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Universal Mental Health Screening in Schools: A Critical Assessment

Issue Brief

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Executive Summary

Mental health screening in public schools has grown in recent years. As of 2021, nearly one-third of American schools reported that their district mandated student screening.[1] While widespread implementation has occurred somewhat inconspicuously, empirical evidence has shown that universal mental health screening does not improve clinical or academic outcomes and indeed has harmful effects.

This issue brief provides an overview of universal school-based mental health screening, related law and evidence, and practical and ethical concerns. It finds that:

- Universal mental health screenings are ineffective: they do not reduce the prevalence of mental health conditions or improve academic outcomes.
- Universal mental health screenings are harmful: they produce overwhelmingly high rates of false positives and, when delivered in schools, have fewer protections in place than in clinical settings.

Given the lack of evidence for universal mental health screening, this brief recommends its prohibition in schools. For targeted and individual school-based mental health screenings, far stronger regulatory conditions are warranted. Model legislation is provided for implementing these recommendations.

Introduction

What Is Mental Health Screening?

A "mental health screening" typically refers to a brief assessment used to identify individuals—students, in the case of schools—who may benefit from mental health intervention. Screening typically involves a short questionnaire about students' emotions or behaviors, completed by students and sometimes teachers. Screening can be administered universally—to all students in a classroom, grade, or school—or targeted to individuals who have raised a potential concern.[2]

A variety of screening tools are used in schools. Examples include the Behavioral and Emotional Screening System (BASC-3 BESS),[3] which asks students to rate their level of agreement with statements such as "I worry but I don't know why,"[4] and the Student Risk Screening Scale (SRSS), a teacher-completed survey on student behaviors and attitudes, such as the extent to which the student is perceived to be sad, depressed, anxious, or lonely.[5]

Schools also use screeners to assess suicide risk.[6] The Columbia-Suicide Severity Rating Scale, for example, asks students: "Have you wished you were dead or wished you could go to sleep and not wake up?" and "Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?"[7] The Patient Health Questionnaire-9 (PHQ-9) asks students whether they have "thoughts that you would be better off dead or of hurting yourself in some way."[8]

In perfect practice, the process for screening would be: a qualified professional selects a valid screening tool, administers it in a clinical setting only to those demonstrating potential need, and scores it promptly; those with a clear indication of a mental health condition are correctly flagged, and appropriate follow-up occurs. For minors, none of these steps would happen without explicit parental engagement and, at minimum, opt-in consent.

But perfect practice is rarely met. A wide array of screeners exists for mental health conditions,[9] social-emotional capacity,[10] behavioral risks,[11] and adverse childhood experiences (ACEs).[12] But no screen can confirm a mental health condition because there are no definitive biological tests or biomarkers for mental illness.[13] Further, mental health treatment is limited because it is not curative or preventive.[14]

Universal mental health screening is administered in addition to several other existing school assessments by which potential mental, emotional, or behavioral challenges may be identified. Universal screening therefore predominantly captures cases that are already known—and the new cases that it captures are likely to be the most minor and least likely to be appropriate for mental health services.[15]

The assessment process for special education, in particular, deserves explicit mention. The federal Individuals with Disabilities Education Act (IDEA) has a "child find" mandate,[16] which requires local education agencies (LEAs) to identify and evaluate all children suspected to have a disability, however minor, including from mental health conditions.[17] Universal mental health screening is not only redundant to this process but inferior: IDEA requires more robust assessments, a higher bar for parental consent and family engagement, and an obligatory course of action for follow-up and resolution, and it defines the scope of services that schools must provide to eligible students. The special-education program is far from perfect, but it is a well-established process for identifying youth with challenges.

Universal mental health screening has nonetheless become widely implemented, and nearly one in three public schools reports mandating screening.[18] Growth has occurred in part due to policy responses to headline-generating incidents like school shootings—which often lead to expanded funding for such programs[19]—and in part through the currently popular Multi-Tiered System of Supports (MTSS),[20] a resource-intensive framework for managing students who may be struggling with a range of challenges.[21] MTSS promotes a three-tiered structure, with programming that becomes more targeted and intensive at each progressing tier. The first tier includes universal programs delivered to all students, such as universal mental health screening.

Universal mental health screening may often involve formal assessment tools, but "screening" should be understood as any systemic effort to identify individuals who may benefit from mental health intervention. "Preventive" programs that educate people to recognize signs of mental health challenges and emotional states work this way. They increase the likelihood that a potential mental health challenge is identified, simply through different pathways (self-identification, peer identification, and formal assessment). There is no *meaningful* distinction between an education effort that prompts assessment and a questionnaire that prompts assessment. Both have the explicit goal of applying mental health concepts to individuals for the purpose of determining whether to provide, or refer for, mental health intervention. To limit what's considered "screening" only to questionnaires and surveys obscures the fact that these programs all serve the same function.

Mental Health Screening in Federal and State Law

School-based mental health screening is not federally mandated, but federal statutes set baseline rules for when and how schools must receive parental consent if screenings or surveys ask students about certain sensitive topics like mental health, or if screenings are paid for with federal funds. States may impose additional parental rights and consent rules that go beyond what is required by federal law.

Under the federal Protection of Pupil Rights Amendment (PPRA),[22] which pertains to any state or LEA receiving funds from the U.S. Department of Education (ED), schools must obtain prior written parental consent before administering a survey or assessment to a minor student if the survey asks about certain "protected categories" of information and is required as part of a federally funded program.[23] The mental or psychological problems of students and their families are a protected category. For surveys addressing protected categories but that are not required or ED-funded, PPRA requires districts to adopt policies that notify parents and allow them to inspect the survey and opt out. In practice, opting out of universal programs is difficult and not always possible.[24]

A second parental consent constraint comes from the federal Every Student Succeeds Act (ESSA), Title IV, Part A (Student Support and Academic Enhancement Grants), which prohibits the use of Title IV-A funds for any mental health assessment unless prior written parental consent has been obtained.[25] This requirement applies to both universal and targeted assessments.

State law is increasingly regulating school-based mental health screening.[26] In 2025, Illinois became the first state to mandate universal screening, requiring annual screening for students in grades 3–12 beginning in the 2027–28 school year. Parents retain the right to opt out, but the state has not specified the process for doing so.[27] In 2021, New Jersey established a program to incentivize screening, rather than mandate it, with funding for districts opting to provide annual

depression screening in grades 7–12.[28] Colorado enacted legislation in 2023 to create an optional screening program for grades 6–12, but the law was repealed in 2025 over concerns of parental rights infringement.[29]

Other states, meanwhile, have moved to place greater limitation on mental health screening. Since 2020, Utah has required schools to receive prior written parental consent before administering psychological or psychiatric examinations, tests, and treatments, or surveys that reveal personal information. The state also sets standards that LEAs must comply with if they do implement a narrow set of approved screening programs (for anxiety, depression, and suicidal ideation).[30] In 2021, Florida enacted a Parents' Bill of Rights[31] that strongly emphasizes parental authority over their children's health care, including school-based mental health services, and requires prior parental consent for screening.[32]

Other states have considered but not enacted legislation pertaining to mental health screening. In 2022, Minnesota failed to pass a proposal to mandate screening in grades K–12, while specifying parental consent requirements.[33] A 2025 measure in Arizona sought to make all school-based mental health services voluntary, including universal screening, and to require active parental consent.[34]

These proposals highlight that parental consent protections are a persistent feature of state consideration, where legislatures are open to greater screening efforts and where efforts have faced greater restrictions.

Review of the Evidence

Proponents of universal mental health screening argue that it can identify students for earlier access to treatment, thereby preventing conditions from developing or worsening.[35] By this logic, screening is justified if it leads to lower prevalence of mental health conditions than would have occurred otherwise. No empirical evidence supports this view.

Several high-quality reviews of screening for depression, anxiety, and suicide risk among children and adolescents in primary care and community settings have found no benefit of screening compared with no screening.[36] Separate reviews find insufficient evidence to support screening for trauma[37] or ACEs.[38] Universal school-based prevention programs (non-formal screening) also fail to reduce incidence of mental disorders[39] or improve anxiety and depression.[40] Researchers and clinicians alike warn against universal screening as it unnecessarily puts more youth at greater risk of harm.[41]

A 2019 systematic review published in *Psychological Medicine* examined school-based prevention programs for detecting mental health challenges, including several studies on formal universal screening programs.[42] The extensive evidence base was weak and mostly low-quality, and the authors could not conclude that prevention programs were effective for improving outcomes. A 2025 review in *Child and Adolescent Mental Health* reached a more discouraging conclusion: universal school-based prevention is less effective than targeted efforts, often has null or short-lived benefits, is not well-liked by students, and, importantly, can have negative effects.[43]

Evidence cited as support for universal screening typically comes from studies that evaluate process rather than outcomes. Screening has been shown to accurately reflect students' well-being, but not to improve well-being.[44] I.e., a student with known distress is likely to appear in screening results as being distressed. Screening can increase referrals[45] and treatment uptake.[46] But these process metrics do not indicate whether predicted problems ever develop, whether referrals are appropriate, or whether treatment is necessary or effective.

The risk of harm is not theoretical. Universal mental health screening results in overwhelmingly high false-positive rates.[47] Incidence rates of serious mental illnesses are low (about 5% of the general population); thus, universal screenings have been discouraged in clinical settings.[48] Most serious conditions do not develop until the late teens and early twenties,[49] exacerbating the risk for misidentification.

In one study from the *Psychological Medicine* systematic review, universal screening was found to produce up to 90% false positives.[50] With some screening tools, teachers are more likely than parents to rate children "at risk,"[51] and teacher ratings can be influenced by factors that seem important to a diagnosis.[52] Once flagged through school screening, students can be pushed toward diagnoses even when clinicians themselves are uncertain as to whether one is warranted. In one survey, 58% of doctors reported erring on the side of diagnosing autism despite not being certain that the diagnosis was appropriate, so as to not hinder access to potential educational support.[53]

Unwarranted action can be seen in the example of ADHD diagnosing: the youngest in a grade are disproportionately diagnosed, consistent with referrals and medicalization in response to immaturity.[54] As Manhattan Institute senior fellow Abigail Shrier notes in *Bad Therapy: Why the Kids Aren't Growing Up*: "More than 10 percent of American kids have an ADHD diagnosis—double the expected prevalence rate based on population surveys in other countries"; but "if you ask mental health experts if young people, in aggregate, have undiagnosed mental health problems, they invariably answer in the affirmative. Meaning, according to experts, not having a mental health problem is increasingly anomalous."[55]

In the 2023 National Survey on Drug Use and Health, one in three adolescents was estimated to have received medical and professional services for treating mental disorders in the past year, but only one in five reported a single two-week or longer period of distress.[56] As Shrier recapitulates in *The Free Press*, "unlike the alleged benefits of mental health screeners, there is solid evidence of the harms produced by receiving a mental health diagnosis, harms that are a pure tragedy in the case of misdiagnosis."[57]

Compounding Concerns

A secondary claim in support of universal screening is that expanding access to mental health services can improve academic outcomes for all students. This claim is a mistaken inference from the observation that students with mental health disorders fare worse academically than their healthy peers.[58] But it does not follow that screening would improve academic outcomes. Indeed, research has found no aggregate academic benefit from school-based mental health screening or services.

In a gold-standard randomized control trial using 19 years of data, access to school-based mental health services increased students' use of services but had no impact on test scores or average attendance.[59] In a multiyear quasi-experimental study from Toronto, massive investments into screening and treatment at an inner-city school-based health center led to more children diagnosed with disorders and medicated—but no improvement in academic achievement.[60]

While these findings do not show that every individualized mental health assessment is inappropriate, they do show that mental health services have not delivered broad academic benefits. Schools are therefore trading away valuable time and resources that could be used to improve academic outcomes if they had been allocated toward educational programming like classroom instruction.

Individual screening may be clinically appropriate for a given student, but federal and expert guidance justifies screening only if schools are able to reliably notify parents, provide or facilitate diagnostic evaluation, and ensure access to effective treatment.[61] Most schools cannot meet these conditions. In a 2025 RAND study, 52% of public schools did not report being able to effectively provide mental health services to all students in need, and 20% of principals did not report typically notifying parents of students identified as having anxiety or depression. Many schools reported that referrals were inconsistently made and treatment was difficult to obtain.[62] Such findings show that the education system is poorly positioned to translate screening results into meaningful intervention.

Proponents of school-based mental health screening note that schools are "the most common provider of mental health services for youth."[63] Schools therefore function as de facto mental health providers, but they do so outside of behavioral health regulation, in settings inherently less structured for high-quality care than clinical settings, and with weaker protections against harmful intervention.

Community-based mental health professionals are licensed and overseen by state behavioral health boards or equivalent agencies. State statutes define the scope of practice of respective professions (e.g., licensed counselors, psychologists), set licensure requirements, investigate complaints, and can revoke licenses for ethical or legal violations. Practicing without a license can be a misdemeanor or felony offense.

By contrast, school-based counselors, social workers, and psychologists are not licensed but are credentialed by state education authorities and overseen by school administrators who lack the required knowledge or training in mental health. Local policy largely determines which services fall within the scope of practice. Limitations, if any, are set by individual districts. Roles and expectations are often left ambiguous, which can lead school counselors and school psychologists to be inappropriately asked by administrators, or expected by parents, to provide services beyond their role or qualifications.

Ethical standards and privacy laws also diverge. For licensed community-based mental health practitioners, it is considered unethical to have both a professional and personal relationship with patients,[64] and all state boards prohibit such "dual relationships" to prevent conflicts of interest. The American School Counselor Association, in contrast, promotes such relationships with students, encouraging participation in extracurricular activities and events and emphasizing an "obligation to students' confidentiality" even when concerns involve parents.[65] Federal laws governing student privacy and confidentiality also differ between education professionals (subject to the Family Educational Rights and Privacy Act [FERPA]) and health-care professionals (subject to Health Insurance Portability and Accountability Act [HIPAA]), which can be in conflict. HIPAA requires that a patient's mental health status be kept private. But school practices such as the MTSS framework emphasize information sharing among school professionals, leading to a much broader sharing of information than would occur if parents had brought their child to a community-based provider.

School-based screening in some cases is an otherwise clinical service without the protections, oversight, or clarity of responsibility of a clinical setting. In theory, screening is not meant to diagnose,[66] but tools marketed for schools can be identical to diagnostic instruments. Mental Health America (MHA), an industry group, makes school screening tests available to districts[67] on its website, including tests for ADHD, depression, and anxiety that are the same as those used in clinical settings.

Parental consent requirements exist for school-based mental health services, but no public data or systematic tracking confirms that these requirements are being met. Survey data suggest that many school professionals are confused about, or not aware of, consent obligations.[68] In one survey

of school counselors, 75% reported giving a survey without parental consent in the last 10 years, while nearly 33% admitted to violating federal privacy laws by asking students about protected categories of information.[69] Recent public comments from the National Association of School Psychologists and the National Association of School Counselors expressed a lack of concern or need for parental consent, suggesting that professional associations may not treat this safeguard seriously. It is worth noting that several states require parental consent only up to age 12, including Illinois, where school-based mental health screening will soon be mandated.

Weak oversight, ambiguous roles and responsibilities, and poor positioning for quality service provision make schools a high-risk environment for both universal and targeted screening. Schools have little to gain and much to lose from these efforts.

Case Study: Oxford High School Shooting

While serious incidents such as school shootings have generated support for universal school-based screening,[70] these efforts are counterproductive. A 2021 shooting at Oxford High School in Michigan illustrates how a district heavily invested in such programming can still fail to recognize risk and act decisively, at a basic level.

Prior to the 2021 shooting, Oxford Community Schools had an extensive school counseling program with a low student-to-counselor ratio, additional mental health staff, and software to capture and score student self-assessments and staff observations. According to a 592-page independent investigation following the incident, enough data had been available to reasonably conclude that the 15-year-old male shooter had been a potential threat.[71] The shooter had been flagged as "at risk" for several years; by 2021, his scores placed him within the highest-risk students nationally. But the data collected were never used. Key staff who interacted with the shooter before the incident did not have access to the software and had never been trained to use it. The school either lacked or did not use clear structures governing who would see the data collected, how risk would be interpreted, or what actions would be taken.

This disconnect became apparent in the days before the shooting. Teachers had reported the student for viewing images of bullets and videos of shootings during class. The morning of the shooting, a teacher discovered disturbing drawings and writings about blood, guns, and death, referring the student to school officials. A counselor met with the student and then his parents, recommending that the student receive mental health treatment but not that he be taken for an immediate evaluation or removed from the school. No backpack or locker search was conducted (though a gun would have been found), and no safety plan was put into place when the student was allowed to return to class. Hours later, he shot and killed four classmates.

Oxford is a tragic but useful case study. The district had invested in and implemented many of the strategies commonly promoted following such incidents, including screening. These investments did not lead to meaningful intervention despite clear, long-standing signs of risk.

Because serious incidents of violence and self-harm are rare, it can be easy to attribute the absence of such incidents to broad, low-intensity programs like universal screening, when that outcome would have occurred regardless. In this way, universal screening programs are not only ineffective but counterproductive. Implementing such programs creates the illusion of having taken steps toward prevention, when no meaningful action has been made. Attention is diluted and resources are misallocated away from the few highest-risk students.

To be clear, even targeted identification and intervention for the highest-risk students will not always be capable of stopping such incidents, which are rare and hard to predict. But universal programs can actively impede commonsense actions, such as removal from school or intensive oversight. Such programs ingrain a blanket response of providing encouragement to seek treatment as appropriate for all students—for those who do not need any treatment as well as those who need stronger protective measures than mere encouragement.

Conclusion and Recommendations

While school districts generally have a degree of autonomy in implementing screening programs, states can and should provide guidance and issue requirements related to mental health screening in schools.[72] Universal mental health screenings are ineffective and harmful; states should prohibit their use in schools. To the extent that individual or targeted screening occurs in school settings, states should introduce meaningful guardrails, such as greater transparency and mechanisms for accountability.

Transparency around school-based screening is particularly important for shared understanding among school administrators, school-based mental health professionals, teachers, and parents—and for enforcement of best practices and compliance with parental consent requirements. States should encourage or require districts to publicly share information such as: What assessment tools are being used? How do they compare with those used in clinical settings? What risks are associated with mental health screening? What licensing, credentials, and scope of practice do administering school professionals have? How will screening results be used, and when? How will student data be used, shared, and protected? What is the school expected to provide in terms of post-screening services? Absent these measures, schools should forgo mental health screening.

Model policy in the following section addresses each of these requirements by prohibiting universal mental health screening, establishing a process of required information sharing, and outlining accountability mechanisms for promoting safe practices.

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Model Legislation

Ensuring Appropriate Protections Related to Student Mental Health Screening Act

Placement

State education law

Purpose

To protect student well-being and parental rights, this proposed legislation seeks to prohibit universal mental health screenings in K–12 public schools and ensures that any individualized mental health screening of students occurs only with active parental consent and with adequate related information communicated. The policy provides safeguards for student privacy and outlines enforcement mechanisms to hold accountable related parties such as school districts, schools, and school-based professionals who administer and review mental health screenings.

Section 1. Definitions

For the purposes of this Act, the following terms have the given meaning:

A. A "mental health screening" means the use, including through electronic means, of any systemic effort to identify individuals for the purpose of assessing potential appropriateness for mental health intervention, or one or more standardized surveys, questionnaires, or checklists that ask at least one question about a student's well-being. The screening is used to identify risk factors that place students at higher risk for behavioral health conditions or to identify the possibility that a student might have a cognitive, mental, emotional, or behavioral health limitation or concern, or to identify the need for referral, treatment, or intervention. This includes any survey, questionnaire, or "social-emotional" or behavioral instrument designed to flag potential signs of cognitive, affective, behavioral, or emotional functioning deficits, or emotional distress, depression, anxiety, trauma, or suicidality. This includes any digital mental health screening through the use of web or app-based tools. Any evaluation of, or survey that collects information about, a student's mental, emotional, behavioral, or psychological well-being that is not expressly exempted by this Act shall be considered a "mental health screening." A mental health screening can be administered by any school personnel, as defined in Section 1D.

B. A "universal mental health screening" means any mental health screening broadly administered or automatically administered, whether on a mandatory, opt-out, or opt-in basis, to students as a group, class, grade, or school population, regardless of whether any prior indication of a concern or problem exists. This includes "universal behavioral health screenings" conducted as part of a multitiered support system to screen for "risk" or potential development of social, emotional, and behavioral problems. Routine screenings required by state or federal law for all students (such as vision or hearing tests, or certain mandated health evaluations) are distinct and not included, unless they contain a component of mental health, behavioral health, or emotional well-being as described in Section 1A.

C. An "individual mental health screening" means any mental health screening that is not a universal mental health screening, i.e., administered to a specific student on a case-by-case basis. This could be prompted by a teacher's/administrator's concern, a parental request, or

referral for services. Individual mental health screenings might also be called "targeted" screenings or assessments. For clarity, a full diagnostic mental health assessment conducted by a licensed professional is considered separate from a mental health screening, whether universal or individual; such assessments would typically fall under existing parental consent requirements for medical or counseling services.

D. "School personnel" means any employee, contractor, or agent of a public school or school district who interacts with students in the school setting. This includes, but is not limited to, teachers, school counselors, school psychologists, psychologists, social workers, nurses, administrators, and support staff.

E. "Parent"/"parental" refers to a student's parent or legal guardian.

F. "Parental consent" means written, informed consent given by a parent/guardian, on an opt-in basis, for a specific mental health screening or other service. "Opt-in" consent requires affirmative written permission; passive consent or "opt-out" (where nonresponse is taken as consent) is not sufficient under this Act.

G. "Student mental health data" means any information or records about a student's mental or emotional health gleaned from a screening or assessment. This includes a student's responses to mental health screenings, the results or scores, any notes or reports generated, and any related referrals or follow-up care information.

Section 2. Prohibition of Universal Mental Health Screenings

A. No public school personnel, school, or school district shall administer or facilitate any universal mental health screening of general education students in any grade (K–12). Implementing universal mental health screening programs among general education students is prohibited, regardless of any consent procedure; i.e., a school may not convert a universal screening program into an "opt-in" program; the practice of broad preemptive mental health screening itself is not permitted under this Act.

B. School personnel are further prohibited from administering to students any mental health screening, or survey or assessment of mental or psychological health not required by law, without first determining that the activity is an individual mental health screening permitted under Section 3 and obtaining necessary parental consent. Schools shall not use any instructional time to conduct or complete an individual mental health screening.

C. Nothing in this Section prohibits the following activities, which are not considered universal mental health screenings for purposes of this Act:

   a. Teacher or staff observations: teachers and staff observing students' behavior or well-being in the normal course of education and recommending that a student speak with a counselor or be evaluated. Such observations are not the same as administering a screening tool.

   b. Targeted threat assessments: assessments that are conducted as part of emergency crisis response, such as to rule out imminent danger, so long as such assessment is initiated because of a specific and present concern for that student's health or well-being and follows the consent requirements of the Act or other applicable law.

c. Special-education evaluations: evaluations for special-education eligibility or services (e.g., psychological evaluations for an Emotional Disturbance classification) performed in compliance with the Individuals with Disabilities Education Act, which have their own parental consent and privacy protections.

d. Screenings required by law: if federal or state law mandates mental or behavioral health screening for all students in a certain context (e.g., a federally required survey or a state program for Medicaid's Early and Periodic Screening, Diagnostic, and Treatment [EPSDT]), the school shall adhere to that law's requirements and ensure that active parental consent is obtained if not already mandated (see Section 3 for consent). This exception is intended to encompass programs like the EPSDT program when carried out in schools.

Section 3. Parental Consent for Permissible Mental Health Screenings

A. Individual mental health screenings only with opt-in consent: a public school may administer an individual mental health screening or assessment to a student only if the student's parent has provided prior written, informed consent. Consent must be "opt-in," affirmative permission for that specific screening, after the parent has been informed of the screening's nature and purpose and informed of the credentials and contact information of the administering/reviewing professionals, as per Section 3B(a)–(e). General or blanket consent for mental health screenings, such as a consent form covering unspecified future screenings, shall not be permitted. Separate consent is required for each instance of screening or each instrument used.

B. Informed notice: before seeking parental consent, the school must provide the parent with a written notice that clearly explains:

a. The nature and purpose of the proposed screening, including what topics or conditions it seeks to identify and whether the screening is diagnostic in nature

b. When, where, and by whom the screening will be administered and when, where, and by whom the screening will be scored and reviewed. For the administering and scoring/reviewing professionals, the following information must be provided: (1) name and contact information; (2) the type of state board of education certification held by the professionals and, if not certified by the state board of education, a statement that the professionals are uncertified; (3) whether the professionals are licensed by the Board of Behavioral Health Examiners, the Board of Psychologists Examiners, or any other health profession regulatory board and, if unlicensed by a health profession regulatory board, a statement that the professionals are unlicensed by a health profession regulatory board; (4) a statement noting whether the professionals have a credential or license for diagnosing mental health conditions and, if the professional is not credentialed or licensed for diagnosing, a statement noting that the professionals are not credentialed or licensed for diagnosing; (5) if the screening is administered/scored/reviewed by a student, intern, or trainee, the individual must be identified as a student, intern, or trainee acting in a supervised capacity under supervision of a qualified individual; a statement that contains the disclaimers provided in Section 3D(a)–(c)

c. A copy of the survey or screening form to be used, in advance of its use

d. A description of the follow-up assessments, services, or referrals that might result if the student "screens positive," including a description of the follow-up services or referrals that are available and will be provided through the school, if any, and which follow-up services or referrals are available outside the school in the community

e. A statement that participation is voluntary and requires opt-in consent

C. Informing students for whom parental consent is not required: to the extent that parental consent is not required under certain circumstances, all information under Section 3B(a)–(e) must be provided to the student in question prior to being screened, with the student signing an acknowledgment that the information has been shared and that the student has consented to be screened.[73]

D. Adequate notice of mental health screenings as used in the district: a school district with schools administering individual mental health screenings shall maintain a webpage that describes in detail any screening tools used within the district and that prominently and conspicuously displays a notice of disclaimer that:

   a. School counselors and school social workers who are not licensed by the Board of Behavioral Health Examiners may not: (1) engage in the practice of behavioral health; and (2) may not diagnose or treat any mental ailment, disease, or disorder or other mental health condition of any person

   b. Certified school psychologists who are employed by or contracted to provide services in a common school, high school, or charter school are exempt from licensure and regulation by the Board of Examiners or Psychologists in the state

   c. Trainees and interns are students pursuing a course of study relevant to mental health support services in an accredited institution of higher education or training institution; activities of trainees and interns are performed under qualified supervision as part of the course of study.

E. Right to decline or withdraw: no student shall be given a mental health screening if consent is not received, except as outlined in Section 3F. A parent's refusal to consent to a screening shall not be used as grounds to deny the student any other benefit, service, or academic opportunity. School personnel are strictly prohibited from pressuring a student or parent to consent to any screening. If consent is given but later withdrawn, the screening must be halted or results disregarded, and no penalty or prejudice shall result. A parent's decision to decline a screening must not be construed or reported as suspect (e.g., it cannot be treated as evidence of neglect or lack of concern).

F. Emergencies: the only exception to the consent requirements outlined in Section 3 is in emergency situations where there is reason to believe that a student is in imminent danger or may present serious harm to himself or others, in which case immediate intervention (such as a crisis evaluation) is necessary to preempt or prevent harm. In such cases, school personnel should act in the best interest of students' safety by summoning emergency medical or psychiatric professionals, and contacting the parent as soon as possible. This emergency exception is not to be used as a loophole for routine screenings, but rather for active situations. E.g., a student expressing suicidal intent at school can be seen by a counselor or other school professional without prior written consent due to urgent safety concerns; or a student acting erratically and outside the realm of normal student conduct may, at the discretion of school professionals, be seen by a counselor or other school professional without prior written consent because of safety concerns that may become urgent. Efforts should be made to actively engage parents in such circumstances.

Section 4. Protection of Student Data and Privacy

A. Confidentiality of screening results: any student mental health data collected through a permissible screening shall be deemed a confidential educational record subject to federal and state privacy protections (including the Family Educational Rights and Privacy Act, 20 USC 1232 [FERPA]) and applicable state student privacy laws. Schools must ensure that

only authorized personnel have access to a student's screening responses or results, and solely for the purpose of providing services to that student. The state education agency shall, if needed, promulgate rules identifying who may access and use a student's screening data, and for what purposes, consistent with FERPA and this Act.

B. Parental access: parents/guardians have the right to inspect and review any questionnaires, screening forms, scores, reports, or referrals resulting from their child's mental health screening. Upon request, the school must provide parents with all related documents and information. If records of screenings are kept, parents may request that their child's data be amended or removed if inaccurate or if the parent withdraws consent.

C. Limits on data sharing: student mental health screening data shall not be shared with or sold to any third parties outside the school/ school district except: (1) with the parent's written consent specifying the recipient (e.g., if a parent wants results shared with their family pediatrician or doctor); or (2) as required by law (e.g., a court order or lawful subpoena, or mandatory reporting of abuse if a screening reveals such information). Even within the school, such data should be shared only on a need-to-know basis (e.g., a counselor working with the student and the student's relevant teaching staff, not the entire teaching staff).

D. Prohibition on secondary use: schools shall not use screening responses for any purpose other than evaluating the student's potential need for services and providing those services. Data mining, research, or inclusion in broader surveys of student populations is forbidden unless the parent has given informed consent for that additional use. Aggregate reporting (e.g., "10% of our students showed high anxiety on a screening") is permitted only if all personally identifiable information is removed.

E. Data security and retention: the school district must implement appropriate data security measures to protect any digital or paper records of mental health screenings from unauthorized access or breaches. Records of an individual student's screening should be retained only as long as reasonably necessary for t the student's educational benefit or as required by law, and must be disposed of securely when no longer needed.

Section 5. Enforcement and Accountability

To ensure adherence to this Act, the following enforcement provisions are established. These mechanisms are cumulative; one or more may be implemented:

A. Administrative oversight and penalties: the state's Department of Education (or other designated oversight body) is empowered to monitor compliance and investigate any violations of this Act. Upon confirming that a school or district has violated the prohibition on universal screenings or the parental consent / student privacy requirements, the Department shall impose appropriate sanctions. Sanctions may include:

   a. Withholding of state funds: reduction or withholding of a portion of the school's or district's state education aid for the current or subsequent fiscal year. E.g., the state may withhold up to 2% of annual funding for a first violation, up to 4% for a second, with increasing penalties for repeated noncompliance. Withheld funds may be restored after the school remedies the violation and implements a corrective action plan.

   b. Administrative fines: a civil penalty (fine) may be imposed on the school district or responsible administrators. E.g., a fine of up to $___ per incident of unlawful screening may be levied, to be paid into a state education fund or used for technical assistance for a given school or district that aligns with delivering the obligations of this Act.

c. Corrective action plans: require the offending school/district to undergo training and institute a corrective action plan to prevent future violations. The Department may hold funds in escrow until the plan is implemented and compliance is verified.

B. Employee discipline and liability: any school professional, employee, or official who knowingly and willfully violates the provisions of this Act (e.g., administers a mental health survey to students without consent, or proceeds with a universal screening program) shall be subject to disciplinary action by the school or district. Discipline may include reprimand, mandatory training on parental consent and student privacy laws, suspension, or termination, consistent with district policies and any applicable employment contracts. School districts shall not retaliate against employees who refuse to administer a screening due to lack of parental consent or who report violations of this Act in good faith. Moreover, a licensed or credentialed educator who egregiously or repeatedly violates students' rights under this Act may be referred to the state credentialing board for potential suspension or revocation of his/her certification.

C. Private right of action of parent or guardian against school districts:

a. Cause of action that a parent or legal guardian of a student subjected to a violation of this Act may bring a civil action against a school district in a court of competent jurisdiction to enforce the duties imposed by this Act.

b. Available relief: in an action under this Section, the court may award declaratory relief, injunctive relief, nominal damages not to exceed $1 per violation [if needed to preserve standing or avoid mootness] and actual out-of-pocket expenses not to exceed $5,000; and the court shall award reasonable attorney's fees and costs to a parent or legal guardian who substantially prevails.

c. Excluded damages: no punitive, exemplary, noneconomic, consequential, emotional-distress, or other nonpecuniary damages may be awarded in an action under this Section.

d. No limitations on claims against individuals: nothing in this Act shall be construed to limit, restrict, or impair any civil or criminal cause of action that may exist under state or federal law against any individual, including, but not limited to, school employees, contractors, mental health service providers, or third-party vendors.

e. No immunity: this Act shall not be interpreted to provide immunity (qualified, statutory, sovereign, or otherwise) to any individual for acts or omissions constituting negligence, professional malpractice, unlicensed practice, breach of professional standards, invasion of privacy, violation of mandated-reporting duties, or any other actionable conduct.

f. Preservation of damages claims: parents, students, or other injured parties retain the full right to seek common-law or statutory damages, including tort damages, against any individual whose conduct causes personal injury, without regard to the limitations imposed in Subsections (a), (b), or (c) above.

g. Distinction between district noncompliance and individual misconduct: the remedies created by this Section D govern district noncompliance with the statutory obligations set forth in this Act and do not govern, limit, or preempt claims arising from individual misconduct, which remain fully actionable under other applicable law.

h. Professional licensing and discipline not affected: nothing in this Act shall be construed to limit the authority of any state licensing board, including, but not limited to, boards governing psychology, counseling, social work, marriage and family therapy, or medicine, to investigate, discipline, sanction, or otherwise act upon any individual mental-health provider for violations of professional standards or applicable state or federal law.

D. Reporting and transparency: school districts must annually certify compliance with this Act to the State Department of Education. Any known violations and the corrective actions must be reported to the Department. The Department shall publish an annual report summarizing any enforcement actions or violations of this Act (while protecting individual student identities) to ensure public transparency and accountability.

Section 6. Miscellaneous Provisions

A. Interpretation: the Act shall be construed to effectuate its intent of protecting students' mental health and parental authority. Nothing in this Act shall be interpreted to conflict with any higher standard of parental consent or student privacy provided by federal law or other state laws, including the federal Protection of Pupil Rights Amendment, which requires parental consent for certain surveys on sensitive topics and protected classes, which includes mental health; this Act builds upon such requirements.

B. No impact on emergency care or reporting: nothing in this Act prohibits a school from seeking emergency medical or mental health care for a student when warranted, or from reporting suspected abuse or neglect as required by law. Schools and staff should always prioritize students' immediate safety. This Act is intended to regulate planned screening programs and nonemergency interventions, not to hinder urgent care, mandatory reporting, or reasonable intervention when cases are serious and outside the realm of normal student behavior.

C. Severability: if any provision of this Act or its application is held invalid by a court, the invalidity does not affect other provisions or applications of the Act, which can be given effect without the invalid provision. To this end, the provisions of this Act are declared severable.

D. Effective date: this Act shall take effect on _____ and shall apply beginning with the _____ school year. Schools shall be given any necessary grace period to come into compliance with the parental consent provisions for ongoing programs, except that any planned universal mental health screening scheduled to occur after the effective date must be canceled or modified to comply with this Act immediately.

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