



Social Emotional Learning Grant

This report describes grant activities related to funds allocated from Chapter 140 of the Acts of 2024, Social Emotional Learning Grants line 7061-0028. This grant aims to build capacity of schools, districts charter schools, and educational collaboratives to do one or more of the following:

- Pilot universal mental health screenings for students in kindergarten to grade 12;
- Develop comprehensive integrated multi-tiered systems for student, family, and educator social-emotional and or/mental health supports; and
- Build sustainable infrastructure to facilitate integrated coordination between schools and community-based and/or providers.

August 2025

This document was prepared by the Massachusetts Department of Elementary and Secondary Education
Pedro Martinez, Commissioner

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August 27, 2025

Dear Members of the General Court:

The efforts funded through this line item helped further the ability of communities across the Commonwealth to maximize coordination with service providers and establish more comprehensive continuums of care. These funds helped to increase student access to behavioral and mental health services, including grant funded services, delivered in partnership with community-based providers, for students. In addition, professional development coordinated by the Department and offered to school staff supported their ability to identify students' social and emotional and behavioral and mental health needs as well as educators' needs as part of comprehensive, integrated, tiered approaches to promoting wellness for all students and educators, and to address needs of students requiring additional supports.

If you have any questions, feel free to contact me or Kristen McKinnon, Assistant Director of Student and Family Support, via Kristen.A.McKinnon@mass.gov, or Rachelle Engler Bennett, Associate Commissioner, Student and Family Support via RachelleEngler.Bennett@mass.gov. We look forward to continuing to facilitate and coordinate this work and thank the Governor and Legislature for your commitment to the students of the Commonwealth.

Sincerely,

A handwritten signature in black ink that reads "Pedro Martinez".

Pedro Martinez,
Commissioner of Elementary and Secondary Education

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Introduction

The Department of Elementary and Secondary Education (Department) respectfully submits this Report to the Legislature: *Social Emotional Learning Grants*, pursuant to [Chapter 140 of the Acts of 2024, line item 7061-0028](#), signed into law July 29, 2024, that reads in part:

“...provided further, that not later than September 3, 2025, the department shall submit a report to the joint committee on education, the joint committee on mental health, substance use and recovery and the house and senate committees on ways and means that shall include: (1) a description of the participants in the pilot program; (2) a summary of the data collected from program participants; and (3) any recommendations to further expand the availability of mental health screenings for students...”

This line item helps advance the Department’s [Educational Vision](#), including our strategic priority to support the [Whole Student](#), which aims to cultivate systems to support the whole student and foster joyful, healthy, and supportive learning environments so that all students feel valued, connected, nourished, and ready to learn. These resources are particularly important in helping to support students’ social and emotional, behavioral, and mental health wellness.

The Supporting Students’ Social Emotional Learning, Behavioral and Mental Health, and Wellness Competitive (SEL and Mental Health) grant, awarded in [November 2024](#), provided professional development (PD), coaching, and technical assistance supports to help school staff identify students in need of services and connect those students to services, as well as address the wellness needs of staff. The grant also supported the piloting of a Universal Mental Health Screener (UMHS). Nineteen (19) out of the sixty (60) grantees opted to implement universal mental health screening (UMHS) through the SEL and Mental Health grant. The grantees represented a mix of urban, suburban, and rural communities across Massachusetts.

Summary of UMHS pilot:

- 7,550 students screened, in grantee districts that opted to participate in the UMHS pilot. This number of students represents 13.8 percent of the total enrollment across all grantees.
- Most screening activity occurred in three districts, which together represented just under 70 percent of all students screened.
- 1,035 students (13.7 percent of those screened) were flagged for follow-up; follow-up occurred within a range of the same day to 21 days, with an average of 4 days
- 3,344 students (44.3 percent of those screened) were classified as high needs*; several districts had a high proportion of high needs students among those screened, including four which ranged from 86.5 percent to 98 percent.
- 2,904 students (38.5 percent of those screened) were classified as low income.

**DESE defines a high-needs student as any student who is an English learner (including former English learners within the past two years), a student with a disability, or low income. Meeting any one of these criteria qualifies a student as high needs.*

Top Successes Identified in setting up a UMHS:

- Strong stakeholder buy-in
- Established infrastructure and clear processes
- Timely follow-up and referral systems
- Data systems integrated with student information systems

Top Challenges identified in setting up a UMHS:

- Time constraints in school schedules
- Limited staffing for both administration and follow-up
- High-flagged rates in high-needs districts
- Communication with families across language and cultural differences

Grantee Survey and Report Overview:

In June 2025, grantees completed an end-of-year survey reporting their universal mental health screening results and reflecting on their experiences implementing screening systems. The survey collected quantitative data (student counts and demographics) as well as qualitative feedback on successes, challenges, and considerations for sustaining screening beyond the grant period. The findings from this survey are presented in two parts:

- Part 1: Grantee data
- Part 2: Grantee experiences

Part 1: FY25 Universal Mental Health Screening Data

All 19 grantees that applied for the pilot implemented universal mental health screening during the 2024–25 school year and selected at least one evidence-based tool and screened at least one group of students by year’s end. By June 2025, a total of 7,550 students had been screened across the cohort.

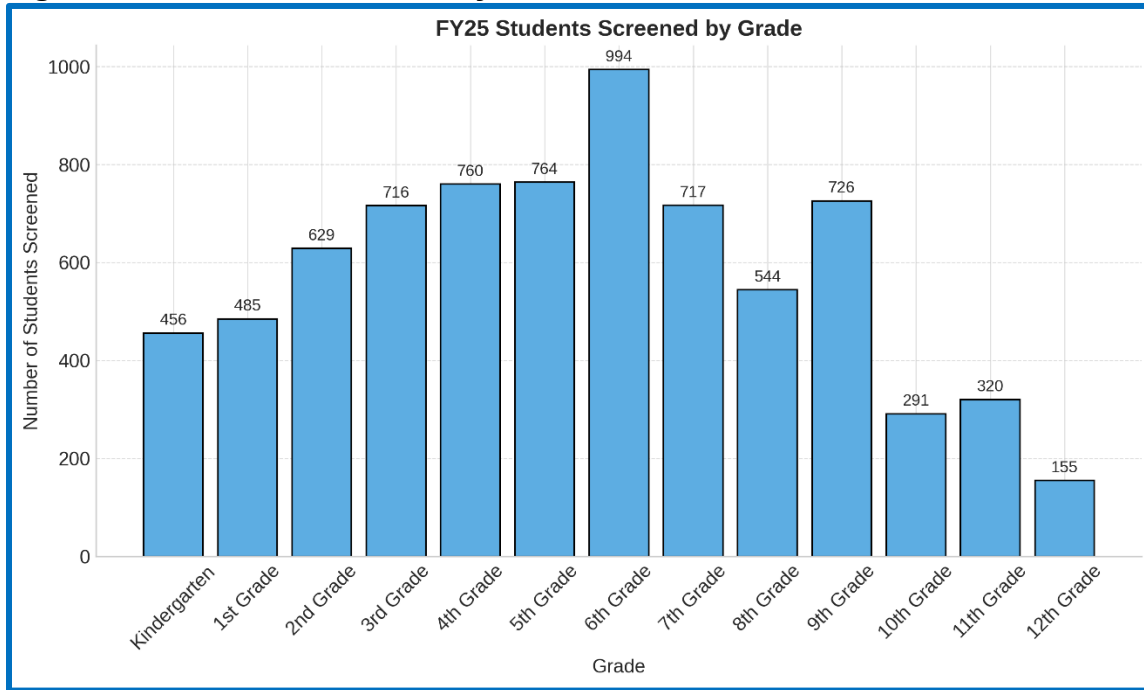
Screening activity varied widely across grantees. For example, three districts together screened a total of 5,241 students, accounting for nearly 70 percent of all screenings completed. High totals can result from a large student population, a high participation rate, or both. Two additional districts also contributed notable numbers (427 students screened), given their enrollment (16.5 percent and 34.8 percent of their district enrollment, respectively). Three additional districts each screened fewer than 50 students, accounting for less than 1 percent of total screenings across the cohort.

Several schools and districts achieved high participation relative to their size. One district screened 50.9 percent of its students, one of the highest rates in the cohort, despite representing only 5.4 percent of total screenings. Another district screened 33.6 percent of its students (47 students), and another district screened 34.8 percent (104 students), both demonstrating strong participation rates for smaller schools.

Overall, grantees screened 15.1 percent of their combined total enrollment. Considering both the number of students screened and the proportion of enrollment reached provides a fuller picture of implementation progress and allows for more meaningful comparisons across districts of different sizes.

Grade: The distribution of screenings by grade level reflects where the pilot’s reach was concentrated across K-12.

Figure 1: Students Screened, by Grade



Middle school students (grades 5-8) accounted for 3,019 screenings, or 39.9 percent of the total. This concentration reflects a continued focus on early identification during the transition into adolescence, a period marked by significant social, academic, and developmental changes. Increased academic expectations, more complex peer relationships, and the onset of puberty can heighten stress and mental health concerns. Many of the tools selected by grantees are designed specifically to identify the psychological and emotional challenges common in this age group, making screenings at this stage more accurate and relevant and enabling timely, targeted interventions. In many schools and districts, the pilot was intentionally implemented in middle school grades to prioritize early intervention and to test processes in a manageable setting before expanding to other grades. High school grades represented a smaller share of screenings, likely reflecting the lower number of participating high schools and competing academic demands. This grade-level focus means that follow-up resources were often concentrated in middle school settings.

Race/Ethnicity: Understanding the distribution of screenings by race and ethnicity provides context for whether participation was equitable and reflective of the student populations served.

Figure 2: Students Screened, by Race/Ethnicity and Percentage of Students Screened, and Compared with Statewide Percentage

Race/Ethnicity	Students Screened	% of Students Screened	Statewide %
American Indian or Alaska Native	53	0.7%	0.2%
Asian	680	9.0%	7.5%
Black or African American	688	9.1%	10.2%
Hispanic or Latino	810	10.7%	25.9%
Multi-Race, Not Hispanic or Latino	445	5.9%	4.6%
Native Hawaiian or Other Pacific Islander	13	0.2%	0.1%
White	4,857	64.3%	51.5%
Chose Not to Answer/Identify	10	0.1%	Not applicable
TOTAL	7,556*	100.0%	100%

**Note: Due to minor reporting discrepancies, the race/ethnicity total differs slightly from the overall total of 7,550 students*

Understanding the distribution of screenings by race/ethnicity provides important context for assessing whether participation was equitable and reflective of the student populations served. Across the pilot, most students screened identified as White (64.3 percent), followed by Hispanic or Latino (10.7 percent), Black or African American (9.1 percent), and Asian (9.0 percent). These four groups represented more than 93 percent of all screenings. Participation from smaller racial and ethnic groups, such as American Indian or Alaska Native (0.7 percent) and Native Hawaiian or Other Pacific Islander (0.2 percent), was limited, consistent with their smaller enrollment in the participating schools and districts.

The distribution of race/ethnicity of students screened varied considerably by grantee, often reflecting the demographics of each individual district. For example, in one district, 59 percent of screened students were Black or African American, and 36 percent were Hispanic or Latino. In another district, about 80 percent of the screened students were Hispanic or Latino. Another district's screened population was 52 percent Hispanic or Latino and 26 percent Black or African American.

Gender: Reviewing the distribution of screenings by gender provides context for participation among male, female, and non-binary students.

Figure 3: Students Screened, by Gender and Percentage of Students Screened

Gender	Students Screened	% of Students Screened
Female	3,801	50.3%
Male	3,730	49.4%
Non-Binary	2	0.0%
Chose Not to Answer/Identify	22	0.3%
TOTAL	7,555*	100.0%

**Due to minor reporting discrepancies, the gender total differs slightly from the overall total of 7,550 students.*

Screenings were nearly evenly split between female (50.3 percent) and male (49.4 percent) students. Two participants identified as non-binary (0.0 percent), and 22 (0.3 percent) chose not to answer. Compared with DESE enrollment data for participating schools and districts, participation rates were closely aligned with enrollment. Female students accounted for a slightly larger share of screenings than their enrollment proportion (50.3 percent vs. 48.7 percent, +1.6 percentage points), while male students were slightly underrepresented (49.4 percent vs. 51.2 percent, -1.8 points). The small proportion of non-binary participants is consistent with their low representation in enrollment data (0.14 percent).

The data suggests that screening access and outreach were broadly equitable based on gender.

Other Demographics: The table below shows the number and percentage of students screened who were identified in other key demographic categories tracked by DESE. These categories highlight student groups that may require additional or more complex educational and support services.

Figure 4: Students Screened, by Additional Demographics and Percentage of Students Screened

Additional Demographics	Students Screened	% of Students Screened
English Learners	809	10.7%
Students with Disabilities	1,672	22.1%
Low Income	2,904	38.5%
High Needs	4,357	57.7%
TOTAL	7,550	100.0%

More than half of the students screened were identified as high needs (57.7 percent), and more than one in three were identified as low income (38.5 percent). Students with

disabilities represented 22.1 percent of those screened, and English learners accounted for 10.7 percent. Several grantees screened particularly high concentrations of high-needs students (ranging from 86.5 to 98 percent).

Students Needing Additional Support or Follow-Up Screenings: Of the 7,550 students screened, 1,035 (13.7 percent) were identified as needing additional support or follow-up screenings. This “flagged rate” includes students who expressed suicidal ideation or intent to self-harm, among other things. Rates varied widely among grantees: in some cases, nearly every student screened required follow-up (e.g., one district at 100 percent), while in others the rate was much lower (e.g., another district at 24 percent). These differences likely reflect a combination of factors, including student population characteristics, the proportion of high-needs students, and the scope of each pilot, such as whether it targeted specific grade levels or was implemented districtwide. Response times for follow-up services occurred on average in 4 days, with a range of response times from the same day to 21 days. Seven students received services within one day; the 21-day response time represented an outlier.

Most flagged students were supported with follow-up services provided through in-school or district-based resources, including school counselors, adjustment counselors, or social workers. Of the total flagged students, 296 (28.6 percent) were referred to external providers. Referrals included community-based behavioral health organizations such as Advocates, Community Health Link, Behavioral Health Network, River Valley Counseling, Carson Center, Worcester Family Resource Center, and Embrace Pathways; telehealth services through Cartwheel Care; and care navigation via the Behavioral Health Help Line, William James Interface, and Care Solace. Additional referrals were made to youth mobile crisis intervention services, existing therapists, pediatricians, and community-based therapists accessed through primary care providers or insurance coverage.

For grantees with higher concentrations of high-needs, low-income, or middle school students, the overlap between demographic risk factors and flagged rates often increased both the volume and complexity of follow-up cases. These patterns highlight the need for adequate staffing, strong referral networks, and timely response protocols to meet the needs identified through universal screening.

Mental Health Screening Tools Utilized: Grantees reported using a total of 10 distinct mental health screening tools. Of the 19 grantees, 10 (52.6 percent) implemented one screening tool, eight (42.1 percent) implemented two tools, and one (5.3 percent) implemented four tools. Some grantees used multiple tools to meet different screening goals, such as covering a range of age groups or assessing multiple areas of concern. The following tools were used, listed in order of the number of schools and districts implementing them*:

- Generalized Anxiety Disorder 7-item (GAD-7): 7
- Social, Academic, and Emotional Behavior Risk Screener (SAEBRS): 6
- Patient Health Questionnaire-9 (PHQ-9): 3
- Revised Child Anxiety and Depression Scale (RCADS): 2

- Columbia-Suicide Severity Rating Scale (C-SSRS): 2
- Brief Screener for Adolescent Depression (BSAD): 1
- CRAFFT 2.1+N (CAR, RELAX, ALONE, FORGET, FRIENDS, TROUBLE, plus Tobacco and Nicotine): 1
- Behavior Intervention Monitoring Assessment System-2 (BIMAS-2): 1
- Social Skills Rating System–Interpersonal Edition (SSRS-IE): 1

**Some grantees used multiple tools from the list above in combination to meet their screening goals.*

The variation in tools used reflects the flexibility built into the pilot, which allowed grantees to select instruments suited to their student populations, grade-level coverage, and staffing capacity. GAD-7 and SAEBRS were the most common, indicating a broad focus on anxiety symptoms and overall social-emotional or behavioral concerns. Tools such as the PHQ-9, RCADS, and C-SSRS were used for targeted assessment of depression and suicide risk. Less commonly used instruments, including the BSAD, BIMAS-2, and SSRS-IE, may have been chosen for specific age groups, specialized programs, or to complement other screening methods. Grantees using multiple tools likely aimed to capture a broader range of student needs, which can provide richer data but also require more staff training and coordination.

Part 2: FY25 Themes & Trends in Open-Ended Responses regarding Experiences

Grantees' reflections on their UMHS pilots revealed a consistent pattern. When key components of an effective screening system were in place, the process ran smoothly, generated useful data, and allowed for timely follow-up. When those components were missing or still under development, challenges emerged that often mirrored the gaps.

Successes: One of the most frequently cited drivers of success was strong stakeholder buy-in. Grantees that began their pilots with clear support from administrators, teachers, school mental health staff, families, and community providers found it easier to build trust in the screening process and secure participation. Visible commitment from senior administrators proved especially powerful. For schools and districts where leaders publicly endorsed the screenings, staff were more likely to engage and view the process as a meaningful part of their work. Grantees further emphasized the value of targeted outreach to teachers and families so they understood the goals of the screening, the details of the selected tool, and how data would be stored and used.

Success was equally dependent on the infrastructure and processes in place before the first student was screened. The most seamless implementations were reported by grantees that had already established a clear purpose for screening, well-defined objectives, and collaborative planning teams with members representing a variety of stakeholder groups. These grantees selected tools that aligned with their goals and reflected the developmental, cultural, and linguistic characteristics of their students and families. They also had secure, user-friendly technology in place, often integrated with

their student information systems, that allowed for real-time data monitoring and protected student privacy.

Grantees with these elements in place found it much easier to manage follow-up. Many also had strong stakeholder support, which contributed to smoother implementation and higher participation. Follow-up plans frequently involved direct outreach to students, conversations with families, and referrals to school-based counselors or outside providers. One grantee shared that they “used the response data to follow up with students who indicated concerns and offer support services to the students and their families,” highlighting how screening data was immediately actionable.

Another success area was student engagement, particularly at the middle school level, where interest and participation rates were notably high. Several grantees expressed surprise at how openly students answered screening questions and how willing they were to meet with counselors for follow-up conversations. For one grantee, middle school screening results directly informed the creation of therapeutic skill-building groups and new connections with community organizations serving youth and families.

Future Considerations: Grantees identified several areas where adjustments could strengthen future screening efforts. Timing emerged as a recurring theme. Many grantees expressed a preference to launch screenings earlier in the school year to allow more time for planning, administration, and follow-up. Competing priorities, such as MCAS testing or large-scale school events, sometimes created logistical challenges that could be reduced with earlier scheduling.

Communication was another key consideration. As grantees expanded screening to additional grades or schools, existing communication plans often needed significant scaling. Reaching newly involved staff, students, and families required more time and targeted outreach than anticipated, particularly in communities with diverse linguistic and cultural backgrounds.

The follow-up phase was one of the most resource-intensive aspects of screening. For several grantees, high numbers of flagged students quickly exceeded available in-school and community-based mental health resources. For example, one district reported that all 111 students screened (100 percent) were flagged for follow-up, requiring immediate triage and coordination. Another district identified 258 students (24 percent of those screened), many of whom were also part of its high needs population, which accounted for 89 percent of its screened students. These concentrations meant that even with strong referral systems, staffing shortages required creative redeployment of personnel to meet demand.

Several grantees also noted that sustaining this level of follow-up beyond the grant cycle could be challenging without dedicated funding or additional staffing. They expressed concern that without continued investment, screening could identify significant needs without the capacity to respond effectively.

In addition, some grantees described adjusting screening tools, administration methods, and outreach strategies to improve participation among English learners, students with disabilities, and other historically underrepresented groups. These adaptations included providing translated materials, offering screenings in students' primary languages, and using formats that are accessible to students with different learning needs. They were seen as critical for equity and should be considered in future implementations.

Benefits of Coaching and Consultation: For many grantees, coaching and consultation provided through DESE were key in navigating challenges during the pilot. Participants valued the high-level orientation to screening implementation, practical strategies for addressing common problems, and access to ready-to-use templates and toolkits. Coaching helped grantees develop detailed implementation timelines, adapt communication strategies, and refine follow-up procedures. In some cases, coaching feedback led to specific changes, such as adjusting the order of grade-level rollouts or revising parent communication materials to improve participation. Coaching was delivered through a mix of individualized check-ins, as-needed consultation, and resource sharing. This flexible format allowed grantees to address both planned milestones and emerging issues in real time.

Equally valuable was the opportunity to connect with other grantees. Peer conversations created a space to share effective practices, troubleshoot challenges, and learn from different approaches. These exchanges sometimes led to ongoing collaborations between schools and districts, including sharing translated materials, sharing strategies related to educator engagement, and aligning referral pathways with shared community providers.

Several grantees noted that the combination of individualized coaching and peer networking reduced the stress of implementing a complex process and increased their confidence in sustaining screening efforts beyond the grant cycle. Participants emphasized that the coaching process was responsive to their local context, with guidance tailored to the unique needs of rural, urban, or high-needs communities.

Conclusion

In Fiscal Year 2025, UMHS pilot grantees screened 7,550 students — 15.1 percent of total enrollment across participating grantees — with several districts screening more than two-thirds of their students. This level of participation shows how targeted state support can help schools implement universal screening at scale. When paired with strong planning, clear communication, and timely follow-up, these efforts generate actionable data and strengthen school-based mental health systems.