZATIONS

EDUCATION SERVICE DISTRICTS

OFFICE OF SUPERINTENDENT OF PUBLIC INSTRUCTION

Bi-Directional Feedback Loops

DISTRICT INSTALLATION

ESTABLISH A SINGLE SET OF TEAMS

- Identify need for merging teams with similar goals
- Expand team membership as needed to include families, students, community MH Partners
- Establish roles and functions of teams across tiers of support
- Consider role changes for staff
- Establish team operating procedures and problem-solving approaches (for each team)

ASSESS CURRENT STATUS OF MENTAL HEALTH AND PBIS SYSTEMS

- PBIS/SMH (Action Planning Companion Guide to TFI)
- Assess structures for identifying students who need more supports
- Conduct Intervention Inventory
- Assess data being used to identify social-emotional-behavioral needs

ESTABLISH SCHOOL LEVEL PROCEDURES AND ROUTINES

- Develop process for implementing universal screening
- Develop request for assistance process
- Develop routines for data-based decision making
- Develop process for selecting EBPs
- Establish a process for tracking fidelity of all interventions
- Establish a process for monitoring the outcomes of all interventions

DEVELOP AN INTEGRATED ACTION PLAN

- Monitor the effectiveness of the system
- Monitor student impact
- Conduct professional development

TEAM | ROLES AND RESPONSIBILITIES OF DISTRICT AND SCHOOL TEAMS

DISTRICT LEADERSHIP TEAM

- Selects district wide screening instrument
- Establishes routines and procedures for conducting screening
- Determines roles and responsibilities for collecting, managing and analyzing data
- Ensures appropriate skilled staffing
- Provide professional learning
- Supports screening implementation in buildings with additional coaching and technical assistance
- Determines additional clinical evaluations
- Determines response plan
- Align with other data collection systems

SCHOOL LEADERSHIP TEAM

- Communicates with school community
- Supports building staff
- Customizes screening procedures and routines
- Coordinates data based-decision making
- Ensures follow up after screening to connect students to support
- Implementing interventions
- Progress monitoring

SCREENING TOOLS

WHICH TOOLS HAVE YOU HEARD OF?

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DECISION MAKING

PROFESSIONAL JUDGEMENT

EVIDENCE-BASED DECISION-MAKING

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W

WHICH SCREENER SHOULD WE SELECT?

What questions are you trying to answer?

What are the policies related to screening? Consent?

What data do we already collect ?

Are the screeners reliable and valid **for your student population?**

WHO will provide information – Parents? Students? Teachers?

Budget?

Time—before, during, after?

Do the screeners come with training and technical assistance?

How will they be completed? Online? Paper/pencil? Translation needed?

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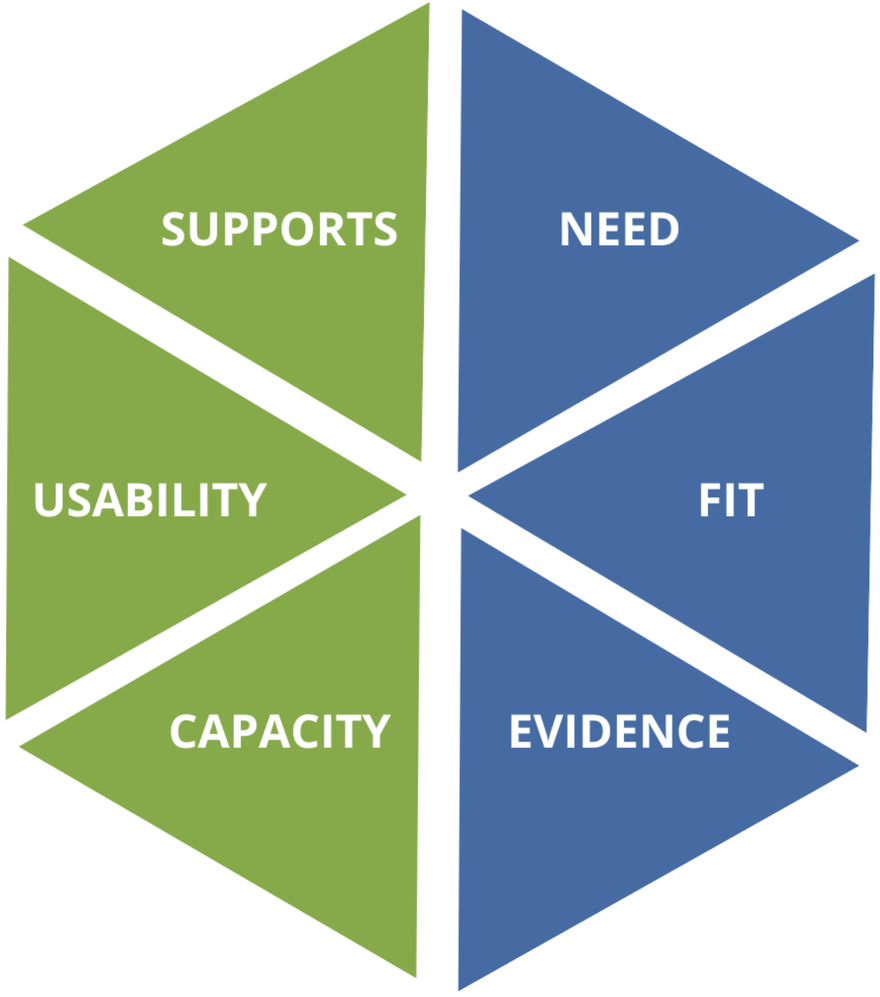
THE HEXAGON TOOL

Scaffolds the decision-making process for **evaluating the fit and feasibility of evidence-based programs or practices** within your **specific context** during the **exploration** phase**.**

- It's more than a tool/resource!
- It's a **continuous improvement process** intended to regularly **evaluate new and existing programs, communicate, and foster stakeholder engagement.**



Adapted From: Metz, A. & Louison, L. (2018) The Hexagon Tool: Exploring Context. Chapel Hill, NC: National Implementation Research Network, Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill. Based on Kiser, Zabel, Zachik, & Smith (2007) and Blase, Kiser & Van Dyke (2013)

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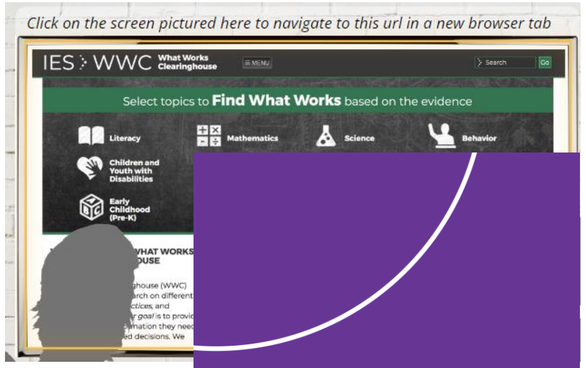
EVIDENCE-BASED DECISION-MAKING

- Consult state guidance and local policy/procedure
- Consult with relevant departments and/or partners on existing practice for adoptions (e.g. Purchasing, Curriculum & Instruction, Assessment, Technology, etc.)
- Review vetted resource banks



RAND CORPORATION

EVIDENCE for ESSA

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THE JOURNEY OF SYSTEMATIC SCREENING IN A PARTNER DISTRICT

"Old way" of screening using ODRs, attendance, teacher referrals.

1

Leveraged state & district resources for prioritization of universal screening (RCW, assessment committee & board interest/recommendation, strategic plan.

2

Joint assessment committee with union partnership for tool selection using an EB process to define community needs & select a tool that's contextually fit.

3

Partnered with UW SMART SEBMH integration, screening foundations, & best practices for selection, implementation, and decision-making.

4

Simultaneous training & coaching with demonstration sites. Focused on interconnecting systems, strengthening Tier 1, & refining Tier 2 & 3.

5

Follow-up training and coaching with UW SMART & district coaches for tool field test with follow-up training & coaching.

6

2024-25 continued roll-out with next cohort.

7

2025-26
All schools screening

8

It is a Continual Improvement Process!

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INSTALLATION → IMPLEMENTATION

Field Test #1	Field Test #2	Implementation Plan
• Spring 2024 • Three demonstration sites • Subset of school population (TBD)	• Fall 2024 • Three demonstration sites • School-wide	• Multi-phase plan beginning in 2024-2025 • Will develop using the information learned through the field-testing process

LESSONS LEARNED

- Anticipate Barriers—work early to mitigate
  - **Communications—who TO, who FROM, when, how frequent, feedback, etc.**
  - **Representation/Partnership**
  - **Buy-In—anticipate champions and investments**
- Frequent monitoring of implementation—what worked/needs work
  - **Opting Out**
  - **Professional development v. coaching (before, during, and after)**
  - **Easy to use protocols, presentations, and resources to increase comfortability and fidelity**

RECOMMENDATIONS & NEXT STEPS

Recommendations:

- Align with district strategic plan and current policy/procedures.
- Seek guidance from your legal department to establish parameters and gain clarity regarding implications of the work.
- Engage and collaborate with labor partners. Co-design when possible.
- Start small with implementation to ensure its success. “Field Testing” may inform a district’s broader implementation plan.

Next Steps:

- Provide learning opportunities to help our first groups of implementing staff to understanding of the “why” and “what” of universal screening.

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Q&A

University of Washington SMART Center

TIER 3 BEHAVIOR SUPPORT CAPACITY

You are invited to take part in a study to build your school's capacity to deliver individual behavior supports (Tier 3) in the classroom. The purpose of the study is to evaluate an online application (ibestt) to help tea
collaborate to deliver effective beh

STUDY INFORMATION

WHAT WILL THIS STUDY

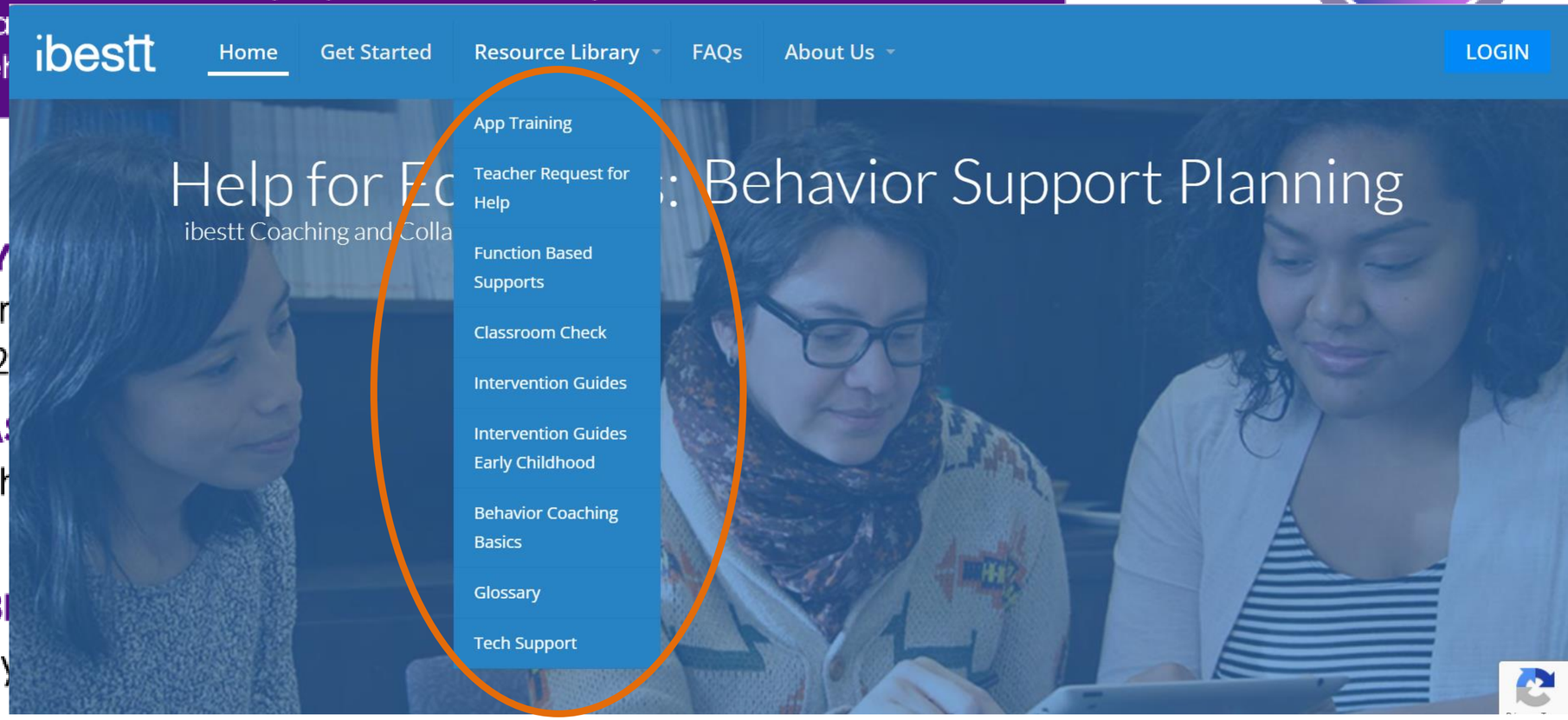
In 1 year, the ibestt tear
intervention begins, yrs 2

WHAT WILL STAFF BE A

Use the ibestt app w/in th
2 surveys per year.

WHAT WILL FAMILIES B

Complete 2 surveys per y



BENEFITS OF PARTICIPATING

- Training topics tailored to your school
- Training on and building capacity to support individual behavior plans
- Free use of the online application
- Quarterly data on participation
- Paid compensation for completion of survey

ibesttstudy@uw.edu

CONTACT US & SESSION MATERIALS

SESSION MATERIALS

SCAN HERE!

linktr.ee/UWSMART

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W

EVALUATION

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