Making School Mental Health Screening and Early Identification a Team Sport:
The Collaborative Roles of Schools, Community and Families

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University of Maryland School of Medicine
Center for School Mental Health
Center for School Mental Health Team
National Center for School Mental Health

MISSION
To strengthen the policies and programs in school mental health to improve learning and promote success for Americas youth

• Established in 1995. Federally funded by the Health Resources and Services Administration.

• Focus on advancing school mental health policy, research, practice, and training.

• Shared family-schools-community agenda.

Co-Directors: Sharon Hoover, Ph.D. & Nancy Lever, Ph.D.
Director of Quality Improvement: Elizabeth Connors, Ph.D.

www.schoolmentalhealth.org
(410) 706-0980  TWITTER - @CtrSchoolMH
AGENDA

• Define best practices and innovation in school mental health (SMH) screening
• Describe free, web-based resources to support SMH screening
• Understand how plan, test and implement an approach to mental health screening in schools
• Understand how to use SMH screening data to match services to appropriate student needs in the education and/or mental health sector
• Questions/Discussion
Mental Health Screening Definition

- Using a tool or process employed with an entire population, such as a school’s student body or grade level, to identify students at risk for a mental health or substance use concern

- Brief assessment in the absence of known risk factors

- Does NOT include assessment for students already identified as being at-risk or having mental health problems

* The scope of the “entire” population screened is up to you. There is value to starting small and scaling up to your “entire” population in a gradual way that allows you to build on success.
Purpose of Universal Screening

• Identify students who may:
  • Be at risk for poor outcomes
  • Need additional intervention (i.e., secondary or tertiary)
  • Need ongoing assessment (i.e., progress monitoring)

• Provide data on the effectiveness of the core instruction and curriculum/universal interventions
PROGRESS MONITORING
Goal: Track student functioning over time to determine progress in services

TIer III: Few Students
Apparent behavioral health needs

When needs are apparent

DIAGNOSIS
Goal: Determine whether student meets criteria for DSM 5 diagnosis and/or disability code

INITIAL ASSESSMENT OF PRESENTING CONCERNS
Goal: Identify nature and severity of presenting concerns. Triage student to Tier II or III, plan for appropriate treatment/intervention.

SCREENING
Goal: Identify those who might benefit from services/supports

OUTCOME MONITORING AND PROGRAM EVALUATION
Goal: Determine whether students individually, by agency, or entire Network are achieving behavioral health outcomes.
One can aggregate data from all of the above assessment purposes depending on outcome monitoring goals.
## Assessment Purpose/Goal/Timing

<table>
<thead>
<tr>
<th>Assessment Purpose</th>
<th>Goal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening</strong></td>
<td>Identify students who might benefit from services/supports</td>
<td>At least once annually and up to two time points during the school year</td>
</tr>
<tr>
<td><strong>Initial Assessment</strong></td>
<td>Identify nature and severity of presenting concerns, triage students to Tiers II or III, plan for appropriate treatment/intervention</td>
<td>Upon referral to behavioral health services</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td>Determine whether a student meets criteria for DSM-5 diagnosis and/or disability code</td>
<td>When a threshold diagnosis is suspected</td>
</tr>
<tr>
<td><strong>Progress Monitoring</strong></td>
<td>Track student functioning over time to determine progress in treatment</td>
<td>Approximately every 1-2 weeks or each session</td>
</tr>
<tr>
<td><strong>Outcomes Measurement/Program Evaluation</strong></td>
<td>Determine whether students individually, by agency, or entire Network are achieving behavioral health outcomes; one can aggregate data from all of the above assessment purposes depending on outcome monitoring goals</td>
<td>Approximately every 3-6 months</td>
</tr>
</tbody>
</table>

CSMH, 2016
Common Concerns to Universal Screening

- Consent and Assent
- Family buy-in
- Confidentiality
- State and Federal Regulations
- Insufficient data and assessment systems
- Lack of resources to support identified need
- Over-identification (false positives)
- Liability
- Cost
- Low agreement between student, teacher, and parent ratings

http://flpbs.fmhi.usf.edu/pdfs/October%202014%20Universal%20Screening.pdf
State of the Field:
What the Research Literature Tells Us

• Literature Review of 35+ articles
  – Universal screening is occurring across the country, in all grade levels
  – Many high quality universal screening tools have been developed and tested.
  – Teacher nomination vs. Screening tools: equally correlated with outcomes, but screening tools may be more sensitive
  – Most studies report on 1 time point of screening
  – Most studies conducted screening at a grade level
State of the Field:  
What the Research Literature Doesn’t Tell Us

• **Publication Bias**
  – Only studies with “good” outcomes get published
  – The trials and tribulations of how they made it happen are not often documented (brief methods/procedures)
  – Investigator-initiated research does not often generalize local system-level practice (e.g., grant funding resources for the “study”)
Behavioral Health Screening: Questions to Consider

Where do we start?
Which students should we screen?
How do we choose our screening tools?
What about consent?
What about staff readiness?
What will the parents say?
How are we going to pay for this?
School Health Services National Quality Initiative

Accountability • Excellence • Sustainability

an initiative of the School-Based Health Alliance and the Center for School Mental Health
Elements of School Mental Health Quality

- Teaming
- Needs Assessment / Resource Mapping
- Screening
- Evidence-Based Services and Supports
- Evidence-Based Implementation
- Data-Driven Decision Making
School Mental Health Collaborative for Improvement and Innovation Network (CoILN)
Comprehensive School Mental Health
National Performance Measure Domains

QUALITY

- Teaming
- Needs Assessment/Resource Mapping
- Screening
- Evidence-Based Services and Supports
- Evidence-Based Implementation
- School Outcomes and Data Systems
- Data-Driven Decision Making

SUSTAINABILITY

- Funding and Resources
- Resource Utilization
- System Quality
- Documentation and Reporting of Impact
- System Marketing and Promotion

These domains were developed by the Center for School Mental Health as part of the National Quality Initiative (NQI). Learn more at TheSHAPESystem.com.
The SHAPE System

https://theshapesystem.com

School Health Assessment and Performance Evaluation System

Join Us!

When you click Join Now and answer a few questions, your school mental health system will be counted in the National School Mental Health Census and will receive a Blue Star SHAPE Recognition.

Also, we will use your name and e-mail address to update you on SHAPE System news and resources. Anyone (district/school leader, educator, health/mental health provider, parent, student, etc.) from a school system can join us!

Schools and school districts can use SHAPE to:
- Be counted in the National School Mental Health Census
- Achieve SHAPE recognition to increase opportunities for federal, state, and local grant funding
- Access free, targeted resources to help advance your school mental health quality and sustainability
- Advance a data-driven mental health team process for your school or district

Free Custom Reports  Strategic Team Planning  Be Counted  Free Resources

Center for School Mental Health
Screening Action Steps

• Build a Foundation
• Clarify Goals
• Identify Resources and Logistics
• Select an Appropriate Screening Tool
• Determine Consent and Assent Processes
• Develop Data Collection, Administration and
• Follow Up Processes
Start Small
Build a Foundation

• Assemble a Team
  • Youth
  • Family
  • School
  • Community
Build a Foundation

• Generate Buy-In and Support
  • Strategize how your goals fit with other initiatives or goals in your school/district
  • Think about how to market to key decision makers
  • Consider how students are currently being identified for MH services and the implications for service provision
Build a Foundation

• Utilize data to justify universal mental health screening, for example:
  • *Students who scored in the moderate to severe range for depression are absent 47% more often than the average.*
  • *GPA was consistently lower for students who scored in the moderate to severe range on two different mental health screeners.*

(Crocker & Bozek, 2017)
Clarify Goals

• Identify the purpose of universal screening and desired outcomes.
Identify Resources and Logistics

- Identify Student Mental Health Support Resources
- Create a Timeline
- Identify Staffing and Budget Resources
- Develop Administration Policies
Identify Resources and Logistics

Key considerations for administration:

- Materials to share screening process with staff, caregivers, students, and community members
- Consent procedures
- Data collection process
  - when/how/where will the screening take place
  - who will administer
  - what supports need to be in place to collect data
- Follow up process for all students
- Administration timeline and checklist
Select an Appropriate Screening Tool

- Is it reliable, valid, and evidence based?
- Is it free or can it be purchased for a reasonable cost?
- How long does it take to administer?
- Does it come with ready access to training and technical support for staff?
- Does it screen for WHAT we want to know? (e.g., type of mental health risk, positive mental health and well-being, age range?)
Options for Screening

- Office disciplinary referrals (ODRs)
- Teacher/Peer nominations
- Informal/”Homegrown” screening measures
- Formal, validated screening measures

Adapted from Mississippi Department of Education
Office Disciplinary Referrals

• Will detect some students with externalizing behaviors
• Varies based on:
  • Efficacy of the school’s referral process
  • “Behavioral tolerance” of teachers or school context (i.e., who gets sent to the office, why, and when, in different classrooms, different schools, different school years)
  • Disciplinary procedures/ initiatives
• Will not typically “catch” students with internalizing symptoms such as depression or anxiety

Adapted from Mississippi Department of Education
Teacher Peer Nominations

• Teachers review examples and non-examples of externalizing and internalizing behaviors.
• Teachers will nominate 3 students in their classroom who exhibit the most behaviors in each category.
• Example form:
  [http://flpbs.fmhi.usf.edu/tier2/Teacher%20Nomination%20Form.pdf](http://flpbs.fmhi.usf.edu/tier2/Teacher%20Nomination%20Form.pdf)
## Teacher Nomination Form

<table>
<thead>
<tr>
<th>Examples of externalizing types of behavior</th>
<th>Examples of internalizing types of behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Displaying aggression towards objects or persons</td>
<td>Low or restricted activity levels</td>
</tr>
<tr>
<td>Arguing or defying the teacher</td>
<td>Avoidance of speaking with others</td>
</tr>
<tr>
<td>Forcing the submission of others</td>
<td>Shy, timid, and/or unassertive behaviors</td>
</tr>
<tr>
<td>Out of seat behavior</td>
<td>Avoidance or withdrawal from social situations</td>
</tr>
<tr>
<td>Non-compliance with teacher instructions or requests</td>
<td>A preference to play or spend time alone</td>
</tr>
<tr>
<td>Tantrums</td>
<td>Acting in a fearful manner</td>
</tr>
<tr>
<td>Hyperactive Behavior</td>
<td>Avoiding participation in games and activities</td>
</tr>
<tr>
<td>Disturbing Others</td>
<td>Unresponsive to social interactions by others</td>
</tr>
<tr>
<td>Stealing</td>
<td>Failure to stand up for oneself</td>
</tr>
<tr>
<td>Not Following Teacher or School Rules</td>
<td></td>
</tr>
</tbody>
</table>

### Non-examples of externalizing types of behavior

<table>
<thead>
<tr>
<th>Non-examples of externalizing types of behavior</th>
<th>Non-examples of internalizing types of behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooperating</td>
<td>Initiation of social interactions with peers</td>
</tr>
<tr>
<td>Sharing</td>
<td>Engagement in conversations with peers</td>
</tr>
<tr>
<td>Working on assigned tasks</td>
<td>Normal rates or level of social contact with peers</td>
</tr>
<tr>
<td>Asking for help</td>
<td>Displaying positive social behaviors toward others</td>
</tr>
<tr>
<td>Listening to teacher</td>
<td>Participating in games and activities</td>
</tr>
<tr>
<td>Interacting in appropriate manner with peers</td>
<td>Resolving peer conflicts in an appropriate manner</td>
</tr>
<tr>
<td>Following directions</td>
<td>Joining in with others</td>
</tr>
<tr>
<td>Attending to task demands</td>
<td></td>
</tr>
<tr>
<td>Complying with teacher requests</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Mississippi Department of Education
## Teacher Nomination Form

### Student Nomination

<table>
<thead>
<tr>
<th>Externalizing Students</th>
<th>Internalizing Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
<td>5.</td>
</tr>
</tbody>
</table>

**Adapted from Mississippi Department of Education**
“Homegrown” Teacher Rating Scale

- Schools may choose to develop their own teacher rating scale to use for the Universal Screening process

Adapted from Mississippi Department of Education
# Social/Emotional Universal Screener

**Student:**

**School:**

**Date Completed:**

**Grade:**

**Period/Block:**

**Completed by:**

**Position:**

---

**Directions:** Rate each behavior exhibited by the student on a scale from 1 to 5, with "1" indicating a minor problem and "5" indicating a serious problem. Place a check in the appropriate block. If the student does not exhibit the behavior, do not check any block and proceed to the next item.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overly active</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talks out of turn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Disturbs others when they are working</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Constantly seeks attention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Impulsive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Acts without thinking of the consequences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Lacks self confidence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Says &quot;can't do&quot; without attempting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Is overly sensitive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Clings with adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Shy, timid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Educator Input Record

### Behavior Metrics

| Metric                           | Dexter Arnold | Riley Allison | Chauncey Armstrong | Tony Beck | Kyle Bird | Moso Bommer | Maia Caster | Yvonne Cotton | Vincent Cotton | Roberta Davis | Samantha Davis | Samson hyde | Trevis Logan | Ginger Maxwell | Holden McCall | LeAnn Mcmurry | Monica Monroe | Kevin McDonald | Ashleigh Olson | Ferris Park | Elton Richard | Brandon Rizzo | Darra Rizzo | Brijanna Sharpe | Daryn Stein | Dakota Steven | Yveta Whites |
|----------------------------------|---------------|---------------|--------------------|----------|----------|-------------|-------------|---------------|---------------|---------------|---------------|-------------|-------------|-------------|---------------|---------------|---------------|-------------|---------------|--------------|-------------|---------------|-------------|-------------|--------------|-------------|
| Poor organizational skills      |               |               |                    |          |          |             |             |               |               |               |               |             |             |             |               |               |              |               |               |             |               |             |             |              |             |             |
| Poor academic performance       |               |               |                    |          |          |             |             |               |               |               |               |             |             |             |               |               |              |               |               |             |               |             |             |              |             |             |
| Easily distracted               |               |               |                    |          |          |             |             |               |               |               |               |             |             |             |               |               |              |               |               |             |               |             |             |              |             |             |
| Does not complete assignments   |               |               |                    |          |          |             |             |               |               |               |               |             |             |             |               |               |              |               |               |             |               |             |             |              |             |             |
| Is disliked by peers            |               |               |                    |          |          |             |             |               |               |               |               |             |             |             |               |               |              |               |               |             |               |             |             |              |             |             |
| Is left out of activities by peers |         |               |                    |          |          |             |             |               |               |               |               |             |             |             |               |               |              |               |               |             |               |             |             |              |             |             |
| Has no close friends            |               |               |                    |          |          |             |             |               |               |               |               |             |             |             |               |               |              |               |               |             |               |             |             |              |             |             |
| Does not work well with others  |               |               |                    |          |          |             |             |               |               |               |               |             |             |             |               |               |              |               |               |             |               |             |             |              |             |             |
| Has poor social skills          |               |               |                    |          |          |             |             |               |               |               |               |             |             |             |               |               |              |               |               |             |               |             |             |              |             |             |
| Is bossy                        |               |               |                    |          |          |             |             |               |               |               |               |             |             |             |               |               |              |               |               |             |               |             |             |              |             |             |
| Trouble expressing feelings appropriately |         |               |                    |          |          |             |             |               |               |               |               |             |             |             |               |               |              |               |               |             |               |             |             |              |             |             |
### Formal, Validated Screening Measures

<table>
<thead>
<tr>
<th>Screener</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001)</td>
<td>• Measures internalizing/externalizing behaviors</td>
<td>• Perceived length of administration time</td>
</tr>
<tr>
<td></td>
<td>• Free measure</td>
<td>• Items skewed toward externalizing behaviors</td>
</tr>
<tr>
<td></td>
<td>• Option of completing pencil and paper, or online version</td>
<td>• Cost for scoring measure</td>
</tr>
<tr>
<td></td>
<td>• Can be scored online</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Technically sound: Large, representative normative group</td>
<td></td>
</tr>
<tr>
<td>Student Risk Screening Scale (SRSS; Drummond, 1994)</td>
<td>• Measures internalizing/externalizing behaviors</td>
<td>• Not as accurate regarding identification of internalizers</td>
</tr>
<tr>
<td></td>
<td>• Free</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Quick to administer (less than 5 minutes per student; 15 minutes for entire class, depending upon number of students)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Easy to understand and interpret score results</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Technically-adequate</td>
<td></td>
</tr>
<tr>
<td>Behavioral Assessment System for Children (BASC-3)</td>
<td>• Measures behaviors associated with internalizing and externalizing problem behaviors and academic competence</td>
<td>• Can be expensive for districts/schools that don’t have access to a scantron machine</td>
</tr>
<tr>
<td>Behavioral and Emotional Screening System (BESS) (Kamphaus &amp; Reynolds, 2015)</td>
<td>• Meets AERA/APA instrument selection criteria</td>
<td>• Online access has a cost per student via AIMSwed: <strong>Additional $1.00 per student</strong></td>
</tr>
<tr>
<td></td>
<td>• Incorporates three validity measures to rule out response bias</td>
<td>• Hand-scoring is time-consuming and reduces</td>
</tr>
<tr>
<td></td>
<td>• Utilizes large (N= 12,350 children &amp; youth), nationally-representative sample</td>
<td>• Computer software is expensive</td>
</tr>
<tr>
<td></td>
<td>• Web-based screening capacity available</td>
<td></td>
</tr>
</tbody>
</table>
Example of how to use Strengths Based Screening Results in Schools

<table>
<thead>
<tr>
<th>Instrument Name</th>
<th>Purpose</th>
<th>Focus Area</th>
<th>Reporter for (Student Age)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism Treatment Evaluation Checklist (ATEC)</td>
<td>Screening/Initial Evaluation</td>
<td>Autism</td>
<td>Caregiver (2+) Educator (2+)</td>
</tr>
<tr>
<td></td>
<td>Progress Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief Problem Checklist (BPC)</td>
<td>Screening/Initial Evaluation</td>
<td>Anxiety Depression</td>
<td>Student (7-18) Caregiver (7-18)</td>
</tr>
<tr>
<td></td>
<td>Progress Monitoring</td>
<td>Disruptive Behavior</td>
<td></td>
</tr>
<tr>
<td>CAGE</td>
<td>Screening/Initial Evaluation</td>
<td>Substance Use</td>
<td>Student (18+) Clinician (18+)</td>
</tr>
<tr>
<td></td>
<td>Progress Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Center for Epidemiological Studies Depression Scale</td>
<td>Screening/Initial Evaluation</td>
<td>Depression/Mood</td>
<td>Student (0-23)</td>
</tr>
<tr>
<td>for Children (CES-DC)</td>
<td>Progress Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Mania Rating Scale, Parent (CMRS-P)</td>
<td>Screening/Initial Evaluation</td>
<td>Depression/Mood</td>
<td>Caregiver (5-17) Educator (5-17)</td>
</tr>
<tr>
<td></td>
<td>Progress Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conditions for Learning (CFL)</td>
<td>Screening/Initial Evaluation</td>
<td>Academic</td>
<td>Student (grade 2-12)</td>
</tr>
<tr>
<td></td>
<td>Progress Monitoring</td>
<td>School Climate</td>
<td></td>
</tr>
<tr>
<td>CRAFFT 2.0</td>
<td>Screening/Initial Evaluation</td>
<td>Substance Use</td>
<td>Student (12-18) Clinician (12-18)</td>
</tr>
<tr>
<td></td>
<td>Progress Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delaware School Climate Survey</td>
<td>Screening/Initial Evaluation</td>
<td>Academic</td>
<td>Student (grade 3-12)</td>
</tr>
<tr>
<td></td>
<td>Progress Monitoring</td>
<td>School Climate</td>
<td>Caregiver (grade K-12)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global Functioning</td>
<td>Educator (grade K-12)</td>
</tr>
<tr>
<td>Eating Attitudes Test (EAT-26)</td>
<td>Screening/Initial Evaluation</td>
<td>Eating</td>
<td>Student (8-18) Clinician (18-18)</td>
</tr>
<tr>
<td></td>
<td>Progress Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED School Climate Survey (EDSCLS)</td>
<td>Screening/Initial Evaluation</td>
<td>Academic</td>
<td>Student (grade 5-12)</td>
</tr>
<tr>
<td></td>
<td>Progress Monitoring</td>
<td>School Climate</td>
<td>Caregiver (grade 5-12)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global Functioning</td>
<td>Educator (grade 5-12)</td>
</tr>
<tr>
<td>Fox's Child PTSD Symptom</td>
<td>Screening/Initial Evaluation</td>
<td>Trauma</td>
<td>Student (8-18)</td>
</tr>
</tbody>
</table>
**Child Mania Rating Scale, Parent (CMRS-P)**

Developers: M. Pavuluri, D. Henry, B. Devineni, J. Carbray, & B. Birmaher

**Overview**

The Child Mania Rating Scale, Parent (CMRS-P) assesses symptoms that reflect the characteristics of a manic episode according to DSM-IV criteria, including symptoms consistent with criterion A (levels of elation/irritability), B (levels of self-esteem/grandiosity), and C (impairment in functioning). An educator/teacher-rated (CMRS-T) assessment and a brief version (10 items; Brief CMRS-P) are also available. Items for the measures were developed specifically for youth and adolescents rather than through adaptation of an existing adult-oriented rating scale.

**Focus Area**

Depression/Mood

**Purpose**

Screening/Initial Evaluation

Progress Monitoring

**Reporter**

Caregiver

Educator

**Versions**

Brief CMRS-P, Caregiver, 10 items (for ages 5-17)

CMRS-P, Caregiver, 21 items (for ages 5-17)

CMRS-T, Educator, 21 items (for ages 5-17)

**Subscales**

N/A

**Sample Items**

- Does your child feel irritable, cranky, or mad for hours or days at a time?
- Does your child have periods of too much energy?
- Does your child experience rapid mood swings?

**Response Options**

Never/rarely

Sometimes

Often

Very often

**Estimated Completion Time**

Less than ten minutes (Brief CMRS-P)

Ten to fifteen minutes (CMRS-P/CMRS-T)

**Languages**

English

**Cost**

Free

Access the measures:

CMRS-P  Brief CMRS-P  CMRS-T (not available)

*Summary compiled by CSMH (2017) for The SHAPE System ([www.theSHAPEsystem.com](http://www.theSHAPEsystem.com))*
### Scoring

<table>
<thead>
<tr>
<th>Possible range</th>
<th>CMRS-P; CMRS-T</th>
<th>Brief CMRS-P</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-63</td>
<td>0-30</td>
<td></td>
</tr>
</tbody>
</table>

#### Item scores
- Never (0) to Very often (3)

#### Administration, & scoring rules
- To use the CMRS for screening:
  - Rate symptoms causing impairment over the past month
  - Each item is considered to be a problem only if it is causing trouble, is beyond what is normal for the child’s age, and has been troublesome during the indicated time frame
  - Sum all items on the CMRS-P or CMRS-T to get a total severity score

- To use the CMRS for progress monitoring:
  - Rate symptoms causing impairment over the past week
  - Sum all items to get a total severity school
  - Ratings can be completed as frequently as every week.

- To use the BRIEF CMRS-P for screening and progress monitoring:
  - Follow above administration/rating procedures
  - Sum all items to calculate the Brief total severity score

#### CMRS-P/CMRS-T:
- **Screening:** scores 20 or greater suggest significant symptoms of mania
- **Progress monitoring:** scores below 20 suggest symptom remission
- On the CMRS-P, the cutoff score provides adequate differentiation of youth with childhood Bipolar Disorder from healthy youth and those with ADHD, whose symptoms of hyperactivity, impulsivity, and distractibility often overlap.
- Research has shown poor discrimination between Bipolar Disorder, ADHD, and healthy children on the CMRS-T, though.
- Although, the CMRS-T shows three factors, there are no cut-off levels available for interpretation:
  - Items 5, 11, 16 are associated with a high energy factor
  - Items 2, 12, 15, 17 are associated with an irritable disinhibition factor
  - Items 1, 18-20 are associated with a manic psychosis factor

#### Interpretation
- **Brief CMRS-P:**
  - **Screening:** scores greater than 10 suggest significant symptoms of mania
  - For progress monitoring, scores falling below this cutoff may suggest remission of symptoms
  - The accuracy of the brief version is similar to the full version

---

*Access to Spanish versions of the CMRS-P: CMRS-P (Spanish) Brief CMRS-P (Spanish)*

*Summary compiled by CSMH (2017) for The SHAPE System (www.theSHAPESystem.com)*
Determine Consent and Assent Procedures

• Passive Consent and Opt-Out Procedures
• Deliver a Consistent Message
• Share Information in Multiple Formats
  • Automated phone call to all families
  • Information on the school website
  • Written notification sent in the mail
  • Signs posted in the school building
  • Script read to students prior to administration
Don’t Forget – Start Small
Develop Data Collection Processes

• Electronic Format
  • Allows students to complete online
  • Facilitates prompt analysis of results and follow up
Develop Administration Procedures

• Who to screen
  • Pilot with a small group of students
  • Collect feedback from students, families and staff to inform modifications

• When to screen
  • Consider advisory or home room time

• Staff to support screening
  • Who will administer the screening
  • Provide information scripts for staff to read including potential troubleshooting tips
Develop Student Follow Up Procedures

• Data rules for levels of follow up
  • High risk – same day
  • Moderate risk – within a week
  • Low risk – follow up process to indicate negative screening result

• Determine interventions that will be implemented for students at different levels of risk

• Process for prompt receipt and analysis of data

• Processes to follow up with caregivers and school staff

* Ensure any students endorsing risk of harm to self or others receive immediate follow up (same day)

Alert crisis teams and local community mental health providers to be on call in advance of screenings
How to Address Barriers
Addressing Barriers

We don’t have the capacity to meet student need.

- If we screen all students for mental health concerns we won’t be able to provide follow up for all students identified.
  - Set up data rules in advance to triage students to different levels of intervention.
  - Do a thorough review of existing resources and capacity both within the school and community.
  - Start small- test how many students in one class require different levels of follow up.
Members of our school community have voiced concerns about mental health screening

- We can’t even bring up the idea of screening for mental health concerns without push back from different groups within our school community.
  - Involve multiple stakeholders, including caregivers and community members, as part of your planning committee
  - Use existing community and parent forums to gather input about screening
  - Consider screening for strengths and resilience as a starting point
  - Pilot screening processes with a small group of students and adapt procedures prior to larger administrations
Addressing Barriers

How will we get parent permission?

• We don’t have the resources to get consent from all parents.
  ✓ Use passive consent and opt-out procedures
  ✓ Share a consistent message in multiple formats
  ✓ Start small- use the passive consent procedure with a small group of students, get feedback from caregivers and students about the process
Addressing Barriers

What will we screen for?

• We would like to conduct a universal mental health screening, but how do we identify what measure to use?
  ✓ Use the SHAPE System free Screening and Assessment Library to get started
    • It allows you to search by age, focus area, administration time and other key features
  ✓ Think about different focus area options including mental health risk and/or resilience
  ✓ Pilot top choices with a few students to refine your process and select the final measure
  ✓ You may also consider using different measures with different student populations
Addressing Barriers

Is the education system responsible for covering the cost of mental health treatment?

• If we identify students at risk for mental health concerns, is the school system responsible for covering the cost of mental health treatment?
  ✓ Partner with a local community mental health agency to conduct the screening and to identify and refer to services when appropriate
  ✓ Consider the role of the school in health prevention, including vision and hearing screening
Examples from the Field
Starting small and scaling up

A school district wanted to get started with mental health screening but they didn’t have prior experience with this work in their district.

Starting Small
- Administered the Patient Health Questionnaire-9 (PHQ-9) to one high school student
  - Active consent
  - Paper administration

Scaling Up
- Administered the Generalized Anxiety Disorder-7 (GAD-7) to grade 9 students in one high school
  - Process for passive consent and opt-out procedure
  - Transcribed screener to Google form
  - Script for administration
  - Follow up procedures
Making Mental Health Screening a Sustainable Practice

Electronic screening using Google forms

Efficient

Allows for easy data analysis

Movement from screening to coordinated follow-up in 20 minutes

Parent notification and opt-out process established in advance of the screenings to secure passive consent

Administration during the school’s advisory block and/or classroom-based (grammar schools)
Passive Consent Message

A consistent message is delivered regarding mental health screening in advance of and immediately prior to all screenings.

“In an effort to promote the health and well-being of students in Methuen Public Schools, students will be periodically provided with questionnaires, surveys, and screeners that address issues related to mental health. The information gained will support the school’s ability to provide comprehensive and timely support for your son or daughter if they require any assistance. Students can opt-out of filling out any questionnaire, survey, or screener that they are not interested in taking and you can opt-out your son or daughter at any time by contacting the Guidance Office of your son’s/daughter’s school or filling out the opt-out form here. A list of the questionnaires, surveys, and screeners is available below for you to review.

We are committed to ensuring your son or daughter is supported academically, socially, and emotionally, and we look forward to partnering with each of you toward achieving this goal.”

The message above (or a slightly adapted version) is:
- Posted on the district’s website
- Delivered immediately prior to screenings
- Sent directly to parents/guardians in advance of screenings via an automated calling system
2016-2017: Screening by Area of Concern

<table>
<thead>
<tr>
<th>Grade</th>
<th>Anxiety</th>
<th>Depression</th>
<th>Substance Use</th>
<th>Global Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>Red</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td>Yellow</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Blue</td>
<td>Green</td>
<td>Yellow</td>
<td>Red</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td>Red</td>
</tr>
</tbody>
</table>
### Screening for Depression - PHQ-9 (Nov. 2016)

<table>
<thead>
<tr>
<th>PHQ-9 (Nov. 2016)</th>
<th>Student Population</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td>1135</td>
<td>100.00%</td>
</tr>
<tr>
<td>No Concern</td>
<td>706</td>
<td>62.20%</td>
</tr>
<tr>
<td>Mild</td>
<td>247</td>
<td>21.76%</td>
</tr>
<tr>
<td>Low-Moderate</td>
<td>91</td>
<td>8.02%</td>
</tr>
<tr>
<td>High-Moderate</td>
<td>60</td>
<td>5.29%</td>
</tr>
<tr>
<td>Severe</td>
<td>31</td>
<td>2.73%</td>
</tr>
</tbody>
</table>

Approximately 16% of students reported moderate to severe symptoms of depression.
### Screening for Anxiety - GAD-7 (Jan. 2017)

<table>
<thead>
<tr>
<th>GAD-7 (Jan. 2017)</th>
<th>Student Population</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td>943</td>
<td>100.00%</td>
</tr>
<tr>
<td>No Concern</td>
<td>575</td>
<td>60.98%</td>
</tr>
<tr>
<td>Mild Anxiety</td>
<td>193</td>
<td>20.47%</td>
</tr>
<tr>
<td>Moderate Anxiety</td>
<td>107</td>
<td>11.35%</td>
</tr>
<tr>
<td>Severe Anxiety</td>
<td>68</td>
<td>7.21%</td>
</tr>
</tbody>
</table>

Approximately 18.5% of students reported moderate to severe symptoms of anxiety.
Students whose scores on the SDQ were in the Very High and High range had a GPA that was, on average, 13 percent lower than all other students.

Students were also absent 45 percent more often if they scored in the Very High or High range on the SDQ.
<table>
<thead>
<tr>
<th>RCADS</th>
<th>Student Population</th>
<th>%</th>
<th>Total Elevated Scores (At-Risk + Clinical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sample</td>
<td>2125</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>Grade 5</td>
<td>474</td>
<td>22.31%</td>
<td></td>
</tr>
<tr>
<td>No Concern</td>
<td>407</td>
<td>85.86%</td>
<td></td>
</tr>
<tr>
<td>At-Risk</td>
<td>21</td>
<td>4.43%</td>
<td>14.14%</td>
</tr>
<tr>
<td>Clinical Concern</td>
<td>46</td>
<td>9.70%</td>
<td></td>
</tr>
<tr>
<td>Grade 6</td>
<td>521</td>
<td>24.52%</td>
<td></td>
</tr>
<tr>
<td>No Concern</td>
<td>453</td>
<td>86.95%</td>
<td></td>
</tr>
<tr>
<td>At-Risk</td>
<td>23</td>
<td>4.41%</td>
<td>13.05%</td>
</tr>
<tr>
<td>Clinical Concern</td>
<td>45</td>
<td>8.64%</td>
<td></td>
</tr>
<tr>
<td>Grade 7</td>
<td>571</td>
<td>26.87%</td>
<td></td>
</tr>
<tr>
<td>No Concern</td>
<td>505</td>
<td>88.44%</td>
<td></td>
</tr>
<tr>
<td>At-Risk</td>
<td>19</td>
<td>3.33%</td>
<td>11.56%</td>
</tr>
<tr>
<td>Clinical Concern</td>
<td>47</td>
<td>8.23%</td>
<td></td>
</tr>
<tr>
<td>Grade 8</td>
<td>559</td>
<td>26.31%</td>
<td></td>
</tr>
<tr>
<td>No Concern</td>
<td>483</td>
<td>86.40%</td>
<td></td>
</tr>
<tr>
<td>At-Risk</td>
<td>27</td>
<td>4.83%</td>
<td>13.60%</td>
</tr>
<tr>
<td>Clinical Concern</td>
<td>49</td>
<td>8.77%</td>
<td></td>
</tr>
</tbody>
</table>

Grades 5-8 AVG = 13.04%
Post-Screening: Coordinated Follow-up

Data review and coordinated follow-up planned for all screenings

Mental health staff receive the data within twenty minutes of the completed screening, allowing for immediate follow-up to be conducted with students who had elevated scores

100% of students who required follow-up received it within 7 days of the screening (within 24 hours for any students who indicated any degree of suicidal ideation or desire self-harm)

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

Mental health staff can then make an informed decision about whether or not to offer services: in-school group or individual therapy, outside referral, etc.
- Individual student run charts are used for students receiving Tier III services.
- Use of psychosocial, academic, and behavioral data is encouraged to improve our understanding of the impact of mental health services on academic outcomes.
- This method of data collection represents a shift away from a reliance on strictly qualitative measures of the effectiveness of mental health services and supports.
Testing our procedures and refining for maximum impact

A community mental health provider was already administering a social emotional screener in the schools in which they provide services but they wanted to better understand how consistently screening occurred across schools and how to best share screening results back with school teams.

Innovation

• Review current use across a subsample of sites
• Develop and test new supporting documents and tools
• Pilot different staff to administer screener (care coordinator vs. clinician)
Register to Improve Your School Mental Health System

Free Custom Reports  Strategic Team Planning  Free Resources  Be Counted
Welcome!

Thank you for expressing an interest in registering your school or district comprehensive school mental health system (CSMHS) with SHAPE System! SHAPE is a free, secure, web-based platform designed just for school mental health systems.

A Comprehensive School Mental Health System (CSMHS) is defined as a school/district/community/family partnership that provides a multi-tiered continuum of evidence-based mental health services to support students, families, and the school community. Your system includes any group of individuals working together to support the social, emotional, and behavioral wellbeing of students, their families, and schools.

To register, you must complete the School Mental Health Profile with your team. This establishes an account for your school mental health team, allowing you to:
- Be “counted” in the National School Mental Health Census
- Self-assess your school mental health resources, staffing, and service array
- Self-assess your quality and sustainability performance
- View and print free customized reports
- Obtain free school mental health tools and resources
- Invite individual team members at your school join your account
- Achieve SHAPE recognition to increase opportunities for federal, state, and local grant funding

How do I get started?

Select your state, district, and school (if applicable) to ADD YOUR SCHOOL OR DISTRICT to the SHAPE System. This will establish your account, from which you can invite other team members to help you complete the School Mental Health Profile. You may register your CSMHS at the district or school level. Learn more about how to complete your School Mental Health Profile collaboratively with your school or district team.

- I am registering a school district
- I am registering a school

State: Select a state
District: Select a district

Register District
YUPIIT SCHOOL DISTRICT
School Behavioral Health System

Thanks for completing the District Mental Health Profile! To produce customized reports for your district to assist in improving your mental health program, please complete the Quality and Sustainability assessments below.

Quality
Last Updated: April 22, 2016

Sustainability
Assessment Needed
Complete Assessment

Quality Progress Report and Resources

April 22, 2016 - Jane Doe

Filter:

All
Training
Resource Mapping
Screening
Services & Supports
Implementation
Outcomes & Data
Decision Making

Quality Guide: Teaming
Quality Guide: Screening
Quality Guide: Evidence-Based Services and Supports
Quality Guide: Evidence-Based Implementation
Quality Guide: Student Outcomes and Data Systems
Quality Guide: Data Driven Decision Making

211.org
Understanding this Summary.

This report is generated based on the information you provided for the quality survey. The composite score for each domain is the average of your ratings for every item within the domain.

Composite scores of 1.0-2.9 are classified as "Emerging" areas, 3.0-4.9 are classified as "Progressing" areas, and 5.0-6.0 are classified as areas of "Mastery."

QUALITY DOMAINS

MASTERY
Composite Score
5.20
Teaming

PROGRESSING
Composite Score
4.00
Needs Assessment/Resource Mapping
Evidence-Based Implementation

EMERGING
Composite Score
2.90
Data Driven Decision Making
Evidence-Based Services and Supports

OTHER PERFORMANCE DOMAINS

Overall Score
83%
Students Screened
18%
Received School Mental Health Services
**Overall Composite Score: 2.80**

- **Use data to determine interventions:** 2
- **Monitor individual student progress:** 4
- **Aggregate student mental health data:** 2
- **Disaggregate student mental health data:** 3
- **Monitor fidelity of intervention implementation:** 3

**About Data Driven Decision Making**

Data driven decision making (DDDM) is the process of using observations and other relevant data/information to make decisions that are fair and objective. Examples of data include mental health screening, climate surveys, attendance, discipline referrals, and classroom observational data. Your CSMHS team's DDDM self-assessment score comprises your ratings on five indicators: (1) using data to determine mental health interventions needed by students; (2) using a system for monitoring individual student progress; (3) monitoring fidelity of intervention implementation across tiers; (4) using a system for aggregating student mental health service and support data; and (5) using a system for disaggregating student mental health service data. Primary action steps to advance your CSMHS's performance in the area of DDDM include evaluating your current DDDM process and data sources to ensure you are maximizing opportunities to use data to identify, monitor, and evaluate target concerns at the student, classroom, and/or school levels. For more in-depth guidance and specific strategies to advance your CSMHS DDDM processes, please refer to the...

[Resource Library > Quality Progress Report and Resources > Quality Guide: Data Driven Decision Making]
School Health Assessment and Performance Evaluation System

Join Us!

When you click Join Now and answer a few questions, your school mental health system will be counted in the National School Mental Health Census and will receive a Blue Star SHAPE Recognition.

Also, we will use your name and e-mail address to update you on SHAPE System news and resources. Anyone (district/school leader, educator, health/mental health provider, parent, student, etc.) from a school system can join us!

Join Now

Schools and school districts can use SHAPE to:
- Be counted in the National School Mental Health Census
- Achieve SHAPE recognition to increase opportunities for federal, state, and local grant funding
- Access free, targeted resources to help advance your school mental health quality and sustainability
- Advance a data-driven mental health team process for your school or district

Register to Improve Your School Mental Health System

Free Custom Reports  Strategic Team Planning  Free Resources  Be Counted
Schools and School Districts Can Use SHAPE To:

- Document your service array and multi-tiered services and supports

www.theshapesystem.com
Schools and School Districts Can Use SHAPE To:

Advance a data-driven mental health team process for the school or district

– Strategic Team Planning
– Free Custom Reports

www.theshapesystem.com
Schools and School Districts Can Use SHAPE To:

Access targeted resources to help advance your school mental health quality and sustainability.
<table>
<thead>
<tr>
<th>Instrument Name</th>
<th>Purpose</th>
<th>Focus Area</th>
<th>Reporter for (Student Age)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism Treatment Evaluation Checklist (ATEC)</td>
<td>Screening/Initial Evaluation</td>
<td>Autism</td>
<td>Caregiver (2+) Educator (2+)</td>
</tr>
<tr>
<td>Brief Problem Checklist (SPC)</td>
<td>Screening/Initial Evaluation</td>
<td>Anxiety, Depression, Disruptive Behavior</td>
<td>Student (7-18) Caregiver (7-18)</td>
</tr>
<tr>
<td>CAGE</td>
<td>Screening/Initial Evaluation</td>
<td>Substance Use</td>
<td>Student (18+) Clinician (16+)</td>
</tr>
<tr>
<td>Center for Epidemiological Studies Depression Scale for Children (CES-DC)</td>
<td>Screening/Initial Evaluation</td>
<td>Depression/Mood</td>
<td>Student (5-23)</td>
</tr>
<tr>
<td>Child Mania Rating Scale, Parent (CMRS-P)</td>
<td>Screening/Initial Evaluation</td>
<td>Depression/Mood</td>
<td>Caregiver (5-17) Educatior (5-17)</td>
</tr>
<tr>
<td>Conditions for Learning (CFL)</td>
<td>Screening/Initial Evaluation</td>
<td>Academic School Climate</td>
<td>Student (grade 2-12)</td>
</tr>
<tr>
<td>CRAFFT 2.0</td>
<td>Screening/Initial Evaluation</td>
<td>Substance Use</td>
<td>Student (12-18) Clinician (12-18)</td>
</tr>
<tr>
<td>Delaware School Climate Survey</td>
<td>Screening/Initial Evaluation</td>
<td>Academic School Climate</td>
<td>Student (grade 3-12) Caregiver (grade K-12) Educatior (grade K-12)</td>
</tr>
<tr>
<td>Eating Attitudes Test (EAT-28)</td>
<td>Screening/Initial Evaluation</td>
<td>Eating</td>
<td>Student (8-18+) Clinician (16-18)</td>
</tr>
<tr>
<td>ED School Climate Survey (EDSCLS)</td>
<td>Screening/Initial Evaluation</td>
<td>Academic School Climate</td>
<td>Student (grade 5-12) Caregiver (grade 5-12) Educatior (grade 5-12)</td>
</tr>
</tbody>
</table>
**Pediatric Symptom Checklist (PSC)**

**Overview**

The Pediatric Symptom Checklist (PSC) is a screening tool intended to identify a wide range of psychosexual concerns. Full (35 items) and abbreviated (17 items) versions were developed for youth (Y-PSC) and caregiver (PSC) respondents. A version for caregivers is also available in pictorials (PPSC, picture options). Originally utilized in primary care, the PSC’s application has also been expanded to school and community health and behavioral health settings.

**Focus Area**

- Anxiety
- Depression/Mood
- Disruptive Behavior
- Global Functioning
- Hyperactivity
- Inattention

**Purpose**

- Screening/Initial Evaluation
- Progress Monitoring

**Reporter**

- Student
- Caregiver

**Versions**

- Y-PSC, 17 items (for ages 6-18)
- Y-PSC, 35 items (for ages 6-18)
- PSC, Caregiver, 35 items (for ages 3-16)
- PSC, Caregiver, 35 items (for ages 3-16)
- PSC, 17, Caregiver, 17 items (for ages 6-16)

**Subscales**

- Psychological impairment
  - Attentional impairment
  - Externalizing symptom impairment
  - Internalizing symptom impairment

**Sample Items**

- Seem to be having less fun
- Felt ghetto, unable to sit still
- Fight with other children
- Worry a lot

**Response Options**

- Never
- Sometimes
- Often

**Estimated Completion Time**

- Less than five minutes (17 items)
- Five minutes (35 items)

**Languages**

- English
- Spanish
- Other

**Cost**

- Free

---

**Scoring**

<table>
<thead>
<tr>
<th>Pediatric Symptom Checklist (PSC)</th>
<th>PSC-35</th>
<th>PSC-17*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Possible range</strong></td>
<td>0-70</td>
<td>0-34</td>
</tr>
</tbody>
</table>

**Item scores**

- Never (0) to Often (2)

**Administration & scoring rules**

**To use the PSC & PPSC (for ages 6-18)**

- Sum all items to get a total mental health impairment score
- Use the below table to interpret a positive score

**To use the PSC-17 & Y-PSC-17 for screening and progress monitoring:**

- Sum all items to get a total mental health impairment score

**To identify an individual at risk for internalizing symptom impairment**

- Sum items 4, 6, 8, 10, 12, 14, 16 to identify an individual at risk for externalizing symptom impairment
- Use the below table to interpret a positive score

**Positive Impairment Score**

- PSC or PPSC for ages 6-18: 28+ Psychosocial impairment
- PSC or PPSC for ages 3-5: 24+ Attentional impairment
- Y-PSC: 30+ Internalizing impairment
- Y-PSC: 30+ Extroverting impairment

**Handling blank items**

- Items left blank are scored as "0"; if there are more than 4 blank items, the questionnaire is invalid

---

*Although the PSC 17 can be used as a youth self-report, it is important to note that neither the total score nor the individual subscale scores have been validated as of this writing.*

**Click here for additional scoring instructions**

Access all versions (including other languages) of the PSC measure.

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Summary compiled by CSHI (2017) for The SHAPE System (www.theshapesystem.com)
Shared Learning Discussion

• What screening methods or tools are being implemented in your school/district/state?

• In what ways do you hope to improve universal screening this year?
  – Any of these options presented seem viable?
  – How might you test universal screening improvements on a small scale to get started?
Discussion/Questions