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A roadmap to equitable school mental health screening

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ABSTRACT

Youth in the United States are experiencing mental health concerns at alarming rates. Considering the nation's legacy of racism and growing recognition of the impact of social determinants of health on educational and mental health inequities, it is imperative to re-envision how we approach mental health screening in schools to center equity. A focus on mental health screening for the sole purpose of identifying individual at-risk students ignores key contextual considerations, is ineffective in addressing health and educational inequities, and has the potential to perpetuate oppressive practices in schools. Equity-focused mental health screening requires a shift from individual- and deficit-focused approaches to systems- and holistic-focused approaches that (a) identify strengths and stressors among individuals, groups, and communities; (b) dismantle structural forms of oppression; and (c) promote positive mental health outcomes for minoritized youth. Integrating recommendations from the educational equity literature and critical school mental health frameworks, this paper identifies core considerations for equitable school mental health screening and provides guiding principles for each phase of the screening process, from screening readiness to execution to follow up. To implement these recommendations and transform school-based mental health care, schools should (a) incorporate multiple perspectives; (b) prioritize student, family, and community voices; and (c) build collaborative partnerships to co-construct a vision for equitable school mental health.

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Children and adolescents in the U.S. are experiencing mental health concerns at alarming rates (U.S. Surgeon General, 2021). The recent declaration of a national emergency in child and adolescent mental health by the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association (2021) urgently called for mental health professionals to "identify strategies to meet these challenges through innovation and action" (para. 3). As the state of child mental health has received increasing public attention, there is also growing awareness that social determinants largely shape children's mental health experiences and outcomes (Abraham & Walker-Harding, 2022; McPherson & McGibbon, 2010). Social determinants are malleable socioeconomic and environmental factors—such as poverty, income inequality, discrimination, trauma exposure, living conditions, housing or food in/security—that deeply influence health and wellness (McPherson & McGibbon, 2010; Shim et al., 2014). These building blocks of health are inequitably distributed in society via public policy, which institutionalizes oppressive ideologies, including white supremacy, xenophobia, ableism, transphobia, homophobia, classism, and fatphobia, among others (Compton & Shim, 2015). As a result, patterns of mental health disparities mirror other social disparities in that those with identities marginalized by oppressive ideologies (e.g., children of color, indigenous children, immigrant children, trans and queer children, children with disabilities, children from low-income backgrounds) receive the fewest resources and worst access to wellness-promoting conditions and opportunities as compared to peers who hold privileged identities (i.e., identities that have advantages; Allen et al., 2014; Shim & Compton, 2018).

Although these inequities have existed in the U.S. for generations, they have been made more salient in recent years by several national crises. As of October 2022, approximately 1,065,000 lives have been lost in the U.S. as a result of the global COVID-19 pandemic, and racially and ethnically minoritized (REM) groups have been disproportionately impacted. Additionally, more than 150,000 children in the U.S. have lost a parent or grandparent caregiver to COVID-19 (Centers for Disease Control and Prevention, 2022; Hillis et al., 2021, 2022). Consistent with the impact of other racial inequities on the nation's health, the risk of such loss was 1.1–4.5 times higher among children of REM groups compared to White children (Hillis et al., 2021). In addition to the physical health toll and trauma associated with caregiver loss, mental health has suffered immensely. Simultaneously, the U.S. is grappling with a reckoning around issues of health equity and racial injustice in the face of the continued killing of Black people (e.g., Breonna Taylor, Brett Rosenau, Daniel Prude, George Floyd, Tony McDade, Rayshard Brooks, Jayland Walker) at the hands of police. The ongoing racial violence and the lack of safety- and health-promoting policy change to address it constitute a persistent threat to the physical safety and vitality of Black individuals. Moreover, this climate of unrelenting violence and fear continues to impact and harm the mental health of young people and communities whose racial and ethnic identities have been minoritized for centuries (Bernard et al., 2021; Bor et al., 2018).

Against this backdrop, the provision of school-based mental health supports is often politicized and wielded by conservative activists to effect division in school board meetings and broader cultural discourse (for examples, see Blad, 2020; Kingkade & Hixenbaugh, 2021; Prothero & Blad, 2021). Despite the national crisis in youth mental health, the voices of those advocating *against* the provision of mental health-related services in schools are being amplified and having an outsized impact in policy and culture. Experts in child mental health recognize that school-based mental health supports are more critical now than ever (Duong et al., 2021). School-based services remove significant barriers to accessing mental health support, including financial and logistical challenges that families often face in pursuing health care outside of school (Swick & Powers, 2018). Research has shown that REM youth experience disproportionate challenges in accessing mental health care, such that they are less likely to be referred for school-based mental health services compared to White students, more likely to be misdiagnosed, and less likely to receive high-quality care (Bernard et al., 2021; Malone et al., 2022; Quirk, 2020)—providing further evidence of oppressive social systems.

Furthermore, although representation of REM and multilingual school mental health professionals (e.g., school psychologists, school counselors, social workers) has been growing in recent years, the rate has not kept up with the pace of demographic changes in the youth population, and the field remains largely White and monolingual in English (e.g., Goforth et al., 2021). These demographic trends mean there is increasing racial, ethnic, and linguistic mismatch between the PK–12 student body and school mental health workforce. The lack of emphasis on critical introspection and anti-oppressive practices to date within this mostly White field have contributed to the maintenance of a pernicious status quo (Edyburn et al., 2022). This complicity highlights the urgency of action toward equity in child mental health and the necessity of uprooting harmful ideologies that exist within ourselves and our practices.

1. Purpose and organization of this paper

Considering the historical and current sociopolitical context in the U.S., the time has come to re-envision how we approach school mental health screening. Traditional screening practices primarily focus on individual problems or risk, result in missed prevention opportunities, ignore key contextual considerations, and have the potential to perpetuate oppressive practices in schools. In this paper, we argue that school-based mental health professionals must implement screening practices that identify and build on students' individual and community strengths and lived experiences and dismantle marginalizing structures that contribute to differential risk for social, emotional, and behavioral difficulties. Adoption of this approach is imperative for breaking down barriers to educational and mental health equity.

This paper offers recommendations for equitable mental health screening approaches, which can be leveraged to support well-being, reduce disparities, and promote effective mental health practices within schools. We begin by describing the positionality of our author team and the theoretical foundation that undergirds our equity-centered school mental health screening paradigm. Next, we describe guiding principles and practices for each phase of the screening process: preparation, implementation, and follow-up. Finally, we discuss implications for policy and advocacy, as well as future directions for school-based mental health screening

research. Given longstanding mental health disparities for REM youth and populations who have historically been marginalized based on their cultural or linguistic backgrounds (e.g., Gudiño et al., 2009), we center these groups in our analysis. Nevertheless, many of our recommendations are likely to be applicable to populations who are minoritized based upon other aspects of their identity (e.g., gender identity, sexual orientation, income status).

2. Author positionality

It is important to acknowledge the positionality of the author team and how our identities have shaped our values, interests, and experiences related to this research. Our initial writing team was formed during the 10th Annual School Mental Health Research Summit, hosted by the National Center for School Mental Health (NCSMH) and the School Mental Health Assessment and Research Training (SMART) Center. Following the summit, we invited additional scholars with expertise focused on equity, intersectional justice, and culturally relevant school mental health. This was important to the writing team to ensure that a diversity of perspectives and lived experiences were represented and informed the recommendations. Together, our team has extensive experience (past and current) related to school-based mental health systems, including delivering direct and indirect services to youth and families, teaching and supervising graduate students in topics related to school mental health, partnering with schools to conduct mental health research including mental health screening, and advocating for policies to increase access to school mental health services. Collectively, our team members identify as female or nonbinary, and we hold many privileged social identities, including identifying as White, heterosexual, middle to upper-middle class, highly educated, English-language proficient, and not currently having a disability. Many of our authors also hold marginalized identities related to race and ethnicity (i.e., biracial, Middle Eastern, Black, and East Asian), national origin (i.e., migrants, immigrants, and first-generation American-born citizens), language (i.e., nonnative English speakers), educational access (e.g., first-generation college students), sexual orientation (i.e., queer), and developmental experiences (e.g., growing up in single-parent households, experiencing family mental health issues, exposure to violence). As we collectively represent both privileged and marginalized identities, we vary in our personal experiences with racial and gender bias, oppression, and injustice, and overall, we hold a significant amount of privilege, specifically related to educational attainment and mental health care access. As an author team, we also share a commitment to racial and social justice in school-based mental health supports; we focus on the importance of preventive, strengths-based, and culturally affirming services. We acknowledge this commitment to racial and social justice, as it has informed every aspect of the research process and shaped our vision for equity in school-based mental health screening.

3. Theoretical foundations for equitable school mental health screening

Universal school mental health screening has been defined as the use of a systematic tool or process to identify both the strengths and needs of all students, but in practice, typically only focuses on identifying individuals at risk for or experiencing mental health distress (National Center for School Mental Health [NCSMH], 2021). Deficit-focused practices, such as using mental health screening for the sole purpose of identifying risk for disorders, are incomplete and therefore often ineffectual in transforming student outcomes. Focusing on the individual student suggests that their "failure" to cope or succeed is a personal deficit to remediate, rather than a societal or school failure (Meyer, 2013; Sullivan et al., 2015), ignoring essential societal and organizational structures that create, exacerbate, and maintain disparities between student groups (Newman et al., 2015). With this mindset, educators and schools disregard social determinants of mental health and often implicitly ask, 'How can we get these disadvantaged students to be or function more like middle-class, White ones?' (Teemant et al., 2021). Conceptualizing problems and solutions solely within-child does not facilitate identifying or critically reflecting on how systemic oppression creates and sustains mental health distress and disparities within schools. This model also fails to identify students' strengths, including social and community networks. To address disparate mental health outcomes, schools must embrace equity-centered school mental health practices. Equitable school mental health screening is an important first step in implementing a culturally responsive school mental health model of care (Lazarus et al., 2021; Malone et al., 2022), as it has the potential to impact the greatest number of students and the school climate.

3.1. Equity in school mental health

The term 'equity' is often insufficiently operationalized to ensure shared understanding and drive effective action. Equity within education is achieved when all students have the chance to optimize their well-being and realize their full academic potential, regardless of background (Fredriksen-Goldsen et al., 2014; Teemant et al., 2021). Put simply, educational equity means that all students receive what they need when they need it. This requires that "educational opportunity be calibrated to need, which may include additional and tailored resources and supports to create conditions of true educational opportunity" (Edley et al., 2019, p. 2). Similarly, equity in mental health is the absence of differences in access to wellness-promoting resources and dual-factor mental health outcomes (well-being and distress) based on social group identities or social positions (Starfield, 2001). Three core principles should undergird all equity efforts in schools (Osta & Perrow, 2008):

1. Student experiences and outcomes should not be predictable based solely on an individual's cultural background, social group membership, or social class. This core principle recognizes that although schools must function within social, cultural, historical, and political realities (Teemant et al., 2021), they do not need to inherit the limits these realities create for many REM students, nor reproduce their inequities. Schools can redesign unjust systems.

2. Equity efforts require disrupting the status quo, including exposing and dismantling biased and oppressive school policies, programs, practices, and interactions. This effort requires critical consciousness—which has been defined as the ability to recognize and analyze systems of inequality and take action to challenge oppression (Freire, 2000)—and accountability. Accountability may include redesigning school practices, the delivery of opportunities, the quality of services, or the allocation of resources to students to ensure fairness (Sullivan, 2020).
3. Schools must maintain learning environments that are intellectually and socially safe and affirming for all students and their families. Schools should cultivate students' unique strengths, talents, and abilities and affirm their intersecting identities (Teemant et al., 2021). Schools' development of collaborative relationships among all relevant contributors (e.g., students, families, educators, community members and organizations) is paramount for the success of equity efforts. Collaborative partnerships help redistribute power, privilege, and decision-making to ensure that REM youth and families are leaders in designing approaches that meet their own needs.

In applying these three foundational equity principles, it is also critically important that schools avoid viewing members of minoritized groups merely as passive victims of prejudice and oppressive social conditions (Meyer, 2013). Such a view is disempowering and denies the complexity, strength, agency, and humanity of students and their families. However, caution should also be given to focusing solely on minoritized groups as resilient actors. This description can shift the responsibility for responding to social oppression from society to the minoritized individual (Meyer, 2013), such that these individuals are expected to change (e.g., become resilient), as opposed to a collective responsibility to change the unjust structures and systems that privilege some while oppressing others. Instead, changing schools to be more supportive of students' social-emotional health and positive behaviors is the optimal way to improve overall student well-being and school mental health equity (Newman et al., 2015).

3.2. Critical school mental health praxis

Given the overwhelming evidence that social and structural determinants contribute to unequal and unjust access to the building blocks of health and well-being (Braveman & Gottlieb, 2014; Taylor et al., 2017), a critically contextualized, systems-informed approach to mental health screening is clearly needed (Edyburn et al., 2022; Fredriksen-Goldsen et al., 2014; Proctor & Rivera, 2022). Put simply, equitable school-based mental health screening begins with a focus on changing schools, rather than changing at-risk students. Grounded in critical theoretical frameworks, the recently developed Critical School Mental Health Praxis (CrSMHP; Ulie-Wells et al., 2020) model can guide decision-making at the intersection of educational equity and mental health in schools. Based on Critical Race Theory (Bell, 1980; Delgado & Stefancic, 2001; Ladson-Billings, 1998) and Relational Cultural Theory (Lenz, 2016; Miller, 1976), CrSMHP uses a critical lens to challenge models that overemphasize resiliency and place the onus on individuals to overcome adversities, rather than acknowledging the root cause of trauma and the oppressive systems that perpetuate inequities in schools.

The CrSMHP framework highlights three key areas that need attention to promote equitable school mental health, which align with the three core educational equity principles mentioned above. First, a critical lens is needed to address the root cause of ongoing systemic oppression, which is reproduced through the policies of institutions and the practices of individuals working within them. Screening measures provide information on student functioning, yet little to no attention is given to identifying student group disparities or structural inequities that may contribute to disparities. Using the CrSMHP framework, key contributors involved in screening must critically reflect on the role of systemic oppression in creating and sustaining educational and mental health disparities within their schools. Next, intensive professional and personal self-reflection is needed to challenge stereotypes, biases, and expectations that influence the ability to build connected relationships with students. Finally, collaborative relationships between students and teachers help to create a culturally conscious school climate that can prepare young people to be agents of individual and institutional change in their society. Leveraging this critical approach, educators and school mental health professionals can increase awareness of school structures that diminish, harm, or limit the choices and opportunities students have to reach their full potential (Teemant et al., 2021) and emphasize the need to screen both individuals and systems, while weighing the importance of the systems with equal or greater prominence.

3.3. A new path toward equity-centered school mental health screening

Striving for equity in school mental health clearly requires critical reflection, dynamic responsiveness, systemic change, and sustainability over time. In the sections that follow, we provide recommendations to engage in these practices and promote equitable screening at each phase of the process (i.e., readiness, implementation, and follow up). The organization of screening phases and associated action steps was informed by the *School Mental Health Quality Guide: School Mental Health Screening* (NCSMH, 2020). We meaningfully extend the evidence base and best practices outlined in this guide by presenting key equity considerations and recommendations for each phase. These considerations are anchored by the three core principles of equity efforts in schools, especially as explained within the CrSMHP framework.

4. Key equity considerations prior to screening

Prior to engaging in universal mental health screening, several important preparative steps are needed, with explicit attention toward equity. In this section, we describe equity considerations for the preparation process, including (a) reflecting on the process of

systemic change; (b) identifying a team; (c) engaging in ecological assessment; (d) engaging in resource mapping; (e) forming school, family, and community partnerships; (f) clarifying goals and objectives; and (g) selecting an appropriate, technically adequate, and usable tool. It is important to note that these stages describe an iterative planning process and are interrelated, meaning that key contributors can—and should—return to earlier activities in response to feedback and data collected during this planning phase.

4.1. Reflecting on the process of systemic change

A crucial first step in equitable mental health screening is to acknowledge, reflect, and attend to the multiple dimensions of the educational environment required for systemic change (Sullivan et al., 2015). To do so, schools may reflect on equity relative to school mental health by asking and answering several key questions. First, "What mental health disparities are most prominent within our school community and most detrimental to students' well-being and social/academic success?" Answering this question will require use of existing records, data collection, and data disaggregation to highlight the primary mental health needs, available resources, and problematic disparities in outcomes based on student group membership (e.g., race and ethnicity, English language proficiency, socioeconomic status, gender identity, sexual orientation). Identification of potential disparities at this phase involves listening to the lived experiences of REM collaborators (e.g., via focus groups), in addition to examining records and data so that potential disparities in needs or coping resources are understood in the appropriate context (Sullivan et al., 2015). For instance, schools can review their policies and data related to discipline, attendance, and school climate to examine if there are differences among certain subpopulations which could reveal racist systemic practices that should be addressed. It is important to account for students' intersectional identities in the process of data disaggregation (Brown Griffin et al., 2020).

Second, recognizing that deficit thinking and stereotypes that are enacted in classrooms and schools can contribute to disproportionalities (e.g., in discipline; Harris, 2022), schools must concurrently ask "What individual and community/cultural assets are most prominent within our school community and contribute to students' well-being and success?" Answering and responding to this question is essential for disrupting deficit lenses and instead creating a school climate wherein REM students and communities are viewed as agents of their own well-being and change (Ginwright, 2018). This strengths-based focus is also critical for developing and maintaining partnerships between the school community and marginalized students and families, as it signals respect and appreciation for these communities and their assets.

A third inquiry question is "How is our school contributing to both mental health disparities and well-being?" This question prompts schools to first focus on changing school policies, practices, and procedures, as opposed to changing students. The ways in which schools create and enact policies and provide access to supports/resources have the potential to build upon or marginalize cultural assets to varying degrees, as well as can perpetuate, buffer, or reduce mental health disparities (Sullivan et al., 2015); schools must consider the effects of policymaking and resource allocation in their unique context. Consideration of the intersecting social positions prominently reflected in the school community is crucial to identifying the structural and contextual factors that create students' challenges and foster students' strengths, assets, and resilience. For example, a school may find it helpful to complete an equity audit (i.e., a study of the impartiality of an institution's policies, programs, and practices) as part of this step (e.g., MAEC, 2021).

A fourth inquiry question is "What would school mental health equity look like in our school?" This last question helps inform specific goals for which progress can be monitored. These goals should be contextually specific and recognize the unique context and histories of each school setting (Sullivan et al., 2015). For instance, schools with similar disproportionality targets may identify different systemic factors perpetuating such inequities and may need to address them in different ways (Sullivan et al., 2015). The information gained in pursuit of these questions is pivotal for informing subsequent planning, screening execution, and follow up efforts. Therefore, it is vital that schools work to incorporate multiple perspectives; prioritize student, family, and community voices; and build collaborative partnerships in co-constructing a vision for equitable screening practices at the onset of planning efforts.

4.2. Identifying a team

To that end, schools should assemble a multidisciplinary team representative of multiple collaborators including members from the school (e.g., teachers, educators of multilingual students, administrators, school mental health providers), family (e.g., caregivers, students, family advocates), and community (e.g., community partners, child welfare staff, juvenile justice staff, homelessness liaison, health providers). It is important that team members identities reflect varying demographic characteristics (i.e., age, ethnicity, disability, gender identity, language, race, sexual orientation, socioeconomic status, and national origin; NCSMH, 2021), with attention to intersectionality within these characteristics and how individuals' social identities interact with systems of power/privilege and oppression. These collaborators should have a (a) vested interest in equity; (b) clear understanding of social, health, and academic inequities that currently exist for REM communities; and (d) commitment to supporting mental health services that help ameliorate these inequities in ways that are congruent with the unique identities, cultures, and contexts in which they live and/or work (Edyburn et al., 2022).

It is critical that the team recognize power differentials among the multidisciplinary team (e.g., between principals and students, between members with different social identities). This is important given that the racial and ethnic diversity of educators, administrators, and school mental health professionals often do not reflect the diversity of student and family populations (Goforth et al., 2021; Lewis & Gadson, 2022). In addition, a focus on intersectionality (Crenshaw, 1989) recognizes that even those with some privileged identities (e.g., principals) may have other aspects of their social identity that are marginalized (e.g., Black, woman). We recommend that all team members have an active and equitable voice, with shared responsibility for decision-making, and clear roles and responsibilities that reflect their areas of expertise. To facilitate equitable screening and ensure consideration of the needs of the

entire school population, teams must also provide opportunities to elevate the voices of historically oppressed populations, including those with multiply marginalized identities (Lewis & Gadson, 2022; NCSMH, 2021). It is also important that screening is not the end goal or task of the team, but rather a crucial step toward prevention and early intervention (Dowdy et al., 2014).

To ensure that equity remains at the forefront of the discussion and is embedded throughout the decision-making process, it may be helpful to assign roles and responsibilities specific to diversity, equity, and inclusion (DEI). For example, a specific team member may be assigned to monitor and reflect on how equity and social justice are being prioritized in screening efforts. This individual may also be responsible for tasks such as ensuring representation of diverse contributors and opportunities for authentic engagement and participation, as well as interrogating: What are the strengths and needs of our community? Who is our system serving? In what ways are we causing unintended harm? How does oppression show up in our work? However, great care should be taken to ensure that this work is not placed solely on minoritized members of the team and that DEI responsibilities are viewed as foundational to the work to mitigate the risk of perpetuating harm and compartmentalizing DEI efforts. Additionally, prioritizing trauma-informed, healing-centered, anti-racist, and culturally responsive school-based mental health services (NCSMH, 2021), inclusive of screening practices, is central to equitable mental health screening. Team members should continuously reflect on their understanding of these topics and continuously seek out professional development to fill gaps in understanding and remain abreast of new perspectives.

4.3. Engaging in ecological assessment

There have been recent calls to improve school-based mental health practices by centering intersectionality, social determinants of health, and radical healing into school service provision practices (Edyburn et al., 2022; Truong et al., 2021). Focusing on equity in school-based mental health screening will require a departure from the use of screening to identify mental health distress in students toward identifying social determinants of mental health that are hindering student well-being and an emphasis on systems-level work to enhance well-being (Edyburn et al., 2022). Aligned with the equity reflection questions underlying systemic change, which aim to identify assets, disparities, and inequities, we recommend that teams engage in ecological assessment (EA) to better understand systemic issues and their community impacts. As a prerequisite to screening, obtaining in-depth understanding of the context and broader environment is critical to understanding the challenges and opportunities that might inform broader screening efforts. Recent calls for EA harken back to Bronfenbrenner's (1979) conceptualization and focus on both historic and current ecological systems and social influencers of health and education (SIHE; NCSMH, 2020; Center for Health and Health Care in Schools, School-Based Health Alliance, and National Center for School Mental Health, 2021). Stern et al. (2022) recently adapted Bronefenbrenner's model to focus specifically on Black youth development and account for racial-ethnic identity, colorism, systemic racism, and historical trauma. It is only with this foundational understanding of factors such as economic in/stability, food and housing in/security, and the broader social environment (i.e., current and historical experience of racism, classism, violence, discrimination, and marginalization, among others) that we can address root causes and truly engage in responsive service delivery (Sullivan & Miller, 2022). Furthermore, by intimately understanding the assets held and needs faced by the communities we serve, the focus of support efforts can move beyond individual-level, reactive strategies to larger endeavors to support communities, inform resource mapping, resource allocation, and reform efforts, and usher in system change. Equitable screening practices involve considering the contextual appropriateness of our efforts, including the perceived fit, relevance, or compatibility of the screening practice to the school and community context, which includes an intentional focus on ecological factors and their impacts (Miller et al., 2022). Importantly, EA can help to identify the unique factors that perpetuate inequities within the school community.

4.4. Engaging in resource mapping

Another recommended step before conducting screening is to engage in a process of resource mapping to identify all resources that are available to support needs that may be identified through screening (NCSMH, 2021). Specifically, teams need to determine what the available school and community resources are, what types of services can be provided at the universal, selected, and indicated levels, and what financial or infrastructural limitations exist (Moore et al., 2015). The development of strong, culturally responsive Tier 1 supports is a foundational, preventative strategy prior to screening (Michigan's Multi-Tiered Systems of Support Technical Assistance Center MiMTSS, 2022). Implementation of positive behavioral interventions and supports (PBIS) and social emotional learning (SEL) can create a school environment that is predictable, safe, inclusive, culturally responsive, and positive (Loftus-Rattan et al., 2021), and use of microaffirmations and equity-focused/transformative SEL programming (Jagers et al., 2019) can contribute to a positive racial climate for REM students (Malone et al., 2022). Furthermore, discussions about mental health stigma and the mistrust of educational and mental health institutions among various student populations may elucidate whether there is a need for connection to trusted community-based services or other additional resources. Cultural brokers, mediators, liaisons, or interpreters are particularly important to include to facilitate the exchange of information, assist with implementation efforts, gain the trust of community members, and identify cultural assets, such as the role of churches in Black communities (Parker et al., 2022; Singh et al., 1999).

4.5. Forming school, family, and community partnerships

A vital part of the development of equitable universal screening practices is the formation of strong school, family, and community partnerships. A community-centered approach to universal screening can increase a school's capacity to provide support for students (Brann et al., 2020). This approach shifts the focus away from targeting individual students and toward interventions involving the community at large—an important goal in providing equitable services (El Mallah, 2022). For example, support efforts can focus on

broader population or community needs, including food insecurity, violence prevention, or wellness activities. A community-centered approach may also serve as a mechanism to connect families to services in their communities and reduce disparities in the treatment of mental health challenges for REM youth (Brann et al., 2020).

In addition to connecting youth to community-based resources to support mental health, listening to the representative voices of the community (e.g., parents, students, community members, staff from child-serving organizations) will build the foundation of a strong collaborative relationship between the school and community and help to inform screening priorities and goals (NCSMH, 2021). This ensures that administrators are not making assumptions about the needs of the community but rather are building trusting relationships and listening to multiple perspectives. Key to accomplishing this goal is the adoption of a culturally humble interpersonal approach, which involves continuous self-reflection on each team members' experiences of privilege and marginalization, with an emphasis on respect and understanding, while also actively addressing positional power within these relationships (Davis et al., 2011; Hook et al., 2013). Critical consciousness is also needed and involves identifying inequities and acting through social justice advocacy to empower communities to play an active role in addressing and dismantling oppressive practices (Malone, 2022). This interpersonal disposition of cultural humility coupled with critical action is necessary in developing strong, supportive community partnerships and multidisciplinary teams that work together to generate a shared understanding of mental health and common goals/priorities for screening efforts (Hook et al., 2013; Tervalon & Murray-Garcia, 1998). Moreover, partnerships centered in cultural humility are key for the first step in this work, reflecting on the process of systemic change. Addressing structural and organizational barriers that may impact individuals' involvement in the screening process (e.g., work schedules, childcare needs, language accessibility) and prioritizing outreach, for example at community hubs, can facilitate strong and representative partnerships that are foundational to all screening practice (Ferguson, 2005; Lazarus et al., 2021).

4.6. *Clarifying goals and objectives*

At the onset of any assessment, the screening team should thoughtfully consider, and ultimately determine, what the primary objectives of the screening will be, as this will inform each subsequent step of the screening process (Moore et al., 2015). Historically, mental health screening has been exclusively deficit-focused, with an emphasis on screening for symptoms of psychological problems, disorders, or distress. However, this approach is not aligned with contemporary dual-factor viewpoints of mental health inclusive of both subjective well-being or social-emotional strengths, in addition to psychological distress (Suldo & Shaffer, 2008). A deficit-based approach is also inconsistent with CrSMHP, which emphasizes a shift away from focusing on resiliency in a way that places ownership on individuals to overcome challenges. Instead, a focus on understanding and eliminating oppressive systems that perpetuate inequities within schools, in addition to a more nuanced understanding of how these experiences impact youth's mental health, is needed.

Universal screening that is based on a culturally responsible, dual-factor approach to mental health (Lazarus et al., 2021) allows for a proactive response to students' mental health needs. This should be considered the gold standard for screening and assessment practice. Dual-factor, or complete, mental health screening, which assesses both well-being and psychological distress, gathers a more holistic view of a child (Moore et al., 2015). Adopting a strength-based approach to assessment may also work to diminish the stigma associated with mental health problems and be more palatable within school systems (Dowdy et al., 2010). Furthermore, it can help to identify skills and assets to build upon and promote continued well-being. Several guiding questions include (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019): “What is the purpose of the screening?” “How will screening improve student access to supports?” and “How will screening inform decision-making?” It is central that these questions (a) are informed by the input provided by community, family, and school partners; (b) are unique to the specific needs of the school population; and (c) include an explicit goal of identifying and dismantling systems-level factors that perpetuate inequities within schools.

When screening within the construct of mental health, it is important to first be mindful that the term mental health is a broad term that is significantly influenced by culture (Bertone et al., 2019). There are multiple perspectives on what constitutes well-being, mental health, mental illness, and distress, and attitudes about engaging in mental health-related activities within schools may differ across and within cultural groups (Dowdy et al., 2014). Cultural differences in what is considered a mental health “problem” versus typical development exist and need to inform the type of information collected within any screening activity to ensure compatibility within a community's values and expectations (SAMHSA, 2019). Learning these perspectives is a vital part of the work to be done during the formation of family and community partnerships. Screening efforts need to actively honor, respect, and affirm shared cultural values and sensitively evaluate the social-emotional health and wellness of students with this in mind, further emphasizing the need for community input in the early stages of the screening process (Bertone et al., 2019). It is also important to be mindful of the stressors and experiences that create challenges for REM youth, especially those with multiply-minoritized identities (Lewis & Gadson, 2022). Minority stress theories indicate that minoritized groups experience additional stressors, such as discrimination and lack of resources, that are not experienced by the dominant group (Meyer, 2003). Integrating school and community collaborators into decision-making about screening goals and objectives and assessing individual and environmental factors, such as perceptions of the school climate and racial/ethnic risk and protective factors, is important for identifying and dismantling practices that may contribute to additional stress experienced by REM populations within schools as part of the screening process.

In sum, goals of equity-driven universal mental health screening include (a) identifying and building upon students' individual and community strengths, in addition to identifying and remediating individual needs; (b) ensuring the contextual, cultural, and ecological relevance of the screening process; and (c) using screening efforts to intentionally and actively dismantle structures that perpetuate disparities in risk and outcomes.

4.7. Selecting an appropriate, technically adequate, and usable screening tool

Once goals for screening have been clarified, the team can evaluate screening measures and select the tool(s) that is aligned with their objectives for screening. Essential considerations when selecting a screening tool are the measure's appropriateness for intended use, technical adequacy, and usability (Glover & Albers, 2007). Consideration for how tools facilitate the identification and dismantling of practices that contribute to mental health inequities and support wellness promotion (rather than risk identification) is important. For a list of potential tools, please see resources such as (a) the NCSMH SHAPE System's Screening and Assessment Library (https://www.theshapesystem.com/assessmentlibrary/); (b) the Mental Health, Social-Emotional, and Behavioral Screening and Evaluation Compendium (2nd Edition; Center for School-Based Mental Health Programs, Ohio Mental Health Network for School Success, 2022); (c) the Center for Health and Health Care in Schools, School-Based Health Alliance, and NCSMH (2021); and (d) reviews of social-emotional/behavioral screeners (e.g., Brann et al., 2022; Jenkins et al., 2014; Levitt et al., 2007; Severson et al., 2007; Whitcomb, 2018).

Measures are appropriate if they are aligned with the collaborator-identified strengths and needs of the school community, culturally informed conceptualizations of mental health, and the intentions and goals for screening, such as focusing on the school population versus the needs of individuals, identifying disproportionate school mental health practices, identifying assets, and assessing SIHE (Glover & Albers, 2007; Romer et al., 2020). The selected measure should also be relevant for the school's demographic characteristics (e.g., age, language, culture, region), such that it was developed or evaluated with a sample similar to the school's population (Ohio PBIS Network, 2016). As measure-specific cut scores and ability to predict future needs may be affected by student and contextual factors (SAMHSA, 2019), using measures that are misaligned with a school's population may perpetuate disparities in school mental health service provision (e.g., perpetuating stereotypes, systematic over- or under-identification).

Population fit is further informed by the availability of teacher, caregiver, and/or student versions of the measure and a multi-informant approach to screening has been recommended (Bertone et al., 2019; Moore et al., 2015). Each informant offers unique information about students, with differences reflecting variability in student behavior across contexts and cultural influences on perceptions of student behavior and experiences (Bertone et al., 2019; De Los Reyes et al., 2019). Thus, school teams should consider potential biases and contextual and cultural impacts on informants' ratings. For example, although teachers are the most frequently used informants, they may not have the requisite cultural knowledge to accurately and appropriately identify symptoms, particularly for students from backgrounds different than their own (Birman & Chan, 2008) and who are experiencing internalizing problems (e.g., anxiety, sadness; Papandrea & Winefield, 2011). Teachers are more likely to be concerned about, to perceive as serious, and to refer students for externalizing problems than internalizing problems (Loades & Mastroyannopoulou, 2010; Splett et al., 2019). Moreover, REM youth with internalizing symptoms are less likely to be referred for and receive mental health services than their White peers, and thus have the greatest potential for unmet mental health needs (Gudiño et al., 2009). Conversely, research suggests that REM youth may be overidentified as having externalizing symptoms (Nandakumar et al., 2021). Providing teachers with training prior to completing universal screening measures may be important for improving their accuracy and the attention and effort given to the screening process (Von der Embse, Kilgus, Ake, & Levi-Neilsen, 2018). Ultimately, the choice of informant(s) should be guided by the relevance and utility of each potential informant's perspective for meeting the identified screening goals (Von der Embse, Kim, Kilgus, Dedrick, & Sanchez, 2019).

Selected measures need to be technically adequate, with research evidence supporting the reliability of screening scores (e.g., internal consistency, test-retest, inter-rater), ability to predict future outcomes, and identification accuracy (Glover & Albers, 2007; SAMHSA, 2019). Although this evidence exists for many individually focused screening tools, few of these measures were designed or have been validated specifically for use with REM populations or to assess system-level factors that shape student mental health (Bertone et al., 2019; SAMHSA, 2019). The accuracy and predictive effectiveness of available tools across REM groups has been under-researched, with fewer than 15% of studies on social, emotional, and behavioral screening/progress monitoring tools explicitly considering cultural factors, cultural adaptations, or culturally responsive use (Brann et al., 2022; SAMHSA, 2019). When this evidence is absent, screening data may not be as reliable, and decisions made with those data may not be as valid for informing intervention for REM students than for White, monolingual English-speaking students (SAMHSA, 2019). Thus, school teams need to be mindful about the limitations of such measures for use with their REM student populations and, as part of the selection process, carefully examine measures' technical manuals and the research literature to investigate whether characteristics of their school's population were reflected in the measure's design, validation, and norming processes (e.g., evidence of measurement invariance and for translated forms, language and reading level of informant; Bertone et al., 2019; Dowdy et al., 2014).

Given the paucity of culturally-responsive screening measures (Brann et al., 2022), school teams may not be able to identify a measure that is both aligned with their screening goals and has demonstrated technical properties for their student population or subgroups within the population. In these instances, it is prudent to partner and consult with cultural liaisons, students, and families to identify culturally bound concepts and phrasing on existing tools that may contribute to misunderstandings (Bertone et al., 2019) and whether these limitations may be addressed through adaptations of item wording or measure scoring completed in consultation with measure developers (SAMHSA, 2019). For example, although translations may be available for a given tool, schools need to determine the effectiveness of the translation, including measurement equivalence, for the specific population they serve (SAMHSA, 2019). Cultural liaisons can inform the degree to which translations are understandable or if certain items may be misinterpreted to select the most appropriate tools (SAMHSA, 2019). Paramount for dismantling inequitable screening practices in the long term, however, is the availability of screening measures that have been developed with REM populations through authentic, participatory university-community partnerships. Consistent with considerations for setting screening goals, development of these culturally-grounded measures is guided by the culturally bound mental health constructs and the culturally-informed conceptualizations of mental health

shared by members of the target population. However, our team was unable to identify any such measures currently available for use in school-based universal mental health screening.

As a final consideration, usability describes the measure's cost, resources, and infrastructure required for administration (e.g., training, technical support), feasibility of administration, scoring time, and utility of outcomes (Glover & Albers, 2007). Financial cost may be a primary concern for schools yet should not outweigh considerations about the personnel required to score and interpret screening results, financial resources to sustain screening, availability of scoring/reporting resources, and the impact of administration on personnel time and student instruction (Romer et al., 2020). To promote mental health equity, school, district, and state education leaders can evaluate whether financial resources are being used effectively to support sustainable student mental health programs that include universal screening (Rafa et al., 2021). Providing additional funding to schools that serve low-income communities can also be used to facilitate equitable screening (Parker & Griffith, 2016). Moreover, measure developers/publishers can increase the accessibility of technically adequate measures and their scoring and reporting systems by making these resources open access.

5. Key equity considerations for implementation of screening

Once the screening team has engaged in effective planning and preparation, the implementation of screening may begin. Below, we describe the primary equity considerations for each major component of screening execution, including (a) obtaining consent and assent, (b) developing data collection and administration processes, and (c) scoring measures and analyzing data.

5.1. Obtaining consent and assent

Before screening, school teams must decide what form of consent will be sought from students' caregivers—*active consent*, which requires parents' written permission, or *passive consent*, in which nonresponse indicates approval for screening—and establish procedures for obtaining student assent (Moore et al., 2015). Decisions about which form of consent to use may depend on state laws and school district policies and should be guided by equity considerations (see NCSMH, 2020, and Romer et al., 2020). Whereas screening using passive consent may reach the most students, active consent can ensure that consent is informed, may promote or strengthen family-school relationships and trust, and tends to align with district protocols and socially just practice (Levitt et al., 2017; NCSMH, 2020; Radliff & Cooper, 2013). However, active consent may contribute to fewer students, overall, participating in screening and to disproportionalities in who participates, for example, such that fewer students from REM backgrounds and with the greatest mental health risk are likely to participate (Burns & Rapee, 2021; Chartier et al., 2008; NCSMH, 2020). If districts mandate active consent, it is important to ensure that no groups are underrepresented or excluded (Moore et al., 2015).

Communication, relationship-building, and trust are thereby critical when seeking consent and assent for screening. Providing caregivers and students with a consistent message about the goals and purpose for screening is essential in ensuring their full understanding and decisions about participation; when this information is clear and the process is transparent, their participation is more likely (NCSMH, 2020). REM families may distrust or fear the screening system, particularly when school teams and screening priorities are aligned with White, English-speaking norms and values (Bertone et al., 2019). For instance, in one study, Black youth and families' dissent to participate in universal screening was found to be concerningly high (as much as 40%; Goodwin et al., 2021). If this occurs, screening teams should revisit their planning and preparation to better understand the lived experiences of their community members. As previously mentioned, partnering with cultural liaisons, cultural brokers, and interpreters for family outreach and communication about screening may be helpful in this endeavor, and can help to build trust or address mental health stigma that may impact help seeking (Allouche et al., 2021; Bertone et al., 2019). Information about screening should be provided in multiple formats, including messages/letters sent home or information on school websites and flyers, as well as through conversations and information sessions scheduled at times that are convenient for families (NCSMH, 2020). Helping families read consent forms, providing documents and answering questions in their preferred language, and providing assurance about screening can further ease tension, confusion, distrust, and discomfort with the screening process—subsequently increasing participation (Bertone et al., 2019; NCSMH, 2020). In recognition that these efforts may require time and personnel not typically available, school teams may consider advocating for district- or state-level funding to hire cultural liaisons that can support school mental health efforts.

5.2. Developing data collection and administration processes

In planning screening administration procedures, it is essential to consider the needs of informants, screening schedules, and school faculty professional development requirements to ensure an effective and efficient process. Schools can start small by conducting a pilot administration, which may be used to gather feedback, adjust procedures, and assess the appropriateness of the measure for the school's student population before school-wide roll-out (Romer et al., 2020; SAMHSA, 2019; Whitcomb et al., 2021). An equitable approach to mental health screening administration will center the development of procedures that address disparities and are critically conscious, such that procedures increase accessibility and reduce bias. For example, clear written and oral communication during administration ensures a smooth process for both proctors and students. Interpreters, bilingual and bicultural clinicians, and/or bilingual cultural brokers can be available at the time of administration (Bertone et al., 2019). This ensures all students understand the purpose of the screening measure(s) and feel comfortable answering honestly when given proper instruction. Given the connection between SIHE and school attendance (Robert Wood Johnson Foundation, 2016), school teams will also need a plan for reaching students who are absent during screening administration and provide additional opportunities for participation (Moore et al., 2015). For teachers completing screening measures, the script/instructions and training provided should encourage teachers to limit their

emotional responses to survey items and to reflect on their prejudices/biases and cultural expectations that may influence their interpretation of student behavior and subsequent ratings on forms (Mason et al., 2014). It is important to allow ample time for teachers to complete such measures, as quick judgments are more prone to bias (Ehrlinger et al., 2016). To support accuracy in data collected via caregiver report, school team members should be proactive in addressing potential caregiver concerns regarding teacher reactions to or use of the screening results, as caregiver concerns about teacher racial bias are consequential and valid (Chin et al., 2020).

5.3. Scoring measures and analyzing data

Screening is not meant to be time and resource-intensive, and yet, scoring and analyzing screening data can be complicated if effective systems are not in place before the screening begins (Moore et al., 2015). Scoring may happen with automaticity when measures are completed within an online system; however, not all schools will have the funds to pay for such systems. With paper and pencil administration, school teams must identify how data will be entered into a spreadsheet that will enable easy access to meaningful results. Some school systems have had success allocating staff time to develop online data entry and analysis systems, which has the benefit of being able to tailor data spreadsheets to capture unique needs of the individual school community and can facilitate an explicit focus on equity (Mackenzie, 2021).

With universal screening, the goal for analysis is not solely to understand the social and emotional behaviors of individual students; rather, it is to understand aggregate information about the population of students that inform a systems-level response. Thus, analysis can be guided by the equity reflection questions underlying systemic change (Sullivan et al., 2015). For example, to identify the mental health strengths and disparities most prominent in the school community, it will likely be helpful to observe data patterns by subgroup. Do results vary by student race, ethnicity or language status, gender, socioeconomic, or special education status? If so, it is necessary to further reflect on and identify what contributes to these data trends. It is also important to examine data relative to the heterogeneity within specific REM groups given unique sociocultural and historical factors and within-group disparities (e.g., educational attainment among Asian American Pacific Islander ethnic groups; Truong et al., 2021). Results may suggest teachers' implicit bias and expectations about student behavior impacted their ratings (Santiago-Rosario et al., 2021) or support an investigation into school practices or policies that are harming student well-being. Given significant variation across cultures as to what is considered "typical" for mental health (SAMHSA, 2019), results may be viewed and understood differently by teachers, students, and families. For example, populations minoritized based on their cultural/linguistic backgrounds face unique language barriers when completing a measure or test in English. Their screening results may signify mental health strengths or symptoms but can also be influenced by students' second language development (Yates et al., 2008). Repeated administration can help to see if students give similar responses and can determine if assessment results are accurate (Bertone et al., 2019). It is important that individuals tasked with analyzing screening data are educated on the prevalence of mental health disorders among cultures, the role that acculturative stress may play on mental health, the different processes involved in language acquisition, and possess important traits, such as bilingual status, to support culturally responsive analysis (Bertone et al., 2019; Dowdy et al., 2014).

6. Key equity considerations after screening is completed

Once screening has been conducted, the knowledge gained from the screening must be used to inform equity-explicit practices and may be used to guide policy decisions at local levels. In the following section, we describe equity considerations as part of connecting screening to interventions, including (a) interpreting data to guide follow-up, (b) prioritizing systems-level change, (c) implementing intentional universal (Tier 1) intervention, and (d) engaging in equitable decision-making for Tiers 2 and 3.

6.1. Interpreting data to guide follow up

Using a public health lens, school mental health screening serves as a needs assessment for a classroom, grade level, school, or district (Dowdy et al., 2010). As previously discussed, teams can develop systems to analyze data from multiple perspectives with careful attention to indicators of in/equity and guided by key questions that focus attention on the entire school/district population and certain subpopulations within a building. When viewed holistically, these data provide areas of strength and base rates of risk for the school community. This analysis can be done with an EA in mind, which identifies SIHE (NCSMH, 2020) that may be prevalent within the community (e.g., economic in/stability, food in/security, racism).

When following up with the results of screening, multidisciplinary school teams need to draw upon pre-implementation discussions regarding feasible and sustainable wellness promotion and intervention implementation procedures to facilitate effective and culturally responsive service delivery (NCSMH, 2020). Understanding these factors is important for tailoring the focus and intensity of interventions that may be needed for all students (Tier 1), some students (Tier 2), and a few students (Tier 3), as well as the resources that may exist within the broader community that can support wellness-promotion and intervention efforts. For example, when SIHE are assessed as part of screening, these data can inform identification of community assets that may be integrated into school policies, practices, and procedures. Social-emotional/behavioral data can be used to identify grade level or classroom-specific strengths or needs that can guide professional development or the implementation of universal programming. Together, these data can be used to identify individuals and groups of students with mental health needs that are targeted for additional supports and the individual and community strengths that can fortify these needs. To assist with decision-making that promotes access to care, multidisciplinary school screening teams can draw upon the Social-Emotional and Behavioral Assessment (SEBA; 2022) framework (Kilgus & Eklund, 2016), a

decision-making and assessment framework that considers base rates of risk to help schools identify the percentage of students that can be equitably served within each tier. Ultimately, enacting systems-level change that centers student well-being and building strong, culturally responsive Tier 1 and 2 supports in response to screening is critical for promoting wellness and efficiently meet the needs of most students through class and school-wide interventions.

Consistent with a dual-factor approach to mental health, when using universal screening data for intervention planning it is important to identify skills, assets, and strengths to build upon and promote continued well-being within students' various lived experiences and contexts. It is critical for school teams to implement a nuanced follow up procedure that fosters not only individual strengths and assets but also community strengths to dismantle pre-existing structures and systems that contribute to social, emotional, and behavioral difficulties. Universal screening is an integral piece of the multi-tiered system of support (MTSS) framework in supporting the whole child and engaging in culturally responsive school mental health (Lazarus et al., 2021; Malone et al., 2022). It is critical that schools couple the CrSMHP framework (Ulie-Wells et al., 2020) with MTSS to ensure service delivery removes the onus on individual students to overcome challenges and, instead, acknowledges the systems that perpetuate inequities in schools. Hence, as a rule, schools should use data to inform how the school environment can be transformed to affirm student strengths and assets and promote and build desired behaviors and social-emotional competencies. This approach does not ignore individual student needs; instead, it ensures there is not a sole focus on the student and the remediation of concerns and challenges.

6.2. *Prioritizing systems-level change*

Screening data can be leveraged to support changes to local systems and policies that impact the well-being of students and families (Eber et al., 2019). In developing and refining comprehensive mental health service systems (Hoover & Bostic, 2021), aggregate screening data can prompt a school/district to engage in further resource mapping, building upon what was done in the preparation stage of screening, to detail who provides what services and in what context. For example, school teams that include community mental health providers, families, and community members can build routines for evaluating screening data together. Through this process, teams can better understand the range of tiered support services, such as school- and class-wide universal Tier 1 approaches, community providers' potential role in providing push-in or wrap-around support for students with more intensive needs at Tier 2 and Tier 3 (Eber et al., 2019), and how community cultural assets may augment these supports. Given the national shortages in school mental health providers (e.g., school psychologists, school social workers; Health Resources and Services Administration et al., 2015), it is essential that service delivery systems are coordinated so that all students that need additional support receive it and do not fall victim to fragmented approaches. School personnel, community members, and partners can lean upon established referral processes, data sharing agreements, and memorandums of understanding to provide wrap-around support to students and families (for an example, see Pearrow et al., 2016). Developing streamlined referral protocols with well-established and trusted programs in the community can prove beneficial as community programs could be considered more accessible and acceptable to students and families (NCSMH, 2020).

In an MTSS service delivery model in which school intervention delivery systems are interconnected with community mental health systems, screening can bring service providers together to expand and align available services so that student well-being is promoted and all students' needs are being met effectively (Eber et al., 2019). The formation of strong and representative school-community partnerships in the preparation stages of universal screening allows for changes to be made to the overall systems and environment that affect all students' success and allows for the co-creation of an integrated system of service delivery that supports families and communities. This takes the focus away from changing the individual behavior of students in a school environment, which may further marginalize students and families and leave system failures in place (Jackson et al., 2018).

There are numerous ways school and district teams can engage in policy work and advocate for local policies that protect and promote the well-being of children and families. Developing and implementing an equity-centered approach to universal screening is in itself establishing new school policy. For instance, a school team that identifies food insecurity as a chronic problem among specific REM student groups (which can, in turn, contribute to depressive symptoms and emotional dysregulation; Alaimo et al., 2002) might advocate to administrators for expanding school meal programs, providing free a la carte snacks available throughout the day, or partnering with community agencies to offer families meals/food resources, especially on weekends and during breaks. Teams may also leverage equity-centered screening processes to combat identified disproportionalities in referrals for special education (e.g., REM youth are overrepresented in referrals for emotional or behavioral disorders; Nandakumar et al., 2021) and receipt of exclusionary discipline (e.g., such that Black boys and girls are up to 10 times more likely to receive exclusionary discipline than their White peers; Crenshaw et al., 2015; Gregory et al., 2014). Relying on results of equitable universal screening to identify student strengths and needs and guide a system of supportive interventions is a recommended alternative to common referral processes that may contribute to these disproportionalities (Dever et al., 2016; Raines et al., 2012). Teams may also give presentations at local school board meetings regarding the prevalence of mental health concerns based on screening data and use this opportunity to highlight the important work of school- and community-based professionals in supporting children's mental health needs. Similarly, these data can be used to advocate for increasing the number of school-based mental health professionals within schools, and the expansion of partnerships with community-based mental health providers.

6.3. *Implementing intentional universal (Tier 1) interventions*

Instituting a strong foundation of culturally responsive Tier 1 supports was discussed as a key part of the preparation process. Once universal screening has been completed, school-wide aggregated data can inform how to alter and enhance Tier 1 supports and inform

ongoing SEL and PBIS efforts and implementation (Malone et al., 2022). Centering universal/Tier 1 intervention following screening is aligned with principles of equity as it does not view individual students as the primary concern and acknowledges contextual factors that require changes to the system (e.g., school environment) to foster wellness and address students' needs.

Screening processes alone will not be enough to bring about equitable change and reform to students' environments and the systems they reside in (Michigan's Multi-Tiered Systems of Support Technical Assistance Center MiMTSS, 2022). Instead, screening data are gathered to guide action. Schools are encouraged to consider strong universal services that support students' intersecting identities positively and responsively, while minimizing discipline issues (Jackson et al., 2018). Schools might adjust their Tier 1 practices based on a review of screening data and observation of disciplinary practices and policies. For example, if screening data indicate that REM students have fewer indicators of well-being, priorities for Tier 1 should include building culturally affirming, healing school environments. Given the relation between racial discrimination and well-being, cultivating environments that are healing centered, where students' identities are affirmed and their cultural context considered as part of existing SEL or PBIS efforts is important in addressing these disparities (Ginwright, 2018; Malone et al., 2022). Screening procedures should also be paired with intervention planning that includes all key contributors and considers the various contextual factors that may impact students. This may necessitate the adjustment of traditional school approaches to teaching behaviors or improving social-emotional skills to be affirming and culturally responsive (Fallon et al., 2021; Malone et al., 2022).

6.4. Engaging in equitable decision-making for Tiers 2 and 3

As universal screening data can help inform systemic and Tier 1 universal interventions, they can also help highlight who might benefit from more targeted (Tier 2 or 3) interventions. For example, Asian American and Latinx American adolescents may face several barriers to receipt of mental health services, including stigma about mental health, linguistic or cultural differences, and racism (Guo et al., 2014; Wang et al., 2020). Equitable universal screening, implemented as described above, is instrumental in identifying these REM students who may benefit from Tier 2 or 3 intervention, but who may not be identified through traditional referral and identification processes, and connecting them with needed services. However, it is important to also prioritize equity during decision-making at these more intensive tiers that require more time and resources (i.e., Tier 2 & 3; Dowdy et al., 2010; Kilgus & Eklund, 2016).

Equity considerations at Tiers 2 and 3 include the use of content and procedural adaptations to increase the cultural relevance of interventions, to promote positive racial identity development, and to incorporate cultural knowledge into treatment planning (Malone et al., 2022). Administration of targeted assessments, such as narrowband rating scales, brief functional interviews, or measures' that ask about racial-ethnic protective (e.g., racial identity) and risk factors (e.g., microaggressions, acculturative stress), might be warranted when planning treatment for targeted interventions to match identified needs at the Tier 2 or Tier 3 level (Kilgus & Klingbeil, 2021; Malone et al., 2022; Walker et al., 2014). Teams can look at the overall strengths and needs of students requiring targeted or individualized intervention and then plan carefully for how they select and implement evidence-based small group or individualized practices. For example, they may use resources, such as The Hexagon Tool (Metz & Louison, 2018) to help them to evaluate evidence backing certain interventions, the fit and adaptability of the intervention within the school or district context, the capacity of school staff to implement such interventions, and professional development needed to implement interventions well.

7. Implications for state, national, and international policy and advocacy

Given the compelling evidence that disparities in youth mental health experiences and outcomes largely emerge from conditions created through public policy (Allen et al., 2014; McPherson & McGibbon, 2010; Shim et al., 2014), another critical component of equity-centered school mental health screening is meaningful engagement with policy and advocacy. That is, educators and school mental health professionals can and ought to leverage their expertise to ensure that policy at all levels—grade, school, district, community/region, state, federal, and international—promotes equitable access to culturally-affirming and wellness-promoting resources for all children and young people. This work should be done throughout and alongside all phases of screening described here, and indeed requires an ongoing commitment.

As social determinants of mental health derive from policies that exist beyond the school environment, educators' and school mental health professionals' engagement in advocacy for policy change and legislation at the state, national, and international level is particularly important. This might look like sharing information and educating students, colleagues, and peers about pending policy changes/legislation that can affect child and family well-being; building coalitions between students, families, community partners, and school personnel to organize, protest, or engage in civil disobedience for policy changes; communicating with school boards and state and federal legislators directly; offering developmental and health equity expertise to policymakers; collaborating with professional associations to sign petitions or write policy/position statements; or submitting public comments on proposed rule changes. Some policies that are particularly critical to improving equity in child mental health include those that address poverty (which has been consistently documented as one of the most potent social determinants; McPherson & McGibbon, 2010), such as providing living wages, expanding the earned income tax credit, and proliferating access to high-quality early childhood care and education (Bhatia & Katz, 2001; Dahl & Lochner, 2012; Manning et al., 2010). For immigrant youth, policies that protect parents from deportation (e.g., Deferred Action for Childhood Arrivals, 2022) have had a demonstrated effect of reducing youth diagnoses of anxiety and stressor-related disorders (Hainmueller et al., 2017); school-based mental health providers should support such policies, as well.

Policies that enable the expansion of equity-centered school mental health screening are also needed. For example, states should mandate universal screening at school entry, as Illinois has done (SB 565, Public Act 99–0927), and further, require use of a dual-factor model. States should also define equity in school mental health screening/MTSS in statute and require an equity-centered approach,

including data disaggregation and ongoing evaluation to address disparities. Recent systematic reviews found that most state departments of education do not provide guidance related to behavior screening, recommendations for screening, or mandates for implementation (Briesch et al., 2018, 2020), let alone with an equity focus. Offering such practice guidelines, along with providing resources and technical assistance to support local school districts, would be an important step toward improving implementation of equitable screening. Educators and school mental health professionals should also consider advocating for more professional development funds to support anti-racist and anti-oppressive training/coaching for implementation of universal screening, as well as funds

Table 1
Summary of key equity considerations and recommendations by screening process stage.

Prior to Screening	Implementation of Screening	Follow up After Screening
Reflecting on the Process of Change	***Obtaining Consent and Assent***	***Interpreting Data to Guide Follow Up***
• Ask, *What assets are most prominent and contribute to students' success? What mental health disparities are most detrimental to students' success? How is our school contributing to well-being/disparities?* And, *What would school mental health equity look like?*	• Use consent procedures aligned with state laws/school district policies; maximize student and family involvement. • Engage in consistent, transparent, and clear communication to build relationships and trust with students, families, and communities.	• Use screening data to identify needs of classrooms, grade levels, schools, or districts to tailor focus of interventions. • Identify social influencers of health education using an ecological lens; use data to plan for needed supports. • Use data to also identify skills, assets, and strengths within students' lived experiences and contexts.
Identifying a Team	***Developing Data Collection and Administration Processes***	***Prioritizing Systems-Level Change***
• Assemble a diverse team of collaborators reflective of the broader school community. • Be mindful of intersectional identities of team members. • Establish clear roles and shared responsibilities; designate a team member specific to diversity, equity and inclusion.	• Establish clear screening procedures aligned with equity-focused goals for effectively administering, scoring, and analyzing data.	• Form strong school-community partnerships to create integrated service delivery systems to meet family/community needs. • Acknowledge and follow up to address the root cause of oppressive systems that perpetuate inequities in schools. • Engage in school and district policy work and advocate for local policies that protect and promote the well-being of children and families.
Engaging in Ecological Assessment	***Scoring Measures and Analyzing Data***	***Implementing Intentional Universal (Tier 1) Interventions***
• Consider historic/current ecological systems and social influencers of health in informing universal screening practices.	• Analyze data with a population-level (vs. individual-risk-level) focus; attend to systemic change. • Identify/investigate disparities between and within student subgroups. • Prioritize allocation of resources to support sustainable implementation of mental health programs, including screening.	• Build strong, culturally responsive Tier 1 supports based on school-wide aggregated data. • Augment existing practices to build affirming school environments.
Engaging in Resource Mapping		***Engaging in Equitable Decision-Making for Tiers 2 and 3***
• Identify available resources and limitations. • Intentionally develop strong, culturally-responsive Tier 1 supports as a foundation.		• Make content and procedural adaptations to increase relevance of interventions. • Administer targeted assessments—including measures of racial-ethnic risk and protective factors—to plan indicated intervention and treatment.
Forming School/Family/Community Partnerships		
• Develop partnerships centered in cultural humility.		
Clarifying Goals and Objectives		
• Focus on prevention and supporting/facilitating student, family and community assets and strengths. • Recognize culturally influenced definitions of mental health.		
Selecting a Screening Tool		
• Choose measures that reflect the demographic characteristics of the school's population and cultural conceptualizations of mental health. • Build and leverage partnerships to evaluate the appropriateness of screening tools. • Advocate for state and district funding policies to improve screening efforts.		

to build more robust community partnerships to conduct screenings and stronger Tier 1 and 2 supports/services. At the federal level, it is important to continue to push Congress to fully fund the Individuals with Disabilities Education Act (IDEA), as Congress has never fully funded its federal share of IDEA (National Council for Disabilities, 2018), and IDEA authorizes the use of up to 15% of special education funds for early intervention and prevention (IDEA, 2004).

8. Concluding comments and future directions

Universal mental health screening that prioritizes early, appropriate identification of mental health concerns *and* individual and community strengths can reduce inequities and promote mental health equity (Lazarus et al., 2021; Radliff & Cooper, 2013). Equitable mental health screening practice requires intentional planning, critical reflection, and a shift from individual- and deficit-focused approaches to identifying individual risk toward a system-focused approach that can identify disparities and disrupt school-specific contributions to inequity. Collaboration, relationship building, and partnerships across school and community contributors, as well as a focus toward building sustainable mental health screening practices, are equally necessary for pursuit of this goal.

In this paper, we applied guiding principles for promoting mental health equity and a critical school mental health framework to develop a roadmap for equitable universal mental health screening. The primary equity considerations and recommendations we provided for each stage of the screening process—from screening preparation, to implementation, and then follow-up—are summarized in Table 1. However, we also want to acknowledge the limitations of the recommendations provided. First, this is not a systematic review of the literature, and there may be important articles and studies related to the topic of equitable mental health screening that have been omitted. Second, we caution that we do not have all the answers to how to do this complex, nuanced, and individualized work. The systems change required to support equitable universal mental health screening must be a locally-driven effort (Sullivan et al., 2015), informed by the unique needs of the communities, resources, and goals of each specific school or district. We have proposed a framework and considerations for this work, but nothing sustainable and individualized can be prescriptive—it must be guided by the local context. With this in mind, we also recognize that our positionality influences our understanding of equitable screening practices and the ideas presented here (Sabnis & Proctor, 2022)—we acknowledge that our recommendations are inextricably linked to the perspectives and experiences of our author team. To embed an equity perspective in our approach, we examined our own backgrounds and biases and worked to guard against the implied or explicit assumption that White is the normative position. As a diverse author team, we engaged in reflexivity by committing to a continuous process of active reflection, seeking feedback, and working to center critical ways of knowing as we developed our framework for equitable mental health screening.

Although the equity considerations presented in this manuscript for each phase of the screening process may help to address barriers to screening and guide execution and follow up procedures that are aligned with equity-driven screening goals, continued work is needed to fully realize these recommendations. To further inform screening preparation practices, research must explore specific strategies to increase student, family, and community engagement in the planning process so that screening efforts are sensitive to the unique needs of the communities served and well-informed. Researchers should explore direct and indirect individual, social, and contextual factors that may influence perceptions of mental health screening and use this information to inform strategies to improve perceptions of mental health screening. This information may also be used to identify mechanisms that may help reduce stigma surrounding mental health and emphasize notions of wellness and healing. In addition, the specific and unique barriers to screening implementation that are experienced within diverse communities, and that may threaten equitable screening practices, are important to identify.

Considering universal mental health screening tools, there is a notable gap between the existing evidence base and availability of measures and technical information that are necessary for screening that is centered on promoting well-being and reducing mental health inequities for REM students. Investigations into the appropriateness of existing measures for use with REM student populations, including the adequacy of measures' technical properties (e.g., evidence of measurement invariance, differential item functioning) and the effectiveness of translations are needed. Necessary for screening systems that can disrupt systems that perpetuate inequity is the intentional development of culturally relevant and culturally grounded screening measures and procedures for use with REM populations. Consistent with principles underlying school-family-community partnerships that center cultural humility, these measures can be developed through community-driven and collaborative methods, such as community-based participatory research (Minkler & Wallerstein, 2003) or youth participatory action research (Cammarota & Fine, 2008). Well-suited for addressing disparities, these participatory approaches equitably involve all partners—research, school, and community collaborators—in all aspects of the measure and screening-procedure development process (Minkler & Wallerstein, 2003). In doing so, measures can be developed that are firmly rooted in and guided by cultural conceptualizations of mental health and collaborator-driven priorities for screening. Improving measurement of mental health strengths and needs for REM populations can facilitate accurate detection and guide processes for linking screening data to culturally affirming interventions. Disseminating accessible reviews of available and newly developed measures and their appropriateness for student subpopulations is further crucial for supporting school teams' selection of screening tools. In addition to individual-focused measures, development and testing of new measures and procedures that assess social determinants of mental health as part of universal mental health screening are essential in moving beyond individual and deficit-focused screening toward more equitable practice. Implementation research that describes screening procedures across contexts and investigates multilevel factors that influence effective adoption, implementation, and sustainability of screening can further inform strategies for conducting equitable screening.

Finally, the degree to which equity-centered mental health screening can champion student well-being and impact mental health disparities is, in part, dependent upon how screening data are used to guide decision-making and service delivery. Although guidance for building MTSS frameworks to address racism and promote mental health (Malone et al., 2022) and student behavior (Fallon et al.,

2021) is available, implementation reports and research investigations into how screening can inform culturally responsive, healing MTSS practices that enrich students' strengths and support identified needs is sorely needed. Whereas we strongly believe in the promise of universal screening to support students' mental health and wellness, screening practices and scholarship must prioritize mental health equity to best meet students', schools', and communities' needs.

Declaration of Competing Interest

We have no known conflict of interest to disclose.

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