**Online supplement**

**Table 1: Search terms for MEDLINE database (date of search 17/05/2017)**

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| # | **Query** | **Limiters/Expanders** | **Last Run Via** | **Results** |
| S7 | S5 AND S6 | Search modes - Boolean/Phrase | Interface - EBSCOhost Research Databases  Search Screen - Advanced Search  Database - MEDLINE | 3,561 |
| S6 | AB ( (screen\* OR identif\* OR detect\* OR assessment OR nominat\* OR “case finding” OR case-finding) N3 (teacher\* or school\* or kindergarten\* or nursery\* or academy\* or pupil\* or student\* or pre-school\* or preschool\*) ) OR TI ( (screen\* OR identif\* OR detect\* OR assessment OR nominat\* OR “case finding” OR case-finding)) N3 (teacher\* or school\* or kindergarten\* or nursery\* or academy\* or pupil\* or student\* or pre-school\* or preschool\* or reception\*) ) | Search modes - Boolean/Phrase | Interface - EBSCOhost Research Databases  Search Screen - Advanced Search  Database - MEDLINE | 16,150 |
| S5 | S1 OR S2 OR S3 OR S4 | Search modes - Boolean/Phrase | Interface - EBSCOhost Research Databases  Search Screen - Advanced Search  Database - MEDLINE | 6,534,873 |
| S4 | TI ( ((“emotional health”) OR ((mental OR emotional OR psychosocial) N2 (wellbeing OR well-being or problem\*)) OR psychopathology OR (mental health N2 ((problem\* OR disorder\* OR risk\* or poor)) OR ((mental\* OR psychiatric) N2 (ill\* OR disorder\*)) OR ((behaviour\* OR behavior\*) N2 (problem\* OR disorder\* OR risk\*)) OR depress\* OR anxiety OR suicid\* OR stress\* OR distress\* OR drug\* OR substance\* OR (“eating disorder\*”) or “ADHD” or “attention deficit” ) OR AB ( ((“emotional health”) OR ((mental OR emotional OR psychosocial) N2 (wellbeing OR well-being or problem\*)) OR psychopathology OR (mental health N2 ((problem\* OR disorder\* OR risk\* or poor)) OR ((mental\* OR psychiatric) N2 (ill\* OR disorder\*)) OR ((behaviour\* OR behavior\*) N2 (problem\* OR disorder\* OR risk\*)) OR depress\* OR anxiety OR suicid\* OR stress\* OR distress\* OR drug\* OR substance\* OR (“eating disorder\*”) or “ADHD” or “attention deficit”) | Search modes - Boolean/Phrase | Interface - EBSCOhost Research Databases  Search Screen - Advanced Search  Database - MEDLINE | 6,530,832 |
| S3 | (MH "Attention Deficit and Disruptive Behavior Disorders") | Search modes - Boolean/Phrase | Interface - EBSCOhost Research Databases  Search Screen - Advanced Search  Database - MEDLINE | 2,361 |
| S2 | (MH "Psychopathology") OR (MH "Psychology, Educational") | Search modes - Boolean/Phrase | Interface - EBSCOhost Research Databases  Search Screen - Advanced Search  Database - MEDLINE | 7,647 |
| S1 | (MH "Mental Disorders") OR (MH "Anxiety Disorders") OR (MH "Disruptive, Impulse Control, and Conduct Disorders") OR (MH "Feeding and Eating Disorders") OR (MH "Mood Disorders") OR (MH "Substance-Related Disorders") OR (MH "Depressive Disorder") | Search modes - Boolean/Phrase | Interface - EBSCOhost Research Databases  Search Screen - Advanced Search  Database - MEDLINE | 315,585 |

**Table 2: Characteristics of included studies**

**RATES OF ACCURATE IDENTIFICATION**

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| UNIVERSAL SCREENING | | | | | | |
| *Depression and anxiety* | | | | | | |
| 1st author (year); country | **Study design** | **Study aims** | **School level**  **Informants** | **Identification measure(s)** | **Programme description** | **Sample characteristics** |
| Morey (2015); USA | Comparison group study | To examine the effectiveness of a multi-stage model to identify students with depression. To establish diagnostic accuracy and hit rates of measures used. | Secondary school  Students | Children Depression Inventory (CDI), Beck Youth Inventory-Depression (BYI-D), Brief Symptom Inventory (DSM-BSI), Schedule  for Affective Disorders  and Schizophrenia for  School Age Children (K-SADS-P-IVR) | Universal screening: (1) Student-report measures (CDI or BYI-D); (2) 1 week later students who scored above the cut-off on either measure completed CDI or DSM-BSI; (3) Students who scored above cut-off on the second administration were invited, along with their parents, to complete K-SADS-P-IVR. Interviews with students were conducted at school, and with parents at school or over the phone. | Students: n=3363: screening n=3318; control n=45  All sample characteristics: age range 8-13; mean age= 10.7; all females). |
| Robinson (2010); Australia | Cohort analytic | To examine the effectiveness of a combined school-based depression education programme and a case detection system to improve recognition of depression and identification of students at risk, increase help-seeking and reduce stigma. | Secondary school  Students | National Mental Health Literacy survey; General Health Questionnaire (GHQ12). | Curriculum-based: One-off 2-hour workshop delivered to all students by clinician, member of school pastoral care team and sporting ambassador. The session included the following: information about depression, coping skills, modelling meaningful communication, help-seeking, information about appropriate support services in local area. | Students: n=246 (age 14-16; mean age = 15.5; all males) |
| Tisher (1995); Australia | Case control study | To assess the accuracy of teacher’s identification of depressed and non-depressed children. | Primary school  Teachers | The Conners Teacher Questionnaire, Children’s Depression Scale - Adult Short Form, Children’s Behaviour Questionnaire for Completion by Teachers. | Selective: Teachers completed a questionnaire for each child in their classroom. | Students: n=163: clinical depressed n=20; clinical non-depressed n=88; ‘normal’ n=55.  All sample characteristics: age range 5-10; 71.8% males. |
| *Behavioural and socioemotional problems* | | | | | | |
| Forness (1998); USA | Comparison group study | To examine identification rates of children in need for special education based on mental retardation (MR), speech on language impairments (SL), learning disabilities (LD) and emotional disturbances (ED) in Head Start children at completion of 1st grade. | Preschool and primary school  Teachers, parents | Peabody Picture Vocabulary Test-Revised, Woodcock-Johnson Psycho-Educational Battery-Revised, the Social Skills Rating System.  Review of school records 1 year after initial screening. | Selective screening: Battery of individual psychoeducational testes were administered to kindergarten children and their families. Parent interview questionnaires regarding the presence of certain disabilities.  Review of school records at the end of 1st grade. | Students: n=4161 (age range: 4-5, 51.8% males) |
| Jones (2002); USA | Cohort analytic | To examine the effectiveness of a universal screening model in predicting future need for MH support, special education services and juvenile justice system. | Preschool  Teachers, parents | Teacher Observation of Classroom Revised (TOCA-R), Child Behaviour Checklist (CBR) (parent). | Universal screening: Teachers completed TOCA-R for each child and parents completed CBR. If a child scored above cut-off on TOCA-R, child’s parents were interviewed. | Students: n=463: high-risk students: n=155; normative group students: n=308 (54% boys) |
| *Risk of suicide* | | | | | | |
| Gould (2009); USA | Cohort analytic | To assess the rate of follow-up service use by students identified by a school-based screening programme as being at risk of suicidal behaviours. To examine barriers to help seeking as perceived by young people and parents. | Secondary school  Students | Suicidal Ideation Questionnaire, Suicide Attempt History, Beck Depression Inventory, Drug Use Screening Inventory, Columbia Impairment Scale, Services Assessment for Children and Adolescents, Help-Seeking Utilization Questionnaire | Universal screening: Self-completion screening questionnaires were administrated to students over two class periods on separate days. Follow-up interviews were conducted over the phone, separately with students and their parents. Students who on the screening measures reported serious suicidal ideations or past attempts were invited for a ‘safety review’ with a clinician. If responses were substantiated during the interview parents were notified and treatment recommendations were provided. | Of 2342 students (age range 13-19) 317 were identified to be at risk and included in the final sample (mean age = 15.0; 58.4% females) |
| Hilt (2018);USA | Cross sectional | To implement and evaluate a universal prevention model. | Secondary schools  Students | Pediatric Symptom Checklist for Youth (PSC-Y); ten additional questions to assess risk factors and six questions assessing constructs from the interpersonal psychology theory of suicide. ` | Universal screening: Screening was conducted by a local team of community professionals. Information about the programme were presented during health class to all grade 9 students. Students completed measures privately on a computer during school day. All students, regardless of screening outcomes completed an interview and were debriefed. | Students n=2022 completed the screening programme; mean age 14.4 (SD=0.6), 49.7% females; 74.6% White. |
| Husky (2011); USA | Randomised controlled trial | To compare rated of referral to MH services among students identified by universal screening or traditional school identification methods. | Secondary school  Students | Columbia Health Screen (CHS) | Universal screening: (1) Student-report measure (CHS). All students participated in individual debriefing with counsellor; (2) Students who scored above cut-off were administrated a second-stage clinical interview using the Post-Screening Structured Interview (PSSI). If a child was determined to be in need of mental health referral after the clinical interview, a referral was provided.  Traditional: Routine in-school identification and referral mechanism provided by Student Assistance Programme (SAP). In order to access it a student has to be identified by a member of school staff, a parent, a peer, or self-refer. | Students: n=2488  Demographic variables reported by risk status:  Not at risk (n=1999): age 13-14: n=1223; age 15-18: n=762; 51.4% males.  At risk (n=489): age 13-14: n=52; age 15-18: n=48; 36.1 males. |
| UNIVERSAL SCREENING VS NOMINATION | | | | | | |
| *Depression and anxiety* | | | | | | |
| 1st author (year); country | **Study design** | **Study aims** | **School level**  **Informants** | **Identification measure(s)** | **Programme description** | **Sample characteristics** |
| Auger (2000; 2004); USA | Cross sectional | To determine whether teachers are able to identify students who self-report symptoms of depression.  To examine the effect of teacher and student characteristics on teachers’ effectiveness in identifying students who self-report symptoms of depression. | Secondary school  Students, teachers | Reynolds Adolescent Depression Scale (RADS), Diagnostic Interview Scale for Children, Edition IV (DISC-IV) Schedule, Teacher questionnaire. | Universal screening: (1) group administration of RADS; (2) re-administration of RADS to those who scored above cut-off; (3) individual clinical interview with students who on both times scored above cut-off.  Nomination: Teacher questionnaire completed concurrently with the first administration of RADS. | Students: n=356 (age 10-15; mean age =12.6; 52% males)  Teachers: n=52. No further characteristics provided |
| Campbell (2004); USA | Comparison group study | To assess the effectiveness of a tripartite model of identification of at-risk students by teacher referral, support staff referral and self-report screening. | Secondary school  Students, teachers,  support staff | The Centre for Epidemiological Studies Depression Scale, The Strengths and Difficulties Questionnaire, The Rosenberg Self-Esteem Scale, Spence Children's Anxiety Scale. | Universal screening: Student-report measures.  Nomination: Teachers were asked to nominate students at risk of depression/ those who they were concerned about. | Students: n=261 (year 9 students; 139 females). No further characteristics provided. |
| Cunningham (2014); USA | Cross sectional | To evaluate the sensitivity and specificity of teacher’s nomination of students who self-report elevated levels of depression and/or anxiety. | Primary school  Students, teachers | Universal screening: Multidimensional Anxiety Scale for Children (MASC), Children Depression Inventory (CDI) Nomination: Teachers nomination forms | Universal screening: (1) Student- report measures; (2) Students who scored above cut off point completed the same measures 1 week later.  Nomination: Teachers received a behavioural descriptors of childhood depression and anxiety and were asked to nominate students showing signs of either disorder. | Students: n=238 (age 9-12; mean age=10.1; 47% males).  Teachers: n=26 (85% females; no further characteristics provided) |
| Sweeney (2015); USA | Cross sectional | To examine the potential value of a two-step model to identify students with Social Anxiety Disorder (SAD). | Secondary school  Students, parents; school professionals | Multidimensional Anxiety Scale for Children-Social Anxiety subscale (MASC); The Social Phobia and Anxiety Inventory for Children (SPAI-C); The Anxiety Disorders Interview Schedule for DSM-IV: Parent and Child Versions (ADIS-P/C) | Universal screening: (1) Student-report measures (MASC, SPAI-C); (2) Parents of children who screened positive at Stage 1 completed 15-minute parent telephone interview to further assess the presence of clinically significant social anxiety; (3) Students and parents of students who screened positive in Stage 2 completed in-person diagnostic evaluation using the ADIS-P/C.  Nomination: School staff received a 10-minute review of the symptoms of social anxiety, and were asked to nominate any students who experience significant social anxiety symptoms. | Students: n=4222 (age 13-19; mean age = 14.9; 2168 males). |
| *Behavioural and socioemotional problems* | | | | | | |
| 1st author (year); country | **Study design** | **Study aims** | **School level**  **Informants** | **Identification measure(s)** | **Programme description** | **Sample characteristics** |
| Dowdy (2013); USA | Cross sectional | To compare the two methods of early identification (universal screening and teacher nomination) to determine how each strategy may differentially identify at risk students. | Primary and secondary school  Teachers | BESS Teacher Screening Form, Teacher Nomination Survey (designed for the study), academic and behavioural grades. | Universal screening: Teachers completed BESS teacher form for all students.  Nomination: Completion of Teacher Nomination survey. | Students: n=849 (age range: 5 years 11 months – 14 years 4 months; 51.5% males).  42 teachers. No further characteristics provided. |
| Dwyer (2006); Australia | Cohort analytic | To compare the performance of four screening methods with parents and teachers as informants to identify children at risk of internalising and externalising problems, and general MH difficulties. | Preschool and primary school  Teachers, parents | Family Risk Factor Checklist (FRFC), Child Behaviour Checklist (CBCL) | Universal screening: Measures completed by parents and teachers.  Nomination: Parents and teachers were asked to make a global judgement concerning child’s risk status by answering ‘yes’, ‘no’ or ‘I don’t know’ to the following questions: ‘Do you think that this child has a higher chance than average of developing a behavioural, emotional, or mental health problem in the future?’. | Students: n=766 (mean age = 6.9). No further characteristics provided. |
| Eklund (2009); USA | Comparison group study | To compare the effectiveness of a teacher-rated universal screening and traditional teacher referral methods. | Primary school  Teachers | BASC-2 BESS Teacher form | Universal screening: BESS teacher form completed for all participating students. | Students: n=48 (3rd graders n=26; 4th graders n=22) No further characteristics provided. |
| Garland (1995); USA | Cross sectional | To examine adolescents’ help seeking attitudes and behaviours, and teachers’ identification of students need for MH services as two basic pathways into MH services. | Secondary school  Students, teachers | Students: Youth Self-Report, Hopelessness Scale, Children's Depression Inventory, Social Support Questionnaire - Short Form, Help-seeking attitudes scale, Help Seeking Behaviour Measure, Self-Report of Use of Mental Health Service. Teacher: Teacher Rating Scale | Universal screening: All students were asked to complete a battery of self-report measures. Two weeks later students were invited to attend an information meeting to review a variety of school and community support services available to them.  Nomination: completion of Teacher Rating Scale | Students: n=181 (age range: 14-17; mean age: 15.0; 54% females). |
| Kieling (2014); Brazil | Comparison group study | To compare the performance of universal screening and teacher nomination to identified children with ADHD. | Primary school  Teachers | Strengths and Difficulties Questionnaire (SDQ), The Swanson, Nolan, and Pelham IV scale (SNAP-IV), The Screening Form of Academic Function, Teacher nomination form. | Universal screening: Teachers completed three rating scales for all students in their classroom.  Nomination: Teacher received a sheet with the following question: ‘‘In your opinion, which (if any) of the students below has attention deficit/hyperactivity disorder (ADHD)?’’ and were asked to place a mark next to the names of students for which they would answer the question affirmatively. | Students: n=247 (age range: 8-12; mean age=9.6; 53.4% females). |
| Kilgus (2018); USA | Cross sectional | To examine the performance of a multiple gating identification procedure against systematic teacher identification procedure and both methods combined. | Primary school  Teachers | Universal screening: Systematic Screening for Behavioural Disorders (SAEBRS), Behavioural and Emotional Screening System (BESS)  Teacher nomination: SAEBRS teacher nomination form | Every teacher met separately with a researcher to complete screening measures. Teachers completed all study measures within the same session. | Students: n=704, 47.7% females; 58.2% White, 24.1% Black |
| Tyne (1981); USA | Cross sectional | To examine the relative agreement between peer ratings and teacher nomination in identifying students experiencing interpersonal relationships problems. | Primary school  Students, teachers | Ohio Social Acceptance Scale (OSAS), teacher nomination form | Universal screening: All students were administered the OSAS to measure social distance. Students rated each classmate on a 6-point scale Nomination: Before administration of OSAS teachers identified students in their classroom who are experiencing problems with peer relationships. | Students: n=72 3rd-5th grade. No further characteristics provided. |
| *Risk of suicide* | | | | | | |
| Scott (2009); USA | Cross sectional | To examine the degree of overlap between students identified through school universal screening programme as being at-risk of suicidal behaviours, and those thought to be at-risk by school administrative staff and school MH professionals. | Secondary school  Students | Columbia Suicide Screen (CSS), the Diagnostic Interview Schedule for Children (DISC 2.3) Youth Informant version, The Flesch–Kincaid grade-level score (reading comprehension). | Universal screening: (1) Student-report measure; (2) Within 1-14 days students completed the mood, anxiety, and substance use modules of the DICS 2.3.  Traditional: identification by school staff | Students: n=1729 (age 11-19; mean age=15.4; 57% females). |
| UNIVERSAL SCREENING VS. TRADITIONAL SCHOOL IDENTIFICATION METHODS | | | | | | |
| *Behavioural and socioemotional problems* | | | | | | |
| 1st author (year); country | **Study design** | **Study aims** | **School level**  **Informants** | **Identification measure(s)** | **Programme description** | **Sample characteristics** |
| Eklund (2014); USA | Cross sectional | To compare the effectiveness of universal screening to identify students’ behavioural and emotional risk, against current identification practices used at school. | Primary school  Teachers | The Behaviour Assessment System for Children (BASC-2) - Teacher Report Scale, BASC-2 Behavioural and Emotional Screening System Teacher Form, school archival data on identification. | Universal screening: Teacher- completed screener and additional omnibus rating scale.  Traditional: Student report cards, traditional teacher referral data | Students: n=867 (age range: 6 years 2 months – 13 years 2 months; 49.8% females)  216 teachers. No further characteristics provided. |
| Hallfors (2006); USA | Comparison group study | To evaluate the utility of attendance (truancy) and GPS as a method of identifying students at risk of substance abuse, suicidal behavioural and delinquency. | Secondary school  Students | High School Questionnaire (HSQ), Suicide Risk Screen. | Universal screening: Student-report measures assessing risk behaviours completed by students in the top quartile for absence and below median GPA.  Traditional: Teacher referral data, GPA, attendance. | N=930  (9th-11th grade). No further characteristics provided. |
| Naser (2018); USA | Cross sectional | To compare predictive validity of a universal screening tool for behavioural and emotional risks, and the predictive validity of traditionally used office disciplinary referrals. | Primary school  Teachers | The BESS Teacher Form, office disciplinary referrals (ODRs) | Universal screening: Teacher-completed universal screening measure assessing emotional and behavioural risks.  Traditional: Office disciplinary referrals for the school year when screening was completed | Students N=135 (1st-3rd grade); mean age 7.67 (SD=1.08); 53.5% females. |
| UNIVERSAL SCREENING VS. STAFF IN-SERVICE TRAINING | | | | | | |
| *Substance abuse* | | | | | | |
| 1st author (year); country | **Study design** | **Study aims** | **School level**  **Informants** | **Identification measure(s)** | **Programme description** | **Sample characteristics** |
| McLaughlin (1993); USA | Comparison group study | To examine whether teachers’ ability to correctly identify students at risk of substance abuse improves after attending specialised teacher training programme. | Secondary school  Students, teachers | Baylor Substance Usage Survey and Attitude Inventory. Teacher-completed questionnaire rating students’ substance use. | Universal screening: Student-report measure. For all students teachers rated the use of alcohol and other drugs (excluding nicotine and caffeine) as not at risk, at risk, high risk.  In-service: Teachers attended three 3-hour sessions focusing on: models of predicting substance abuse based on risk factors and enhancing skills in predicting risks. | Students: n=63 (8th grade).  Teachers: Intervention: n=36  Control: n=27 (did not participate in training). No further characteristics provided. |

**RATES OF REFERRALS AND SERVICE UPTAKE**

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| 1st author (year); country | Study design | Study aims | School level  Informants | Identification measure(s) | Programme description | Sample characteristics |
| Cotter (2015); Ireland | Comparison group study (nested in an RCT) | To establish the prevalence of young people reporting current suicidality, to establish the rate of attendance to a clinical interview following screening, to identify factors influencing interview attendance (SEYLE study). | Secondary school  Students | The Paykel Suicide Scale, The Beck Depression Inventory II, The Zung Self-rated Anxiety Scale, Strengths and Difficulties Questionnaire, The WHO Well-being Scale, Deliberate Self-harm Inventory. | Universal screening: Student- report measures. Those who scored above pre-established cut-off points were offered a follow-up interview with MH professional. | Students: n=12.328 (age 14-16; 55.2% females). |
| Also see: Gould (2009), Hilt (2018), Husky (2011) | | | | | | |

**COST-EFFECTIVENESS**

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| 1st author (year); country | Study design | Study aims | School level  Informants | Identification measure(s) | Programme description | Sample characteristics |
| Burke (2013); Ireland | Cross sectional (nested in an RCT) | To assess the cost-effectiveness of four methods of school-based suicide prevention programmes (SEYLE study). | Secondary school  Students, teachers, MH professionals | Beck Depression Inventory (BDI) divided into four categories: minimal, mild, moderate and severe. Health utilities attached to each BDI state and quality adjusted life years (QUALY) | Universal screening: Student-report measures and professional MH clinical assessment for those who scored above cut-off.  In-service: Manualised teacher training to recognise suicide risks and improve communication skills.  Curriculum-based: Manualised student programme to increase MH awareness and enhance skills to deal with adverse life events. | Students: Intervention: n=8114  Control: n=2993.  All sample characteristics: age 14-16, from sites with not more than 60% of same sex students. |

**Table 3: Findings**

**RATE OF ACCURATE IDENTIFICATION**

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| UNIVERSAL SCREENING | |
| *Depression and anxiety* | |
| 1st Author (Year) | **Findings** |
| Morey (2015) | Stage 1: Twenty-six percent of students (of n=3318) met the cut-off criterion at Stage 1. A significant different in scores between depressed and non-depressed students was found on both CDI (p<.001) and BYI-D (p<.001). Stage 2: Students who completed CDI at Stage 1, 75% of continued to meet the cut-off criterion for the CDI at the second stage of screening. Of students who completed BYI-D at Stage 1, 48% reported possible depressive symptoms on the DSM-BSI in Stage 2. Stage 3: of 456 girls identified 378 completed stage 3 clinical interview. In cohort 1 (CDI) 47% of girls received final diagnosis of depression. In students who completed DSM-BSI 63% of girls received diagnosis of depressive disorders.  A simultaneous logistic regression was conducted with the BYI-D and CDI to assess the overall classification accuracy of the measures depressed. The measure reliably distinguished depressed and non-depressed girls (p<.001). |
| Robinson (2010) | There were 41 students who were identified as being at risk of depression, 32 who reported self-injuring and 25 who reported deliberate self-harm; some students self-identified twice, i.e. before and after completing the curriculum-based program. Taking into account the overlap a total of 71 students were identified as being at-risk. Out of 61 students who were identified as being at risk via the manual screening and subsequently interviewed, 28 students were considered to require further support from the school welfare team. Additionally 10 students were missed in by the process of manually checking the case-detection tool results. These 10 students were also subsequently referred to the school welfare coordinator. |
| Tisher (1995) | On Children Depression Scale teachers reported children in the clinical depressed group as significantly more depressed than children in the clinical non-depressed or normal groups (p<.0001). On the Children’s Behaviour Questionnaire for Completion by Teachers reported children in the clinical depressed group to have significantly higher scores than children in the clinical non-depressed or normal group (p<.001). |
| *Behavioural and socioemotional problems* | |
| Forness (1998) | The number of children meeting research diagnostic criteria (RDC) for the learning disability category (12.65% of the total sample of 4,161) was much greater than the number identified by schools in this category (1.86%). In the speech and language category schools identified 6.3% of the sample while the RDC qualified only 2.41%. In mental retardation category school identified 0.51% of the sample with RDC 0.26%. In emotional disturbances category school identified 0.95% and RDC 0.32% of the sample.  Out of 98 children identified in the kindergarten as having learning disabilities only 19 children were identified by the schools in this category, while remaining 79 (80.6%) were identified outside their diagnostic area. Fourteen children with learning disabilities were identified by the schools as emotionally disturbed, while only three out of six children with and actual diagnosis of emotional disturbances were correctly identified by the schools. In the speech and language category 56.8% of children identified according to RDC, were identified by the schools in different diagnostic area. In mental retardation category, all but one of the six children were identified by the schools in other categories. In emotional disturbances category, three of the six children meeting RDC criteria were identified by the schools in other categories. A half or fewer children meeting RDC were identified by the schools as having the same difficulty: 19.4% in learning disabilities, 43.2% in speech and language, 16.7 % in mental retardation, and 50% in emotional disturbances. |
| Jones (2002) | For all outcome measures children identified as high-risk in kindergarten had significantly higher service use for behavioural and emotional problems over the subsequent 6 years (over 50% vs. 16% of non-risk children). 82% of high risk children had received assistance in at least one of the defined categories. High-risk children were significantly more likely to receive MH assistance including professional services (specialty mental health or general medical for mental health reasons), medication (p < .01), and inpatient MH services (p < .05). High risk children were also significantly more likely to receive special education services and MH-related school counselling (p<.001). High risk children were also significantly more likely to have had contact with the police (p < .05). |
| *Risk of suicide* | |
| Gould (2009) | Student report universal screening identified 317 students (out of 2342 screened) as being at-risk of suicide. Of those 159 met more than one criteria. Serious suicidal ideation and/or past suicide attempts were endorsed by 138 students. Subsequent clinical interview indicated that universal screening yielded 43% false positive results. The students who received a referral were significantly more likely to have expressed current serious suicidal ideation (35.9%). |
| Hilt (2018) | 579/2022 screened positive on stage 1 screening tool. Of these 433 were referred to services after completing the clinical interview (true positives).Also 11 students who screened negative in stage 1 were subsequently referred after completing the interview (false negatives). |
| Husky (2011) | Out of 2488 screened students a total of 400 screened positive on the DPS. Ann additional 89 screened negative but were deemed to be in need of a clinical interview after the debriefing indicating that universal screening yielded nearly 20% false negative results. Approximately one in five (19.6%) screened adolescents were identified as being at risk (either through universal screening or debrief with counsellor), and received a second-stage clinical interview. After completing the interview 172 at-risk students were refereed to specialist MH services. |
| UNIVERSAL SCREENING VS NOMINATION | |
| *Depression and anxiety* | |
| 1st Author (Year) | **Findings** |
| Auger (2000; 2004) | 62/356 (17.4%) of the students scored at or above the RADS cut-off score in first measure completion. Of the 62 students who received the second RADS, 42 still scored at or above the cut off and were interviewed with the DISC. Five of these 42 were identified as meeting criteria for a depressive disorder. Correlation between the teachers’ depression ratings and the students’ initial RADS scores was .22 (p <.001). Of 26 teachers who provided depression judgements for five students with DISC-identified depressive disorders only 27% of teachers correctly identified the student as being depressed. For 351 students without DISC-identified depressive disorders 91% (out of 1644 teachers’ judgements) were concurrent with DISC results. Teachers’ ability to provided differentiated Likert depression ratings for students who self-report symptoms of depression versus those who do not was compared using t-test with significant result (p<.001).  Teachers’ ratings were significantly more congruent with students’ self-report results when they were more familiar with students (p=.007). The more time teachers spent with students, the more congruent their ratings were with students’ RADS scores (p<.0001). |
| Campbell (2004) | In the urban school out of 193 students 54 (28%) in total were identified by any mean as being at risk for anxiety/depression. In the rural school out of 68 students 31 (46%) were identified by any mean as being at risk. In the urban school teachers nominated 20 students comparing to 15 in rural school. Support staff additionally identified 13 students but only 9 out of total 33 identified by school staff were nominated by both class teachers and support staff.  At the urban school 22/32 students identified by the survey were also nominated by teachers compared to 6/22 students identified by the survey at the rural school. Staff at the urban school nominated 22 students who did not self-identify while in the rural school teachers nominated 9 students who did not self-identify. Only 10 students self-identified in the urban school without a teacher referral while 16 students self-identified without teacher referral in the rural school. |
| Cunningham (2014) | At stage 1 1271 (30.1%) students screened positive; of those 454 screened positively at stage 2. Half of the students who self-reported CDI scored were above cut-off point at second assessment were also correctly identified by teachers, yielding sensitivity rate of 50%. Teachers correctly identified 83.8% of students who did not self-report elevated levels of depression by intentionally not nominating them. 35/216 students who did not self-report elevated CDI scores were incorrectly identified by teachers as depressed yielding misidentification rate of 16.2%.  Teachers correctly identified 41% of students who self-reported elevated MASC scores at second assessment. 16/27 students who self-reported elevated MASC scores were not identified by teachers, yielding miss rate of 59.3%. 174/211 students who did not demonstrate elevated anxiety were also not nominated by teachers (specificity 85.5%). |
| Sweeney (2015) | Of all positive Stage 1 screens (n=1271) 1148 (90.3%) were identified through the self-report measures only, 78 (6.1%) were teacher nominated only, and 45 students (3.5%) were identified through both nominations and self-report measures. In stage 2 over 50% of parents confirmed their child’s heighten anxiety. Of those, 432 (95.2%) students reported heightened social anxiety on at least one of the self-report measures and 48 (10.6%) were identified through teacher nomination. Of those 48 identified by nomination, 26 were also identified by a self-report measure, resulting in 22 cases identified solely by school staff.  Of 454 students invited to participate in a diagnostic interview 286 (63%) completed ADIS-P/C. The majority (n=204; 71.3%) received SAD diagnosis based on the interview. OF those diagnosed 77.4% were also identified by MASC, 80.3% by SPAI-C and 61.2% scored positive on both measures. Of 204 students with final SAD diagnosis only 25 (12.3%) had also been nominated, however 18 were also identified by a measure leaving 7 students with SAD diagnosis who were solely identified through nomination. |
| *Behavioural and socioemotional problems* | |
| Dowdy (2013) | Out of 849 students participating in the programme 68.6% students (n=582) were not identified by either universal screening or teacher nomination (‘not identified’). A total of 13.8% (n = 117) were placed in the ‘BESS identified’ group because they were identified by the BESS only, and 7.3% (n = 62) were placed in the ‘nomination identified’ group because they were identified by the Teacher Nomination Survey only. 10.4% students (n=88) were identified as being at-risk by both tools (both identified group). The BESS identified significantly more at risk students (24.1%) than the Teacher Nomination Survey (7.3%) (p<.001)  The ‘both identified’ group received significantly lower study habits/cooperation grades than any other group (p values ranged from <.001–.002), significantly more ODRs than any of the other group (p values ≤.001), and more suspensions than any other group (p values ranged from <.001–.007). The ‘non-identified’ group received significantly higher study habits/ cooperation grades than any of the other groups (p < .001 for all comparisons). ‘BESS identified’ and ‘teacher identified group’ did not differ significantly in regard to study habits/ cooperation grades.  ‘The ‘BESS identified’ group received significantly more ODRs than the ‘not identified’ group (p < .001) but did not differ significantly from the ‘nomination identified’ group (p = .08). Finally, the ‘nomination identified’ group did not differ significantly from the ‘not identified’ group in the number of ODRs received (p = .48). The ‘BESS identified’ group did not differ significantly from the ‘not identified’ (p = .05) or ‘nomination identified’ (p = .10) groups in the number of suspensions received. |
| Dwyer (2006) | The parent-report measures correctly identified only 30–46% of children who subsequently developed internalizing problems, and correctly identified 68–78% of those who did not. The teacher-report measures correctly identified 26–34% of those who later developed internalising problems and 75% of those did not. Parent-report measures had slight but nonsignificant higher sensitivity than simple nomination for the prediction of externalizing problems (63% vs. 53%), but simple nomination was better than the risk factor measure for predicting those not at risk of externalizing only (specificity: 78% vs. 70%) or total behaviour problems (82% vs. 72%). For teachers simple nomination was more accurate than the risk factor measure for predicting those at risk of externalizing only (sensitivity: 69% vs. 49%) or total behaviour problems (68% vs. 47%), and was equally accurate as the risk factor measure for predicting those not at risk of externalizing only or total behaviour problems (77–80%). Teacher nomination was significantly more sensitive comparing to parents’ for the prediction of externalizing only (69% vs. 53%) or total behaviour problems (68% vs. 53%). |
| Eklund (2009) | 11/48 (23%) of students were identified by both BESS and teacher nomination (Both Identified), 27% (n=13) were identified by BESS (BESS Identified) but were not concurrently identified by their teachers as needing additional services, and 8% (n=4) by teachers only (Teacher Identified). Students in the Both Identified group had significantly lower academic achievement than students who were not identified as at-risk and those only identified as at-risk through teacher referral. Differences in academic were not significant between the remaining three groups: BESS Identified, Teacher Identified, and Not Identified. All students identified as at-risk by the BESS (in Both Identified and BESS Identified groups) had significantly lower student engagement scores than the Teacher Identified or Not Identified groups. |
| Garland (1995) | Attendance at the information meeting was the most direct measure of help-seeking. Low risk students were significantly more likely to attend the meeting than high risk students (p≤.0006); out of 23 students attending the meeting, 19 were in the low risk group. Risk lever had a significant effect on Use of Service scores, but gender and the interaction did not (p<.025).  The percentage of students identified by teacher ranged from 21-50% but the teacher with a 50% rate had a small number of students in the study (n=15). Teachers with the highest number of students (n=127) identified 21-31%. Teachers were significantly more likely to identify students with higher risk scores than those with lower risk scores (p<.0001). Of 54 students identified by the universal screener as being at high risk teachers correctly identified 33. Of 127 low risk students teachers indicated 21 to be at risk. |
| Kieling (2014) | Agreement among the strategies was very low (with mean Kappa score 0.28; all p<0.002). A significant correlation was found between teachers’ SDQ ratings of ADHD and SNAP-IV scores in the hyperactivity (p<0.001) and oppositional behaviour dimensions (p<0.001), but not for inattention problems (p = 0.324).  Of 122 students invited for a full clinical assessment diagnosis was confirmed for 18. Of those 17 had been positively identified by at least one of the structured questionnaires (SDQ, SNAP-IV, or both). Agreement between teachers’ nomination and final diagnosis was higher for negative cases. |
| Kilgus (2018) | Findings yielded support for SAEBRS universal screening measure with correct classification =.92, sensitivity = .93 and specificity = .91. Teacher nomination tool was significantly less accurate with correct classification =.91, sensitivity =.86, and specificity = .74. Combining universal screening and nomination did not increase accuracy of identification compared to universal screening alone. |
| Tyne (1981) | The agreement between the two methods of identification (peer-informed universal screening and teacher nomination) was equal to chance for 3rd grade females (19% agreement), and was significantly higher for 3rd grade males, and males and females and 4th and 5th grades (p<.01). The greatest level of agreement (55%) was achieved for 5th grade students. Consonance of the two procedures was in 27%-55% range (under a half of the joint judgements are agreement when chance is excluded). |
| *Risk of suicide* | |
| Scott (2009) | There was a minimal overlap between universal screening and school staff identification of students at risk of suicide (κ=0.206; SD=0.023; P<.001). Forty-one percent of students who screened positive for suicide risk were also identified by school professionals. Among students with recent suicidal ideation or a history of a suicide attempt, 83.1% were identified via screening, 40.2% were identified only via screening, and 8.9% identified only by school staff. School professionals identified most of the students at the highest level of suicide risk. Two thirds of students with a suicide attempt in the preceding 6 months were identified by a school staff member (administrative staff only, 8.3%; clinical staff only, 50.0%; both, 8.3%). Among students with both suicidal ideation and a history of a suicide attempt, a current mood, anxiety, or substance use disorder, 63% were identified by school professionals (administrative staff only, 17.4%; clinical staff only, 37.0%; both, 8.7%). Universal screening identified 100% of students in both of these high-risk subgroups. In the absence of screening, more than one third of high-risk students would have been missed.  There was very little within-school overlap between identification by administrative staff and clinical professionals. Overall 24% of identified students were concern only to clinical professionals, 12% were identified only by administrative staff and 5.3% were identified by both clinicians and administrative staff. |
| UNIVERSAL SCREENING VS. TRADITIONAL SCHOOL IDENTIFICATION METHODS | |
| *Behavioural and socioemotional problems* | |
| 1st Author (Year) | **Findings** |
| Eklund (2014) | Significant relation was found between students’ risk level and identification method (p<.01). Of the 160 students identified as at-risk by the screening measure, only 61 were previously identified through current school identification methods. Students identified by the teacher-report universal screener had significantly higher internalising and externalising scores comparing to school identified and not identified students (p<.01). Students identified by both school and teacher screener had significantly lower reading scores than students identified by teacher screener only (p<.01), however, there were no significant differences in reading scores between the screener identified and school identified students. For both reading and math standardized test scores, the not identified group had significantly higher standardized test scores. There were no significant differences in maths scores between groups. |
| Hallfors (2006) | In one research location (Texas) low GPA was significantly associated with cigarette, alcohol, and marijuana use. Attendance and teacher referral was not associated with substance use, suicide risk, or delinquency. However in other research site (California) attendance was significantly associated with cigarette, alcohol, and marijuana use, suicide risk and delinquency, and teacher referral predicted alcohol and marihuana use, as well as delinquency. |
| Naser (2018) | Universal screener (BESS TF) identified 16.3% of students (out of n=135) as being within the elevated risk range and 5.9% within extremely elevated risk range. Using accepted ODRs cut-off points 33.9% of students were within extremely elevated risk range and 24.5% in elevated risk range. BESS TF risk score positively correlated with absence (p<.01) and suspension (p<.01); ORDs were only correlated with suspensions (p<.01). When controlling for gender and grade BESS TF significantly predicted end of year academic and behavioural functioning including GPA, absences and suspensions. BESS TF accounted for significantly more variance in GPA than ODRs (p<.02), but there was no difference for number of suspensions. |
| UNIVERSAL SCREENING VS. STAFF IN-SERVICE TRAINING | |
| *Substance abuse* | |
| 1st Author (Year) | **Findings** |
| McLaughlin (1993) | The 1250 (T1) and 1239 (T2) students were categorised as Abstainers (52% and 48%), Experimenters (26% and 24%) and Users (21% and 27%). Before training teachers’ ratings in intervention and control groups were overall match 53%. After training the overall match dropped to 46.5% in control group and 41.8% in intervention group. The difference between observed and expected matches in the intervention and control group across usage categories was significant (p<.001). However the intervention group achieved higher match rates among Experimenters (36.6% vs 25.5% in comparison group) and Users (19% vs 5.8% in comparison group), while control group more accurately identified Abstainers (83.2% vs 57.6% match). |

**RATE OF REFERRALS AND UPTAKE**

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| --- | --- |
| 1st Author (Year) | Findings |
| Cotter (2015) | Of 516 students who screened positive 37.6% attended the clinical interview. Improved attendance was associated with using the school as the only interview setting (p = 0.006) and arranging the interview within 1 week of contacting the student (p = 0.013). Attendees had significantly higher levels of depressive symptoms, anxiety symptoms, emotional symptoms, hyperactivity/inattention, peer relationship problems and functional impairment. A recent suicide attempt increased interview attendance.  Student’s unwillingness to attend the interview was the most common reason for not following up (58.1%), followed by parental refusal (14.9%). Almost one in ten (9.3%) were not interviewed as they were already in contact with MH services. The greater travel time for a clinical interview the lowered the attendance (p=0.034). |
| Gould (2009) | Of 227 students who screened positive and were not receiving any MH services at the time a referral was made for 118 students, 35 students were given a list of local providers without specific referral and 74 received no list or referral. Referral was made for 29 out of 90 students who were already in some form of treatment. The uptake of follow-up recommendations was 70.3% and did not differ significantly by screening’s referral recommendations (p=.05). However students who were not in treatment already were significantly more likely to follow-up with the referral comparing to those in treatment (p<.001), with those who received a specific referral being the most likely to follow-up (69.2% vs. 42.3% who received a list of providers and 31.9% who received no referral information; p<.001). Of students who were not in contact with servicers 77% of those who followed through with referral recommendations reported that their decision to make contact with MH services had been influenced by the screening. Only 50% of those who were given a list of providers and 53.3% of those who did not receive any referral recommendations reported such influence. Overall, 24% of the new service users had their first appointment within a month following the screening. Within 6 months, 52% had kept their first appointment, and within a year, 70% had successfully reached a MH provider. |
| Hilt (2018) | A total of 579 students out of 2022 screened positive; after clinical interview 433 deemed to be in need of MH support. Additionally 11 students who screened positive received a referral after completing a clinical interview. Of 444 students determined to be in need of MH services 77% were currently not in treatment. Majority (89%) were referred to community services; remaining received referral to school services. Case-management confirmed that 50.2% of referred students attended one or more appointments; 22.5% completed three or more appointments. |
| Husky (2011) | A total of 400 students screened positive on the DPS, an additional 89 screened negative but were deemed to be in need of a clinical interview after the debriefing. Of students identified as being at-risk 128 received a referral to school-based MH services, 78 to community-based MH services, 93 to both school-based and community-based services and 60 no referral at all. Of those referred, 76.3% received at least one follow-up visit and 56.3% received minimally adequate treatment. Among students referred to school-based services 80.2% received at least one visit, and 71.3% of those who received one visit received minimally adequate treatment. Of students referred to community-based services 41.9% received at least one visit, and 68.0% of those who received one visit received minimally adequate treatment.  Students in universal screening group who were referred for further support to Student Assistance Programme were significantly more likely than students identified in traditional way to receive support and subsequent referral to school-based or community services. |

**COST EFFECTIVENESS**

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| --- | --- |
| 1st Author (Year) | Findings |
| Burke (2013) | The most cost-effective intervention was universal screening (ProfScreen) at €190.00 per QUALY. Without taking costs of delivering the intervention under consideration, the most effective intervention in terms of improving QOL is universal screening with the largest change in QUALYs from baseline to 3-month follow-up being 0.0272. The control condition triggered the lowest change in QAYLs. The high personnel costs of gatekeeper and curriculum-based approaches may have caused a reduction in the cost-effectiveness at €1000 per QUALY as measured by the BDI utilities. |

**Table 4: Components of identification programmes**

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| DEPRESSION AND ANXIETY | | | | | | | | | | | | | | | |
| 1st author (year) | ID model | Informants | | | Parent consent | | Student assent | | Staff delivering intervention | | No of assessments | Follow-up clinical evaluation | Feedback | | Referral |
| Student | Parent | Teachers/school staff | Yes/No/ ND | Active/ Passive | Yes/No/ ND | Active/ Passive | Who is delivering | Training provided | Yes/No/ ND | Student/Parent/ School |
| Morey (2015) | Universal screening | x | x |  | Yes | Active | Yes | ND | Research staff | Yes | 2 | Yes | Yes – at risk only | Parents | ND |
| Robinson (2010) | Universal screening | x |  |  | Yes | Active | Yes | ND | Research staff, pastoral | Yes | 1 | Yes | ND |  | Yes |
| Tisher (1995) | Universal screening |  |  | x | Yes | ND | ND |  | Research staff | No | 1 | ND | ND |  | ND |
| Auger (2000; 2004) | Universal screening | x |  |  | Yes | ND | ND |  | Teachers | Yes | 2 | Yes | ND |  | ND |
| Nomination |  |  | x | Yes | ND | ND |  | ND | No | 1 | ND | ND |  | ND |
| Campbell (2004) | Universal screening | x |  |  | Yes | Active | Yes | ND | ND | ND | 1 | ND | ND |  | ND |
| Nomination |  |  | x | Yes | Active | Yes | ND | ND | ND | 1 | ND | ND |  | ND |
| Cunningham (2014) | Universal screening | x |  |  | Yes | Active | Yes | Active | Research staff | Yes | 2 | No | Yes at-risk only | Parents | Yes |
| Nomination |  |  | x | Yes | Active | ND |  | ND | ND | 1 | ND | ND |  | ND |
| Sweeney (2015) | Universal screening | x | x |  | Yes | Active | ND |  | ND | ND | 2 | Yes | ND |  | ND |
| Nomination |  |  | x | Yes | Active | ND |  | ND | Yes | 1 | Yes | ND |  | ND |

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| BEHAVIOURAL AND SOCIOEMOTIONAL PROBLEMS | | | | | | | | | | | | | | | |
| 1st author (year) | ID model | Informants | | | Parent consent | | Student assent | | Staff delivering intervention | | No of assessment | Follow-up clinical evaluation | Feedback | | Referral |
| Student | Parent | Teachers/  school staff | Yes/No/ ND | Active/ Passive | Yes/No/ ND | Active/ Passive | Who is delivering | Training | Yes/No/ ND | Students/ Parents / School |
| Forness (1998) | Universal screening |  | x | x | Yes | Active | ND |  | Research staff | ND | 1 | No | ND |  | ND |
| Jones (2002) | Universal screening |  | x | x | Yes | Active | ND |  | Research staff | ND | 1 | No | ND |  | ND |
| Naser (2018) | Universal screening |  |  | x | ND | ND | ND |  | Research staff | ND | 1 | ND | ND |  | ND |
| Dowdy (2013) | Universal screening |  |  | x | ND | ND | ND |  | ND | ND | 1 | No | ND |  | ND |
| Nomination |  |  | x | ND | ND | ND |  | ND | ND | 1 | No | ND |  | ND |
| Dwyer (2006) | Universal screening |  | x | x | Yes | Active | ND |  | Research staff | ND | 2 | No | ND |  | No |
| Nomination |  | x | x | Yes | Active | ND |  | Research staff | ND | 1 | No | ND |  | ND |
| Eklund (2009) | Universal screening |  |  | x | ND | ND | ND |  | ND | ND | 1 | No | ND |  | ND |
| Nomination |  |  | x | ND | ND | ND |  | School staff | ND | 1 | No | ND |  | ND |
| Garland (1995) | Universal screening | x |  |  | ND | ND | ND |  | Research staff | ND | 1 | ND | ND |  | ND |
| Nomination |  |  | x | ND | ND | ND |  | Research staff | ND | 1 | ND | ND |  | ND |
| Kieling (2014) | Universal screening |  |  | x | Yes | Active | ND |  | Research staff | Yes | 1 | Yes | Yes | Parents | ND |
| Nomination |  |  | x | Yes | Active | ND |  | Research staff | ND | 1 | Yes | Yes | Parents | ND |
| Kilgus (2018) | Universal  screening |  |  | x | Yes | Passive | ND |  | Research staff | ND | 1 | No | ND |  | ND |
| Nomination |  |  | x | Yes | Passive | ND |  | Research staff | ND | 1 | No | ND |  | ND |
| Tyne (1981) | Universal screening | x |  |  | ND |  | ND |  | ND | ND | 1 | No | ND |  | ND |
| Nomination |  |  | x | ND |  | ND | ND | ND | ND | 1 | No | ND |  | ND |
| Eklund (2014) | Universal screening |  |  | x | Yes | Active | ND |  | Research staff | ND | 1 | No | ND |  | ND |
| Traditional identification |  |  | x | Yes | Active | ND |  | School staff | ND | 1 | No | ND |  | ND |
| Hallfors (2006) | Universal screening | x |  |  | Yes | Active | ND |  | Research staff | ND | 1 | No | ND |  | ND |
| Traditional identification |  |  | x | Yes | Active | ND |  | School staff | ND | 1 | No | ND |  | ND |

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| RISK OF SUICIDE | | | | | | | | | | | | | | | |
| 1st author (year) | **ID model** | **Informants** | | | **Parent consent** | | **Student assent** | | **Staff delivering intervention** | | **No of assessment** | **Follow-up clinical evaluation** | **Feedback** | | **Referral** |
| **Student** | **Parent** | **Teachers/**  **school staff** | **Yes/No/ ND** | **Active/ Passive** | **Yes/No/ ND** | **Active/ Passive** | **Who is delivering** | **Training** | **Yes/No/ ND** | **Students/ Parents / School** |
| Hilt (2018) | Universal screening | x |  |  | Yes | Active | Yes | Active | Community professional | ND | 1 | Yes | ND |  | Yes |
| Husky (2011) | Universal screening | x |  |  | Yes | Passive | Yes | ND | ND | ND | 1 | Yes | ND |  | Yes |
| Gould (2009) | Universal screening | x |  |  | ND | ND | ND |  | ND | ND | 2 | Yes | Yes at-risk only | Parents | Yes |
| Cotter (2015) | Universal screening | x |  |  | Yes | ND | Yes | ND | Research staff | ND | 1 | Yes | ND |  | Yes |
| Scott (2009) | Universal screening | x |  |  | Yes | Passive | Yes | ND | Research staff | ND | 2 | Yes | ND |  | ND |
| Traditional identification |  |  | x | Yes | Passive | ND |  | School staff | ND | 1 | Yes | ND |  | ND |
| Burke (2013) | Universal screening | x |  |  | Yes | Active | Yes | ND | Research staff | ND | 1 | Yes | ND |  | Yes |
| Curriculum-based | x |  |  | Yes | Active | Yes | ND | Research staff | Yes | Optional | Yes | ND |  | Yes |
| In-service |  |  | x | Yes | Active | Yes | ND | Research staff | Yes | Optional | Yes | ND |  | Yes |

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| SUBSTANCE ABUSE | | | | | | | | | | | | | | | |
| 1st author (year) | **ID model** | **Informants** | | | **Parent consent** | | **Student assent** | | **Staff delivering intervention** | | **No of assessments** | **Follow-up clinical evaluation** | **Feedback** | | **Referral** |
| **Student** | **Parent** | **Teachers/**  **school staff** | **Yes/No/ ND** | **Active/ Passive** | **Yes/No/ ND** | **Active/ Passive** | **Who is delivering** | **Training** | **Yes/No/ ND** | **Student/ Parent/ School** |
| McLaughlin (1993) | Universal screening | x |  |  | ND | ND | ND |  | Research staff | ND | 1 | No | ND |  | ND |
| Staff in-service |  |  | x | ND | ND | ND |  | Research staff | Yes | 1 | No | ND |  | ND |