



2023-2024 School Health Professional Grant Legislative Report

Submitted to:

The Education Committees of the Colorado Senate and House of Representatives

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Table of Contents

Executive Summary	3
SHPG Reach & School Health Professionals Hired	3
Services Provided to Students	3
Additional Progress Toward Grant Goals	4
Barriers & Facilitators to Grant Implementation	4
1. SHP Hiring & Staffing	5
2. Leadership Support & Buy-in	5
3. Community Mental Health Partnerships	5
Conclusion	5
Introduction	6
History of the School Health Professional Grant	6
Grant Goals	6
Legislative Reporting Requirement	7
Achievement of Grant Goals	7
Number of Grantees, Schools, and Students Supported with SHPG Funding	7
Number of School Health Professionals Hired	7
SHPG Goal 1: Direct Support for Students	8
Table 1. Number of Grantees Reporting Having Used Each Program by Tier	10
SHPG Goal 2: Training and Resources for School Staff	11
SHPG Goal 3: Coordination of School Mental Health Supports	12
Impact on Student Outcome	13
Barriers and Facilitators to Grant Implementation	14
Turn the Curve Thinking Data	14
Unfilled Positions	15
SHP Survey Data	15
Conclusion	16

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Executive Summary

Colorado Senate Bill 14-215 established the School Health Professional Grant (SHPG) Program to enhance the presence of school health professionals (SHPs)—including school counselors, nurses, psychologists, and social workers. The Behavioral Health Care Professional Matching Grant Program Act (C.R.S. 22-96-101 through 22-96-105), effective August 14, 2014, provides matching grants to education providers to improve screening, education, and referral coordination for students with substance use and behavioral health needs. The goals of the grant program include increasing the presence of SHPs in schools, providing direct mental and behavioral health care services to students, providing training and resources to school staff, and improving coordination of mental and behavioral supports for students.

Since its inception, seven cohorts of Local Education Providers (LEPs) have received SHPG funding. The current report is for the first year of implementation of SHPG Cohort 7.

SHPG Reach & School Health Professionals Hired

In the 2023-24 school year, 59 LEPs received SHPG funding and supported 134,960 students, representing 15% of Colorado's student enrollment, in 231 schools in the following ways:

- Hiring grant-funded SHPs
- Providing mental and behavioral health services to students
- Contracting with nurses or mental health professionals
- Supporting school climate initiatives
- Strengthening mental health systems
- Providing training for both grant-funded and non-grant-funded staff

Consistent with the goal of increasing the presence of SHPs in schools, a total of 149 SHPs were hired. Around one-third of SHPs hired were school counselors, one-third were school social workers, and the remaining third were either school nurses or school psychologists. Comparisons with district-wide data submitted to the Colorado Department of Education (CDE) revealed that approximately 15% of the total funding for SHPs (i.e., FTE) in participating LEPs came from SHPG funds and this increase in staffing led to a reduction in SHP to student ratios from approximately 1 SHP:235 students to 1 SHP:202 students.

Services Provided to Students

SHPG-funded services follow a tiered system of support. Services to students are categorized according to the level or tier of support provided, from Tiers 1 through 3. The tiers include instruction, interventions and supports, as a layered continuum. Students may receive services in only one tier or may receive services across multiple tiers; the level of support is driven by what each student needs. In addition, grantees determine which tiers of support are most needed for their communities and do not necessarily fund services at all three tiers.

Tier 1 (Universal Prevention) supports focus on prevention and mental and behavioral health promotion and are by design, provided to all or most students in a school. Tier 2 (Targeted Support) supports students who need more individualized support, schools typically provide tier 2 in a small group or short-term services. Tier 3 (Intensive Support) supports are provided when students need more individualized or intensive intervention.

Consistent with the goal of providing direct mental and behavioral health care services to students, grantees:

- reached 121,920 students, focusing on mental and behavioral health promotion for all students (Tier 1);
- provided 17,223 students with small-group or short-term interventions (Tier 2); and
- served 14,851 students with individualized interventions (Tier 3).

Commonly reported programming provided included: social-emotional learning (SEL) lessons, restorative practices, trauma-informed approaches, calming corners/sensory rooms at the Tier 1 level and small group



interventions, the Check-in/Check-out intervention, community mental health referrals, and crisis response/intervention at Tiers 2 and 3.

Grantees reported that this programming was used to address a wide range of student mental health needs and concerns. The most frequently reported student needs and concerns addressed were:

- anxiety
- healthy relationships
- social-emotional skills and character development, and
- depression and suicidal ideation

Additional Progress Toward Grant Goals

In addition to direct services for students, grantees also reported providing the following supports related to training and care coordination goals:

- Training: 1,944 professional development opportunities were provided for 17,786 staff (126 grant-funded SHPs, 1,406 non-grant-funded-SHP, and 16,254 non-SHP-school staff) with mental and behavioral health promotion as the top focus area.
- School Climate Initiatives: 46% of recipient schools used SHPG funding to implement evidence-based programs to support a positive school climate.
- Mental Health Screening: 88% of grantees had either implemented or planned to implement universal mental health screening. The most common use was to identify students with increased mental health risk or need.
- Family Engagement:
 - Mental health education reached 79,670 families/caregivers.
 - 11,824 families/caregivers received direct support for children in Tier 2 and Tier 3 services.
- Community Partnerships:
 - Mental health organizations were the most common community partners among the 2,259 community partners grantees reported.
 - 14,937 students were connected to a community mental health provider.

Impact on Student Outcome

Though the data reported above points to the progress grantees made toward grant goals, they do not demonstrate the impact these services had on students. It should be noted, however, that many of the specific programs that grantees reported using have been shown in previous research to positively impact student mental health and academic outcomes. (See [Appendix B](#) for a listing of this research.) In addition, improvements in data collection for more current SHPG cohorts will allow for the use of several data sources with information on student outcomes (e.g., data points from the Healthy Kids Colorado Survey; CDE's attendance and discipline data) for comparison of trends in SHPG schools to state-level trends.

Barriers & Facilitators to Grant Implementation

Grantees are prompted to report on what they believe are facilitators and barriers to achieving their goals. Unsurprisingly, the primary factors that grantees indicated as helpful in achieving their goals were also noted as barriers when they were absent or not fully available. Grant-funded SHPs also were provided the opportunity to complete an anonymous survey to provide feedback on their perception of support for the work of the grant as well what factors they believed were important to impact student mental health and wellbeing. The results of this individual-level survey closely aligned with what was reported at the grantee level. Three key factors identified by these metrics were:

1. SHP Hiring & Staffing

- As a facilitator: Hiring SHPs enabled grantees to provide Tier 1-3 services to students, to coach and train staff, to conduct universal screening, and to educate and engage parents/caregivers.
- As a barrier: Difficulty finding qualified SHPs impacted grantees' ability to achieve their goals; 16 positions (9.7%) went unfilled and only 66% of grantees maintained full staffing throughout the school year.
- SHPs identified "SHP staffing consistent with recommended student-to-provider ratios" as an essential factor for supporting student mental health and wellbeing. However, more than half of SHPs surveyed indicated these staffing levels were "somewhat" or "not at all" available in their schools.

2. Leadership Support & Buy-in

- As a facilitator: Leaders who prioritized mental health training, integrated mental-health-related indicators within their district action plans or Unified Improvement Plans (UIPs), and supported Tier 1 initiatives were reported as important for achieving grant goals.
- As a barrier: A lack of administrator buy-in was reported to hinder implementation efforts.
- 19% of SHPs surveyed disagreed that the work of the SHPG had been prioritized by their school; 22% reported inadequate resources to fulfill their role.

3. Community Mental Health Partnerships

- As a facilitator: Grantees indicated strong community partnerships helped connect students to Tier 2 and Tier 3 services and host educational family events.
- As a barrier: Many grantees reported they lacked sufficient community mental health providers. Even when there was access, the community-based mental health organizations were understaffed and did not have adequate numbers of mental health providers to meet the need.
- Two-thirds of SHPs reported that availability of and student access to community mental health providers was essential for supporting student mental health and wellbeing, but only "somewhat available" or "not at all available" in their communities.



Students participating in a CREW meeting - Silverton School District 1

Conclusion

In the 2023-24 school year, SHPG grantees hired 149 SHPs and supported 231 schools, impacting 15% of Colorado students. The grant addressed the needs of students, staff, and families through providing evidence-based programs and services across all tiers of support, coordinating care for students, and training grant-funded and non-grant-funded staff. Key factors for success were also identified, specifically, the ability to fund staffing for SHPs, administrator buy-in, and the presence of community-based mental health partnerships were common.



Introduction

History of the School Health Professional Grant

The School Health Professional Grant (SHPG) Program was established in 2014 under C.R.S. 22-96-101 through 22-96-105 to increase the number of school-based health professionals, including school counselors, school nurses, school psychologists, and school social workers. Initially, the program aimed to enhance prevention, early intervention, and services to reduce student substance use and misuse, particularly related to marijuana, in 7th through 12th grades. In 2017, funding was increased and the program’s scope expanded beyond substance use to address broader mental and behavioral health needs in grades K-12, a focus that continues today.

Since 2014 there have been a total of seven cohorts funding 94 unique grantees [referred to in this report as either grantees or Local Education Providers (LEPs)]. Funding for each cohort is reported in the “History of SHPG Funding” table.

History of SHPG Funding			
Cohort	Funding Cycle	Annual Funded Amount	Number of Funded LEPs
1	2014-15	\$2,332,760	25
2	2015-16	\$2,154,094	20
3	2016-19	\$2,283,155	22
4	2017-20	\$9,123,471	41
5	2019-22	\$5,203,269	42
6	2020-23	\$9,296,314	36
7	2023-26	\$14,464,760	59

Grant Goals

The legislative declaration in C.R.S. 22-96-101 notes that the legalization of retail marijuana in the state of Colorado may increase the availability of marijuana to underage youth. The law states that “Marijuana use by minors can have immediate and lasting health implications, and many youths who engage in substance use or misuse develop or have underlying behavioral health needs.” (C.R.S. 22-96-101(1)(f)). In addition, school health professionals are in a unique position to educate, assess, and refer youth who have behavioral health issues. (C.R.S. 22-96-101(1)(h)). Based on this legislative declaration, CDE has delineated the following goals for the School Health Professional Grant (SHPG):

School Health Professional Grant Goals

Overarching Goal: Increase the presence of school health professionals (SHPs) in schools in order to:

Goal 1: Provide direct mental and behavioral health care services and supports to students, including positive school climate efforts;

Goal 2: Provide training and resources for school behavioral health team members and other staff; and

Goal 3: Bolster efforts to coordinate mental and behavioral health supports for students including but not limited to, screenings,



Legislative Reporting Requirement

In any fiscal year in which the General Assembly makes an appropriation to the department for the purposes of the program, each education provider that receives a grant through the program shall report the following information to the department each year during the term of the grant: (a) the number of school health professionals hired using grant moneys; and (b) a list and explanation of the services provided using grant moneys (C.R.S. 22-96-105). This information is summarized by the department below.

Achievement of Grant Goals

Number of Grantees, Schools, and Students Supported with SHPG Funding

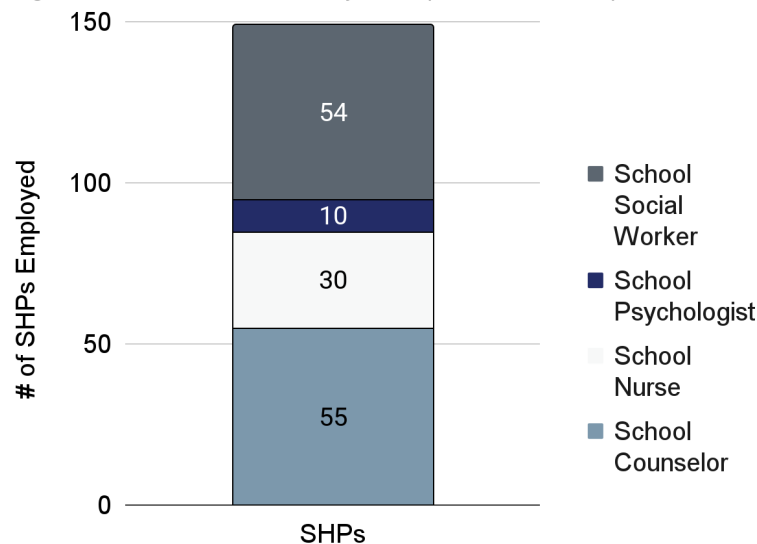
Fifty-nine grantees received SHPG funding in the 2023-24 school year. Grantees listed schools supported by the grant in each of the following ways: employment of a grant-funded School Health Professional (SHP); implementation of evidence-based mental and behavioral health education promotion or programming to address mental and behavioral health problems; provision of services by a contracted nurse or mental health professional; implementation of programming in support of school climate; efforts to improve mental health systems; and/or training for non-grant-funded staff. Grantees identified a total of 231 schools, with an enrollment of 134,960 students, supported in some way with grant funding. This represents 15.3% of the total 2023-24 enrollment of Colorado school students. The highest number of students supported was reported at the high school level (76,740 students) followed by middle school (36,221 students) and then elementary (21,999 students). By level, 27.1% of high school, 18.7% of middle school, and 5.4% of elementary students in Colorado were in a school supported in some way by the School Health Professional Grant.

15%
of Colorado students are in a school supported with SHPG

Number of School Health Professionals Hired

A total of **149 School Health Professionals** were hired with a total FTE of 133.79. School social workers and school counselors each accounted for approximately one-third of all SHPs hired (36% and 37% respectively); 20% of SHPs hired were school nurses and 7% were school psychologists. Specific numbers hired by role can be found in Figure 1.

Figure 1. Numbers of SHPs by Role (149 Total SHPs)



Information on FTE for the SHPs hired with SHPG funding by role was compared to data provided to CDE on the total district-wide FTE for each SHP role¹. Based on this comparison, SHPG funding provided an average of approximately 15% of the funding for the total FTE for participating districts' SHPs. It should be noted that comparisons were not available for all grantees; see [Appendix A](#) for additional information. FTE information was also used to determine the impact of SHPG funding on the reduction in SHP caseloads (i.e., provider-to-student ratios). On average, among grantees for whom state-comparison data were available and who were able to hire SHPs, with grant funding SHPs carried a caseload of 202 students

¹ This information can be found [here](#).

compared to 235 students without funding. School Health Professional Grant funding reduced grantee districts SHP caseloads by 16%, or by 33 students.

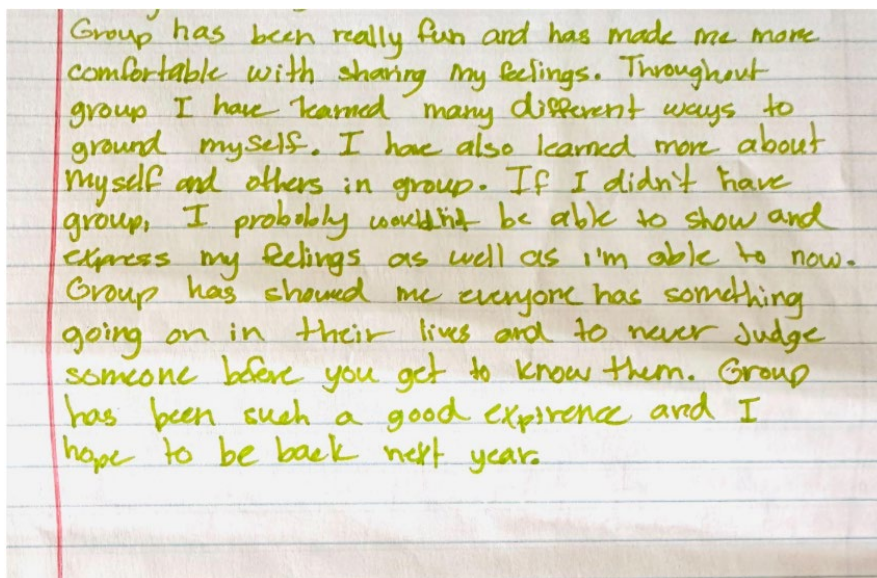
SHPG Goal 1: Direct Support for Students

Grantees were given a list of Tier 1 (Universal)², Tier 2 (Targeted)³, and Tier 3 (Intensive)⁴ interventions and asked to indicate all interventions they provided as part of their SHPG funding. All 59 grantees reported they provided Tier 1 supports, 58 reported they provided Tier 2 supports, and 49 reported they provided Tier 3 supports. Table 1 presents the specific interventions provided across the tiers as well as information on the number of grantees that reported using each intervention. A listing of research in support of the programs outlined in Table 1 is provided in [Appendix B](#).

The most frequently used approaches at the Tier 1 level included providing social emotional learning lessons and engaging in restorative practices. At the Tier 2 level, grantees most frequently reported small group interventions and use of the Check-in/Check-out Intervention and at Tier 3, they reported providing students community mental health referrals, use of the Check-in/Check-Out intervention, and crisis intervention/response.



Average Reduction in SHP Caseload Due to SHPG Grant Funding



Student reflections on Group - Thompson School District R-2J

² Services designed to promote positive mental and behavioral health, typically delivered to all students

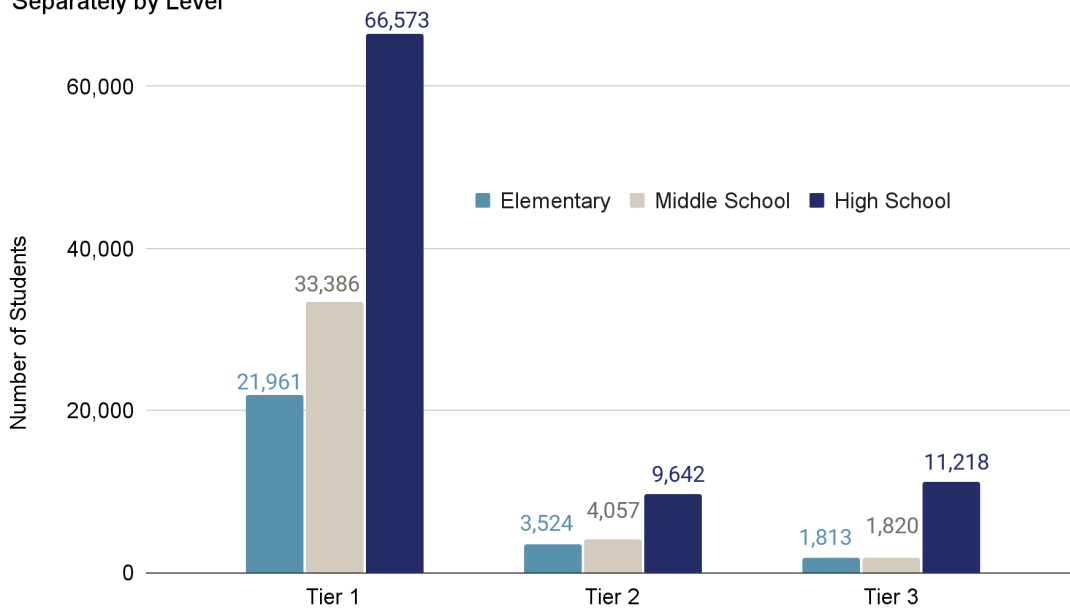
³ Supports provided to a smaller number of students who are identified as having increased mental or behavioral health needs, typically implemented in small group settings, based on a similar need identified through assessment

⁴ Supports implemented for students not responding to Tier 2 supports or who demonstrate a more intense need, typically more frequent, intense, and individualized interventions

Grantees reported this programming was used to support a wide variety of student mental health concerns. The most frequently reported concerns addressed included: anxiety (94.9%), healthy relationships (91.5%), social emotional skills/character development and depression/suicidal ideation (both 89.8%). The full listing of mental health concerns addressed by grantees is available in [Appendix C](#).

The numbers of elementary, middle, and high school students who received services at each tier is reported in Figure 2. Overall, 121,920 students were reported to have received Tier 1 services, 17,223 to have received Tier 2 services, and 14,851 to have received Tier 3 services. This represents 90.3%, 12.8%, and 11.0% respectively of students in the schools supported in any way with SHPG grant funding.

Figure 2: Number of Students Who Received Tier 1, Tier 2, and Tier 3 Supports Reported Separately by Level



(L) "What do you care about?" - CEC Parker (R) Arlo the Therapy Dragon - Poudre School District R-1



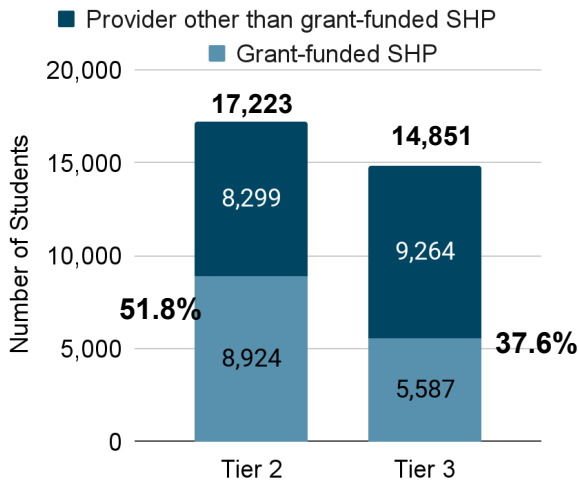
Table 1. Number of Grantees Reporting Having Used Each Program by Tier

Program Name	Tier 1	Tier 2	Tier 3	Program Name	Tier 1	Tier 2	Tier 3
Community Referrals - mental health			42	Sources of Strength	12		
Small Groups (social skills, grief and loss, etc.)		42	35	Neurosequential Model in Education (NME)		12	
Check In-Check Out		42	37	Marijuana Education Initiative (MEI)	10	9	
Social Emotional Lessons	38			Cognitive Behavioral Intervention for Trauma in Schools (CBITS)		10	
Crisis Intervention/Crisis Response			37	Second Chance		9	
Community Referrals (unspecified)		36		CATCH My Breath	8	5	
Restorative Practices/Restorative Justice Discipline Practices	36	39	24	Why Try	7	7	3
Individual Support Plans (re-entry, 504s, Behavior Intervention Plans)			36	Teen Intervene		7	
Threat Assessments			35	Superflex		6	
Suicide Risk Assessments			35	GSA	6		
Calming Corners/Sensory Rooms	33			Capturing Kids Hearts	6		
Support for Families/Caregivers		33	35	7 Mindsets	6		
Individual Intervention/School-based Therapy			32	Conscious Discipline		5	
Attendance Support			31	Teen Mental Health First Aid	5		
Trauma Informed Approach	31			Stanford Tobacco Prevention Toolkit/ You and Me Together Vape Free	5	5	
Individual Academic Support			29	Classroom 180	5		
Substance Use Education	27			Vaping: Know the Truth (EVERFI)		4	
Positive Behavior Intervention and Supports (PBIS)	26			Riding the Waves	4		
Community Referrals - Social Safety Net Services			26	Botvin's LifeSkills	4	3	
Other (please specify)	23	22	9	Kelso's Choice	3		
Substance Use Intervention: Suspension Reduction			22	Unstuck and On Target		3	
Mindfulness (Mind Up, Mindful Schools, etc.)	21	29		Coping Cat		3	
Non-suicidal Self Injury Assessment			21	Too Good for Drugs	2		
Zones of Regulation	20	25		BrainWise	2	2	
Second Step	20	17		Not on Tobacco (NOT)		2	
Random Acts of Kindness	19			RULER Approach	1		
Dialectical Behavior Therapy (DBT)		19		Harmony SEL	1		



Bullying/Cyberbullying Prevention/Upstander Lessons	18			Mightier		1
Signs of Suicide	17			Aggression Replacement Therapy (ART)		1

Figure 3. Proportion of Tier 2 & 3 Services Provided by Grant-Funded SHPs



As the Tier 2 and 3 services provided to students could have been provided by a contracted provider or an SHP who was not employed with SHPG funding (but could have received training and/or consultation with grant funds), grantees were also asked to report separately on the number of students who received these services provided by a grant-funded, LEP-employed SHP. Just over half of students (51.8%) who received Tier 2 services received them from an SHPG-grant-funded SHP; 37.6% of students who received Tier 3 services received them from an SHPG-grant-funded SHP.

Finally, grantees indicated the number of schools that used grant funding to provide evidence-based efforts to improve school climate. Grantees reported supporting 106 schools with a total of 49,061 students (45.9% of schools and 36.4% of students supported by the grant).

SHPG Goal 2: Training and Resources for School Staff

Grant-funded SHPs were surveyed directly to determine the amount of training they received over the course of the school year. In addition, grantees reported on the number of professional development (PD) opportunities they provided to non-grant-funded staff with support of grant funding. The 126 SHPs who completed the SHP survey reported participating in a total of 1,184 PD opportunities; grantees reported providing a total of 760 additional PD opportunities to non-grant-funded staff. SHPs. Grantees also reported whether the focus of professional development included mental and behavioral health promotion, substance use prevention, or suicide prevention. Mental and behavioral health promotion was the most frequently reported training focus area (58.4% of training opportunities for grant-funded SHPs and 67.4% of training opportunities for non-grant-funded staff). In contrast, substance use and suicide prevention were the focus area for 17-18% of PD opportunities for grant-funded SHP staff and 30-33% of training opportunities for other school staff. Numbers of PD opportunities and numbers of staff trained by training focus areas for both grant-funded SHPs and other school staff are reported in [Appendix D](#). The numbers of grantees reporting trainings across several more specific content areas are reported in [Appendix E](#).

		# of Training Opportunities	# of Staff Trained
	Grant-Funded SHPs	1,184	126
Non-Grant-Funded Staff	Non-Grant-Funded SHPs	760	1,406
Non-Grant-Funded Staff	Other (non-SHP) School Staff		16,254
	Total	1,944	17,786

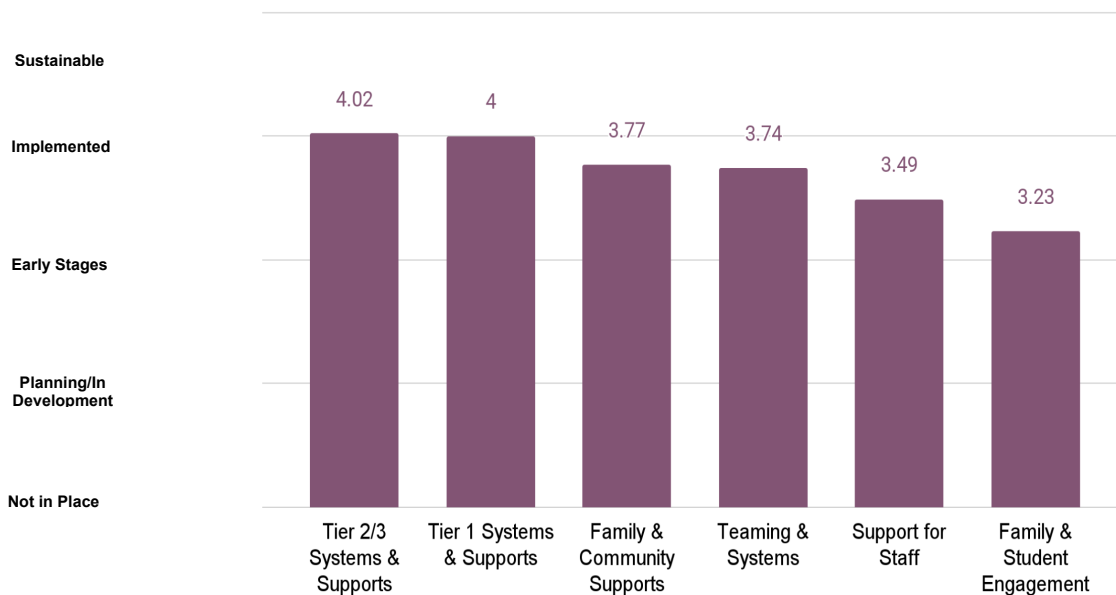
numbers of staff trained by training focus areas for both grant-funded SHPs and other school staff are reported in [Appendix D](#). The numbers of grantees reporting trainings across several more specific content areas are reported in [Appendix E](#).



SHPG Goal 3: Coordination of School Mental Health Supports

To broadly assess the degree to which schools supported with SHPG funding were creating and implementing comprehensive mental health systems⁵, grantees were asked to have each school in which they had a grant-funded SHP complete a 22-item mental health systems assessment survey⁶. Grantees rated each item based on whether they believed each factor (e.g., measures in place to support staff social-emotional well-being) was not in place; in planning or development; in the early stages of implementation; implemented, but incomplete/not sustainable; or fully implemented sustainably. The 22 items were then collapsed into six conceptual component areas: Tier 1 systems and supports; Tier 2/3 systems and supports; family and community supports; teaming and systems; support for staff, and family and community engagement. Preliminary data suggest schools describe their tiered systems (1, 2, and 3) as being implemented, though not in a way that is sustainable or complete and that the remaining components are in early stages/only partially implemented. The department will track this information to determine whether changes are seen over time. A total of 159 surveys were completed, 68.8% of the total number of schools (231) in which grantees reported they had a grant-funded SHP. Average scores across the component areas are reported in Figure 6.

Figure 6. Average Rating of Mental Health Systems Components



Other data related to coordination of mental health supports reported by grantees include: information on mental and behavioral health screening efforts; supports provided to families and caregivers; and connections with community-based partners. All but seven grantees (88%) reported they had either engaged in some form of universal mental health screening (40 grantees) or they had plans to do so (12 grantees). The most common ways grantees reported they had used information from the mental and behavioral health screening were to identify

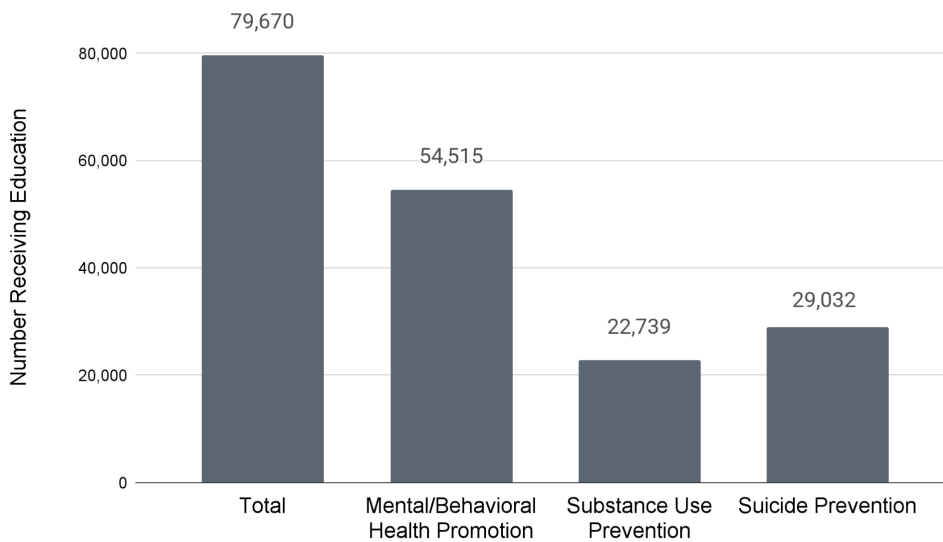
⁵ In [Advancing Comprehensive School Mental Health Systems Guidance From the Field](#), the National Center for School Mental Health defines comprehensive school mental health systems as the people, policies, programming, and structures that “provide a full array of supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness.”

⁶ See [here](#) for more information on the sources used in the development of this survey and [here](#) for a copy of the survey questions.

students with increased mental health risk or need, to connect students with increased needs to supports, and to identify classroom- or school-wide areas of common concern (all reported by at least three-fourths of grantees engaging in screening). Exact numbers of grantees using screening information in several different ways is reported in [Appendix F](#).

Grantees provided information on both mental health education provided to families/caregivers as well as supports provided to families when students received Tier 2 or Tier 3 services. Mental health education was provided to 79,670 families/caregivers; numbers are reported separately by areas of focus in Figure 7. Grantees reported providing supports to 7,290 families/caregivers whose children received Tier 2 services and to 4,534 families/caregivers whose children received Tier 3 services (42.3% and 30.5% of students receiving Tier 2 and Tier 3 services, respectively).

Figure 7. Number of Families/Caregivers Provided with Mental Health Education Overall and by Education Focus Area



Note: Training could cover more than one focus area; therefore, focus areas #s do not add up to the total #.

Mental health partners were by far the most common type of community partner that grantees reported connecting with in support of their school health professional grant work. Of the 2,259 community partners grantees reported, 1,034 were community mental health partners. Grantees reported using grant funds to contract with 88 of those partners to provide services related to the grant. Grantees also reported engaging with over 100 social safety net partners (e.g., for food or housing), health care providers, law enforcement, and social services. The total number of each type of partner is reported in [Appendix G](#).

14,937
students were connected with a community mental health partner.

Impact on Student Outcome

This summary is written primarily to adhere to the legislative reporting requirements as well as to demonstrate the progress grantees’ work has made towards achieving grant goals. In order to address any potential questions about the impact of this work on student health and wellbeing, the department has begun to gather data that will speak more directly to the impact on students’ mental health and wellbeing. Prior to discussion of some of the barriers to these efforts to date, it should be noted that [Appendix B](#) outlines an overview of the body of research providing existing empirical evidence of the positive impact of the programming grantees have implemented on student outcomes. Barriers to gathering additional evidence of the impact of the grant on student outcomes include:

- 1) The School Health Professional Grant is generally not the only grant focused on student mental health and wellbeing that grantees have in place. This makes it difficult to attribute any school or district level changes that are seen over time solely to the grant.
- 2) Implementation of research design methodologies such as use of control schools or tracking individual-level student data requires data collection not authorized in the legislation and likely not available at the school and district level.
- 3) Data sources have been identified that are available over time and with which comparisons can be made between SHPG grantees and state-level trends (e.g., data points from the Healthy Kids Colorado Survey; CDE's attendance and discipline data). However, incomplete data exists regarding which specific schools have received SHPG funding since the inception of the grant in 2014; several grantees⁷ have received funding during some or all of that time period, though not necessarily in support of the same schools. It should be noted that data collection for more recent cohorts (5 through 7) better tracks individual schools and how they are supported with grant funding. In addition, work is in progress to attempt to quantify the length of time individual schools historically have been supported with grant funding so that accurate comparisons between SHPG-funded schools and state-level trends can be made.
- 4) Cohort 7 grantees have begun to gather data to evaluate training implemented with grant funding as well as to provide information on school staff comfort supporting school mental health. However, to minimize data collection burden on schools, these surveys were optional for grantees to complete. Staff from 19 schools representing 14 grantees completed the staff survey; 6 grantees completed training evaluations for 7 trainings. This limits the generalizability of the results. Grantees are provided with reports from these surveys and it is hoped that over time adoption will improve.

Barriers and Facilitators to Grant Implementation

Turn the Curve Thinking Data

Grantees are asked at mid-year to select two Turn the Curve Thinking Goals⁸. The purpose is for grantees to identify data points that track an important indicator of successful implementation of their SHPG goals and to then reflect on factors that contributed to their outcome. See [Appendix H](#) for descriptions of the 2023-24 Turn the Curve Thinking data points selected by grantees and their connection to the SHPG goals. Grantees are asked at end-of-year to report on progress made towards their Turn the Curve goals; if the information reported by grantees is insufficient and the achievement status of their goal is unclear, then this goal is categorized as resulting in an "unknown outcome." All other goals are considered to have known outcomes. Of the 118 goals set by grantees, 111 of those have known outcomes related to whether the goal was met/unmet by the end of the school year. The known achievement rate is 69.5% (82 of the 118 goals set were achieved), but could potentially be as high as 75.4% if the goals with unknown outcomes were met.



Students teaching anti-vaping lessons - Fountain Fort Carson 8

⁷ Only 14 grantees in Cohort 7 received funding for the first time; a total of 20 grantees have received funding for 4 or more cohorts; 5 grantees have received funding since the inception of the grant

⁸ Information about Clear Impact, Turn the Curve Thinking is available here <https://clearimpact.com/results-based-accountability/turn-the-curve-thinking/>



Unsurprisingly, the primary factors that grantees indicated as helpful in achieving their goals were also noted as barriers when they were absent or not fully available. For instance, the overarching goal of the grant is to increase the presence of SHPs and for the grantees that were able to fill these positions, they highlighted the ability to hire as a facilitator to achieving their goals. In other words, hiring SHPs who could be fully dedicated to the work expanded their capacity and enabled them to provide Tier 1-3 services to students, to coach and train staff, to conduct universal screening, and to educate and engage parents/caregivers. In contrast, some grantees indicated difficulty finding candidates with the right qualifications and/or skills to work effectively in their school community, which in turn made it difficult to achieve their goals.

Another example is buy-in from district and school-level leadership. Numerous grantees highlighted administrator support as a facilitator to ensuring that mental health-related trainings for staff were prioritized, for increasing buy-in among school staff to implement Tier 1 programming in the classroom, and to incorporate mental-health related indicators within their district action plans or UIPs. Conversely, other grantees indicated that a lack of adequate support and buy-in from their leadership created a barrier to achieving these same types of goals. Utilization of community partners is a final example that was noted by grantees as both a facilitator and a barrier to achieving their goals. Some grantees indicated having limited access to community mental health partners in their region and in many instances, even when there was access, the community-based mental health organizations were understaffed and did not have adequate numbers of mental health providers to meet the need. However, for the grantees that were able to contract with community-based mental health organizations, this partnership enabled them to connect students to Tier 2 and Tier 3 services as well as host educational family events. See [Appendix I](#) for more details on the factors grantees indicated were helpful in achieving their goals as well as factors they believed served as barriers.

Unfilled Positions

Because previous SHPG cohorts reported difficulty filling all available SHP positions, grantees were asked to provide information not only on the number and FTE of SHPs they hired, but also the number and FTE they planned to hire. Based on this information, a total of 16 SHP positions went unfilled, with a total unfilled FTE of 16.58. This represents 9.7% of total planned-for positions and 11% of total planned-for FTE.

% Unfilled:	
Positions	9.7%
FTE	11%

Grantees also reported at mid-year and end-of-year whether their SHP positions were not at all staffed, partially staffed (in terms of numbers of people or FTE or both), or fully staffed. One grantee decided prior to mid-year to provide services to students with a contracted provider and did not attempt to fill any grant-funded, LEP-employed staffing; three grantees remained fully unstaffed for the entirety of the school year. At mid-year, 43 grantees (or 74.1% of grantees who had attempted to fill their staffing) were fully staffed; at end-of-year, only 38 grantees (or 65.5%) had been fully staffed for the entirety of the school year. See [Appendix J](#) for additional information.

SHP Survey Data

All grant-funded SHPs were asked to complete a survey to provide information on professional development they received (reported on page 11) as well as to delineate the relative importance of various aspects of their role as an SHP (see [Appendix K](#)). In addition, SHPs were invited to complete an anonymous survey to provide feedback on their perception of support for the work of the grant as well what factors they believed were important to impact student mental health and wellbeing. Of the 126 SHPs who completed the initial survey, 86 (68.3%) completed the anonymous survey.

Around 80% of SHPs completing the anonymous survey reported they agreed their community and school were supportive of the work of the School Health Professional Grant; 84% believed students' social emotional needs were adequately supported by their school. Seventy-eight percent of SHPs reported they had adequate support



and resources to carry out the expectations of their role as an SHP; conversely, 22% of SHPs did not agree that they had adequate support and resources. See [Appendix L](#) for responses to these SHP survey questions.

Finally, SHPs were asked to indicate how important they believed several factors were for supporting student mental health and wellbeing, as well how available each factor was. Each of the factors listed below was identified by more than half of SHPs surveyed⁹ as being “essential” for supporting student mental health and wellbeing. Items are bold-faced if more than 50% of SHPs indicated the factor was only “somewhat” or “not at all available”; items have a * if more than two-thirds of SHPs indicated the factor was only “somewhat” or “not at all available.” Responses to individual items are provided in [Appendix M](#).

- **SHP staffing consistent with recommended student to provider ratios**
- Reliable funding for their work
- **Strategies to support the well-being of school staff**
- **Adequate numbers of community mental-health providers***
- Dedicated time in the school day for students to work on social and emotional learning and mental health
- **Ease of access to community mental health providers***
- **Funding for mental-health-related curricula**

Conclusion

“I began working with two siblings this year in high school who had significant attendance issues all year...They were failing almost everything and getting them to share was extremely difficult... I spent the majority of the first semester trying to build a relationship with them without making them feel like we had to talk about attendance and grades. I made it a goal to help them build a positive adult relationship with me that let them know they were safe and that I was here to help both of them... I think oftentimes people forget that we are not working with “bad kids”, but rather kids who are suffering

In the 2023-24 school year, 59 SHPG grantees hired 149 SHPs and supported a total of 231 schools with grant funding; 15% of Colorado students were in a school supported by the School Health Professional Grant. Consistent with the goals of the grant, grantees implemented a variety of evidence-based programs and services across all three tiers of support in order to address the multifaceted needs of students. In addition, both mental health and non-mental health staff received training in support of student mental health, families/caregivers received mental health education and more targeted supports based on student need, and schools assessed and

bolstered their systems to coordinate student mental health supports.

Grantees and SHPs also provided feedback on factors they saw as critical to achieving grant goals and improving the mental health and wellbeing of Colorado students. Specifically, they cited the importance of adequate and reliable SHP staffing, buy-in and support from school and district leadership for mental and behavioral health work, and availability of and access to community-based mental health supports for students.

Throughout this report, the pictures and stories grantees shared to show what they have been able to do with grant funding provide one final piece of evidence of the impact of the School Health Professional Grant.

⁹ Of the 126 SHPs who completed the initial survey, 77 (61.1%) responded to these items.



Appendix A: Overall District SHP Staffing Supported With SHPG Funding

Percentage of Grantee Districts' Overall School Health Professional Staffing Supported with SHPG Funding

SHP Role	# of Grantees	% of SHP Staffing Funded by SHPG			
		Min	Max	Mean	Median
School Counselor	18	0.7%	80.7%	25.4%	16.9%
School Nurse	11	2.9%	100%	33.7%	20.0%
School Psychologist	3	6.1%	29.8%	14.4%	7.5%
School Social Worker	11	0.4%	97.3%	37.4%	25.6%
Total	28	0.4%	50.0%	15.0%	12.2%

NOTES: (1) Comparison information was not available for individual charter schools (19 grantees) but was available for the Charter School Institute as a whole. (2) Because of discrepancies in job codes/characterization of the SHP role, 10 grantees reported more SHP staff as part of their SHPG grant reporting than was reported to the state as a whole and were not included in this table. (3) 3 grantees did not hire any staff.



Appendix B: Supplemental Information on Grantee Programming

References for Research on Interventions Used by Grantees

7 Mindsets

SEG Measurement. (2022, April). Can SEL Instruction Improve Student Behavior. Paper presented at the annual meeting of AACE SITE. San Diego. Retrieved from <https://5196981.fs1.hubspotusercontent-na1.net/hubfs/5196981/7%20Mindsets%20Efficacy%20Study%20New%20Caney-1.pdf>

Aggression Replacement Therapy (ART)

Ensafdar, F., Krahe, B., Njad, S.B., & Arshadi, N. (2019). Efficacy of different versions of Aggression Replacement Training (ART): A review. *Aggression and Violent Behavior, 47*, 230-237. <https://doi.org/10.1016/j.avb.2019.02.006>

Botvin's Life Skills

For a listing of peer reviewed research on Life Skills see <https://www.lifeskillstraining.com/evaluation-studies/>

BrainWise

Miller, B. M., Wilson, A., Volpone, B., Hauser, K. L., Suddeath, E., Reichert, J. D., & Muller, S. (2025). Efficacy of BrainWise on Social-Emotional Skill Development of Elementary Students. *Professional School Counseling, 29*(1). <https://doi.org/10.1177/2156759X251316531>

Calming Corners/Sensory Rooms

Buckner, L. (2022). Calming spaces in schools and classrooms. Retrieved from <https://ca-safe-supportive-schools.wested.org/wp-content/uploads/2022/10/Calming-Spaces-in-Schools-and-Classrooms.pdf>

Capturing Kids Hearts

Holtzapple, C. K., Griswold, J. S., Cirillo, K., Rosebrock, J., Nouza, N., & Berry, C. (2016). Effectiveness of the Capturing Kids' Hearts Process: Research Summary of the 2008-2009 Randomized Control Trial. Retrieved from <https://static1.squarespace.com/static/5f724125f6188411188187ec/t/5fa9e9df066f8a0264d4526d/1604970978152/CKH-2008-2009Randomized-Controlled-Trial-Research-Summary.pdf>

CATCH my Breath

Baker, K.A., Campbell, N.J., Noonan, D., & Deouin, A. (2022). Vaping prevention in a middle school population using CATCH My Breath. *Journal of Pediatric Health Care, 36*, 90-98. <https://doi.org/10.1016/j.pedhc.2021.07.013>

Check-In/Check-Out

Maggin, D. M., Zurheide, J., Pickett, K. C., & Baillie, S. J. (2015). A Systematic Evidence Review of the Check-In/Check-Out Program for Reducing Student Challenging Behaviors. *Journal of Positive Behavior Interventions, 17*(4), 197-208. <https://doi.org/10.1177/1098300715573630>

Classroom 180

A trauma-informed approach; no specific research



Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

A listing of research on CBITS can be found at

<https://www.rand.org/well-being/social-and-behavioral-policy/projects/cbits/publications.html>

Conscious Discipline

Rain, J.S. (2014). Loving Guidance, Inc. Final Report Conscious Discipline Research Study. Retrieved from <https://consciousdiscipline.s3.amazonaws.com/Research/CD-FINAL-Research-Report-for-NREPP-2014.pdf>

Coping Cat

Norris, L.A., & Kendall, P.D. (2020). A close look into Coping Cat: Strategies within an empirically supported treatment for anxiety in youth. *Journal of Cognitive Psychotherapy*, 34, DOI: 10.1891/0889-8391.34.1.4

Dialectical Behavior Therapy

Zapolski T.C.B., Smith, G.T. (2017). Pilot study: Implementing a brief DBT skills program in schools to reduce health risk behaviors among early adolescence. *Journal of School Nursing*, 33(3), 198-204. doi: 10.1177/1059840516673188. Epub 2016 Oct 14. PMID: 27742897; PMCID: PMC6263959.

GSA's

Baams, L., & Russell, S.T. (2020). Gay-straight alliances, school functioning, and mental health: Associations for Students of Color and LGBTQ students. *Youth & Society*, 53(2), 211-229. <https://doi.org/10.1177/0044118X20951045>

Harmony SEL

Reilly, J., Yoder, N., Ross, S., Morrison, J,m & Mulholland. (2021). Getting started with Harmony SEL: Benefits of teachers using evidence-based social and emotional learning programs in U.S. schools. Retrieved from <https://harmony-academy.org/wp-content/uploads/2021/03/GettinStartedWithHarmonySEL.pdf>

Kelso's Choice

Mariani, M., & Silvestro, K. (2019). Making choices to resolve conflict: An evaluation of the Kelso's Choice program for elementary students. *Professional School Counseling*, 23, <https://doi.org/10.1177/2156759X20940665>

Marijuana Education Initiative

Washington State Institute for Public Policy (2023). Marijuana Education Initiative Impact Awareness Curriculum. Retrieved from <https://www.wsipp.wa.gov/BenefitCost/ProgramPdf/934/Marijuana-Education-Initiative-Impact-Awareness-curriculum>

Mindfulness

Marshall, T., Farrar, A., Wilson, M. et al. (2024). Mindfulness-based interventions in schools: Assessing the evidence base. *Psychiatric Services*, 76, <https://doi.org/10.1176/appi.ps.202400>

Mightier

Vaudreuil, C., Abel, M.R., Barnett, Y., DiSalvo, M., & Hisrhfeld-Becker, D.R. (2024). A pilot controlled trial of relaxation training combined with a video game reinforcing emotional regulation to improve anger management in children and adolescents. *Research on Child and Adolescent Psychopathology*, 52, 1847-1859.

Neurosequential Model in Education (NME)



Lohmiller, K., Gruber, H., Harpin, S., Belansky, E.S., James, K.A., Pfeiffer, J.P., & Leiferman, J. (2022). The S.I.T.E. framework: A novel approach for sustainably integrating trauma-informed approaches in schools. *Journal of Child and Adolescent Trauma*, 15, 640-661. 1011-1027. DOI: 10.1007/s40653-022-00461-6

Not on Tobacco (NOT)

Horn, K., Dino, G. Kalsekar, I., & Mody, R. (2005). The impact of Not on Tobacco on teen smoking cessation: End-of-program evaluation results, 1998 to 2003. *Journal of Adolescent Research*, 20, <https://doi.org/10.1177/0743558405274891>

Positive Behavioral Interventions and Supports

Positive Behavioral Interventions and Supports (PBIS) an Evidence-Based Practice? Center on PBIS, University of Oregon. www.pbis.org. Retrieved from <https://www.pbis.org/resource/is-school-wide-positive-behavior-support-an-evidence-based-practice>

Random Acts of Kindness

Schonert-Reichl, K.A., & Whitehead Arruda, J. (2016). Random Acts of Kindness Foundation UBC Summary Report of Research: Preliminary Findings. Retrieved from https://www.randomactsofkindness.org/lesson-plans/reports/RAK_UBC_Executive_Summary_Report.pdf

Restorative Practices

University of Chicago Education Lab. (2023). From Retributive to Restorative. Retrieved from <https://educationlab.uchicago.edu/wp-content/uploads/sites/3/2023/09/UChicago-Restorative-Practices-2-pager-09.07.23.pdf>

Riding the Waves

Listed among CDE/CSSRC's suicide prevention resources <https://spl.cde.state.co.us/artemis/psserials/ps614internet/ps6142017internet.pdf>

RULER Approach

Brackett, M. A., Bailey, C.S., Hoffmann, J.D., & Simmons, D.N. (2019). RULER: A theory-driven, systemic approach to social, emotional, and academic learning. *Educational Psychologist*, 54(3), 144–161. <https://doi.org/10.1080/00461520.2019.1614447>

Second Chance

RMC Health. Evaluation Results for the Second Chance Online Program retrieved from https://www.rmc.org/wp-content/uploads/2023/09/Second-Chance-Program-Report_Evaluation-Results-for-2022-2023.pdf

Second Step

Moy, G.E., & Hazen, A. (2018). A systematic review of the Second Step program. *Journal of School Psychology*, 71, 18-41. doi: 10.1016/j.jsp.2018.10.006. Epub 2018 Oct 30. PMID: 30463668.

Signs of Suicide

Volungis, A. M. (2020). The Signs of Suicide (SOS) Prevention Program Pilot Study: High School Implementation Recommendations. *North American Journal of Psychology*, 22(3), 455-468. <https://digitalcommons.assumption.edu/psychology-faculty/21>



Social and Emotional Learning

Cipriano, C., et. al. (2023). The state of evidence for social and emotional learning: A contemporary meta-analysis of universal school-based SEL interventions. *Child Development*, 94(5), 1181-1204. doi: 10.1111/cdev.13968. Epub 2023 Jul 13. PMID: 37448158.

Sources of Strength

Wyman, P., Cero, I., Brown, C.H., Espelage, D., Pisani, A., Kuehl, T., & Schmeelk-Cone, K.. (2023). Impact of Sources of Strength on adolescent suicide deaths across three randomized trials. *Injury Prevention*, 29(5), 442-445. doi: 10.1136/ip-2023-044944. Epub 2023 Jul 28. PMID: 37507212; PMCID: PMC10579464.

Superflex

Rachmah, H. (2016). Superflex® learning model to improve social skills. *Journal Sampurasun*, 2, 90-106 DOI: <https://doi.org/10.23969/sampurasun.v2i01.116>

Stanford Tobacco Prevention Toolkit/You and Me Together Vape Free

Research is ongoing out of the Halpern-Felsher REACH Lab at Stanford; their research is focused on improving adolescent and young adult health through conducting research and translating evidence into effective programming; <https://med.stanford.edu/halpern-felsher-reach-lab/research.html>

Teen Intervene

Carney, T., & Myers, B. (2012). Effectiveness of early interventions for substance-using adolescents: findings from a systematic review and meta-analysis. *Substance Abuse Treatment, Prevention, and Policy*, 7, <https://doi.org/10.1186/1747-597X-7-25>

Teen Mental Health First Aid

Ng, S.H., Tan, N.J.H., Luo, Y., Goh, W.S., Ho, R., & Ho, C.S.H. (2021). A systematic review of Youth and Teen Mental Health First Aid: Improving adolescent mental health. *Journal of Adolescent Health*, 69, 199-210. <https://doi.org/10.1016/j.jadohealth.2020.10.018>

Too Good for Drugs

Hall, B. W., Bacon, T. P., & Ferron, J. M. (2013). Randomized controlled evaluation of the Too Good for Drugs prevention program: Impact on adolescents at different risk levels for drug use. *Journal of Drug Education*, 43(3), 277-300. <https://doi.org/10.2190/DE.43.3.e>

Unstuck and on Target

Kenworthy, L., Anthony, L.G., Naiman, D.Q., et al. (2013). Randomized controlled effectiveness trial of executive function intervention for children on the autism spectrum. *Journal of Child Psychology and Psychiatry*, 55, 374-383. <https://doi.org/10.1111/jcpp.12161>

Vaping Know the Truth (EVERFI)

Hair E.C., Tulsiani S., Aseltine M., et al. (2024). Vaping—Know the Truth: Evaluation of an Online Vaping Prevention Curriculum. *Health Promotion Practice*, 25, 468-474. doi:10.1177/15248399231191099

Why Try

Why Try is described by its developers as “research informed” – see <https://whytry.org/research/>

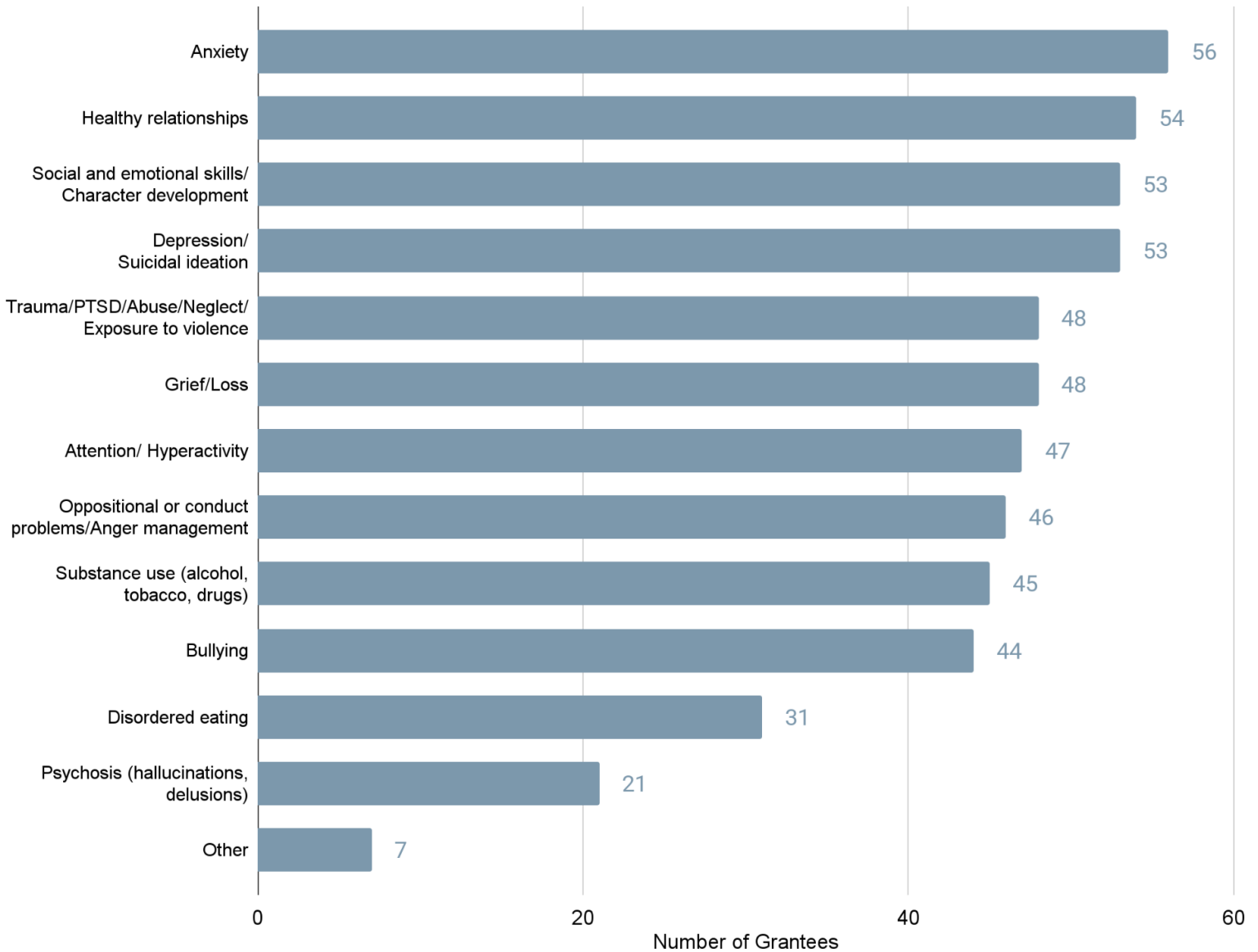
Zones of Regulation

Mason, B. K., Leaf, J. B., & Gerhardt, P. F. (2024). A Research Review of the Zones of Regulation Program. *The Journal of Special Education*, 57(4), 219-229. <https://doi.org/10.1177/00224669231170202>



Appendix C: Student Mental Health Concerns Addressed by Grantees

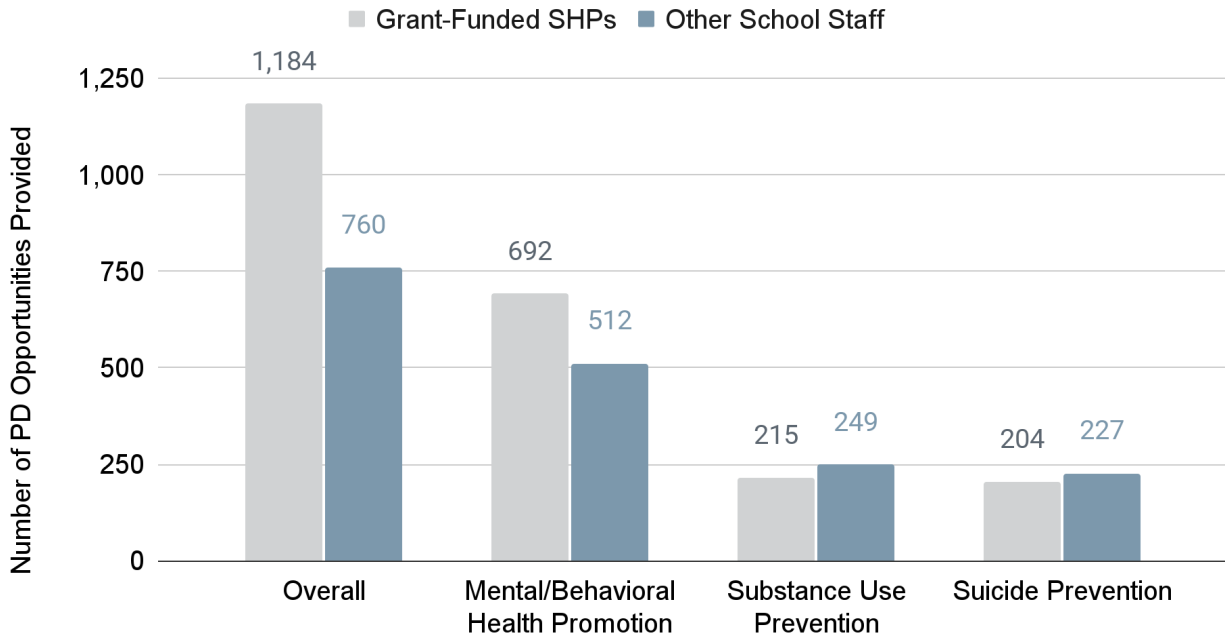
Number of Grantees Reporting They Addressed Each Mental Health Need or Concern



Appendix D: Professional Development Opportunities & Staff Trained

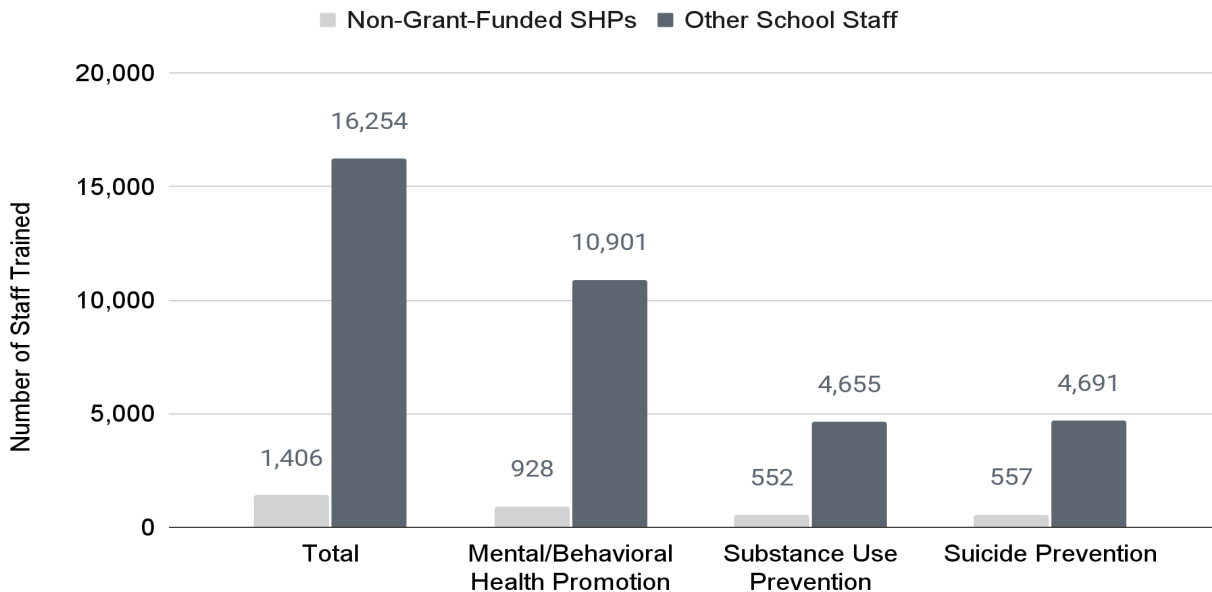
Number of Professional Development Opportunities and Number of Staff Trained Reported Separately by Training Focus Area

Number of Professional Development Opportunities Provided to Grant-Funded SHPs and Other School Staff Overall and by Training Focus Area



Note: Training could cover more than one focus area; therefore, focus areas #'s do not add up to the total #.

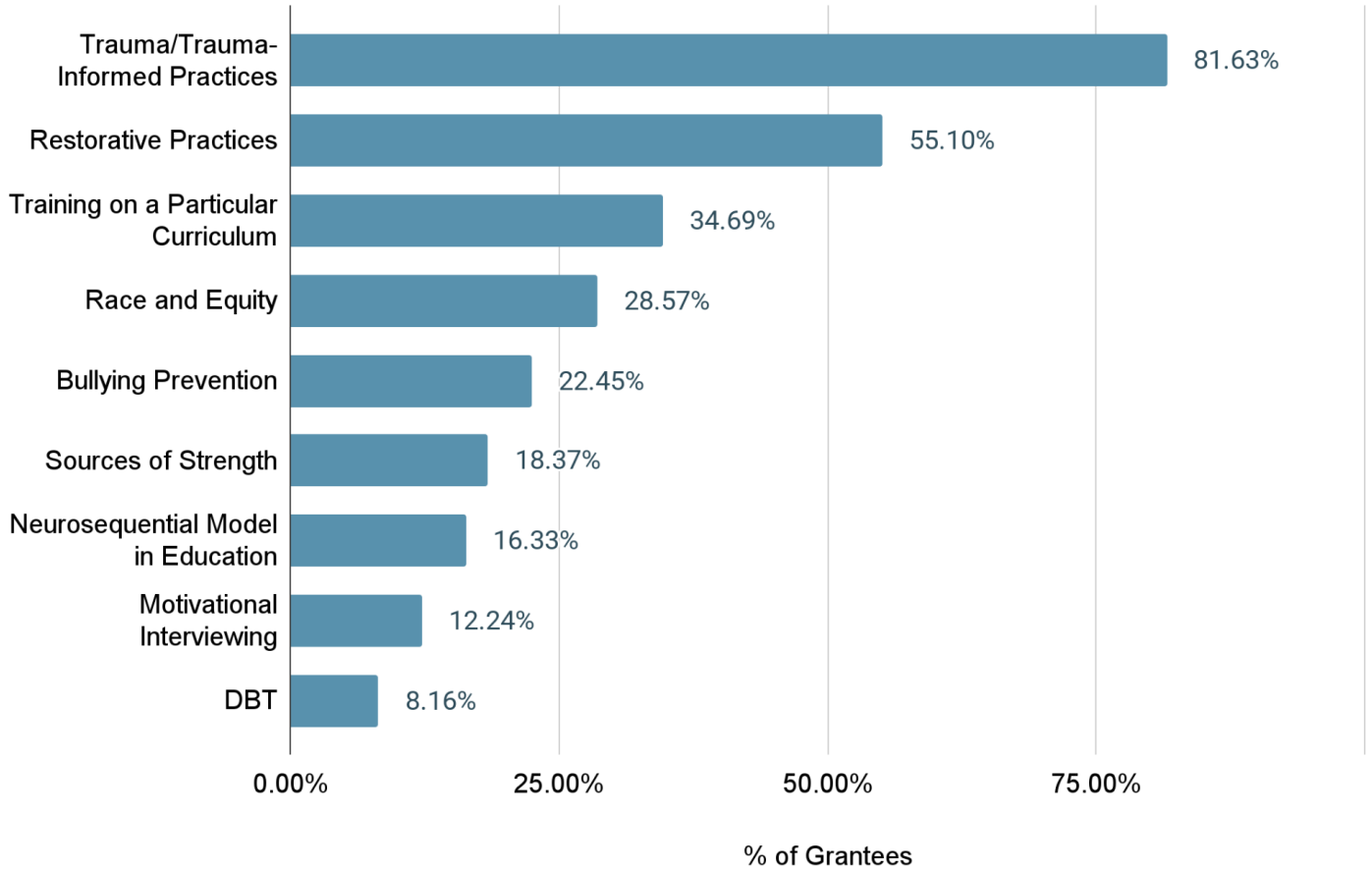
Number of Non-Grant-Funded SHPs and Other School Staff Trained Overall and by Training Focus Area





Appendix E: Additional Training Content Areas

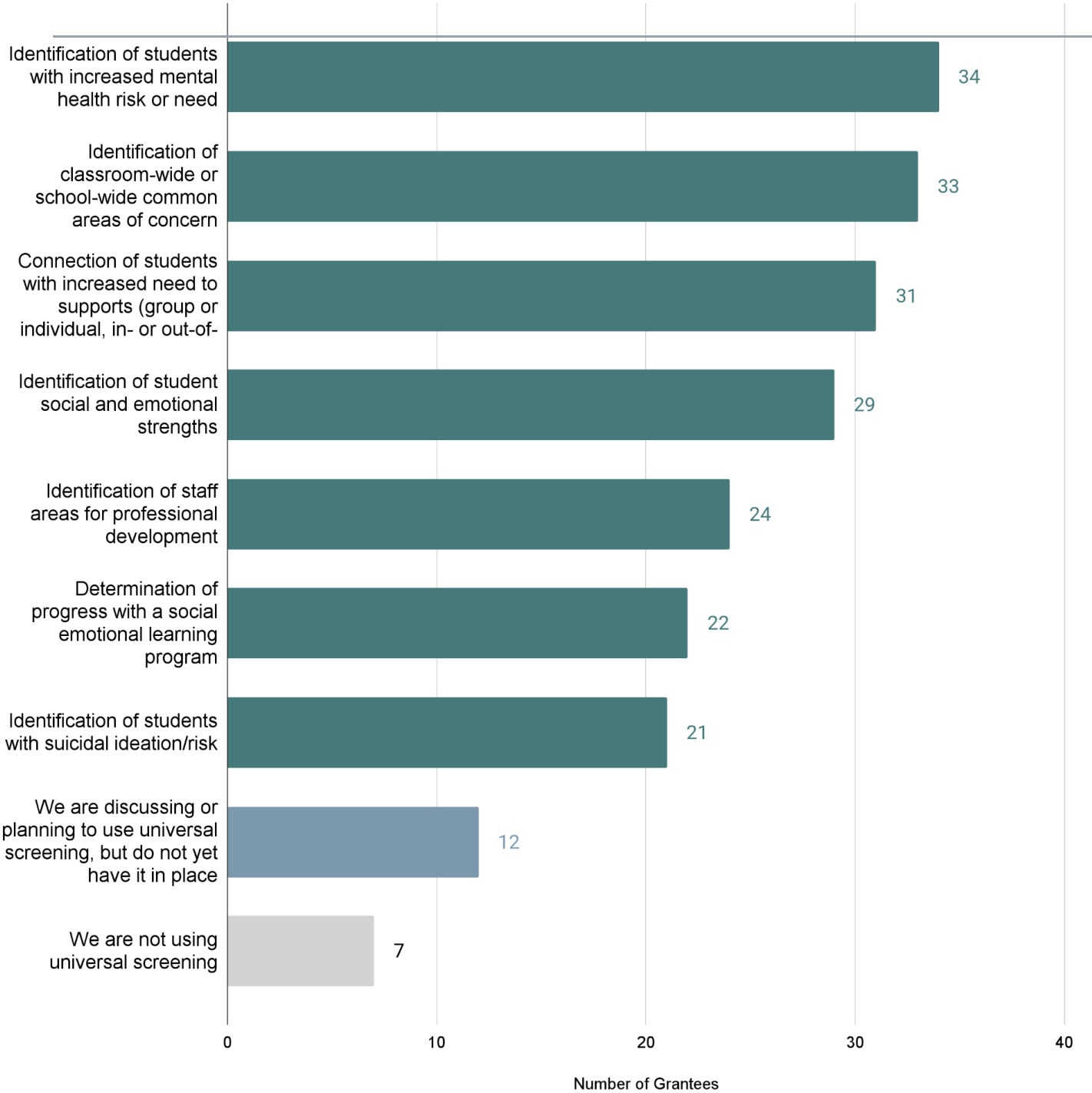
Percentage of Grantees Reporting Training in Each of the Following Areas:





Appendix F: Grantee Utilization of Screening Data

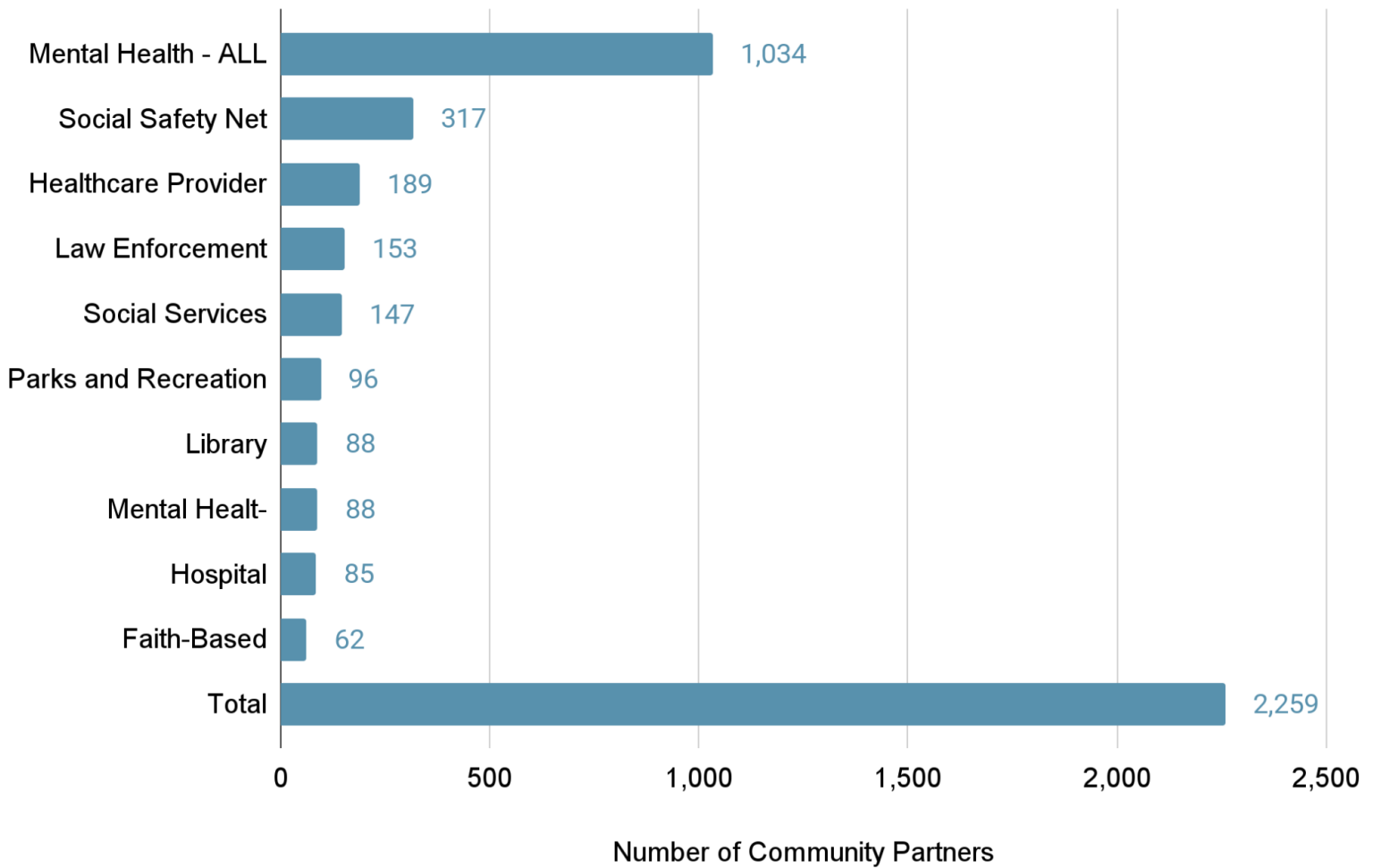
Ways Grantees Reported Using Mental and Behavioral Health Screening Data





Appendix G: Numbers & Types of Community Partners

Numbers of Community Partners Reported by Grantees Across Type of Community Partner



NOTE: Only 58 grantees provided this information

NOTE: Grantees could indicate multiple ways they used screening.



Appendix H: Turn the Curve Thinking Data Points Grantees Selected & Their Connection to SHPG Goals

SHPG Goal	# of Times Goal Selected	Data Points Selected for Turn the Curve Goals
Increase Presence of SHPs	22	<ul style="list-style-type: none"> # of School Health Professional staff hired and/or remain on staff
Mental or Behavioral Health Services & Supports for Students	35	<ul style="list-style-type: none"> # of students who received Tier 1 services or substance abuse prevention and/or mental health/behavioral health instruction # of students referred to Tier 2 services and/or supports # of students referred to Tier 3 services and/or supports
Training & Resources for Staff	26	<ul style="list-style-type: none"> Training and resources for counselors, nurses, psychologists or social workers (# of trainings or # trained) Training and resources for school staff other than counselors, nurses, psychologists or social workers (# of trainings or # trained) % of staff reporting positive impact of training [from Training Survey] % of staff reporting confidence supporting student mental health [from optional Staff Survey]
Coordination of Mental & Behavioral Health Supports	26	<ul style="list-style-type: none"> # of schools providing evidence-based programming in support of school climate # of schools adopting evidence-based programming in support of mental and behavioral health education or promotion (Tier 1) # of schools adopting evidence-based programming in support of mental and behavioral health problems (Tier 2/3) Reach of universal screening (implementation, # of ways used, # grades assessed) # of students connected with community-based mental health supports # of students receiving Tier 2/3 supports provided in school by a community-based therapist Presentations for families/caregivers in mental/behavioral health (# of presentations or # of attendees) # of Tier 2/3 parent/caregiver supports provided
Student Outcomes	6	<ul style="list-style-type: none"> # of drug-related behavior incidents % of students reporting a trusted adult, feeling safe at school, enjoying school, and/or belonging at school [Healthy Kids Colorado Survey]
Unique LEP Goal	3	<ul style="list-style-type: none"> Family perceptions of quality of care provided to students Use of heart rate monitors for self-regulation skills



Appendix I: Barriers & Facilitators Impacting Achievement of TTC Goals

Factors Grantees Indicated Were Barriers to Achieving Their Goals:

LEP Leadership

- Lack of buy-in from administrators
- Competing interests
- Turnover among leadership

Difficulty Hiring/Retaining SHPs

- Difficulty finding candidates with the right qualifications/skills
- Unable to find bilingual candidates
- Less interest to work in small rural communities
- Unable to match salaries offered elsewhere
- Lack of access to affordable housing in nearby area
- SHPs being tasked with work they felt fell outside the scope of their position

Utilizing Community Partners

- Unable to contract with community partners due to staff shortages and inability to provide the needed level of support
- Limited access to community mental health partners/resources that serve the area
- High costs of community-based services

Student Education/Tier 1 Programming

- Schools at varying levels of readiness to implement
- Newly hired staff lacked capacity to implement
- Being understaffed made it difficult to offer the originally intended number of classes/programs
- Site-based programming (rather than district-wide) led to lack of consistency regarding content addressed
- Only being able to integrate content into certain classes that not all students take limited overall reach

School Climate & Culture

- High levels of bullying/cyberbullying and teasing reported by students

Universal Screening

- Difficult to find a screener that can be used with every grade level
- Lack of time and capacity to review existing screening tools in order to select/adopt for implementation
- Unable to coordinate systems and train staff in implementing a screener across grades/settings
- District switching to a new student information system made managing student data more complicated
- Lack of awareness among stakeholders for how screening data would be used
- Other services took precedence (e.g., threat assessments, crisis response)

Parent Engagement/Education

- Significant mental/behavioral health needs of students took precedence and SHPs lacked the time needed to coordinate events/presentations for parents/families
- Not having a system in place to collect parent/family feedback
- Parents/guardians declining offer for their child to receive school-based mental health services
- Parents/guardians are working multiple jobs and may not have much time to engage with the schools
- Difficulty making contact with parents/guardians



Factors Grantees Indicated Helped to Achieve Their Goals:

Hiring/Retaining SHPs

- Hire SHPs who are fully dedicated to the work
- Provide ongoing guidance/support to SHPs
- Offer intentional and effective trainings for SHPs

Utilizing Community Partners

- Contracting with community partners to offer more Tier 2/3 small group interventions
- Collaborating with community partners to host parent education events

Training Staff

- Administrators prioritize staff trainings
- Safe, non-judgemental learning spaces
- Collect staff input on areas of interest/need for training content
- Collaborate with district mental health leadership
- Complete PD as a team throughout the year
- Host staff lunch and learns
- Host education events for staff, students, and parents to attend

Student Education/Tier 1 Programming

- School-wide support for the programming
- Access to Tier 1 materials, curriculum and training
- SHPs provide support+info to staff around Tier 1 programming options to help determine which programs to implement
- Have SHPs teach lessons and/or train other staff on how to deliver Tier 1 instruction
- Coordinate with classroom teachers to have a regularly scheduled time to teach SEL
- Develop a specials course for SEL that all students complete
- Develop virtual resources for students
- Ensure students are aware of the Tier 1 supports/resources available to them

School Climate & Culture

- Prioritize mental health and aim to reduce the stigma
- Recognize students' strengths rather than deficits
- Incorporate goals into district action plans and UIP
- Train staff on how to be trusted adults for students
- SHPs available to provide support to staff and students
- Use a variety of approaches to support positive communication with parents/guardians

Universal Screening

- Use screener results to identify students in need and determine necessary supports
- Use screener results to develop Tier 2/3 small group interventions
- Weekly team meetings to review screener data and discuss students of concern
- Partner with technology and multi-language education staff to provide devices and translation for families to complete the screener during school events

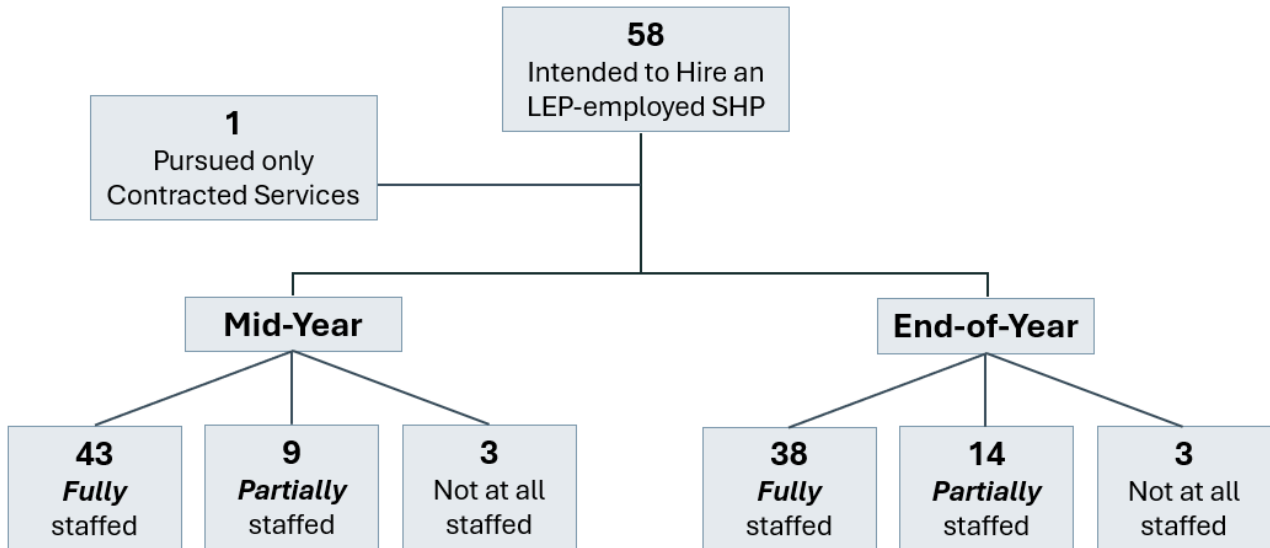
Parent Engagement/Education

- Use various strategies to increase parent attendance at events: multiple modes of communication, translation services, food and childcare, offering multiple sessions with various start times, personal invitations, diverse presentation content
- Host school-level events (rather than district)
- Provide mental health resources at various school events



Appendix J: Tracking of Grantee SHP Hiring

Tracking of Grantee Hiring of SHPs at Mid- and End-of-Year

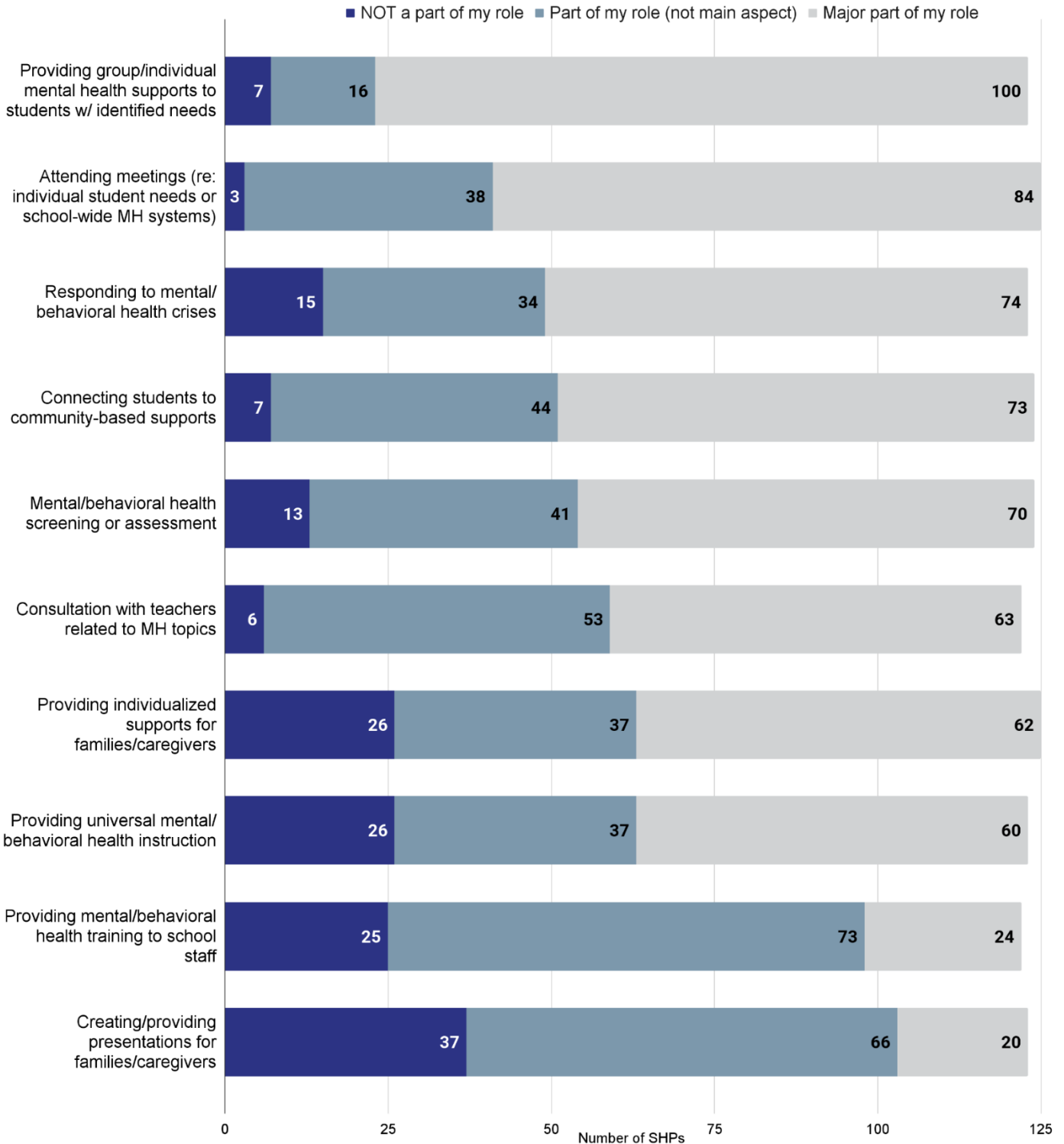


Notes: (1) #s refer to # of grantees; (2) 3 grantees at each time point did not provide descriptions of their staffing



Appendix K: SHPs' Description of their Roles

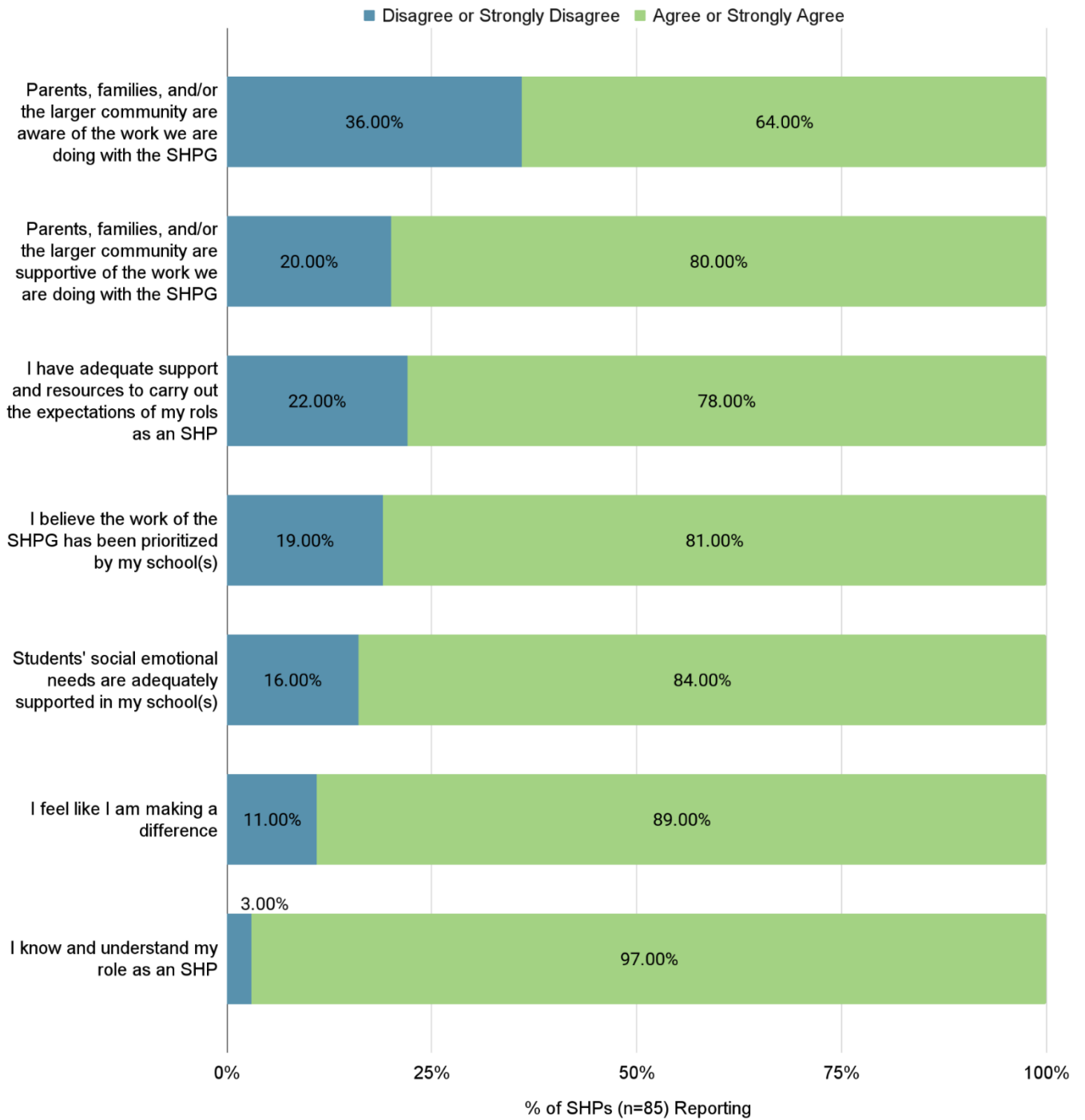
Grant-funded School Health Professionals' Reports of the Relative Importance of Various Aspects of their Role as an SHP (Note: MH = Mental Health)





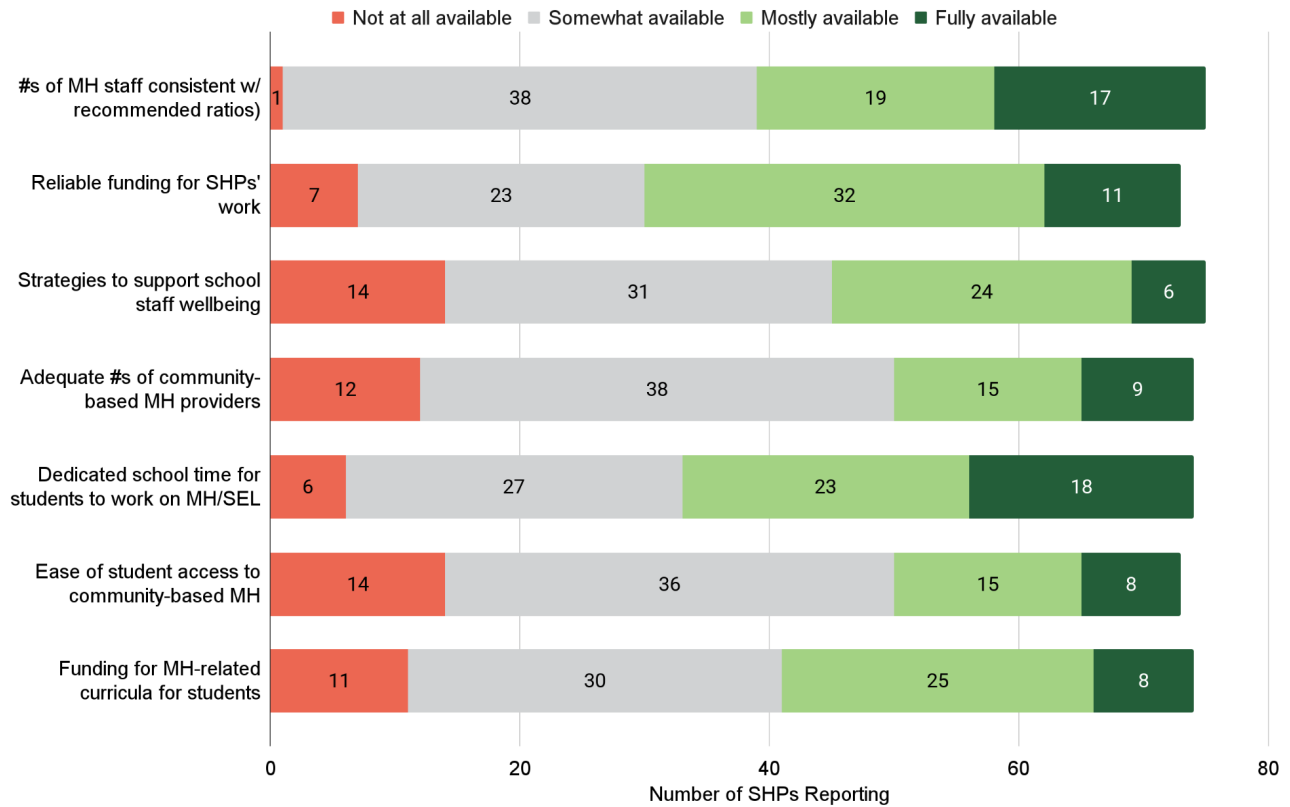
Appendix L: SHP Anonymous Survey

School Health Professionals' Perceptions of the Work of the School Health Professional Grant



Appendix M: SHP Perspective on Availability of Essential Supports

School Health Professionals' Perceptions of the Availability of Factors Rated by the Majority of SHPs as Essential for Supporting Student Mental Health and Wellbeing



Note: Completion of this anonymous survey was optional; these responses represent 68.3% of all SHPs who completed end-of-year reporting.