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Emotional and Behavioral Disorders Screening in Utah Schools

Oakley Dean Banks

A thesis submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of
Educational Specialist

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ABSTRACT

Emotional and Behavioral Disorders Screening in Utah Schools

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This descriptive study provides insight on the prevalence of Emotional and Behavioral Disorders (EBD) screening and school psychologists' roles in that screening process in Utah schools. EBD screening plays an important role in implementing Multi-Tiered System of Supports (MTSS). An electronic questionnaire was sent to 260 practicing Utah school psychologists. A total of 89 of those school psychologists completed the survey resulting in a 34% participation rate. Twelve percent (n=11) of participants reported that EBD screening was happening in their schools. Participants reported that the lack of resources to address student needs, the lack of administrative support, and the school having too many other concerns were barriers to EBD screening implementation. Survey results also reported that successful EBD screening consisted of a combined effort consisting of teams, administration, and school districts. Additionally, school psychologists reported that their role in EBD screening should mainly be focused on data interpretation and intervention implementation. The goal of this thesis project was to increase awareness of how universal EBD screening was occurring in Utah schools.

Keywords: screening, multi-tiered system of supports, emotional and behavioral disorders, social and emotional learning

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CHAPTER 1

Introduction

Today's schools are bombarded with many challenges in meeting the social, emotional, physical, and academic needs of students. Students' emotional and behavioral issues are just one facet of the challenges that schools face (Hanko, 2005). Universal social and emotional screening to encourage timely efforts to address these student problems has become more widely discussed among practitioners and researchers (see McIntosh & Goodman, 2016). This study explores the prevalence of universal emotional/behavioral screening in Utah schools in the context of implementing multi-tiered systems of support. This research identifies the details of implementing screening, who is involved, and what instruments are being used. Also, problems often encountered when conducting screening for Emotional and Behavioral Disorders (EBD) are explored.

The small amount of research on the prevalence of EBD screening suggests that screening is happening infrequently (Bruhn, Wood-Groves, & Huddle, 2014). Additionally, there is a lack of research regarding its implementation in schools even though effective program implementation has been thoroughly explored (Smith et al., 2014).

Using a survey of practicing school psychologists, this research aims to discover how often screening is happening in Utah schools and what barriers stand in the way of effective screening in schools. The results contribute to understanding effective ways to implement and sustain EBD screening.

CHAPTER 2

Literature Review

A recent effort to improve student outcomes is the implementation of several frameworks (i.e., Response-to-Intervention, Positive Behavioral Interventions and Supports, and Multi-Tiered Systems of Support) that focus on meeting the individual needs of students, regardless of general or special education placement. This study sought to describe how universal screening is being implemented as a vital part of system-wide frameworks. This screening can identify students at risk for emotional or behavioral issues and provide the steppingstone for intervention (Stiffler & Dever, 2015).

Multi-Tiered System of Supports

Multi-Tiered System of Supports (MTSS) is the integration of the Response-to-Intervention (RTI) and Positive Behavioral Interventions and Supports (PBIS) models into a combined system that addresses students' academic and social problems (Freeman, Miller, & Newcomer, 2015). RTI is a preventative systems model that uses progressively intensive interventions to improve academic achievement tailored to the individual student. PBIS is a framework used to support all students' positive behaviors by using tiered interventions and evidence-based practices (McIntosh & Goodman, 2016). MTSS is based on a public health model for prevention (World Health Organization, 2004). The combination of RTI and PBIS helps to identify struggling students early to avoid progressive academic delays and problem behaviors by accessing support and through progress monitoring (McIntosh & Goodman, 2016).

Levels of support. MTSS uses a three-tier framework in its proposed structure of prevention strategies and timely intervention. It is not a specific model or program but rather a system that uses RTI and PBIS to address multiple content areas in education (McIntosh &

Goodman, 2016). Traditional MTSS has three tiers of support. Tier 1 refers to the first level of academic and behavioral prevention in which services are offered to all students attending the school. These services are typically effective for the majority of students. Tier 1 includes robust evidence-based instruction and other supports that are deemed appropriate for all students (McIntosh & Goodman, 2016).

In Tier 2, identified students are given additional targeted instruction. This support for these students is considered necessary given that these students were not successful and did not make adequate progress with regular instruction and other services provided in Tier 1. Tier 2 interventions include a variety of strategies that usually incorporate small group work with targeted instruction to address specific skill deficits. Tier 2 supports are explicitly connected to core instruction. In this tier, progress is carefully and frequently monitored so that interventions are adjusted to student needs. However, if Tier 2 efforts are unsuccessful, Tier 3 services are considered (Kovaleski, VanDerHeyden, & Shapiro, 2013).

Tier 3 services are the most intensive supports in the model and are offered to those students who have usually received Tier 1 and Tier 2 services but did not respond nor progress sufficiently in academic achievement and/or social and behavioral development. Yet, for students exhibiting skills that are significantly behind their peers, Tier 3 services may be initially offered rather than sequentially attempting Tier 1 and 2 services (Kovaleski et al., 2013). Because Tier 3 is the most intensive level, it is also the most restrictive. It is restrictive because students receiving Tier 3 services are likely to be pulled out from their regular instruction and are often included in one-on-one instruction in another classroom (Kovaleski et al., 2013). Individualized intervention requires more frequent data collection to monitor the student's

progress and data inform instructional strategies. Changes are necessitated when previous strategies fail to show adequate growth.

Benefits. VanDerHeyden, Witt, and Gilbertson (2007) showed that an RTI approach can decrease special education referrals and increase the likelihood that students who are evaluated more likely to qualify for services. Bradshaw, Koth, Thornton, and Leaf (2009) showed evidence that PBIS can reduce students' disruptive behavior and bullying, increase a sense of being safe at school, and improve social competence, emotional regulation, and academic achievement; PBIS also can improve school climate. Rather than only offering supportive services to children identified with special education services, MTSS (RTI and PBIS combined) expands the focus of prevention and intervention to include the entire school population to address behavioral and academic needs.

Screening. Screening is a Tier 1 practice that helps identify the needs of struggling students (Severson, Walker, Hope-Doolittle, Kratochwill, & Gresham, 2007). By assessing the needs of the general student population and those students who are at risk, potentially helpful Tier 1 preventative evidence-based strategies can then be implemented, as well as Tier 2 and Tier 3 interventions for those students who are at greater risk. Screening provides information for developing and implementing interventions to meet student needs. The results of screening offer student-specific information and ensure that implemented interventions match students' needs using timely data. Rather than being put into one large group receiving the same service (that may or may not be what they need), services can be developed to address the needs of students identified in the screening process (Yates et al., 2008). The three-tier system is a useful framework to integrate universal screening, early intervention, and progress monitoring in schools (Stiffler & Dever, 2015). There have been some concerns regarding the practicality of

screening, claiming that the monetary and time expense of implementing a school-wide program may prove problematic (Dowdy, Ritchey, & Kamphaus, 2010).

School-wide implementation. Screening also drives school-wide intervention implementation. For example, if 50% of students are receiving Tier 2 services it is likely that Tier 1 support needs to be strengthened. In the MTSS model, Tier 2 services are designed to serve approximately 20% or less of the student population (Kovaleski et al., 2013). If more than 20% of students are served in Tier 2, then additional and/or more effective interventions are needed. When effective interventions and supports are provided to all students in Tier 1, then it is intended that the number of students requiring Tier 2 services will decrease. As schools provide interventions and supports across the various tiers, screening assists schools in more effectively targeting and meeting student needs, such as emotional and behavioral issues in an integrated fashion (Lane, Oakes, Lusk, Cantwell, & Schatschneider, 2016).

Emotional/Behavioral Disorders

Definition. Emotional and Behavioral Disorders are characterized by emotional and behavioral responses that adversely affect the youths' performance, including performance in school, home, and social environments (Kauffman & Landrum, 2009). The term EBD is defined by the American Psychiatric Association (2000) as all emotional, behavioral, or psychiatric disorders listed in the psychiatric diagnostic manual that can affect children or adolescents, excluding all developmental disorders. EBD occurs along a continuum. Some students may have many behaviors related to EBD while other students may have just a few behavioral and emotional concerns and may display a few risk factors for developing more maladaptive behaviors.

Externalizing/internalizing behaviors. Children with EBD usually express behaviors that are categorized as internalizing or externalizing. Externalizing behaviors are directed outward, towards others. Some of these behaviors are defiance, aggression, impulsivity, and disruptive behaviors (Walker, 2010). These behaviors are highly visible and tend to be quite disruptive. Such behaviors occur when students interact with peers and adults. Parents and teachers recognize these problematic behaviors because children with EBD often argue, disrupt, and refuse to follow adults' requests.

Internalizing behaviors may not be easily noticed. Children with internalizing concerns usually direct these behaviors inwardly, making them less obvious to adults and other observers (Walker, Cheney, Stage, & Blum, 2005). Some common internalizing behaviors are withdrawal, shyness, depression, and anxiety (Walker, 2010). Unfortunately, since these behaviors tend to be less visible, they are more difficult for adults to identify. In a study conducted by Bruhn et al. (2014), it was found that among students who were identified for Tier 2 interventions, those with internalizing behaviors are three times less likely to be identified for support in comparison to students with externalizing behaviors.

Effectively identifying internalizing behaviors. Students who exhibit internalizing behaviors can be challenging to identify and are often in need of support, which can be a nuanced problem in schools, where quiet, undisruptive behavior tends to be valued. Teachers, counselors, and psychologists may overlook a child who has low activity levels because they are trying to actively aid and redirect children with more externalizing behaviors. Some internalizing behaviors like depression and anxiety can have negative outcomes, such as increased risk for substance abuse, family relationship problems, and weak coping skills (Wagner, Muller,

Helmreich, Huss, & Tadić, 2015). This makes the need for screening for internalizing behaviors even greater, as they are not as obvious to educators and parents.

Although teachers and parents may have greater difficulty in identifying internalizing behaviors, schools in general need clearer directions on how to identify the less visible challenges children face (Bruhn et al., 2014). Identifying students' internalizing behaviors becomes much less difficult when multiple observers (e.g., teachers, administrators, and school psychologists) collect and compare screening and observational data. To be effective, this process would include a series of ongoing screenings across the school year and including data from teachers, students, and parents. The process should be one that continually determines which students are at risk for EBD (Dever, Dowdy, Raines, & Carnazzo, 2015), how students are benefitting from tiered interventions, and the type of follow-up supports that are required to address students' needs.

Characteristics of students with EBD. Struggling children with EBD may need a variety of supports. Kauffman and Landrum (2009) claimed that youth with EBD frequently experience substantial challenges when it comes to building and maintaining interpersonal relationships. They also may display disruptive and aggressive behaviors that commonly provoke negative feelings in others. Children with EBD usually struggle in school (Kauffman & Landrum, 2009); for example, in elementary school students with EBD show a 1.2–2-grade level deficiency when compared to their peers (Trout, Nordness, Pierce, & Epstein, 2003).

Writing, an essential piece of most academic classes, may be particularly difficult for students with EBD. Datchuk, Kubina, and Mason (2015) warned that “the EBD population remains at a high likelihood for sustained writing difficulty without intervention” (p. 48). This potential difficulty in writing also supports the justification for screening to help correctly

provide a variety of possible interventions for students with EBD. Writing challenges and other difficult tasks may be addressed with useful interventions, and effective screening can help find the needs of struggling students including the social and academic challenges for students with EBD.

Also, “other symptoms such as anxiety or fear, unhappiness or depression, and learning difficulties may affect youths’ personal functioning” (DiCroce et al., 2015, p. 259). Students with EBD often tend to have these problems that persist into adulthood (DiCroce et al., 2015). Youth with EBD are less likely to reach typical social and educational achievement and can place a significant strain on their families and the healthcare system (O’Connell, Boat, & Warner, 2009). Students with EBD also have higher rates of substance abuse and arrest within three to five years of leaving high school (Bullock & Gable, 2006).

Some students with EBD exhibit externalizing behavior problems, which interfere with or compete with the acquisition or performance of both social and academic skills (Gresham & Elliott, 2008). Students exhibiting behaviors such as aggression, noncompliance, and defiance often show academic skill deficits ranging from moderate to severe (Coie & Jacobs, 1993). Gresham (2015) indicated that these problem behaviors function as *academic disablers* because they are associated with decreases in student academic performance. Because of these externalizing behaviors, students with EBD then experience insufficient academic performance because their behaviors limit their academic progress in the classroom (Gresham, 2015).

Trout et al. (2003) wrote that students with EBD tend to have average intelligence, yet their behavioral struggles can have a negative influence on their math, reading, and written expression performance. Many students with EBD may lack grade-level reading skills (Vaughn, Levy, Coleman, & Bos, 2002). More than half of students with EBD may meet criteria for a

learning disability under school classifications (Glassberg, Hooper, & Mattison, 1999). In comparison with other students with disabilities, they have poorer academic experiences and outcomes, including lower satisfaction with school, lower rates of school completion and job retention, and higher rates of school disciplinary exclusions, arrests, and involvement with the juvenile justice system (Losinski, Cuenca-Carlino, Zablocki, & Teagarden, 2014).

Prevalence of EBD. Students with behavioral issues have historically been viewed as the responsibility of special education but actually, less than 1% of students with disabilities are provided support under the special education category of emotional disturbance (ED; Individuals with Disabilities Education Improvement Act, 2004; National Center of Education Statistics [NCES], 2016). Having EBD does not automatically qualify students for special education under the ED category. Students labeled EBD may have some similar behaviors as students with ED, but their behaviors are not sufficiently significant so that they do not need special education or related services to access the general education curriculum (Forness & Knitzer, 1992).

About 20% of the adolescent population has a mental health, behavioral, or emotional disorder (O'Connell, Boat, & Warner, 2009). Most people with lifetime mental disorders have onset by age 24 (Merikangas et al., 2010). The median age of onset for anxiety is even earlier at 11 years old (Kessler et al., 2005). It was found that in 2015 about 18% of 9th to 12th grade students seriously considered suicide, 9% having made an attempt one or more times (National Association of School Psychologists (NASP), 2019). As can be seen from these statistics, a notable number of school-age youth experience emotional and behavioral challenges.

School-Based Screening for EBD

In the school setting, there are many types of screening. Common screenings include hearing screening, vision screening, scoliosis screening, and emotional/behavioral screening

(Dowdy et al., 2010; Yawn et al., 1999). These screenings are used to identify risk factors for a variety of concerns so that students who need assistance are identified and receive help quickly (Salinger, 2016). Screenings also assist with laying the groundwork for the opportunity to implement prevention efforts and responsive Tier 1 and Tier 2 interventions (Lane et al., 2016).

Specifically, for youth with emotional and behavioral issues, screening that leads to prevention and early intervention is a wise use of educational resources; providing early intervention is more cost-effective than reacting to fully developed disorders (Dever et al., 2015; Levitt, Saka, Romanelli, & Hoagwood, 2007). Additionally, early intervention potentially reduces the number of children who fully develop disorders and catches emerging problems early, rather than waiting and responding to emergency situations and fully entrenched behaviors. Chin, Dowdy, and Quirk (2013, p. 54) claimed that “universal screening during the middle-school years may provide an opportunity to identify sub threshold problems, prevent the occurrence of more significant problems, and reduce the time lag between the onset of symptoms and treatment.” Once at-risk children are identified, interventions can be implemented.

Wergeland et al. (2014) completed a study that shows an example of effective EBD treatment. Among youth with anxiety (separation anxiety, social phobia, or generalized anxiety disorder) those who receive cognitive behavioral therapy (CBT) have decreased anxiety compared to youth who received no intervention (Wergeland et al., 2014). In this study, 23% of youth experienced a full recovery from their anxiety issues (Wergeland et al., 2014), showing that interventions for those with EBD can improve the well-being of youth. Universal screening is an integral part of supporting students in an effective and timely manner (Dever et al., 2015).

EBD screening is typically used as a school-wide program to reduce emotional and behavioral issues. School personnel can prevent difficult behaviors through different strategies

and methods (Kauffman, 1999). Emphasizing universal interventions ensures that all students receive the help that they need (Nelson, Banner, Reid, Epstein, & Currin, 2002).

Lack of screening. Although universal screening is an integral part of supporting students, in many schools screening is not being effectively used (Bruhn et al., 2014). It is estimated that only 12-13% of schools screen for mental health risk (Bruhn et al., 2014). Given that about 25% of school-age children meet the criteria for needing social-emotional support (Forness, Kim, & Walker, 2012), and screening is happening infrequently there appears to be a mismatch between the needs of students who have social-emotional and behavioral concerns and educational practices. Furthermore, if MTSS hopes to provide a continuum of supports for students who have social-emotional and behavioral needs, then screening appears to be a reasonable way to identify students who need interventions and services across the tiers.

Effective screening. In order for screening to be most effective, it must address specifically targeted areas (Glover & Albers, 2007). Miller et al. (2015) identified three critical considerations of screening: (a) appropriateness to the school/district, (b) technical adequacy, and (c) usability of the screener. By addressing these three elements, schools can more effectively meet the needs of students and educators.

In order to evaluate the appropriateness of screeners, there are several questions that schools should consider. One question is related to practical scheduling and the ultimate purpose of the screening: Will this screening be compatible with local service delivery needs? Simply put, educators need to determine the timing and frequency of screening administration and the relevancy of intended outcomes. Educators will want to consider if the screening aligns with planned or currently implemented interventions and resource available to implement the interventions with fidelity. Then, educators need to consider if the measured constructs correctly

assess a child's risk status (Glover & Albers, 2007). This plays a large role in determining the utility of the screening and the validity of the data that are produced. Another question comes in assessing whether or not the screening has evidence for validity for the purposes it is used. Have the format and content of this screening been validated in previous research and does the intended context match or closely align with the research context (Glover & Albers, 2007). Finally, schools will need to determine if the screening fits the developmental needs of the population (Glover & Albers, 2007).

Glover and Albers (2007, p. 6) stated, "Specifically, an instrument should be (a) appropriately standardized for use with the target population, (b) consistent in its measurement, and (c) accurate in its identification of individuals at risk." If a screener does not have reliable scores or evidence of validity for the purpose it is being used, then the data from the screening may have questionable value to inform decisions based on the screening data.

Also related to the need for technical adequacy, students' scores must be standardized (normed within a specific population) in order to make comparisons with the general population. When scores are standardized or when there are accurate cut scores (Glover & Albers, 2007), individuals with atypical, elevated, or depressed scores are easily identified. Schools can then address these students' needs, offering interventions and extra support.

The last element of evaluating effective screening is to consider the utility and usability of the measure and the data generated. According to Glover and Albers (2007), there are six considerations when evaluating this element of usability: feasibility of cost; simplicity of use; acceptability to various stakeholders; accessibility of required infrastructure for managing and interpreting the resulting data; availability of accommodations for the intended population (i.e., English language learners); and utility of information gathered from screening, optimally to

improve treatment outcome. Each of these particular elements is both complex and essential, but the last element—the utility of information gathered from the screening—could be the most important consideration when determining the usability of a particular screener (Glover & Albers, 2007).

Screening can be a productive way to find those youth at risk for EBD. For screening to be most effective, EBD must be clearly defined. The appropriateness, technical adequacy, and utility of the screening should be assessed by each school that is planning implementation (Glover & Albers, 2007). This type of evaluation described by Glover and Albers will allow the school/district to implement the most effective screening. Implementation of the screening can also pose its own set of challenges, for that implementation science can prove helpful.

Implementation Science

Implementation science is defined as “the scientific study of methods to promote the systemic uptake of research findings and evidence-based practices into professional practice and public policy” (Forman et al., 2013, p. 80). Another viewpoint is “the study of the processes needed to bring new practices into widespread use” (Smith et al., 2014, p. 4). The use of implementation science can be very beneficial in schools. Innovations and new practices in education are constantly being created, and implementation science helps educators take those and put them into their schools. Smith et al. (2014) offered the following advice:

...changing policies or guidelines, providing information and training alone are not adequate to bring about sustainable changes in practice. To adopt evidence-based practices, the implementation process must also address the organizational supports which are necessary to initiate and sustain the practices with fidelity. (p. 4)

The implementation process uses a five-stage system to include all aspects needed for the practice to be fully and adequately implemented into the entity, in this case, a school (Smith et al., 2014).

There are a variety of ways of conceptualizing the stages of implementation. But most models use stages that include an initial stage of exploration and adoption, an installation stage, an initial implementation stage, a stage of full implementation/operation, and an expansion or scaling up stage/innovation (Metz & Bartley, 2012). These stages give structure to the implementation process, help implementers gather resources that match the stage of implementation, and then contribute to sustained implementation over time.

The exploration and adoption stage consist of the initial research, which involves understanding and exploring the options available to a school or district. This research allows the school system “to assess the potential match between community needs, evidence-based practice and program needs, and community resources and to make a decision to proceed (or not)” (Fixsen, Naoom, Blase, & Friedman, 2005, p. 15). The school must consider all of its potential options of possible programs, and then they must determine if the potential program(s) will fit the needs of the community. Implementors should consider the resources available to the school to finance and implement the program. Having sufficient personnel with expertise is another aspect of ensuring that resources are available to implement the initiative. The final portion of this exploration stage is to choose the best program for the school and community (Fixsen et al., 2005). Once the choice has been made, the school can move on to the installation stage. This is where structural supports are put into place to begin implementing the new practice. Some of these supports are policy development, working out funding streams, and creating outcome expectations. Once these supports are added, initial implementation can start.

Initial implementation can be difficult, as the school discovers the reality of implementation challenges. Some programs may even falter after this point, as the school encounters too much difficulty or the program is simply determined to be ineffective for the needs of that community (Metz & Bartley, 2012). However, if the program is found to be beneficial, the initial challenges can be addressed and then the school can establish full operation and implementation of the program. According to Fixsen et al. (2005), “the anticipated benefits should be realized... as the new evidence-based program staff members become skillful and the procedures and processes become routinized” (p. 17). This is the eventual hope for all schools as they participate in this implementation stage. Eventually, these programs will become integral to the school, demonstrating a mark of successful implementation.

A school can then choose to expand or scale up the implementation of the selected program. The goal of this scaling up stage is “to increase the number of sites using the practices with fidelity” (Smith et al., 2014, p. 14). Scaling up focuses on expanding the reach of the initiative and refining the practice in a way that adapts to the needs of the setting. By adding to the program through research, trial, and innovation, the implementing stages work like a cycle, allowing schools to constantly grow in a process of improvement and development.

Implementation science can be very helpful when implementing EBD screening. To implement EBD screening in a school long term, one would benefit from following the implementation stages outlined by implementation science. In the exploration stage, the school would be able to research whether EBD screening is needed in their school. They would be able to determine the resources required to finance the program. Next, the school would move into the installation stage and create outcome expectations and develop the policies required for the EBD screening. In the initial implementation stage, changes can be made, and practices can be

tweaked. Full implementation follows a period of implementing the practice in a limited setting to better understand how the initiative will best meet the needs of that setting. It will take time for EBD screening to become an accepted, established, and fully operational practice in the school. Lastly, the expansion stage allows for innovation and growing of the EBD screening program. The last implementation stage encourages organizations to scale up and expand the practice to other sites while continuously improving the practice in established sites (National Implementation Research Network, n.d.).

Since screening is an integral part of the MTSS framework, EBD screening can be a useful tool in the prevention of emotional and behavioral mental illness and/or concerns. Screening used properly can be effective in drawing attention to at-risk students and addressing their needs in a timely manner. Like previously mentioned, the prevalence of EBD among youth as well as dealing with all the symptoms of anxiety, depression, or mental health concerns can affect their ability to start and maintain interpersonal relationships (DiCroce et al., 2015; Kauffman & Landrum, 2009). And if implemented correctly, following the stages of the implementation science model, EBD screening could become a long-lasting program that would help many students.

Rationale

Universal EBD screening is a useful tool to identify at-risk students (Severson et al., 2007). Prevention and early intervention directed at students who have behavioral problems or social-emotional concerns should be a high priority when setting school goals. Screening is a key aspect of early intervention to ensure that students' needs are identified and addressed in a timely way. The purpose of this research is to discover how often universal EBD screenings are being conducted in Utah schools according to the perceptions of school psychologists. And further, to

consider how effectively EBD screening is being implemented. By learning this, we can help schools address barriers and difficulties of implementation.

This study is an introductory project to provide knowledge for more research and to inform practice. The data from this study should provide the field with valuable insight to effective EBD screening. This project can be a useful tool for advancing the goal of increasing supportive mental health services and building awareness of mental health needs in Utah schools.

Research Questions

This research was designed to determine prevalence of EBD screening in Utah schools based on the perceptions of practicing school psychologists. The specific research questions this study addresses are as follows:

1. To what extent are universal EBD screenings being conducted in Utah schools?
2. When EBD screening occurs, what components are included?
3. What barriers limit the implementation of EBD screenings?
4. If screening is being conducted, what contributed to implementing that practice?
5. What role do school psychologists play in EBD screening?

CHAPTER 3

Method

This research study describes the perception and involvement of Utah school psychologists in universal EBD screening. To answer the research questions, a case study that included an online survey was used. This online questionnaire fits the methodology for a descriptive study for statewide data collection.

Participants

Participant contact information was provided by the Utah State Board of Education. The list of potential subjects included all certified school psychologists currently working in Utah schools during the 2017/2018 school year. There was a total of 285 school psychologists on the list but only 260 publicly available email addresses were found. These 260 email addresses were used to distribute the link to the online survey. A total of 89 (34%) school psychologists completed the survey although 10 chose not to answer demographic questions. Of the 79 participants who responded to demographic questions, 55 (69.6%) were female and 24 (30.4%) were male, which do not include the ten participants who opted out of the demographic questions. The six participant demographic questions included age, gender, ethnicity, highest degree earned, organizations affiliated with, and years as a licensed school psychologist excluding internship (See Table 1). Commonly reported highest degrees earned included Ed.S., Master's, and Ph.D. Other responses included Psy.S. and Bachelor's with 20 credits towards Master's. Participants reported belonging to multiple professional organizations, locally and nationally, such as the National Association of School Psychologists (NASP), Utah Association of School Psychologists (UASP), and the American Psychological Association (APA). Some participants reported not belonging to any professional organizations. Other organizations reported included the International Society for Autism Research (INSAR), Utah Alternative

Education Association (UAEA), American Mental Health Counselors Association (AMHCA), American Association for Marriage and Family Therapy (AAMFT), Utah Psychological Association (UPA), American School Counselor Association (ASCA), and multiple school employee advocacy organizations/unions.

There were four additional demographic questions that were asked regarding the participants' school(s). Demographic data were collected on the schools at which the participants worked, specifically, the time spent in different school settings, school types, school locations, and schools with students who received free or reduced school lunch (see Table 2). Regarding the demographic question regarding school location, one participant did not report the percentage of time they spent in urban areas.

Table 1

Participant Demographics

Category	Number of Participants	Percentage of Total Sample
Ethnicity		
White	71	90%
Asian	3	3.8%
Mixed/Multiracial	3	3.8%
Latino/Hispanic	1	1.3%
American Indian/Alaska Native	1	1.3%
Age Range		
20-29	9	11.4%
30-39	29	36.7%
40-49	25	31.6%
50-59	10	12.7%
60+	5	6.3%
Highest Degree Received		
Ed.S.	47	59.4%
Master's	20	25.3%
Ph.D.	10	12.7%
Other	2	2.6%
Years Licensed (Excluding Internship)		
0-9	42	53.8%
10-19	23	29.5%
20-29	11	14.1%
40-45	2	2.6%
Organizations Belonging To		
NASP	41	39.4%
UASP	36	34.6%
APA	5	4.8%
Other/None	22	21.2%

Table 2

School Demographics

Category	Percentage of Time Spent
School Setting	
Elementary	64.5%
Middle/Junior High	17.7%
High	10.8%
Administration/Leadership roles	3.3%
Preschool	2.1%
Post-high setting	1.5%
Other settings	0.1%
School Type	
Traditional Public	92.5%
District Office/Administrative	3.0%
Charter	1.9%
Special/Severe/Profound	1.7%
Alternative	0.6%
Other settings	0.3%
School Location	
Suburban	92.5%
Urban	3.0%
Non-Urbanized	1.9%
Rural	1.7%
Free/Reduced School Lunch	
More than 75%	6.3%
Between 25-75%	45.6%
Less than 25%	31.7%
Not Sure	16.5%

Procedures

An incentive system was implemented to encourage study participation. If the participants completed the survey during the first week that the survey had been active, they were put into a drawing for one of three \$30 Amazon gift certificates. If the participants did not complete the survey during the first week, a reminder email was sent to them. If the participants completed the survey within the second week that the survey was active, then they were put into a drawing for one of three \$20 Amazon gift certificates. If they did not complete the survey, a final reminder email was sent. If they completed the survey during the third and final week, they were put into a final drawing to win one of three \$15 Amazon gift certificates. The three-week system was used to reward participants who completed the survey early but also give other participants motivation to complete the survey if they did not finish it early.

Instrument Development Procedures

To measure responses, the survey was created and administered through the online questionnaire software, Qualtrics. It included Yes/No questions, multiple choice questions, and open-ended fill-in-the-blank questions. This selection of questions was used to specify the extent of screening in the schools. There was one Yes/No question, 13 multiple choice questions, and 3 open-ended fill-in-the-blank questions. There also were 10 demographic information questions in the survey (see Appendix A).

The survey was created by the research team (including a graduate student and three associate professors from the David O. McKay School of Education at Brigham Young University). Once the survey was drafted, it was reviewed by the three professors, experts in survey development, social/emotional learning, and school psychology, to determine the survey questions' appropriateness to the study. Cognitive think-aloud interviewing was conducted with

four other, different individuals. Cognitive interviewing is a method used to determine whether the participants understand the questions as they were intended and to discover whether those questions can be accurately answered (Dillman, 2007; Forsyth & Lessler, 1991). In the think-aloud interviews, the questions were read out loud, then the participants were prompted to express what they were thinking, how they interpreted what was being asked in the question, what their response would be, and where they would indicate their response on the response scale. This method helped to ensure that the survey items were clear, and the response scale functioned as intended. Cognitive interviewing is a necessary element of survey research (Haeger, Lambert, Kinzie, & Gieser, 2012). After the think aloud interview, the survey was sent to five local school psychologists and university professors to pilot test the instrument and to elicit additional feedback on the online version. Feedback was used to revise the survey as needed. Finally, the survey was then emailed to Utah school psychologists with publicly available email addresses.

Data Analysis

The responses to Likert-type questions were summarized using descriptive statistics. For the three open-ended questions, content analyses were used to understand the data. The qualitative responses from these questions were analyzed and coded through content analysis (Berg, 2001). These questions included (a) what else researchers should know about EBD screening, (b) how did your school implement EBD screening, and (c) what is needed to address the barriers of EBD screening implementation. The responses of the question (a) what else researchers need to know about EBD screening was coded into six categories. The six categories were created by developing inclusionary and exclusionary data to discriminate between qualitative responses. Each idea was coded by two research assistants, individually, who

reviewed the comments and agreed on how to separate the comments into distinct ideas. If the interrater reliability was less than 90%, the items coded differently were discussed and coders were able to change their response if they chose. Once the qualitative responses were coded into categories, descriptive statistics were used to summarize responses (Berg, 2001).

CHAPTER 4

Results

Prevalence of EBD Screening

According to the survey results, 11 (12.3%) of the participants reported that their schools were conducting EBD screening. A total of 78 (87.7%) of participating school psychologists reported that EBD screening is not happening in their schools. Although these 89 participants responded to the questions about EBD screening prevalence, not all participants finished the survey or answered all the questions.

Components of EBD Screening Being Conducted

Six participants identified the EBD screeners that were used at their schools. The most common screener was the Student Risk Screening Scale for Internalizing and Externalizing Behaviors (SRSS-IE). Two responders reported more than one screener being used (see Table 3). Reports of how often EBD screening was happening varied among participants from once a year, quarterly, not known, or as often as it is requested (see Table 4). When asked how the screening data is used, the majority of participants indicated that the data were used to decide which interventions and supports should be implemented after the screening was completed, to refer students to the school's problem-solving team, and to encourage teachers to be aware of students' needs and meet those needs in the classroom. Other responses included focused skill groups which were being held for the at-risk students. Some responses indicated that the school psychologists did not know how the data were being used (see Table 5).

Table 3

Which EBD Screeners Are Used

Responses	Percentage of participants	Number of participants
Student Risk Screening Scale for Internalizing and Externalizing Behaviors (SRSS-IE)	31.3%	5
Skills Improvement System Performance Screening Guide (SSiS)	25.0%	4
The Behavioral and Emotional Screening System (BASC-3 BESS)	18.7%	3
Systematic Screening for Behavior Disorders, Second Edition (SSBD-2)	12.5%	2
School Social Behavior Scales, Second Edition (SSBS-2)	12.5%	2

Note. Responses are only from participants ($n=6$) who reported that screening was happening in their schools. Respondents were instructed to select all that applied.

Table 4

How Often EBD Screening Happens

Responses	Percentage of participants	Number of participants
Once a year	40%	2
Every quarter	20%	1
Other	20%	1
Don't know	20%	1

Note. Responses from participants ($n=6$) who reported that screening was happening in their schools.

Table 5

How the Data Is Used

Responses	Percentage of participants	Number of participants
To decide which interventions and supports should be implemented after the screening has been completed	29.4%	5
To refer student to the school's problem-solving team	23.5%	4
To encourage teachers to be aware of students' needs and meet those needs in the classroom	23.5%	4
Other	11.8%	2
Don't know	11.8%	2

Note. Responses from participants ($n=6$) who reported that screening was happening in their schools.

Implementation Barriers

Survey participants ranked the top three barriers that impeded the practice of EBD screening. Of all the responses, lacking the resources to provide for the needs of these students, insufficient administrative support, and schools having too many other concerns were most reported (see Table 6). Other responses included that EBD screening is not necessary with the current systems in place and not knowing if EBD screening had been considered.

The six school psychologists who reported that screening was happening were asked what is needed to address these barriers. One respondent did not answer the question. The other five school psychologists responded that teacher buy-in, additional mental health professionals to meet the needs brought up by EBD screening, administrative urgency, and district policy around this topic was needed.

Table 6

Top Three Barriers to Impede Practice of EBD Screening

Responses	Percentage of participants	Number of participants
Don't have the resources to meet needs	23.2%	50
School has too many other concerns	13.9%	30
Insufficient administrative support	12.6%	27
Believe parents do not want us to implement screening	10.7%	23
Other	9.8%	21
Leadership does not want to implement screening	8.8%	19
Lack skills to implement screening	8.4%	18
Lack desire to implement screening	8.4%	18
No barriers impede the practice	4.2%	9

Note. Responses from both participants who reported that screening was happening in their schools ($n=6$) and those who reported that screening was not happening in their schools ($n=72$). Respondents were instructed to select the top three options that applied.

Contributing Factors of Implementation

When asked how screening was initiated in their schools, one participant reported that they have continued the practice that was previously in place at their school or district but did not mention any other details. Another participant commented that a school district hired behavioral assistants to support the school psychologists' duties, freeing up more time to do other activities

like EBD screening. The top three reported factors that contribute to EBD screening implementation are a district requirement, implementing as part of MTSS or PBIS, and having a mental health team initiative (see Table 7).

Table 7

Top Three Factors that Contribute to EBD Screening Implementation

Responses	Percentage of participants	Number of participants
District requirement	28.4%	4
Part of implementing MTSS or PBIS	21.4%	3
Mental health team initiative	21.4%	3
Administrative request	7.2%	1
Parent request	7.2%	1
School-wide screening for social-emotional concerns is not happening in my school	7.2%	1
Other: school-based team initiative	7.2%	1

Note. Responses from participants ($n=6$) who reported that screening was happening in at least one of their schools. Respondents were instructed to select the top three options that applied.

School Psychologists' Role in EBD Screening

Participants were asked what the role of school psychologists should be in EBD screening. The question was asked of both school psychologists who reported that screening was *not* happening in their schools (see Table 8) and those who reported that screening was happening in their schools. Where screening was *not* happening, most responses indicated that

the school psychologists' role should include deciding on interventions to be implemented after screening, summarizing the data, and managing aspects of the screening process. Other responses included consulting and collaborating with a team, overseeing and/or supporting the management of the screening process, data interpretation, and working with administration to achieve teacher buy-in. Because participants could select more than one option, the percentages do not sum to 100.

Of the six participants who reported that screening was happening in their schools, all six indicated that school psychologists either should or definitely should decide which screener to use, when screening will be done, decide which interventions and supports should be implemented after the screening has been completed, and summarize the data from the screening. Four participants agreed that school psychologists should not or definitely should not administer the screening. Participants were divided when determining if school psychologists should manage the screening process. Three said that they should or definitely should and the other three said they should not or definitely should not.

Table 8

What Role of School Psychologists Should Be in EBD Screening

Responses	Percentage of participants	Number of participants
Decide which interventions and supports should be implemented after the screening has been completed	22.4%	58
Summarize the data	21.9%	57
Decide which screener to use	18.8%	49
Manage screening process	17.3%	45
Administer the screening	6.5%	17
Decide when screening will be done	6.2%	16
Other	5.4%	14
Don't know	1.5%	4

Note. Responses from participants ($n=72$) who reported that screening was not happening in their schools.

Participants also answered questions regarding the responsibility of EBD screening claiming that it is mostly school psychologists, the general education teacher, and other school teams' job (see Table 9). When asked who ultimately decides on a screening measure to use (see Table 10) and the time to do the screening (Table 11), the respondents mostly answered that a district representative does. Another school team was the most common response when asked who manages the screening process (see Table 12). When asked who summarizes the screening data, participants responded mostly school psychologists and other school teams (see Table 13).

Another school team was also the most common response when asked who decides on ways to use the data received (see Table 14). Additionally, participating school psychologists were asked what their role in EBD screening has been. The most common responses were summarizing the data and deciding on interventions to be implemented after the screening has been completed (see Table 15).

Table 9

Who Is Responsible for EBD Screening

Responses	Percentage of participants	Number of participants
School Psychologist	25%	2
General Education Teacher	25%	2
Other School Team	25%	2
Other	12.5%	1
Problem Solving Team	12.5%	1

Note. Responses from participants ($n=6$) who reported that screening was happening in their schools.

Table 10

Who Decides on a Screening Measure

Responses	Percentage of participants	Number of participants
District Representative	37.5%	3
School Psychologist	25%	2
Other School Team	25%	2
Problem Solving Team	12.5%	1

Note. Responses from participants ($n=6$) who reported that screening was happening in their schools.

Table 11

Who Decides When Screening Is Done

Responses	Percentage of Participants	Number of participants
District Representative	37.5%	3
School Psychologist	25%	2
Other School Team	25%	2
Administrator	12.5%	1

Note. Responses from participants ($n=6$) who reported that screening was happening in their schools.

Table 12

Who Manages Screening Process

Responses	Percentage of participants	Number of participants
Other School Team	37.5%	3
District Representative	25%	2
School Psychologist	25%	2
Other	12.5%	1

Note. Responses from participants ($n=6$) who reported that screening was happening in their schools.

Table 13

Who Summarizes the Screening Data

Responses	Percentage of participants	Number of participants
School Psychologist	37.5%	3
Other School Team	37.5%	3
Don't know	12.5%	1
Administrator	12.5%	1

Note. Responses from participants ($n=6$) who reported that screening was happening in their schools.

Table 14

Who Decides on Intervention to Use Based on Screening Results

Responses	Percentage of participants	Number of participants
Other School Team	37.5%	3
Problem Solving Team	25%	2
School Psychologist	12.5%	1
Don't know	12.5%	1
Other	12.5%	1

Note. Responses from participants ($n=6$) who reported that screening was happening in their schools.

Table 15

What Has Been Your Role in EBD Screening

Responses	Percentage of participants	Number of participants
Decide which interventions and supports should be implemented after the screening has been completed	22.8%	5
Summarize the data	18.2%	4
Decide which screener to use	13.6%	3
Nothing	13.6%	3
Administer the screening	9.1%	2
Manage screening process	9.1%	2
Decide when screening will be done	9.1%	2
Other	4.5%	1

Note. Responses from participants ($n=6$) who reported that screening was happening in their schools. Respondents could select more than one response.

The last survey question explored what else researchers needed to know about EBD screening in their schools. This question was open-response and after analysis, responses were grouped into six categories. A total of 44 participants chose to share additional comments regarding their opinions on EBD screening (see Table 16). These responses included 53 codable ideas. Six responses were not codable, for example, when the participants reported that they were unsure how to respond.

From this analysis, six categories emerged. The most common response to this question dealt with time and personnel. Of the individuals responding to this item, there were 25% (11 of the 44) that indicated frustration because they needed more time to effectively implement screening. Similarly, almost 23% (10 of 44) respondents indicated that district, school, and parent buy-in was needed to support screening practices. About 18% (8 respondents) expressed the need for an implementation plan. The eight also suggested that the plan be streamlined, efficient, and developed collaboratively. Five individuals (11%) suggested there was a need for education and/or training on the subject. Responses in this category included participants who said they did not know how to implement EBD screening. Five respondents' comments were categorized into an 'Other' section. Responses included researchers needing to focus on screening for risk factors, differentiating between disorders and those just experiencing symptoms, using Adverse Childhood Experiences (ACEs) resilience data, understanding the difficulty to rule out false positives, and understanding concerns about privacy issues. Lastly, four responders (9%) felt more funding was required to support students identified as someone in emotional or behavioral distress.

Table 16

What Else Researchers Need to Know About EBD Screening

Content	Percentage of responses	Number of participants
Need for more personnel and/or time	25.6%	11
District/teacher/school/parent buy-in	23.3%	10
The need for an implementation plan	18.6%	8
Education/training to school personnel	11.6%	5
Other	11.6%	5
Funding to increase resources for student support	9.3%	4

Note. Responses came from an open-ended question answered by participants ($n=44$) who said EBD screening was *not* happening in their schools.

CHAPTER 5

Discussion

The goal of this study was to describe school psychologists' perceptions and experiences with the current state of EBD screening in Utah schools and provide additional insight into what might be needed for implementation and further research.

Screening in Utah

Even though Bruhn and colleagues (2014) surveyed district-level administrators and this sample only included school psychologists, the studies showed similar results: Bruhn et al. reported that 12-13% of schools were screening for mental health risks and in the current study 12.3% of participating school psychologists indicated that EBD screening was being implemented in the schools where they worked. Although there are differences between Bruhn and colleagues' sample and the current research, we generally see that EBD screening is implemented infrequently. Students are consistently experiencing emotional and behavioral difficulties (NASP, 2015), yet screening is not a common practice. The results of this study reveal that notable barriers contribute to the lack of systematic screening. Some of those barriers that were reported in this study included (a) the lack of resources to address the needs of students who would be identified as needing additional supports and interventions, (b) schools having too many other concerns, and (c) insufficient administrative support.

Regarding a lack of resources, a surprising finding was that survey participants identified the monetary cost of EBD screeners as a barrier to implementation. However, the respondents who were screening reported using the SRSS-IE, which is a screening instrument in the public domain that is available at no cost. Other screeners being used in Utah include the Behavioral and Emotional Screening System (BASC-BESS), costing approximately \$316 for 25 protocols

with a year's worth of online scoring, and the Skills Improvement System Performance Screening Guide (SSiS), which costs approximately \$165 for 30 protocols (Pearson Assessments, 2019). This outcome suggests that some schools/school districts who are committed to screening are willing to find and use funds for EBD screening, while other school psychologists see costs as a barrier.

A common theme throughout the survey results was the importance of using teams to implement the screening process. There were multiple participants (e.g. school psychologists, administrators, district representatives, teachers, and school teams) involved in successful implementation. Establishing strong school teams is a practice that can lead to sustainability of a wide variety of practices when implementing PBIS or MTSS (Fixsen et al., 2005); this seems to apply to participating school psychologists' experiences with screening. Having teams involved in the EBD screening process and implementation was reported by survey respondents who were involved in the screening process in their schools.

Results from this survey indicate that participating school psychologists tend to believe EBD screening is a shared responsibility among educators. The participants reported that teams rather than individuals should participate in determining the specific screener, determining interventions to be implemented, managing the screening, administering the screening, and summarizing the data. School psychologists have expressed that their role in EBD screening should mainly be around data summarization, interpretation, and intervention implementation.

School psychologists expressed that their role should not be administering or individually managing the screening process. Responses throughout the survey report barriers to EBD screening implementation such as school psychologists not having enough time, having higher workloads, and being spread too thin. An increase of school psychologists in schools may allow

these professionals to devote more of their time to delivering school-wide, systemic services (NASP, 2019).

Because of the school psychologist shortage and heavy workloads (NASP, 2019), many school psychologists may spend their time reacting to students' behavior problems rather than implementing systematic preventative and intervention strategies to work with at-risk students. Rather than waiting for students to fail, implementing EBD screening would be a proactive measure to decrease school psychologist workloads so that student problems are identified and addressed in a timely manner using a systematic approach. In contrast, the wait-to-fail approach tends to be reactive and prioritize the urgent needs of students. Without the cooperation with organization and district leaders, building administrators, and other educators, school psychologists may find themselves so busy responding to emergencies and other critical needs that they have little time for the early intervention work that is part of PBIS and MTSS (McIntosh & Goodman, 2016). To address this problem, district leaders could proactively problem solve and create ways for school psychologists to engage in more systematic preventative work. As seen in Table 6, an important factor that influences EBD screening implementation involves the lack of administrative support and desire to implement EBD screening.

Summarizing the participants' reflections on the most influential factors in EBD screening implementation, respondents indicated that screening is most effective when it is a district requirement, including it as a part of MTSS or PBIS, and having a mental health team initiative. Using these methods to implement EBD screening may provide a higher likelihood of successful and sustained implementation.

Lastly, the school psychologists who are involved in school-wide screening indicated that screening data were used to develop individual interventions and to address individual student needs. Generally, screening data are used to inform universal, school-wide prevention strategies, assign students to Tier 2 supports, and encourage additional data collection for students who need individualized, Tier 3 interventions. School-wide screening is more often used to develop strategies that meet the needs of students who needed universal strategies (Tier 1) or targeted, small group instruction (Tier 2). “Schoolwide screening allows administrators, teachers, and support staff to identify predictable problems in student behavior relating to times and settings of concern, before selecting universal interventions” (Marchant et al., 2009, p. 133).

Summary

This descriptive study aimed at gathering information on the prevalence and implementation of EBD screening. Despite its limitations, this study extends the field’s knowledge base by providing useful information regarding Utah school psychologists’ perspectives on EBD screening implementation and the prevalence of EBD screenings being conducted in Utah. The prevalence of screening reported by this study suggests that EBD screening is happening quite infrequently. The most common barriers to its implementation include the lack of resources to address the needs of students, schools having too many other concerns, and insufficient administrative support. Additionally, this study reported that a district requirement was an influential factor in successful EBD screening implementation. This study was intended to be an introductory study to increase understanding of the prevalence of screening practices and the barriers facilitators face when implementing the screening process the barriers and facilitators when implementing screening process.

Limitations

A notable limitation of this study is its generalizability. The sample consists of 89 working school psychologists in Utah. This small sample's demographics do not represent the nation's working school psychologists. Unfortunately, the authors could not find data to describe the demographic characteristics of Utah school psychologists to compare the demographic characteristics of this sample to the broader population of Utah school psychologists. Additionally, the questionnaire was distributed by online administration, which typically have a response rate of about 33% (Nulty, 2008). Our response rate was 34.2% even with the three-week incentive system used to encourage study participation; we would hope for response rates close to 50% to make firm conclusions about the meaning of the data. Only 11 school psychologists responded that they were involved in implementing screening in their schools, which further limits the generalizability of this part of the findings. Additionally, not all respondents finished the survey. Of those 11, only six answered all the questions regarding screening implementation in their schools.

Direction for Future Practice and Research

The study provided direction for future practice and research of EBD screening. One of the major concerns of participating school psychologists was getting buy-in and support from teachers and administration; future research could identify the specific strategies for getting buy-in and support from colleagues and leaders. Additionally, not having the resources to meet the needs of students who were identified through EBD screening was the most common concern mentioned. Future research could identify what initiatives had a higher priority than addressing students' social-emotional concerns. Future research on this topic could explore how schools and district leaders decide to implement EBD screening and what screeners to use. Understanding

more specific ways that educators use the data also would be helpful. Additionally, exploring and identifying strategies to address the barriers to implementing screening would be another helpful research topic. Because of the limitations of this study, repeating the survey with larger and more diverse sample could show more data regarding effectiveness and the lack thereof in EBD screening implementation.

The specific effects of having a mental health team initiative in schools is also a topic to research further; these mental health teams could be responsible for implementing social-emotional learning initiatives. Durlak, Weissberg, Dymnicki, Taylor, and Schellinger (2011) showed that school implementation of social-emotional learning programs can lead to improved academic outcomes for students. Along with academic outcomes, the results of Durlak et al. (2008) showed increased prosocial behavior, reduced conduct and internalizing problems, and positive effects on attitudes of self, others, and schools when social-emotional learning program were systematically implemented; however, the research is limited in understanding the role and function of a school-based mental health team. Mental health team initiatives were mentioned as an important factor in EBD screening implementation but there is little information about these teams and EBD screening in the research literature. More studies about the relationship of mental health team initiatives and EBD screening implementation may provide needed insight to enact social and emotional goals in a school or district.

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APPENDIX A

Survey Questions

- How many schools are you assigned to work in during the 2017-2018 school year?
 - 1
 - 2
 - More than 2

- What is your age?
 - Drop down menu (18-75)

- What is your gender?
 - Male
 - Female
 - Prefer not to answer

- What is your ethnicity?
 - White
 - Black/African American
 - American Indian/Alaska Native
 - Asian
 - Native Hawaiian/Pacific Islander
 - Mixed/Multiracial
 - Hispanic/Latino
 - Prefer not to answer
 - Other _____

- What is your highest degree earned?
 - Bachelor's Degree
 - Master's Degree
 - Education Specialist Degree (EdS)
 - PhD
 - PsyD
 - EdD
 - Other _____

- Indicate the professional organizations that you belong to. (Check all that apply.)
 - National Association of School Psychologists
 - Utah Association of School Psychologists
 - American Psychological Association

- Other _____
 - Other _____
 - None
 - Prefer not to answer

- Over the course of the 2017-2018 school year, what percentage of time did you spend in these school settings?
 - _____ Preschool
 - _____ Elementary Schools
 - _____ Middle or Junior High Schools
 - _____ High Schools
 - _____ Post-high school settings
 - _____ Administrative/leadership positions
 - _____ Other

- During the 2017-2018 school year, what percentage of time did you spend in urbanized or rural settings?
 - _____ Urban (at least 50,000 people)
 - _____ Suburban (2,500-50,000 people & in an urban area)
 - _____ Non-Urbanized Area (2,500-50,000 people & out of an urban area)
 - _____ Rural (less than 2,500 people & out of an urban area)

- During the 2017-2018 school year, what percentage of time you spend in each of these types of schools?
 - _____ Traditional Public School
 - _____ Special/Severe/Profound School
 - _____ Alternative School
 - _____ Charter School
 - _____ Administrative Role/District Office
 - _____ Other

- During the 2017-2018 school year, what percentage of students in your schools receive free or reduced lunches?
 - More than 75%
 - 25% to 75%
 - Less than 25%
 - Not sure

- How many years have you been a licensed school psychologist (excluding internship)?
 - ____ (OPEN ENDED)
- How many years have you been a licensed school psychologist in Utah (excluding internship)?
 - ____ (OPEN ENDED)
- Is systematic school-wide screening for emotional and behavioral disorders happening in your schools?
 - Yes
 - No
- How many years has this screening been ongoing in your schools?
 - ____ (OPEN ENDED)
- What emotional and behavioral disorder screeners are being used? (Check all that apply.)
 - SSBD-2 (Systematic Screening for Behavior Disorders Second Edition)
 - SSBS-2 (School Social Behavior Scales, Second Edition)
 - SRSS-IE (Student Risk Screening Scale for Internalizing and Externalizing Behaviors)
 - BASC-3 BESS (The Behavioral and Emotional Screening System)
 - SSIS (the Social Skills Improvement System Performance Screening Guide)
 - Other _____
 - Other _____
- What organizational and other factors contribute to the implementation of systematic school-wide screening for emotional and behavioral disorders? (Check all that apply.)
 - Administrative request (e.g., building principal)
 - Professional development

- District requirement
 - Part of implementing Multi-Tiered Systems of Supports (MTSS) or Positive Behavioral Intervention and Supports (PBIS)
 - Parent request
 - Mental health team initiative
 - Other school-based team initiative
 - Other
 - Schoolwide screening for social-emotional concerns is not happening in any of my schools.
-
- What barriers impede the practice? (Check all that apply.)
 - Insufficient administrative support
 - Our team does not have the skills to implement systematic school-wide screening
 - Our team does not have the desire to implement systematic school-wide screening
 - The LEA/district leadership does not want us to do systematic school-wide screening
 - We are concerned that parents do not want us to do systematic school-wide screening
 - Our school has too many other concerns to attend to systematic school-wide screening
 - Even if we identified students who were at risk for EBD, we do not have the resources to meet those needs.
 - No barriers impede the practice.
 - Other

- What is needed to address these barriers?
 - _____(OPEN ENDED)

- How often is systematic school-wide screening for emotional and behavioral disorders happening in your schools?
 - Once a year
 - Twice a year
 - Every quarter
 - Other _____
 - It is not happening.
 - Don't know

- How did your school begin the practice of systematic school-wide screening for emotional and behavioral disorders?
 - _____(OPEN ENDED)

- Who is ultimately responsible for completing a screening measure in your schools?
 - School Psychologist
 - Administrator
 - Special Education Teacher
 - General Education Teacher
 - District Representative
 - School Counselor

- Social Worker
 - Problem Solving Team
 - Other School Team
 - Other _____
 - Don't know
- Who decides on a screening measure in your school?
 - School Psychologist
 - Administrator
 - Special Education Teacher
 - General Education Teacher
 - District Representative
 - School Counselor
 - Social Worker
 - Problem Solving Team
 - Other _____
 - Don't know
- Who decides on when the screening will be done?
 - School Psychologist
 - Administrator
 - Special Education Teacher
 - General Education Teacher
 - District Representative

- School Counselor
 - Social Worker
 - Problem Solving Team
 - Other _____
 - Don't know

- Who manages the screening process (e.g., distributes the instrument and collects the data)?
 - School Psychologist
 - Administrator
 - Special Education Teacher
 - General Education Teacher
 - District Representative
 - School Counselor
 - Social Worker
 - Problem Solving Team
 - Other _____
 - Don't know

- Who summarizes the data?
 - School Psychologist
 - Administrator
 - Special Education Teacher

- General Education Teacher
 - District Representative
 - School Counselor
 - Social Worker
 - Problem Solving Team
 - Other _____
 - Don't know

- Who decides what interventions or supports should be implemented based on the screening data? (Check all that apply.)
 - School Psychologist
 - Administrator
 - Special Education Teacher
 - General Education Teacher
 - District Representative
 - School Counselor
 - Social Worker
 - Problem Solving Team
 - Other _____
 - Don't know

- What has your role been in systematic school-wide screening for emotional and behavioral disorders? (Check all that apply.)

- Administer the screening
 - Manage the screening process (e.g., distributes the instrument and collects the data)
 - Decide which screener to use
 - Decide when the screening will be done
 - Decide which interventions and supports should be implemented after the screening has been completed
 - Summarize the data
 - Other _____
 - Other _____
 - OR
 - Nothing
-
- What should the role of School Psychologists be in systematic school-wide screening for emotional and behavioral disorders? (Check all that apply.)
 - Administer the screening
 - Manage the screening process (e.g., distributes the instrument and collects the data)
 - Decide which screener to use
 - Decide when the screening will be done
 - Decide which interventions and supports should be implemented after the screening has been completed
 - Summarize the data

- Other _____
- Other _____

OR

- Nothing
- Don't know

- How is the data generated from your systematic school-wide screening for emotional and behavioral disorders being used? (Check all that apply.)
 - To decide which interventions and supports should be implemented after the screening has been completed
 - The data is not being used
 - To refer students to the school's problem solving (e.g., TAT) team
 - To encourage teachers to be aware of students' needs and meet those needs in the classroom
 - Other _____
 - Other _____

OR

- It's not being used
- Don't know

What else do researchers need to know about school-wide social-emotional screening in schools?

- _____(OPEN-ENDED)

APPENDIX B

Implied Consent

Oakley Banks, School Psychology Graduate Student, Brigham Young University, and Ellie Young, Ph.D., Brigham Young University invite you to participate in this research study about Emotional and Behavioral Disorder (EBD) screening in Utah schools. We want to know your experiences and opinions about EBD screening. The purpose of this research is to discover how often EBD screenings are being conducted in Utah schools according to the perceptions of school psychologists. And further, to consider how effectively EBD screening is being implemented. By learning this, we can help schools address barriers and difficulties of implementation.

Your participation in this study will require you to complete an online survey. This should take approximately 10-15 minutes of your time. Your participation will be confidential. An incentive system for Amazon gift certificates will be used to encourage study participation. If you complete the survey during the first week that the survey has been active, you will be put into a drawing for one of three \$30 Amazon gift certificates. If you did not complete the survey during the first week but did complete the survey within the second week that the survey was active, then you will be put into a drawing for one of three \$20 Amazon gift certificates. If you did not complete the survey within the first or second week but did complete the survey during the third and final week, then you will be put into a drawing to win one of three \$15 Amazon gift certificates. This survey involves minimal risk to you. The benefits, however, may impact society by helping increase knowledge about EBD screening in Utah schools. This project can be a useful tool for advancing the goal of increasing supportive mental health services and building awareness of mental health needs in Utah schools.

You do not have to be in this study if you do not want to be. You do not have to answer any question that you do not want to answer for any reason. We will be happy to answer any questions you have about this study. If you have further questions about this project or if you have a research-related problem you may contact me, Oakley Banks at oakdb11@gmail.com or Dr. Ellie L. Young at (801) 422-1593 or ellie_young@byu.edu.

If you have any questions about your rights as a research participant you may contact the IRB Administrator at A-285 ASB, Brigham Young University, Provo, UT 84602; irb@byu.edu; (801) 422-1461. The IRB is a group of people who review research studies to protect the rights and welfare of research participants.

The completion of this survey implies your consent to participate. If you choose to participate, please complete the survey and return it by May 31, 2018. Thank you!