# Universal Complete Mental Wellness Screening Via Student Self-Report

## Rationale and Step-by-Step Approach 1



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# DEFINING COMPLETE MENTAL WELLNESS SCREENING

Until recently, mental wellness has primarily been defined as the absence of social-emotional or behavioral problems and pathology; that is, mental illness and mental wellness lie on opposite poles of a single continuum. Increasingly, however, contemporary "dual-factor" (Suldo & Shaffer, 2008) or "two-continua" (Keyes, 2005) models consider mental wellness as consisting of two separate yet related constructs: (a) symptoms of psychological distress, and (b) subjective well-being and/or social-emotional strengths. Whereas subjective well-being consists of positive affective emotions, negative affective emotions, and a generalized satisfaction with life (Antaramian, Huebner, Hills, & Valois, 2010), social-emotional strengths can be defined in several ways. For example, strengths have been defined as "emotional and behavioral skills, competencies, and characteristics that create a personal sense of accomplishment; contribute to satisfying relationships … ; enhance one's ability to deal with adversity and stress and promote one's personal, social and academic development" (Epstein & Sharma, 1998, p. 3), or as internal (e.g., positive values or coping skills) and external assets (e.g., supportive relationships or community characteristics; Scales, 1999). Utilizing an expanded perspective of mental wellness, individuals with low risk or distress and who also report high subjective well-being and/or strengths are described as having complete mental wellness. Support for the dual-continua model of mental wellness exists in research describing a variety of positive outcomes associated with complete mental wellness, including higher levels of student engagement (Antaramian et al., 2010), academic achievement, social functioning (Suldo & Shaffer, 2008), and physical health (Renshaw & Cohen, 2014).

Scholars supporting the dual-continua model of mental wellness recommend screening for individual strengths or assets in addition to symptoms and risk; that is, screening for complete mental wellness (Furlong, Dowdy et al., 2014). This recommendation is based on an awareness that solely evaluating risk leads to an incomplete picture of students' functioning, overestimating or underestimating student needs in important areas (Suldo & Shaffer, 2008). Complete mental wellness screening allows for a balanced, comprehensive view of youth development, enabling the identification of students who may not be indicated as at risk, but who are also not thriving (Furlong, Dowdy et al., 2014). Data collected through universal complete mental wellness screening can be used to promote the well-being of all

students, for example, when used to inform interventions to build individual and school-wide strengths.

## CURRENT SCHOOL-BASED SCREENING PRACTICES

Although the proportion of schools engaging in universal screening has increased in recent years (Bruhn, Woods-Groves, & Huddle, 2014), emotional and behavioral problems are often the primary focus of mental wellness screening and intervention (Dowdy et al., 2015). Problem-focused screening, however, do not fully address positive contributions to mental wellness and is provides actionable data for only approximately 15% of students who are identified with these measures. Conversely, the information obtained when assessing for strengths is relevant for all students. Although a relative minority of youth are both at-risk and ultimately experience negative outcomes (Masten et al., 1999), all youth have strengths that can be built upon in an effort to promote life-long positive outcomes (Epstein, 1999).

The inclusion of a strength-based approach in screening broadens educators' understanding of mental wellness, and can inform both reactive and proactive interventions by treating problems and enhancing developmental assets. A strength-based approach enhances students' sense of empowerment and self-esteem as well as their parents' and teachers' feelings of comfort and engagement in the assessment process (LeBuffe & Shapiro, 2004). Complete mental wellness screening approaches frequently focus on information obtained from subjective well-being measures as the sole indicator of positive mental wellness (e.g., Lyons, Huebner, Hills, & Shinkareva, 2012). However, other comprehensive strength-based instruments can be used to measure the range of positive psychological constructs beyond subjective well-being. For example, these instruments offer information regarding students' external assets, such as family involvement and caring relationships, and internal assets or resilience factors, such as cooperation/communication, goal orientation, problem-solving, self-efficacy, self-awareness, and empathy (e.g., Epstein & Sharma, 1998; Furlong, You, Renshaw, Smith, & O'Malley, 2014). An overarching goal of assessing for positive psychological assets in youth, and including comprehensive measures in complete mental wellness screening, is to facilitate positive, healthy, and thriving educational environments for all children (Huebner, Gilman, Reschly, & Hall, 2009).

# COMPLETE MENTAL WELLNESS SCREENING: FIVE KEY STEPS

We have parsed universal complete mental wellness screening into five manageable steps: identifying the key participants and plan, selecting screening instruments, obtaining consent, administering the screener, and following-up. Major considerations and recommendations for self-report complete mental wellness screening at each step are detailed below.

## Step 1: Identify the Key Participants and Plan

Conducting complete mental wellness screening is a multistep process that requires detailed planning and careful analysis of contextual factors. There are several pre-implementation considerations to address before conducting the screening itself. The first step for the successful implementation of complete mental wellness screening is to determine the key participants. School mental wellness staffs are ideally situated to take on a leadership or consultative role in complete mental wellness screening due to their knowledge of assessment, the psychological nature of the information obtained, their training in interventions to improve well-being, and their understanding of the importance of prevention and early intervention (Dowdy et al., 2015). However, because of the intricacies of the process, screening should be a multidisciplinary effort where numerous stakeholders (e.g., teachers, administrators, and support staff) collaborate to develop and implement the screening process (Desrochers & Houck, 2013). In order to be successful, screening needs to be incorporated into the functions of a school-based team. Schools may consider using pre-existing teams (e.g., response to intervention team, student support team, coordination of services team) as opposed to creating a new team.

One of the primary duties of the screening team is to carefully consider the principle objectives for the screening. For example, the team determines whether results will be used to plan schoolwide support efforts and to select students for various interventions. Additionally, the team can discuss the benefits of gathering complete mental wellness information across time to monitor the effectiveness of schoolwide programs designed to foster the well-being of all students. An understanding of financial and/or infrastructural limitations that may affect the screening process should guide the pre-implementation decisions. Similarly, the team will need to determine

who will be responsible for each step involved in the screening process. For example, the team will need to decide who will be responsible for obtaining parental consent, what type of consent will be sought, how screening assessments will be scored, what follow-up services are possible and who can provide these services, and how staff will be informed about the logistics of screening and results. Establishing clear objectives, creating a team, and assigning duties to team members can aid in the successful implementation of universal complete mental wellness screening.

### Step 2: Select Screening Instruments

After the objectives of the screening have been established, the screening team is ready to move on to ensuing phases of the screening process. One key pre-implementation step in the process of universal mental wellness screening is the selection of measures or instruments. Glover and Albers (2007) provide a set of criteria for evaluating instruments for potential use, including: (a) the compatibility of the instrument with the purposes for the screening, (2b) the theoretical and empirical support that addresses the technical adequacy of the instrument, and (c) the usability of the instrument.

The process of complete mental wellness screening calls for the assessment of both positive psychological functioning and psychological problems or distress. Thus, conducting complete mental wellness screening may require the co-administration of measures. When co-administering measures, however, additional considerations are necessary. For example, the order in which measures are presented can affect responses, with earlier items influencing responses to later items (Strack, 1992). However, the primary consideration when selecting screening tools is whether target instruments are adequately capturing both areas of student functioning. School mental wellness staff can provide leadership within the screening team to select appropriate measures with sufficient content coverage and strong psychometric support (e.g., sensitivity, specificity).

Determining the fit of the measure for the intended population is also of vital importance for the screening process and requires consideration of the age of the students to be assessed as well as what informants are available to provide information (Levitt, Saka, Romanelli, & Hoagwood, 2007). A comprehensive review of the rating scale informant literature revealed that different informants are recommended depending on the type of problem assessed (e.g., internalizing or externalizing), and age of the

client; for example, self-reports are recommended when working with adolescents to detect internalizing symptoms (Smith, 2007). Kamphaus and Frick (2002) suggest collecting information from multiple informants, when possible, to have a better and more holistic understanding of students' well-being.

The practicality and usability of the selected screening instrument for the target population is another factor to consider. This includes the amount of time required to complete the measure, the type of training required to administer it, and any special requirements for scoring and interpretation (Glover & Albers, 2007). Additionally, in accordance with a culturally competent screening practice, it is critical to consider the demographics of the population and ensure that the screening measures chosen have adequate psychometric support for the intended population (Dowdy, Kamphaus, Twyford, & Dever, 2014).

Although an in-depth review of the various types of instruments used in school-based screening is beyond the scope of this report, the reader can reference Levitt et al. (2007), Severson, Walker, Hope-Doolittle, Kratochwill, and Gresham (2007), or Jenkins et al. (2014) for reviews of problem-focused social-emotional and behavioral screeners. In Appendix 1, we provide an overview of four strength-based screening instruments: Multidimensional Students' Life Satisfaction Scale (MSLSS; Huebner, 1994), Students' Life Satisfaction Scale (SLSS; Huebner, 1991), Positive and Negative Affect Scale for Children (PANAS-C; Laurent et al., 1999), and the Social Emotional Health Survey – Secondary (SEHS-S; Furlong, You, et al., 2014). We focused our review on measures that (a) had been used in complete mental wellness research, (b) offered support for use with U.S. students, and (3) could be completed via student self-report. Currently, complete mental wellness screening often necessitates choosing both a problem-focused and a strength-focused measure to ensure adequate coverage in each area.

## Step 3: Obtain Parent Consent and Student Assent

As decisions are made regarding instrument selection, informants, and other pre-implementation factors, the screening team will want to determine the best approach to obtain consent for screening. In its Principles for Professional Ethics (PPE), NASP (2010b) highlights the need for consent and assent in the screening process. Congruent with the ethical principles, school mental wellness staffs and members of the screening team may consider

gaining consent from parents or legal guardians in one of two ways: active or passive consent. Active and informed consent is preferred by professionals to ensure that the family-school relationship remains intact and that parents feel their voice is valued (Levitt et al., 2007). This is in contrast to passive consent, wherein a parent's non-response is their consent. However, there are strengths and limitations associated with both approaches to consent. See Appendix 2 for an example of a parent consent letter related to a school-university partnership.

Use of active consent calls for caution regarding bias in the consent process. Active consent has been associated with the selection of fewer minority students, larger numbers of two-parent households, students with higher academic achievement, students who participate in more extra-curricular activities, and more female participants (Anderman et al., 1995; Unger et al., 2004). This may alienate the students who could benefit most from the screening. With this caution in mind, the screening team must consider district protocols as well as their unique school population. If a district mandates active consent, the team should make every effort to ensure that no one group is underrepresented or excluded from screening. Should passive consent be utilized, the team must be aware that any further screening or intervention that is triggered by the initial screening would require additional consent.

It is also important to actively involve the youth participants in the consent process. To the maximum extent possible, school mental wellness staffs should seek to gain the voluntary assent of the students whom they are screening, in accordance with the Autonomy and Self-Determination guideline imposed by NASP's ethical principles (NASP-PPE I.1). School-based mental wellness professionals should consider how to best communicate with students and their parents to further explain the process and ensure an informed decision.

## Step 4: Administer the Screener

As the day of screening approaches, the screening team will want to ensure that all materials (e.g., consent forms, screening scripts, screeners if paper/pencil or link if online) and staff guidelines have been prepared and are ready to be distributed to all staff involved. Screening is more likely to proceed smoothly when any printed materials are organized by classroom, and teachers have received communication about the logistics of screening,

including when the screening will occur, who will be responsible for distributing surveys and proctoring during the screening period, how to track and follow-up with students that are late or absent, and where to return completed surveys. An important consideration for determining at what time during the school day screening will occur is whether or not students will miss instructional time (Dever, Raines, & Barclay, 2012). Dever and colleagues (2012) recommend screening during a homeroom period, if possible, as teachers typically prefer maximum use of instructional time. However, not all schools incorporate a homeroom period into their students' schedules. In these instances, school mental wellness staffs can consult with teachers and administrators to determine an ideal screening period and ensure organizational infrastructure is in place for screening to proceed smoothly (Glover & Albers, 2007). School mental wellness staffs can also work with teachers to communicate the importance of data to be collected and to help teachers understand their role in the screening process. Additionally, if screening is conducted online, all students may be unable to complete the screener at the same time if there are limited computers available. As schools move towards online standardized assessments, the infrastructure or rotation schedule that already exists may be used to complete the screening process.

Once the screening method, period, and location have been determined, screening proctors (typically teachers, aids, counselors, or the psychologist) need to be informed of their role. Best practice guidelines recommend that proctors are provided with scripts so that administration across classrooms is standardized (Dever et al., 2012). Scripts may include information such as an introduction to the screening including its goals, notes about confidentiality of results, and relevance to be relayed to students. Step by step instructions for survey completion and guidelines for returning surveys to the appropriate location can also be included.

On the day of screening, in addition to the above organizational efforts, the school mental wellness staff can check-in with teachers, offer support in large classrooms, and monitor absentees, late arrivals, and students who declined consent/assent. Once a list of absent students has been generated, the school mental wellness staff can work with administrators and teachers to delineate the process for following-up with these students, ideally as soon as possible after the initial screening day. The school mental wellness staff may also help to ensure that all data are

collected for processing and scoring. If paper-and-pencil surveys were completed, schools likely will need to coordinate staff efforts to score student surveys. An advantage of online screening via survey response systems (e.g., Qualtrics ®) is that data can be readily downloaded into computer software for processing. School mental wellness staffs can also be instrumental in analyzing and interpreting data or in organizing these efforts with other personnel (Glover & Albers, 2007). Best practice guidelines stress the necessity for data to be processed as quickly as possible so that students indicating risk and/or low strengths are identified and receive supports promptly.

### Step 5: Follow-Up

Once screening data have been collected and analyzed, the screening team needs to determine the process for reporting results back to staff, students, and parents and for following-up, as needed, with students. As universal screening is intended to alert the screening team about students who may need additional support, follow-up efforts should occur as soon as possible after screening and include additional data collection, when necessary, via assessments targeting specific strengths and concerns (e.g., perceived peer support or internalizing problems). Data regarding school-wide patterns can be presented at staff meetings or during professional development. For example, the school mental wellness staff might share that many students endorse feeling connected to school staff but also report low persistence on academic tasks. These observations can then be linked with research-informed recommendations for school-wide or classroom-based interventions that continue to promote students' well-being while also ameliorating risk (Doll & Cummings, 2008). Screening efforts must also include intervention planning, where screening data are used to inform and guide follow-up intervention (Cook, Volpe, & Livanis, 2010). As discussed by Meier (1975), screening without also planning for subsequent support is wasteful and can have a negative impact on students who are labeled during the screening process.

A common concern of school stakeholders is that screening will identify more students than can be served with current school resources. Though more students may initially be identified through universal screening, when screening is implemented within a multi-tiered system, over time, the number of students requiring intervention is theoretically expected to

decrease (Dever et al., 2012). Preliminary investigations into early identification programs have been promising, empirically finding that the numbers of children identified were manageable within those existing school and community systems (Foy & Earls, 2005; Levitt et al., 2007; Murphy, 2005; Nemeroff et al., 2008). However, research empirically investigating the proportion of students identified for follow-up intervention as a result of universal screening and the potential for a decrease over time is needed. Despite these limitations in our knowledge base, current best practices suggest that, as part of their initial planning, schools carefully examine available resources and determine how many students they can expect to serve adequately and what types of services can be provided.

Screening for complete mental wellness allows for the development of interventions to support students by preventing or addressing risk while also promoting positive development and personal well-being (Suldo & Shaffer, 2008). It is recommended that interventions be implemented at all levels of service delivery, that is, at universal, selected, and indicated levels (Vannest, 2012). Suldo and Shaffer (2008) explain how multi-tiered interventions can be designed utilizing complete mental wellness screening data. Although all students can benefit from school-wide programs, those students who have low risk but who also report low personal well-being can benefit from small group interventions aimed at developing assets and well-being. Students with elevated risk but also reporting high levels of assets, on the other hand, would benefit from interventions addressing their risk while also capitalizing on their strengths and continuing to promote well-being. Finally, interventions with the greatest intensity, and often individually tailored, would be provided to students reporting elevated risk and few strengths. School mental wellness staffs can use their knowledge of effective interventions when working with their screening team to design and coordinate follow-up intervention efforts.

Once screening has concluded and follow-up efforts are in place, the screening team can conduct a thorough review of the recent screening process. The team's evaluation may include analyzing measures used, administration procedures, and data analysis techniques, as well as soliciting feedback from teachers, students, and other staff as to what went well and what can be improved upon. A critical examination of the entirety of the screening process is important in sustaining and improving complete mental

wellness screening practices and informing follow-up efforts to promote students' thriving well-being.

# ILLUSTRATION OF COMPLETE MENTAL WELLNESS SCREENING

During the 2014-2015 school year, the current research team was involved in the universal complete mental wellness screening of adolescents at a public high school in Southern California. This Title 1 school served 702 students in grades 9 through 12, who are predominantly Latino (89.7%), and where a majority of the students are from families that are experiencing disadvantaged economic circumstances. Prior to school starting, school and university collaborators met to discuss each of the five screening steps. Below, we illustrate the considerations and actions taken by the screening team.

### Step 1: Identify the Key Participants and Plan

Prior to screening, a Coordination of Student Services Team (COST), comprised of the school mental wellness staff, administrators, teachers, psychiatric social worker, and university partners, met to delineate the necessary materials and resources needed to move forward with universal screening. This pre-existing team was responsible for the oversight of student support services, and determined that the objectives of screening were consistent with their overarching purpose to proactively support students. The team discussed goals of screening, measures assessing constructs relevant to these goals, obtaining parental consent, and when and how screening would be conducted. The primary stated objective of screening was to determine school-wide and individual student needs, focusing on preventing or addressing current problems as well as building students' strengths and school-based resources; this is aligned with screening for complete mental wellness. The school mental wellness staff took responsibility for organizing team efforts, tracking absent and late students, and monitoring consent. The administrator took responsibility for ensuring that the staff was informed of the purpose and plan for the screening and disseminating results to the staff. The teacher was responsible for determining the optimal timing of the screening during the school day, and the psychiatric social worker was responsible for coordinating follow-up prevention and intervention activities. Due to the unique situation of having

university involvement, the university partners took responsibility for scoring assessment results, providing results to the COST team, and training the school mental wellness staff in scoring techniques to foster independence in the future.

**Step 2: Determine Screening Instruments**

Consistent with the goals of complete mental wellness screening, the COST team was interested in information on symptoms of psychological risk and social-emotional strengths. After reviewing available measures, the team determined that data would be collected using the Behavior Assessment System for Children-2 Behavior and Emotional Screening System (BESS; Kamphaus & Reynolds, 2007) and the Social Emotional Health Survey - Secondary (SEHS-S; Furlong, You et al., 2014). The BESS is 30-item self-report instrument for students in 3rd through 12th grade, assessing a wide range of behavioral risk symptoms, including inattention/hyperactivity, internalizing problems, school problems, and personal adjustment. Psychometric properties of the BESS Student are generally acceptable, with good test-retest reliability, split-half reliability, and moderate correlations with other measures of behavioral and emotional problems (Kamphaus & Reynolds, 2007). The SEHS-S is a 36-item self-report measure designed to assess social-emotional strengths. It includes a total score and 12 positive psychological dispositions that load onto four second-order traits: Belief in Self (Self-Efficacy, Self-Awareness, Persistence), Belief in Others (School Support, Family Coherence, Peer Support), Emotional Competence (Emotion Regulation, Empathy, Self-Control), and Engaged Living (Optimism, Zest, and Gratitude). Psychometric properties for the SEHS-S are also acceptable (Furlong, You et al., 2014). The BESS and SEHS-S were chosen for several reasons: (a) both are brief instruments that allow for efficient screening, (b) both instruments provide an overall measure of either positive psychological functioning or psychological problems, (c) co-administering measures allows for adequate representation of each area of student functioning, and (d) each has considerable psychometric support. Distinct measures of student problems and strengths were selected as the COST team was seeking comprehensive representation of each psychological domain.

### Step 3: Parent Consent and Student Assent

After discussing the benefits and consequences of passive and active consent, the COST team determined that passive consent would be optimal in order to screen the largest number of students possible. Following consultation with the district Director of Psychological Services, passive consent forms were included in the yearly registration packets. Parents were informed about the purpose of the screening and were provided the opportunity to decline consent for their child to participate in the universal screening or any follow-up screening. Parents who declined consent were called to confirm the child's exclusion from screening activities. Prior to screening, an administrator created a comprehensive student roster including names, district identification numbers, and class schedules to identify students who would not participate. These lists were distributed to teachers on the day of screening to ensure only students with parental consent would complete the screening survey. Student assent was also attained; those students who preferred not to participate or whose parents declined consent were summoned from class by the school mental wellness staff and offered independent study in the library for the duration of screening.

### Step 4: Administer the Screener

School-wide screening occurred toward the end of the first month of school on a date the COST team determined. Despite the recognized benefits of online screening, the COST team determined that paper/pencil surveys would be used due to a lack of technology infrastructure. Therefore, prior to screening, the team prepared packets of surveys, organized by classroom. On the morning of screening, packets were delivered to teacher mailboxes, and the COST team members were available to answer any remaining questions about the screening procedure. Included in each teacher's screening packet was a script with specific instructions for how to present the screening, directions to follow to ensure smooth administration, and a class roster indicating students who were not to participate. The COST team determined that students would complete the screening surveys during their second period classes, most often with teachers proctoring. For courses with large enrollment (e.g., gym, band), additional staff (e.g., school psychologist, counselors) offered support to teachers, helping to distribute materials and answer student questions.

Screening data were collected from teachers at the conclusion of the screening period for processing. A school-wide list of absent or tardy students was compiled. The school mental wellness staff made five additional attempts to meet with these students and administer the screening survey. The university partners entered the data, simultaneously consulting with the school mental wellness staff to decide how this step would be completed in future years. The COST team determined that an existing staff member or temporary district employee would be devoted to data entry the following year unless the online infrastructure improved. Once all data were entered, students were sorted into priority groups for follow-up based on their reported levels of psychological distress and social emotional strengths. Students reporting high levels of distress and low levels of strengths were placed into the highest priority groups. Table 1 presents the percentage of students falling into each priority group. Most students reported low average to high strengths and average risk, while fewer students reported high risk and low strengths.

**Table 1: Percentage Students in Priority Groups from Universal Screening Data**

| SEHS-S Strength Groups | BESS Risk Groups | | |
|---|---|---|---|
| | Normal Risk | Elevated Risk | Extremely Elevated Risk |
| Low Strengths | 4. Languishing 2% | 2. Moderate Risk 3% | 1. Highest Risk 3% |
| Low Average Strengths | 5. Getting By 23% | 3. Lower Risk 5% | |
| High Average Strengths | 6. Moderate Thriving 41% | 9. Inconsistent 4% | 8. Inconsistent 1% |
| High Strengths | 7. High Thriving 18% | | |

Note. Shading indicates highest priority students for follow-up. The percentage of students falling into each priority group may vary by school.

## Step 5: Follow-up

Following school-wide complete mental wellness screening, school results were presented to teachers and other support staff during a professional development workshop approximately one month after screening day. Prior to the staff meeting, the COST team met to review results, identify students in need of follow-up assessment, and discuss interventions appropriate to meet individual student and school-wide needs. The COST team used a multi-tiered approach to service delivery, including individual, group, and school-wide prevention and intervention activities. Students reporting moderate to high risk and also low personal strengths (i.e., Highest, Moderate, and Lower Risk); as well as students reporting low risk and low personal strengths (i.e., Languishing) were targeted in follow-up efforts (see Table 1). The majority of students were identified as having normal risk and average strengths (i.e., Getting By and Moderate Thriving) while fewer students were identified to be at-risk or in need of follow-up (i.e., Highest, Moderate, and Lower Risk; Languishing).

Students identified through screening as potentially needing additional supports were discussed by the COST team to: (a) determine who was already receiving services, (b) connect with other existing sources of data (e.g., failing grades, excessive absences), (c) match students with existing services, and (d) determine who was in need of additional support. Using a triage approach, whereby the students most in need of support were considered first, the COST team initially followed up with students in the highest risk priority groups (see Table 1). The school mental wellness staff and psychiatric case worker provided individual counseling to the students most at-risk or those deemed most appropriate for individualized supports. Additionally, students who were identified to have elevated risk and low to low average strengths were offered the opportunity to participate in various prevention and intervention groups, for example, aimed at building skills to aid in the reduction of depressive symptomatology or increase peer support. Students with significant externalizing or internalizing symptoms were recommended for small skill-building intervention groups led by members of the COST team targeting these areas of need.

Meanwhile, the COST team discussed plans for school-wide efforts to address commonly reported areas of student need. For instance, at this school, a majority of students indicated low gratitude via the SEHS. Therefore, during staff meetings occurring in the following months, the school mental wellness staff met with teachers to recommend classroom-based interventions found to be effective for building gratitude (e.g., a weekly gratitude journal; Emmons & McCullough, 2004). At each subsequent staff meeting, the school mental wellness staff reviewed skills for teachers to use in planning interventions in their classrooms, tying results from the screening to evidence-based interventions. Twelve handouts were created summarizing classroom-based interventions and resources targeting the 12 strength areas measured by the SEHS-S; one was reviewed at each meeting (see an example handout in Figure 1). Finally,



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## Zest in the Classroom

*Zest* is the degree of enthusiasm and energy with which a student approaches work.

In response to the statement, "Since yesterday, I have felt Energetic?" students responded:
Not at all true: 24%    A little true: 28%    Pretty much true: 27%    Very much true: 21%

### Humor in Tests

Tests can cause a great deal of anxiety for students. This anxiety can be reduced through the inclusion of humorous or "joke" items on tests. Humor and laughing have been shown to have positive psychological effects and to produce a sense of well-being that allows people to deal with stressors more effectively. The humorous question should not be confusing, difficult, or include humor above the level of understanding of the students. A simple, silly question on a test that provokes laughter can improve student performance.

### Funny Introductions

Humor is especially effective in increasing enthusiasm and motivation when used during the introduction of a new topic. Before beginning a new lesson, begin by telling a humorous related anecdote. Students also benefit from humorous visual stimulation, so, if possible, include a funny picture that relates to the topic. Humor is most effective when used with students who are not already engaged or motivated, so using it at the beginning of a new lesson allows you to reap the greatest benefits.

### Student Participation

Involve students in creating an open, comfortable classroom climate by encouraging them to be humorous as well. Ask students to find funny quotes relating to the topic at hand and share them with the class. You can post these quotes on the whiteboard, or make them into more permanent classroom decorations. You can also challenge students to invent their own puns relating to the topic.

**Zest is closely linked to happiness.**

Studies have identified zest as one of three strengths of character most closely related to happiness in youth. The other two strengths identified are love and hope. While other character strengths, such as gratitude, are robustly linked to happiness in adults, zest has been shown to have these effects even in young children.

**Zest prevents negative outcomes.**

Beyond promoting positive effects such as happiness, zest has also been shown to mediate the association between avoidance and life satisfaction. The development of zest in anxious or avoidant individuals may promote increased happiness. Additionally, zest prevents other negative outcomes such as boredom and anxiety.

**Resources**

Using Humor in the Classroom

Best Teaching Practices: Humor in the Classroom

Humor in the Classroom: Stu's 7 Simple Steps

For more information about the Social Emotional Health Survey, see: www.project-covitality.info

*Figure 1. Example of Zest Information Handout. Also, see http://project-covitality.info/prevention-and-intervention/covitality-resource-list.pdf for additional information and strategies for the 12 Covitality Mindsets.*

after all data were processed and interventions were underway, the COST team met again to evaluate the screening process and note activities to continue or modify for the following year's screening.

## FUTURE DIRECTIONS AND CONCLUSION

Universal complete mental wellness screening that assesses for students' positive psychological functioning in addition to problems offers schools valuable data that can be used in promoting the thriving social, behavioral, and emotional well-being of all students. As a relatively new approach to fostering student well-being, further investigations into the application and benefits of complete mental wellness screening are warranted. For example, future research into the long-term predictive validity of universal screening tools, including both problem-focused and strength-focused measures, is needed (Albers, Glover, & Kratochwill, 2007; Nickerson & Fishman, 2013). Although research on problem-focused measures has supported the ability of screening tools to predict academic and behavioral outcomes, there is still a need for research investigating the ability of these instruments to predict later outcomes (e.g., referrals for special education, participation with the juvenile justice system, and dropout rates; King & Reschly, 2014). Investigation into complete mental wellness screening with culturally and linguistically diverse students is also needed to assess the effectiveness of various instruments and approaches across populations (Dowdy et al., 2014). In light of many districts moving towards multi-tiered systems of support and response to intervention frameworks, future research and practice may also examine how screening tools measuring subjective well-being and social-emotional strengths as well as those measuring distress symptoms can be optimally integrated into a comprehensive system of assessment, prevention, and intervention (Kim et al., 2014).

In order for complete mental wellness screening to be practical and sustainable for schools, it is also critical to consider how schools without university partnerships are able to independently conduct all aspects of the screening and follow-up needed. For example, in the illustration above, university partners provided consultation, entered data, scored assessments, and delivered results to the team. Hiring a temporary employee, or reallocating duties to an existing staff member to enter data may not be feasible or sustainable. To help manage the data entry, scoring, and

interpretation processes from the outset, schools may wish to consider screening via an online format with built in scoring and reporting software (e.g., Review360 available for the BESS). Unfortunately, however, when combining information across multiple surveys and constructs of interests, as is recommended in complete mental wellness screening, the options for automatic scoring and reporting are limited. Online screening using multiple surveys (e.g., via Qualtrics ®) will require an initial investment in time, professional development, or consultation to build a sustainable infrastructure including a way to easily export, merge, and analyze data that can be efficiently input into template reports for use at schools. School mental wellness staffs are knowledgeable in data-based decision making, research, and program evaluation and likely have the requisite skills required to manage the scoring and reporting of results (NASP, 2010a). Furthermore, school mental wellness staffs are versed in school-wide practices to support learning and resource-mapping; skills helpful when determining how best to serve students identified as in need of additional services. To aid in this process, school mental wellness staffs can also advocate with their principals and district administrators for additional professional development opportunities to further build their skills in management of screening data or to allocate funds to enable consultation and partnership with a data analyst.

As school-based mental wellness continues to move in the direction of prevention and promotion of student well-being, it will be critical to ensure that the science behind screening continues to evolve. Meanwhile, we hope that schools will continue to identify and serve students in proactive ways, by engaging in universal complete mental wellness screening for both psychological risks and strengths. School mental wellness staffs have the potential to play an important role in this process of serving youth in need.

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## APPENDIX 1. STRENGTH-BASED INSTRUMENTS

| Characteristics | Instrument | | | |
|---|---|---|---|---|
| | **MSLSSI** | **SLSS** | **PANAS-C** | **SEHS-S** |
| Age/Grade | 3-12 Grades | 3-12 Grades | Ages 6-17 | Ages 12-17 |
| Number of Items | 40 | 7 | 27 | 36 |
| Administration Time | 10-15 min | 2 min | 10 min | 10-15 min |
| Constructs Assessed | Satisfaction with Family Friends Living Environments Self Total Life Satisfaction | Overall Life Satisfaction | Negative Affect (NA) Positive Affect (PA) | Belief-in-Self Belief-in-Others Emotional Competence Engaged Living Overall Covitality |
| Reliability & Validity | IC: Domains and Total: .78-.93 (Huebner, Laughlin, Ash, & Gilman, 1998) | IC: .82 with 4th-8th graders (Huebner, 1991); .86 with 8th, 10th, and 12th graders (Dew & Huebner, 1994) | IC: .92-.94 for NA .89-.90 for PA (Laurent et al., 1999) | IC: Domains and Overall Covitality .76-.91 (You et al., 2014) |
| | TRT: 4-week interval for Domains and Total: .53-.81 (Huebner et al., 1998) | TRT: 4-week interval .64 (Gilman & Huebner, 1997) 1- to 2-week interval .74 (Huebner, 1991) | N/A | N/A |

| Characteristics | Instrument | | | |
|---|---|---|---|---|
| | **MSLSSI** | **SLSS** | **PANAS-C** | **SEHS-S** |
| | CV: Family domain r = .73 with Parent Relations scale of the Self-Description Questionnaire (SDQ)-II (Huebner et al., 1998) | CV: r = .53 with the Piers-Harris Self-concept total score (Huebner, 1991) | CV: NA r =.59-.60 Children's Depression Inventory, r = .62-.68 with Trait Anxiety Scale of the State-Trait Anxiety Inventory for Children (Laurent et al., 1999) | CV: Overall Covitality r = .89 with subjective well-being, as measured by the SLSS and PANAS-C (Furlong et al., 2014) |
| | Friends domain r = .55 with Same Sex Peer Relations scale of the Self- Description Questionnaire (SDQ)-II (Huebner et al., 1998) | r = .65 with the Self Esteem Inventory (Huebner & Alderman, 1993) | | |
| | School domain r = .68 with the Quality of School Life Scale (Huebner, 1994) | r = .52 with global self-esteem subscale of the Self-Description Questionnaire-II (Dew & Huebner, 1994) | | |
| | Self-domain r = .62 with General Self scale of the Self-Description Questionnaire-I (Huebner, 1994) | DV: r = -.52 with the Nowicki-Strickland Locus of Control Scale-Short Form (Dew & Huebner, 1994) | DV: PA negatively correlated r = -.42 to -.55 with Children's Depression Inventory and r = -.20 to -.30 with Trait Anxiety Scale of the State-Trait Anxiety Inventory for Children (Laurent et al., 1999) | DV: Covitality r = -.63 with BESS (You et al., 2014) |
| | DV: School domain r = -.70 with the BASC Attitude Toward School Scale | r = -.30 with the Externalizing subscale, r = -.26 of the Internalizing subscale, and the composite | | |

| Characteristics | Instrument | | | |
| --- | --- | --- | --- | --- |
| | **MSLSSI** | **SLSS** | **PANAS-C** | **SEHS-S** |
| | (Gilman, Huebner, & Laughlin, 2000) | Total Behavior Problem score of the Achenbach Teacher Report Form<br><br>r = -.61 with the Reynolds Child Depression Scale (Huebner & Alderman, 1993)<br><br>r = -.56 with the Loneliness and Social Dissatisfaction Scale (Huebner & Alderman, 1993) | | |
| Web Link | https://ww2.cas.sc.edu/psyc/sites/default/files/directory_files/huebslssitems.pdf | https://ww2.cas.sc.edu/psyc/sites/default/files/directory_files/huebslss.pdf | https://deepblue.lib.umich.edu/bitstream/handle/2027.42/91559/leahhope_3.pdf?sequence=1 | www.project-covitality.info |
| Reference | Huebner, E. S. (1994) | Huebner, E. S. (1991) | Laurent et al. (1999) | Furlong, You, Renshaw, Smith, & O'Malley (2014) |

Note. IC = Internal Consistency; TRT = Test Re-Test Reliability; CV = Convergent Validity; DV= Discriminant Validity

# APPENDIX 2: EXAMPLE OF PARENT CONSENT LETTER

**Using data sharing with a university research partner**

Dear Parents/Guardians,

Our school is interested in the behavioral and emotional health of our students. This year, San Marcos High School will be participating in a brief, universal screening survey for measuring behavioral and emotional strengths and weaknesses in adolescents. All students who agree to participate will complete a brief form during part of one class period on one occasion during regularly scheduled school activities. This survey has been approved by High School and the School District, in collaboration with researchers from the University.

Assessing the behavioral and emotional functioning of adolescents helps to promote student success. Academic difficulties, along with challenges associated with developing and maintaining positive relationships with others, can be the result of underlying behavioral and emotional factors. When caught early, any difficulties can be addressed before negatively affecting an adolescent.

Your child does not have to participate. Participation in the survey is voluntary, and opting out will not impact your child's academic status or access to services. Prior to taking the survey, all students will be informed that participation is voluntary and that opting out will in no way impact their standing at school. All information collected will be kept confidential.

The school counselor at your child's school will receive the results of the survey. If your child responds to the survey in a way that indicates possible risk for behavioral, emotional, or social challenges that impact school performance, they will be invited to meet with their school counselor to determine if they would be interested in, or benefit from, any additional support services so that your child feels like an important and engaged member of our school. This could include extra programs, services, clubs, or campus activities, or communicating with teachers and guardians about how to help them be successful at school. You will be informed before any further assessments, interventions, or services are conducted, developed, or implemented.

Researchers at university would like to use your child's survey results for research purposes in order to better understand how to help all schools to identify emotional and behavioral risk in support of intervention. Survey results will be correlated with educational school records from xxxx-xxxx (e.g., demographic data, standardized test scores, grades, attendance, credits earned, disciplinary referrals, placement in programs). University researchers will use the student identification numbers rather than your child's name in the study records to link educational records to survey results. Because researchers will receive student records for the purpose of education research in developing a predictive test (the survey), the disclosure of your students' records including their ID number is compliant with Family Educational Rights and Privacy Act (FERPA) regulations; again, your student's name will not be provided to the researchers.

If you do not want your child to complete the survey or to participate in the research, please send the bottom portion of this letter back to your child's school. Your child's participation in the survey will signal to us your acceptance for your child to participate in the school's behavioral screening process.  Please note that you can choose for your child to complete the survey but not to be involved in the research. You may also have your child withdraw participation at any time. If you have additional questions regarding the screening program, please contact Dr. Researcher at email or xxx.xxx.xxx. If you have any questions regarding your rights and participation as a research subject, please contact the Human Subjects Committee at xxx-xxx-xxxx or email. Or, write to the University Human Subjects Committee, address.

Sincerely,

Principal

YES: I want my child to participate in the screening and research.

     You DO NOT need to return this form.

  NO: Please PRINT this form, check all that apply, and return this form.

  I do NOT want my child to participate in the screening. Your child will NOT complete the survey.

  I do NOT want my child to participate in the research. Records will NOT be shared with researchers.

Student Name: _____     Grade: _____Date of Birth: _____

# APPENDIX 3: EXAMPLE SCREENING ADMINISTRATION PROTOCOL

Thank you for your help! Your class has been assigned to complete the survey in one of the computer labs. Please take your students to the computer lab on the assigned day during this period. A Leadership student will be available to assist you.

Attached to this page is your class roster. We have highlighted all students in your classroom that opted out of the survey with a parent signature. Please don't administer the survey to these students.

Please mark on the roster who was absent (write "A" next to student name) or is no longer enrolled in your class (write "E" next to student name). When students are finished taking the survey, turn in your envelope with the roster to the Leadership student who was assisting you. Then, we will follow-up with those students to take the survey at a different time.

**Script for the Survey Process (Please read the following aloud to your students)**

Example School is committed to developing programs to help you learn better and feel better about your experiences in school. Today you are being asked to complete a survey to answer some questions about how you feel and how you have felt over the last few weeks. Please be honest in your responses as the counselors and other staff at your school will use this information to support students. The school staff will not share your answers with anyone unless they think you might benefit from extra support. We are truly interested in your opinions so we can help out students like you. This is NOT a test and there are no right or wrong answers.

The survey link is pulled up on all of your computers. In the top right corner of each page, there is a dropdown menu where you can choose which language, English or Spanish, to take the survey in.

You'll be asked to provide some background information about yourself. Then, you'll be asked if you agree to participate in the survey. Please indicate if you will or will not take the survey. Then, please click NEXT to begin the survey.

> *(If a student chooses not to complete the survey, out of courtesy to the other students please ask them to sit quietly until the other students finish)*

If you do not understand one of the statements, please raise your hand and I'll come around to answer your question.  You can now begin.

Thank you

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|---|---|---|
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|---|---|---|

# INTERNATIONAL CENTER FOR SCHOOL-BASED YOUTH DEVELOPMENT



University of California Santa Barbara
Santa Barbara, California, USA, 93016
Website: www.project-covitality.info

Ongoing research is also being carried out on the developmentally linked Primary (Grades 4-6) and Higher Education (transition age youth). Contact Project Covitality for information about the entire Social Emotional Health Survey System. If you would like to learn more about our current research, please contact Mike Furlong to set up a Zoom conference meeting.

*Social Emotional Health Survey System*
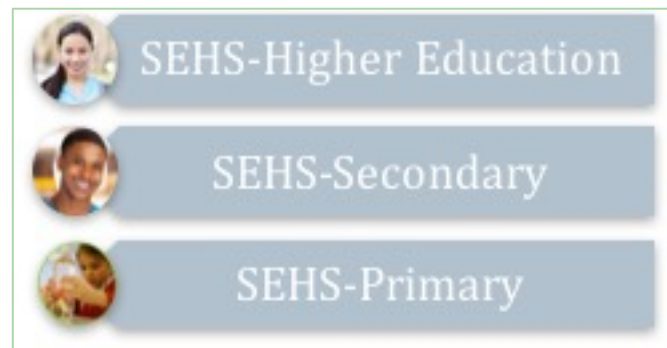
# ACKNOWLEDGEMENTS

# INTERNATIONAL COLLEAGUES

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