USING UNIVERSAL SCREENING FOR EARLY IDENTIFICATION OF STUDENTS AT RISK:

A CASE EXAMPLE FROM THE FIELD

This study describes the benefits of systematic universal screening (US) for school counselors engaged in the creation of effective, multi-tiered systems of support that address academic, social, emotional, and behavioral student concerns. The authors used an action research framework to present a case example of one school district's pilot of US and the role of the school counselor in the identification of students in need of social-emotional support. This article discusses implications for school counselor collaboration with other school-based mental health professionals.

Between 1980 and 2012, there were 137 shootings in K-12 schools in America, resulting in 297 deaths (Klein, 2012). In the wake of a school shooting, the entire school community is left asking questions. What could we have done to prevent this? How will we regain normalcy? How can we assure students and parents that our school is a safe place to learn? The dialogue about school violence prevention was made even more urgent by the events of December 14, 2012, when 20 first-grade children and six educators were fatally shot at Sandy Hook Elementary School in Newtown, Connecticut (Office of the Child Advocate [OCA], 2014). In an effort to learn from this tragedy and provide professional recommendations, the Connecticut OCA developed a detailed report of the shooter's history from birth through age 20, his age at the time of the shooting (OCA, 2014). While authors of this report held him solely responsible for this tragedy, they acknowledged "the role that weaknesses and lapses in the educational and healthcare systems' response and untreated mental illness played in [the shooter's] deterioration" (OCA, 2014, p. 8). Furthermore, this report suggested flawed support from and coordination between the

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shooter's family and his education and healthcare providers.

As a result of their investigation, the OCA provided several recommendations to inform educational practices, the first of which was universal screening (US) of youths' behavior and development (OCA, 2014). Universal screening is the preventative, systematic, and standardized process of assessing every student for predetermined criteria (e.g., social-emotional or behavioral functioning), with the aim of providing early identification and intervention to identified students (Albers & Kettler, 2014). Schools can be an integral aspect of the US process, connecting school, home, and mental health professionals to identify students with elevated needs and provide integrated supports (OCA, 2014). Schools universally assess students' academic performance, including grade-level benchmarks; in a similar vein, schools can screen for student behaviors and social-emotional functioning (Lane, Menzies, Oakes, & Kalberg, 2012).

Although ample material on US has been published in education and school psychology literature (Albers, Glover, & Kratochwill, 2007), there remains limited pertinent information in the school counseling literature. In this article, the authors provide an action research-framed case example of one school district as its staff identified and implemented US over multiple years. The authors then discuss implications for practicing school counselors.

STUDENTS' MENTAL HEALTH CONCERNS AND THE SCHOOL'S ROLE

Students' unmet mental health needs are a substantial concern. Each year, 14-20% of youth are diagnosed with mental, emotional, or behavioral

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US can be used within multi-tiered systems of support (MTSS), such as School-wide Positive Behavioral Interventions and Supports (PBIS) and Response to Intervention (RTI), to identify students needing additional social-emotional and mental health support (Albers & Kettler, 2014; Burke et al., 2012; Cowan, Vaillancourt, Rossen, & Pollitt, 2013; Hawken, Vincent, & Schumann, 2008; Lane et al., 2012; Walker, Cheney, Stage, & Blum, 2005). Further, providing MTSS is consistent with a comprehensive school counseling program such as the ASCA National Model (American School Counselor Association [ASCA], 2014; Goodman-Scott, Betters-Bubon, & Donohue, 2016).

mental health disorders (National Academy of Sciences, 2009), which often manifest as internalizing or externalizing behaviors (Forns, Abad, & Kirchner, 2014; Lane et al., 2012; Walker et al., 2005). Despite the prevalence of mental health disorders in youth, only 45% of youth with a mental health diagnosis receive treatment, and only 24% of those individuals receive care in the school system (Costello, He, Sampson, Kessler, & Merikangas, 2014). Furthermore, early identification of students with mental health concerns aligns with the Individuals with Disabilities Education Act (U.S. Department of Education [DOE], 2006). Thus, the school has the responsibility to provide early identification and interventions for students with mental health concerns. Universal screening is one tool to assist in identifying student mental health concerns (e.g., internalizing and externalizing behaviors) and preventing school violence (OCA, 2014; Kaffenberger & O'Rorke-Trigiani, 2013; Sprague, Nishioka, & Stieber, 2004).

UNIVERSAL SCREENING AND MULTI-TIERED SYSTEMS OF SUPPORT

Not only has US been recommended as a means for prevention and early intervention by the OCA (2014) and the U. S. President's Commission on Excellence in Special Education (U.S. Department of Education Office of Special Education and Rehabilitative Services, 2002), but US is recommended as a part of MTSS (e.g., Cowan et al., 2013). Multi-tiered systems of support are preventative, data-driven, evidence-based, culturally responsive frameworks for addressing students' academic and behavioral concerns through three tiers of intervention: tier one, universal prevention for all students, and tiers two and three, identification of and services for students with elevated needs (PBIS, 2015; Sugai & Horner, 2006). Universal screening is a commonly used tier one practice to identify students with tier two and three behavioral or mental health needs (Lane et al., 2012). School counselors have been active in implementing MTSS such as PBIS (e.g., Curtis, Van Horne, Robertson, & Karvonen, 2010; Donohue, 2014; Goodman-Scott, 2014; Sherrod, Getch, & Ziomek-Daigle, 2009).

Positive Behavioral Interventions and Supports is an MTSS focused primarily on student and staff behaviors. Office discipline referrals (ODRs) are

a type of student outcome data used to identify individual and school-wide behavioral patterns (Sugai, Sprague, Horner, & Walker, 2000). At the same time, tracking students' ODRs is not necessarily preventative, as staff must rely on students accruing a negative pattern (Burke, Davis, Hagan-Burke, Lee, & Fogarty, 2014). Furthermore, ODRs are often based on externalizing behaviors (Severson, Walker, Hope-Doolittle, Kratochwill, & Gresham, 2007), may not capture all students with elevated needs, and should not be the sole source for referring students to tier two and three services (Walker et al., 2005). Thus, US is recommended in PBIS implementation to complement the analysis of ODR trends by proactively identifying students exhibiting internalizing and/or externalizing behaviors (Walker et al., 2005). Walker, Cheney, Stage, and Blum (2005) found that integrating the use of ODRs and US within PBIS implementation led to a more proactive approach to identifying and serving students, especially those with a broad range of needs.

UNIVERSAL SCREENING IMPLEMENTATION

Universal Screening can be facilitated at the school or district level and should be coordinated by a leadership team (Lane et al., 2012), which may consist of school counselors, teachers, school psychologists, school social workers, and administrators. The leadership team selects the screener, or assessment, that best fits their needs and criteria (Albers & Kettler, 2014). Table 1 describes several screeners. Screeners should be psychometrically sound, normed/standardized for a population similar to the school/district, and aligned with the school/district's budget and time constraints for administering and scoring. Parent permission is not necessarily required before administering a screener; however, best practice includes informing parents of all ongoing assessments (RTI Action Network, n.d.).

> UNIVERSAL SCREENING IS A COMMONLY USED TIER ONE PRACTICE TO IDENTIFY STUDENTS WITH TIER TWO AND THREE BEHAVIORAL OR MENTAL HEALTH NEEDS.

Each school should have supports in place to implement the screenings and the corresponding evidence-based interventions for identified students (Albers & Kettler, 2014; Glover & Albers, 2007; Lane et al., 2012; Stormont, Reinke, Herman, & Lembke, 2012). Tier two services often include targeted interventions such as group counseling and social skill instruction, while tier three services may include coordinated and intensive wraparound services (Shepard, Shahidullah, & Carlson, 2013). After intervention implementation, students should be continually monitored to determine their progress and the effectiveness of interventions.

School Counselors' Role

Implementing MTSS, and thus US, fits within the school counselor's role of running a comprehensive school counseling program (ASCA, 2014; Erickson & Abel, 2012; Goodman-Scott et al., 2016). First, school counselors, as members of the US implementation team, are instrumental in the US process and assist in US implementation in all stages. They can assist with identifying screening instruments and collaborate and consult regarding the administration and scoring process. School counselors collect and utilize student data to understand student needs, close the achievement gap, and determine the effectiveness of interventions and programs (ASCA, 2012), all of which can be done through US. "School counselors are encouraged to collect, track, and report data related to any screening or prevention program they implement" (Erickson & Abel, 2012, p. 287). After analyzing screener results, school counselors can inform stakeholders, advocate for appropriate student interventions, and monitor progress. Last, school counselors can provide direct services, including individual and small group counseling to identified students, and develop classroom guidance lessons based on school-wide trends. Erickson and Abel (2012) examined school counselors' role in screening for suicide and depression. They found that systematically screening every student for specific criteria was a useful school counseling prevention strategy. However, there otherwise exists a dearth of literature describing school counselors' role in US, especially within MTSS such as PBIS.

Far too many students with mental health concerns are not identified and, therefore, go unserved every year in K-12 schools (Dvorsky, Girio-Herrera, & Owens, 2014). Implementation of US assists schools, including the school counselor, in intervening earlier, creating a helpful baseline for further assessment, and reducing overall costs of mental health services over time (Humphrey & Wigelsworth, 2016). Given that research supports the use of US as part of MTSS, identifying the role of the school counselor in this process is essential.

PURPOSE

The purpose of this study is to explore the process and outcome of a school counselor-led US implementation in one school district. Using an action research framework, the authors provide a case example of a small New England school district. Robin Public Schools (RPS; a pseudonym) piloted US to screen for students in need of additional social and emotional support. The first author of this article was a school counselor in RPS and a member of the district multidisci-

TABLE 1 COMMONLY USED UNIVERSAL SCREENERS

Name and Author	Grade Levels	Description	Price	Links and resources
Systematic Screening for Behavior Disorders (SSBD; Walker & Severson, 1992; Walker et al., 2004)	K-9	Three-stage process from perspective of teacher for stages 1-2. Stage 3 relies on student services professional observation and parent questionnaire. Screens for internalizing and externalizing concerns.	$225.00 (portfolio includes admin guide, CD technical manual, 10 classroom screening packs grades 1-9, 2 classroom screening packs PK-K. Online version with automated scoring: $30.00/100 students	https://pacificnwpublish.com/products/SSBD-Portfolio.html
Student Risk Screening Scale (SRSS; Drummond, 1994)	K-12	Administered three times per year; teacher rating for each student in the class in relation to seven externalizing behavioral criteria; (e.g., lies, cheats, sneaks, steals, behavior problems, peer rejections, low achievement, negative attitude, and aggressive behavior). Scored to determine risk level (low, moderate, high). 10-15 minutes for a teacher to screen an entire classroom of 20-25 students	Free	http://miblsi.cenmi.org/MiBLSiModel/Evaluation/Measures/StudentRiskScreeningScale.aspx
The Behavior Assessment Scale for Children Two: Behavior and Emotional Screening Scale (BASC-2 BESS; Kamphaus & Reynolds, 2007)	PK-12	Identifies students with needs in both the academic and social domains: internalizing problems, externalizing problems, school problems, and adaptive skills from multiple informants (teacher, parent, student [grades 3-12]) 4-6 minutes for student form; parent or teacher form (K-12); self report form (grades 3-12) Available in Spanish	Manual: $75.00 BESS student forms: $29.00 (pack of 25); BESS teacher forms: $116.00 (pack of 100) Web-based system: $667.95	http://www.pearsonassessments.com/haiweb/cultures/en-us/productdetail.htm?pid=PAaBASC2bess http://www.aimsweb.com ($4/student)
Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997)	K-12 (ages 3-16 years old)	25 items examining broad behavioral domains: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior. Can get multiple stakeholder perspectives (teacher, parents, students age 11 and older). 5-10 minutes	Free (minimal cost for online version: www.sdqinfo.org)	http://www.youthinmind.com and http://www.sdqinfo.com/d0.html

plinary, school-based mental health team for the first year of US. Data for this case study example were gathered from her professional records and subsequent communication with and data from RPS staff.

METHOD

Action research relies on practitioners' experiences and ability to make positive changes internally. Specifically, action research is defined as "systematic inquiry" undertaken by educators for the purpose of obtaining "information about how their particular schools operate" (Mills, 2014, p. 8). Action research can focus on teaching and learning or other regular functions of the school. The goal is to gain a new perspective and make effective and positive improvements for the purpose of enriching all aspects of student development (Mills, 2014). Mills conceptualized action research as a four stage process: (a) identifying an area of focus (e.g., defining the research problem or subject), (b) collecting data, (c) analyzing and interpreting data, and (d) developing an action plan (e.g., after reflecting on the data, making a plan for future action). Action research is ongoing and cyclical.

Setting and Participants

RPS was a small New England public school district in Connecticut with 1,500 students in three schools: one elementary, one middle, and one high school. During the 2012-13 school year, approximately 17.3% of students in RPS were eligible for free and reduced meals, which is well below the state total of 36.7%. Almost all students attended preschool (94%) and were fluent in English (98.5%). In RPS, 14.6% of students were identified for special education services compared to the state total of 11.9%. Those students identified for special education services include all exceptionalities that encompass learning disabilities and emotional disturbance. This figure does not include students identified as gifted and talented.

In 2012, RPS was fairly homogenous demographically, including 85.2% White students, 5.9% Hispanic, 5.4% Asian American, 1.7% Black, 1.6% biracial or multi-racial, and two students of Pacific Islander descent (0.1%). RPS's median family income was $30,000 and students were high achieving. For example, their fourth-grade students surpassed 89.2% of other fourth-grade students on state wide reading and exceeded 98% in math; further, students scored above state averages in all three areas of the Scholastic Achievement Test. During the 2012-13 school year, RPS had a 95.8% graduation rate and 94.2% of seniors matriculated into higher education programs. The school counselor-to-student ratios varied, including 1:412 for elementary, 1:200 for middle, and 1:250 for high school.

> IMPLEMENTATION OF US ASSISTS SCHOOLS . . . IN INTERVENING EARLIER, CREATING A HELPFUL BASELINE FOR FURTHER ASSESSMENT, AND REDUCING OVERALL COSTS OF MENTAL HEALTH SERVICES OVER TIME.

Procedures

A multi-disciplinary team of RPS school-based mental health providers (the Team), which included school counselors, school psychologists, and school-based and district-level administrators, met to reflect on the Sandy Hook shooting and discuss prevention strategies applicable to their school district's needs. Due to the district's commitment to identify students in need of mental health services and RPS's strategic plan to identify student barriers to learning, the Team decided to implement US as a means of prevention. The Team decided that a key area of focus included identifying students with mental health issues, such as students with atypical behavioral and emotional concerns in need of tier two interventions.

The Team reviewed multiple instruments that would be completed by parents or teachers and several that would be completed by the students themselves. The Team favored student-completed surveys because some parents could be unaware of how their child approached social situations at school or the child's true feelings of self-worth. Many instruments were deemed too lengthy or did not address the concern areas the Team was most interested in identifying.

Instrument

The Team selected the Behavior Assessment System for Children, Second Edition Behavioral and Emotional Screening System (BASC-2 BESS) to identify students at risk in the areas of emotional distress and behavioral concerns (Kamphaus & Reynolds, 2007). The BASC-2 BESS is a widely utilized and research-validated instrument including 27 items scored on a 4-point ordinal scale (i.e., *never, sometimes, often,* and *almost always*). Further, this assessment measures externalizing problems (e.g., disobeying authority or breaking rules), internalizing problems (e.g., sadness or worry), school problems (e.g., distraction or difficulty following directions), and adaptive skills (e.g., giving suggestions or encouraging others; Dever, Mays, Kamphaus, & Dowdy, 2012). The Team decided the BASC-2 BESS was manageable to administer and score, given the limited number of questions on the assessment (N = 27.) The extended version of the BASC-2 BESS was already widely used in the district by school psychologists as needed for special educations assessments and was cost efficient (see Table 1).

Data Collection

Before implementing US, the Team apprised the school board and school

attorney of the proposed US process and created a plan for communicating with parents before and after the assessment administration and scoring. Parents were informed through letters and e-mail communication 4 weeks prior to the screening and their responses were overwhelmingly positive, with only three parents district-wide declining their child's participation. An overview of the data collection timeline is presented in Table 2.

Year 1. During year 1 of implementation, school counselors administered the paper and pencil version of the BASC-2 BESS to students in grades 3, 6, and 9 in their homerooms. The Team decided to pilot US with students in these grade levels due to significant grade-level student transitions occurring directly before of after entering these grades (RPS grade levels were grouped into the following: K-3, 4-5, 6-8, and 9-12). The grade-level cohorts for each of the three grade levels varied from 88 to 110 students.

Year 2. In year 2 of implementation, RPS expanded screening to also include students in grades 4, 7, and 10. Thus, the total number of grades screened went from three to six. This expansion of data collection was used to follow up on students previously identified with elevated needs, monitor potential changes in students not previously identified, and to screen students new to the district. Similar to year 1, student responses to questionnaires were input by hand.

Data Analysis

All RPS school counselors assisted in data input and analysis after receiving training from a district school psychologist with expertise in the instrument administration. Grade-level school counselors manually entered student data into scoring software, then the software generated a score that was verified by the school psychologist. The standard scores were represented as a *t* score, with scores of 60 or below indicating that a student met or exceeded the basic expectations for school functioning, scores between 61 and 70 indicating that a student was at elevated risk, and scores of 71 or higher indicating extremely elevated risk levels (Dever et al., 2012). In the case of elevated scores, the Team suggested further assessment if the child had not been assessed prior to the screener.

As US data were collected, the Team divided into school-based teams comprising the grade-level school counselor(s) and the site school psychologist. Each team reviewed results and looked for trends in student scores. According to an RPS administrator, US "provided a vehicle for counselors and school psychologists to discuss the needs of students by being able to use concrete data. It has also given us data on specific needs in order to form our counseling groups" (personal communication, April 20, 2015). After scoring and analysis, data were stored in a locked cabinet in each school counselor's office; at no time were the completed testing protocols shared with parents or other staff in the school. The same process was completed for analyzing year 1 and year 2 data.

TABLE 2 PROCEDURAL CALENDAR FOR FIRST-YEAR IMPLEMENTATION OF UNIVERSAL SCREENING AT RPS

Month	Action Taken
November	Parent letter sent informing parents of screener in grades 3, 6, and 9.
December	BASC2-BESS administered in homeroom classes (grades 3 and 6) and health class (grade 9).
January	Student support team members called the parents of students with heightened scores on the screener to discuss their child's score and available interventions.
February	All parents informed of district-wide or individual student results via mail.
February to June	Implementation of tier two intervention groups
March to June	Regular progress monitoring of intervention groups
May	Meeting to plan for the new year of implementation

Informing Parents and Guardians

After identification of students, school counselors and school psychologists at the three schools developed action plans that included informing the parents of identified students through written communications and phone calls. Rather than share specific responses on test items, RPS protocol included providing parents with general information on student test scores and self-perception, in an effort to focus on overarching trends. Parents were informed of follow-up supports available, including outside mental health service providers. The school district worked closely with clinicians from a local community health agency to refer students to either school-based or agency-based group and/or individual counselors. Several agency clinicians were already conducting groups in the schools and groups were added to address newly identified student needs. Most clinicians employed by this agency were marriage and family therapists and were available to extend support to the family system if desired. These

ACCORDING TO AN RPS ADMINISTRATOR, US "PROVIDED A VEHICLE FOR COUNSELORS AND SCHOOL PSYCHOLOGISTS TO DISCUSS THE NEEDS OF STUDENTS BY BEING ABLE TO USE CONCRETE DATA."

TABLE 3 STUDENTS IDENTIFIED AS ELEVATED BY US DURING TWO PILOT YEARS OF IMPLEMENTATION.

Pilot year #1

2013-14	Gr. 3	Gr. 6	Gr. 9	Total
Total # of students per grade	91	124	98	313
Students identified per grade	9	12	9	30
Percent identified	10%	10%	10%	10%

Pilot year #2

2014-15	Gr. 3	Gr. 4	Gr. 6	Gr. 7	Gr. 9	Gr. 10	Total
Total # of students per grade	99	90	109	120	116	97	631
Students identified per grade	11	5	5	11	13	13	58
Percent identified	11%	5%	5%	9%	11%	13%	9%

Note: Percentages based on BASC2-BESS administered to all students in named grades.

services were not mandated by the district but suggested to parents as a parent-provided intervention to address concerns raised by the screener.

RESULTS

Year 1

During the first year of implementation, students in grades 3, 6, and 9 completed the US (N = 313). Based on the analysis (see Table 3), approximately 10% of students (n = 30) per grade level had scores denoting elevated needs. Of those identified, 80% (n = 24) had previously been found to have atypical behavioral and emotional concerns through a teacher or an office discipline referral. The remaining 20% (n = 6) had not been previously identified nor had received related services. Thus, the RPS US process increased the percentage of students identified with behavioral and emotional concerns, newly recognizing students.

Year 2

In the second year of the pilot, additional grade levels were screened with different results. Between 9% and 13% of students in grades 4, 7, 9, and 10 were identified with elevated needs. However, 5% of students in grades 5 and 6 were identified as elevated, a decrease from the same cohort the previous year. Further, for progress monitoring, the Team compared scores from students identified in year 1 to their results in year 2. Aligned with the action research process, the results were used to inform future practices and interventions.

STUDENTS WERE ENGAGED IN GROUPS FOCUSED ON DEVELOPING SOCIAL SKILLS AND COPING SKILLS WITH AN EMPHASIS ON DEVELOPING HEALTHY RELATIONSHIPS.

Follow Up

The Team included the district's PBIS framework as part of the action plan to meet the needs of students with elevated scores. For example, the Team facilitated tier two focused group and/or individual counseling for identified students and implemented further assessments as necessary. In the elementary and middle school, students were engaged in groups focused on developing social skills and coping skills with an emphasis on developing healthy relationships. At the high school, students met with school counselors and collaborating clinicians both individually and in groups that emphasized self-care during transitions, self-awareness, and developing decision-making skills. Many of the students who had elevated scores on the screener were entered into the site consult process. Specifically, consult meetings took place between school counselors, grade-level teachers, administrators, and special educators to identify and support students who struggled academically, socially, and/or emotionally; this process and interventions were documented. Further, student progress was monitored and recorded on a regular basis. All records were kept confidential in a digital database that was shared with the Team and grade-level teachers as the student moved from grade to grade.

Reflection

In alignment with the action research steps outlined, examining the effectiveness of US was evolving and ongoing. At the time this article was written, RPS staff were planning for year 3 of US implementation after reflecting on their process. For example, according to the elementary school counselor, many third-grade students struggled with the wording of the BASC-2 BESS during years 1 and 2. They described the self-assessment as difficult for the students to understand; questions had to be repeated and restated during administration. As a result, team members decided for year 3 to use the BASC-2 BESS parent questionnaire for third-grade students instead of the student self-assessment, while retaining the student self-assessment for stu-

dents in fourth, sixth, seventh, ninth, and 10th grades. Eventually, the district intends to expand their screening procedures to include all students in third through 12th grades; all students but those in third grade will complete self-reports. Furthermore, due to the time-consuming nature of administering and inputting student data (i.e., scores), the district aims to streamline the process by using electronic assessments and purchasing software for more efficient analysis.

Progress monitoring. The Team has and will continue to provide monitoring and interventions to students with elevated scores from previous screenings as long as those needs are present. Once students receive scores in the typical range for the BASC-2 BESS, they will be monitored but no longer receive direct services. Decisions about continuing services were and will continue to be made based on progress monitoring data and in conjunction with agency clinicians. As more students are identified and more interventions occur, the Team plans to use pre and post group evaluations to measure ongoing effectiveness.

Benefits and challenges. Implementing US has resulted in several district benefits. According to the RPS director of Pupil Personnel Services, US implementation increased the district's awareness of student's atypical behavioral and emotional concerns (personal communication, October 6, 2014) and led to greater collaboration with local community mental health agencies. Further, US implementation reportedly assisted the district to act proactively, providing services to students before major incidents or needs developed. Last, and perceived to be most important, as a result of US, parents/caretakers developed a greater awareness of their child's mental health needs (e.g., atypical behavioral and/or emotional concerns; personal communication, October 6, 2014), which engaged parents in their child's overall development.

While RPS's US implementation had many reported benefits, the schools also encountered several challenges. US implementation required an extensive amount of time to input and analyze the data. Once students were identified, RPS needed increased staff and support to facilitate student interventions.

SUMMARY

Through the pilot of US in the school district, RPS created a systematic process to identify students at risk behaviorally and emotionally and provide monitoring and services to best meet their needs. RPS's use of US aligned with the district's strategic plan and included a range of stakeholders, including school counselors. As part of an interdisciplinary team, RPS school counselors implemented US within a MTSS/PBIS framework.

PARENTS/CARETAKERS DEVELOPED A GREATER AWARENESS OF THEIR CHILD'S MENTAL HEALTH NEEDS, WHICH ENGAGED PARENTS IN THEIR CHILD'S OVERALL DEVELOPMENT.

The genesis of US in this district was preventative in nature. Rather than responding reactively after student concerns escalated, the district identified students with high needs and provided interventions proactively. Correspondingly, the identification of students in need of support can lead to early intervention and a greater likelihood of positive student outcomes (Walker, Ramsey, & Gresham, 2004). Prevention efforts are crucial in schools in order for timely, lasting and effective interventions (ASCA 2011; Graczyk, Domitrovich & Zins, 2003).

School counselors are members of school and district interdisciplinary leadership teams (ASCA, 2012; Janson, Stone, & Clark, 2009), including those that implement PBIS and promote systemic change (ASCA, 2014; Cressey, Whitcomb, McGilvray-Rivet, Morrison, & Shander-Reynolds, 2014; Goodman-Scott, 2014; Singh, Urbano, Haston, & McMahan, 2010). At RPS, school counselors served on the interdisciplinary team to implement US. Furthermore, school counselors are systemic leaders and change agents who advocate for students and the school as a whole (ASCA, 2012; Goodman-Scott, 2014; Cressey et al., 2014). As members of the Team, RPS school counselors played an essential role in creating intentional systemic change through US implementation and the referral and coordination of mental health services.

School counselors on the Team collaborated and consulted with myriad stakeholders during the US process, including other Team members, teachers, parents/caretakers, and community mental health agencies. Collaboration and consultation is a crucial dimension of the school counselor's role serving students (ASCA, 2012). For example, although teachers interact with students throughout the day, they may feel unsure about how to best support students with mental health or behavioral concerns (Reinke, Stormont, Herman, Puri, & Goel, 2011). Thus, through consultation and collaboration, RPS school counselors supported teachers as they served students with challenging behavioral and emotional concerns in the classroom setting.

Through the implementation of US, school counselors were able to use data to guide their decisions and interventions. Specifically, data were used to identify students with elevated needs, track the effectiveness of corresponding school interventions, and determine students' future interventions. By utilizing US beginning in mid-elementary school, RPS also created a baseline of students' behavioral and emotional functioning, enabling staff to monitor and provide interventions throughout students' K-12 education. In this age of educational accountability, school counselors systematically

use data to determine their impact on students; close students' achievement gaps; assist every student to achieve academic, career, and social-emotional success; and inform the development of their comprehensive school counseling program to maximize identification, prevention, and intervention efforts (ASCA, 2011, 2012, 2014; White & Kelly, 2010).

Last, students' mental health concerns historically have not been consistently identified or met (Costello et al., 2014; National Academy of Sciences, 2009). Through utilizing US, RPS school counselors advocated for students by increasing staff and parent/caretaker awareness regarding students' mental health concerns and needed interventions. They also assisted students in receiving needed services. RPS school counselors provided time-bound individual and group counseling to serve students identified for tier two interventions; such direct services are an important dimension of the delivery system of a comprehensive school counseling program (ASCA, 2012).

IMPLICATIONS FOR SCHOOL COUNSELORS

The action research process in RPS highlighted school counselors as unique school staff positioned to advocate for and implement universal screening in their districts as members of a larger interdisciplinary team and as part of implementing a comprehensive school counseling program. The following school counseling implications are drawn from this study. First, school counselors can advocate for and support US implementation at their respective schools. US in K-12 schools has been recommended by a number of sources, and school counselors can be instrumental in informing educational stakeholders, such as building and district administrators, regarding the benefits and processes of US (Cowan et al., 2013).

> RATHER THAN RESPONDING REACTIVELY AFTER STUDENT CONCERNS ESCALATED, THE DISTRICT IDENTIFIED STUDENTS WITH HIGH NEEDS AND PROVIDED INTERVENTIONS PROACTIVELY.

Next, US is aligned with school counselors' training and professional roles, meaning they are in a key role to participate in US as part of facilitating a comprehensive program, including prevention, collaboration, direct and indirect student services, the use of data, and systemic leadership and advocacy. For example, US provides an avenue for school counselors to increase collaboration and consultation with other school stakeholders, such as school psychologists, when identifying screening tools; teachers, including the use of a shared vocabulary and understanding when communicating about identified students; school-based staff, to create a positive and responsive classroom environment and curriculum; and additional stakeholders including community agency counselors and parents/caretakers. School counselors can administer US as part of their classroom lessons, and can use data collected through US to determine students with elevated needs and monitor their progress. Moreover, school counselors may use US data to plan evidence-based interventions, such as small group counseling, social skills instruction, academic advising, and the development of wraparound services for students with the greatest behavioral and emotional concerns.

Last, through US implementation, school counselors could raise awareness among stakeholders about the critical need to address mental health concerns and prevention early in students' development.

LIMITATIONS

The presented case example was a pilot action research study meant to inform a school-based mental health team in a small school district. Given the nature of action research, this study was conducted by practitioners in a school environment, rather than a clinical environment. Results of this pilot study cannot necessarily be generalized to other districts but were used to understand the needs of students in the given school district. The possibility of human error also exists in this study's implementation, data input, or calculation of scores.

Future studies could examine a larger sample of school counselors and schools regarding US implementation trends. A qualitative study of school counselors' experiences in US implementation could provide rich information across school counselors. A longitudinal study of US would offer the opportunity to study trends, including student outcomes, for a longer period of time.

CONCLUSION

Screenings are commonplace in public education, used to identify deficits in literacy, numeracy, vision, and hearing. Screening students' mental health may create a more comprehensive portrait of students. This proactive, preventative, and systemic approach to identifying students' needs can yield essential data to inform both individual intervention and school-wide decisions. According to the OCA (2014), the investigation of the Sandy Hook shooter's history highlights the need to address

> the profound gaps in our continuum of services for children with developmental and mental health needs, and further develop our capacity to provide carefully individualized,

timely, and sustained assistance not only to children and young adults but also to their families, instead of waiting until severe crises or developmental failures…(p. 107).

As school counselors, we cannot prioritize one deficit area over another. Academic concerns do not trump mental health concerns; both are important. Similarly, we cannot fail to act because a student with mental health concerns has not failed academically. Building capacity in school counselors to identify students with atypical behavioral and emotional concerns assists counselors in intervening with students at an early age, making a lasting impact on students' lifelong mental health, and ensuring schools are safe places for achievement and personal growth.

It is imperative that we learn from the devastating losses sustained by the families and community of Sandy Hook Elementary School and the other tragic school shootings in recent years. Educational stakeholders must heed recommendations and best practices resulting from these incidents, including preventative, comprehensive, and uniform measures such as universal screening. Educators need to work in tandem with each other, and with mental and physical health providers to support students and their families comprehensively and preventatively. ■

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