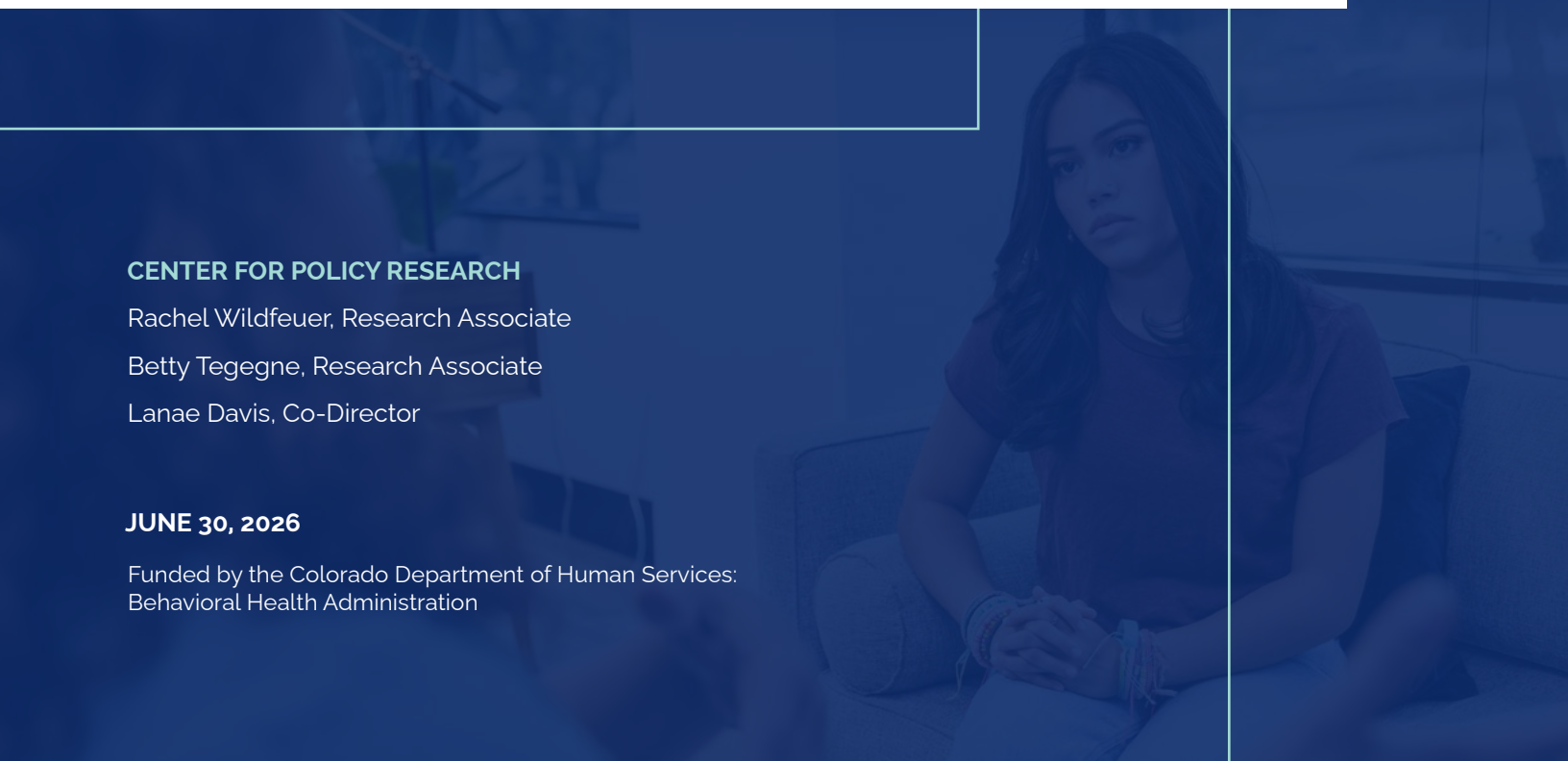
CPR center for policy research

COLORADO Behavioral Health Administration

School Mental Health Support Program (SMHSP)

2025-2026 School Year Evaluation Report



CENTER FOR POLICY RESEARCH

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JUNE 30, 2026

Funded by the Colorado Department of Human Services: Behavioral Health Administration

Executive Summary

The **School Mental Health Support Program (SMHSP)** was a statewide initiative designed to strengthen mental health and wellness for students and educators, particularly in rural and underserved schools in Colorado, by offering training, resources, and hands-on implementation support to help schools build sustainable, trauma-informed mental health systems. Funded by the Behavioral Health Administration (BHA), SMHSP was implemented by the Trauma-Responsive Implementation and Practice (TRIP) program housed at the Kempe Center for the Prevention of Child Abuse and Neglect (Kempe), University of Colorado-Anschutz Medical Campus, in partnership with the Butler Institute for Families at the University of Denver (Butler). While originally planned as a multi-phase statewide program running from 2025 through 2028, due to a state funding error, the program ended on June 30, 2026. An evaluation of program implementation for the 2025-2026 school year by the Center for Policy Research (CPR) integrated data from the program implementers with evaluator-led data collection through a program evaluation survey and focus groups to describe program implementation, evaluate program efficacy, identify opportunities for improvement, and evaluate partnership effectiveness.

Several key themes emerged from the evaluation.

- **SMHSP established a strong foundation during its first year of implementation:** The program successfully engaged educators, school staff, mental health professionals, and other partners across Colorado, including in rural and underserved communities.
- **Participants consistently viewed SMHSP as high quality, relevant, and responsive to local needs:** Participants reported strong satisfaction with the trainings, technical assistance, practical resources, and a collaborative approach to implementation.
- **The program worked to strengthen educator capacity to support student mental health:** Participants reported increased knowledge, confidence, and use of trauma-informed practices, while focus group participants described applying new strategies to support students, collaborate with colleagues, and strengthen school mental health efforts.
- **Collaboration and relationships were central to successful implementation:** Participants valued SMHSP's partnership-based approach, describing program implementers as trusted thought-partners who helped schools identify priorities, and tailor supports to local contexts.

- **Participants identified opportunities to strengthen implementation by expanding coaching and ongoing support:** Respondents emphasized the need for continued implementation support, follow-up consultation, peer learning opportunities, and practical resources to sustain long-term and lasting changes.
- **SMHSP demonstrated a commitment to serving rural and underserved communities, but broader structural barriers remain:** Participants viewed the program as responsive to local contexts while recognizing that workforce shortages, limited behavioral health resources, and geographic challenges continue to affect schools' ability to meet student mental health needs.
- **The greatest barriers to implementation were systemic rather than programmatic:** Limited time, competing priorities, staffing shortages, burnout, workforce capacity, and challenges engaging families affected educators' ability to participate in the program and implement new practices.

Overall, the findings from the evaluation indicate that SMHSP established a strong foundation for supporting school mental health across Colorado. Despite ongoing workforce and resource challenges, participants consistently viewed the program as relevant, responsive, and valuable for strengthening educator capacity, partnerships, and school mental health systems.

SMHSP was a critical program intended to expand and provide needed school-based mental health services to students, particularly in rural and underserved schools, across Colorado. Educators, school staff, and mental health professionals across Colorado responded positively to the activities, resources, and supports provided by SMHSP. Participants viewed SMHSP as a valuable resource and would benefit from ongoing support and further expansion to support school mental health practices across Colorado. Together, these findings suggest that the need for a coordinated statewide initiative to strengthen school mental health remains strong.

Contents

Introduction and Purpose

This report summarizes the evaluation of the **School Mental Health Support Program (SMHSP)**, conducted by the Center for Policy Research (CPR) and funded by the Behavioral Health Administration (BHA), during the 2025-2026 school year.

Established under **House Bill 24-1406**, SMHSP was a statewide initiative designed to strengthen mental health and wellness for students and educators, particularly in rural and underserved schools in Colorado, by offering training, resources, and hands-on implementation support to help schools build sustainable, trauma-informed mental health systems. SMHSP supported schools in aligning efforts with the **Colorado Multi-Tiered System of Supports (MTSS) framework**. SMHSP provided training and resources at no cost to:

- Colorado schools, with an emphasis on rural and underserved schools
- Educators, school staff, and mental health professionals
- Leaders in districts, schools, Boards of Cooperative Educational Services (BOCES), and community partners working to create safe, supportive, learning environments

SMHSP was implemented by the Trauma-Responsive Implementation and Practice (TRIP) program housed at the Kempe Center for the Prevention of Child Abuse and Neglect (Kempe), University of Colorado-Anschutz Medical Campus in partnership with the Butler Institute for Families at the University of Denver (Butler). An external evaluation was required to assess the program's efficacy across different school and agency types and student populations. While originally planned as a multi-phase statewide program running from 2025 through 2028, due to a state **funding error**, the program ended on June 30, 2026.

As highlighted in the program's Menu of Services (See **Appendix A**), SMHSP offered a variety of activities: live application to practice sessions; on demand eLearning modules; yearlong learning series; communities of practice; in-person or virtual synchronous training; learning collaboratives; and implementation support. The Kempe/Butler team (implementers) worked with schools and other organizations on a needs assessment process to gauge staff perspectives on schools' needs and strengths, and determine actionable steps, prior to engagement.

The Menu of Services defined three types of participation in the program. *Flexible Learning Opportunities* activities were open and free of charge to all Colorado educators and related professionals, involved flexible learning opportunities (e.g., application to practice sessions), and focused on skills and knowledge for any interested school staff to promote student mental health, staff well-being, trauma-informed practices, and positive school climate. *Targeted Skill Development* activities were available free of charge to Colorado schools, districts, BOCES, and partner agencies serving grades 6-12, involved flexible learning opportunities plus targeted skill development (e.g., synchronous trainings), and focused on supporting collaborative growth for staff seeking deeper knowledge in specific areas. *Intensive Implementation Support* activities were available free of charge to Colorado schools, districts, BOCES, and partner agencies serving grades 6-12, involved flexible learning opportunities plus targeted skill development plus intensive implementation support (e.g., synchronous trainings with follow-up), and focused on intensive individualized support for those organizations committed to specific practice change.

From August 2025 to June 2026, the implementers sent a monthly SMHSP newsletter that provided program information and updates, highlighted upcoming events and learning opportunities, and shared evidence-based tools and resources. The Rise to the Challenge: Colorado SMHSP Virtual 2026 Kickoff Event took place on February 20, 2026, and speakers focused on self-compassion and skills to address burnout and secondary trauma. The virtual SMHSP Spring Summit, Getting to the Root of It: Colorado's Youth Mental Health Crisis and the Role of Schools in Primary Prevention, took place on May 1, 2026, and featured a panel discussion of the youth mental health crisis and the best methods of prevention. The implementers also launched a **Learning Management System** in March 2026 for participants to access eLearning modules, resources, and certificates of completion for synchronous trainings.

Evaluation Objectives

CPR's evaluation was guided by three primary objectives.

1. **Evaluate Program Efficacy:** Assess the efficacy of SMHSP in supporting educators and improving student mental health outcomes, with a focus on rural and underserved communities.
2. **Identify Opportunities for Improvement:** Recommend actionable strategies to enhance SMHSP's overall effectiveness and impact.
3. **Evaluate Partnership Effectiveness:** Assess the strength and effectiveness of partnerships between the program implementers, schools, partner organizations, and relevant support resources.

CPR's evaluation focused on advancing BHA's **Colorado for ALL Initiative** by identifying barriers and disparities to improve mental health outcomes in rural and underserved communities across Colorado.

Evaluation Design and Approach

CPR designed the evaluation to utilize both quantitative and qualitative methods. CPR integrated data provided by the implementers with evaluator-led data collection to respond to the evaluation objectives and provide insight and lessons learned for implementation of SMHSP in the 2025-2026 school year.

Data Sources

Data was collected and analyzed from a variety of sources. The implementers provided CPR data from their activities (August 2025-June 15, 2026), which included:

- Participation data
- Evaluation data
- Needs assessment data

Available participation data included information on the number of SMHSP participants and their role, organization, specific school(s), and demographics; the number of participants at select webinars and application to practice sessions; the number of participants at the monthly learning series sessions; the number of participants at the monthly Community of Practice sessions; the number of participants who completed the available eLearning modules; the number of participants who accessed the available resources; and the number of trainings, attendees at the trainings, composition of the implementation team, and number of meetings between the implementation team and implementers for the schools that committed to *Targeted Skill Development* or *Intensive Implementation Support* participation.

The implementers provided evaluation data from their activities, including evaluations of webinars, eLearnings, and trainings, as well as data from participants who completed knowledge tests corresponding to an eLearning course. This data did not provide information on the organization and/or school that participated as it was collected anonymously.

Available needs assessment data included information from the baseline needs assessment forms that participants completed before engaging in SMHSP activities. Since the implementation of SMHSP had to end early and engagement was ongoing, participants had not yet completed a post-needs assessment form.

To supplement the data provided by the implementers, the evaluation incorporated data collected by CPR from:

- A program evaluation survey of staff and administrators who participated in SMHSP
- Virtual focus groups with staff and administrators who participated in SMHSP

From April-May 2026, CPR administered an online survey to staff and administrators who participated in SMHSP during the school year. The program evaluation survey was promoted in the SMHSP newsletter, via emails to participants, and at the SMHSP Spring Summit. A total of 68 respondents completed the survey. Respondents noted 39 specific schools they worked in, with some working districtwide or at other types of organizations. The survey included questions on program implementation, opportunities for improvement, cross-agency collaboration, and equity-related impacts. See **Appendix B** for the program evaluation survey questions.

During the same timeframe, CPR conducted virtual focus groups with staff and administrators who had participated in SMHSP during the school year to learn more about their experiences. CPR held four focus groups with a total of five participants, each lasting approximately one hour.

Focus group participants included school mental health professionals, educators, school administrators, and other staff who had participated in SMHSP activities during the school year. Recruitment occurred through two channels: program evaluation survey respondents were given the option to provide their contact information if they were interested in participating in a focus group, and the implementers conducted targeted outreach to highly engaged participants. Focus groups were conducted via Zoom using a semi-structured discussion guide and explored participants' experiences with SMHSP implementation, perceived benefits and challenges, student outcomes, partnerships, and opportunities for program improvement. Discussions were recorded with participant consent and analyzed to identify common themes and provide additional context for the survey findings. See **Appendix C** for the focus group guide.

Analysis

CPR received all data from the implementers, reviewed, and cleaned it to ensure consistency. CPR then analyzed the data, including utilizing the participation data received from the implementers, specifically the information on participating school districts and schools, and data from the **Colorado Department of Education**, to determine SMHSP's reach to rural areas and underserved populations.

CPR collected the program evaluation survey data through an online survey, reviewed, cleaned, and analyzed it for reporting. The quantitative data analysis was descriptive, for example, describing participation in the various SMHSP activities. For the focus group data, CPR conducted virtual focus groups and recorded audio with participant consent. The transcripts were reviewed, organized, and coded for themes that align with the evaluation objectives. Qualitative data analysis was largely centered on thematic analysis which identified common themes, for example, staff perceptions of SMHSP partnerships. Findings from the qualitative analysis were used to provide context, explain quantitative results, and identify opportunities for program improvement.

Findings

CPR's findings focus on describing program implementation during the 2025-2026 school year and addressing the three evaluation objectives.

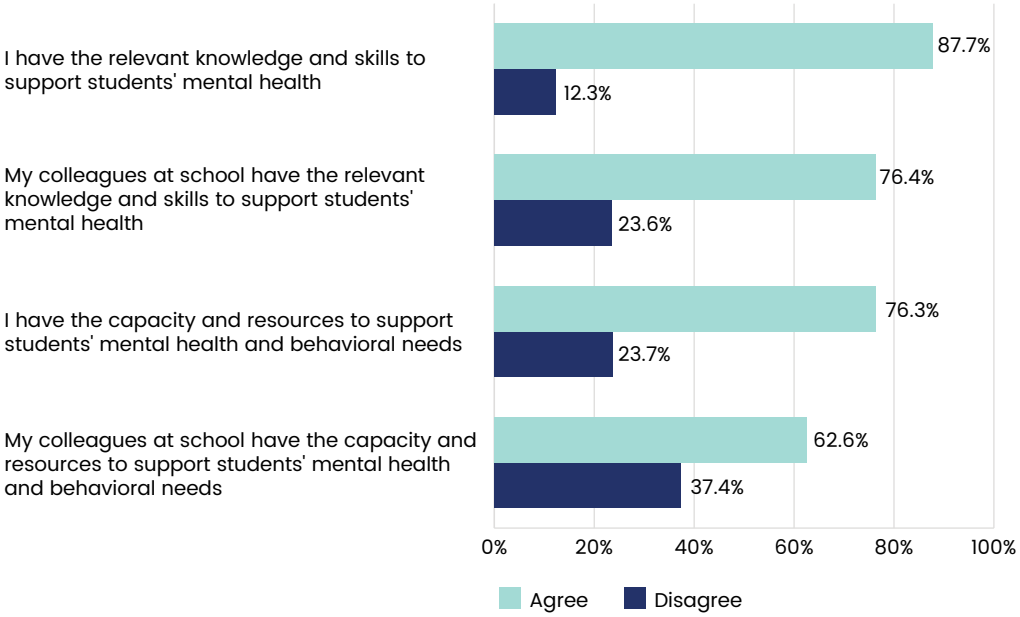
Program Implementation

Needs Assessment

Prior to engaging in SMHSP activities, a baseline needs assessment was conducted to identify schools' needs and strengths, and to determine actionable steps for their engagement in SMHSP. A total of 198 participants completed baseline needs assessment forms. Respondents answered based on the school(s) they work at. If they did not work directly in a school, but supported other professionals who worked in schools, they were to answer based on those schools. The needs assessment form addresses key constructs related to staff (knowledge and skills, capacity and resources, trauma-informed practices, cultural responsiveness, resiliency); students (skills); and schools (community partnerships, care coordination, suicide resources, and the MTSS framework). Due to the program ending early, respondents did not complete post-needs assessment forms after engaging with SMHSP activities.

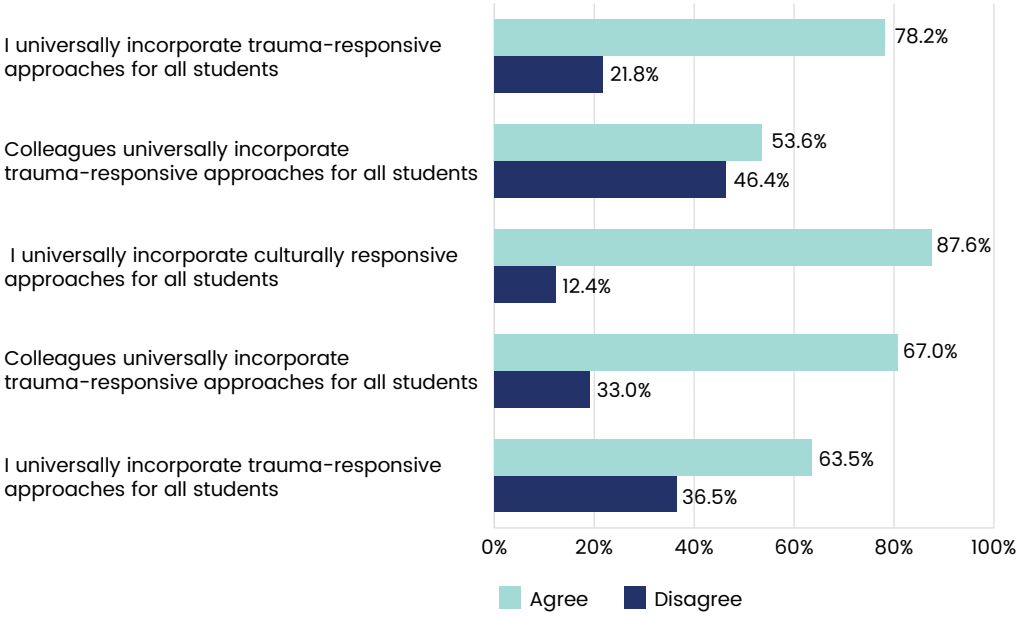
As seen in Figure 1, respondents were less likely to agree that they or their colleagues had the capacity and resources to support students' mental health and behavioral needs compared to the relevant knowledge and skills.

Figure 1. Baseline Needs Assessment Results on Staff Knowledge and Skills & Capacity and Resources



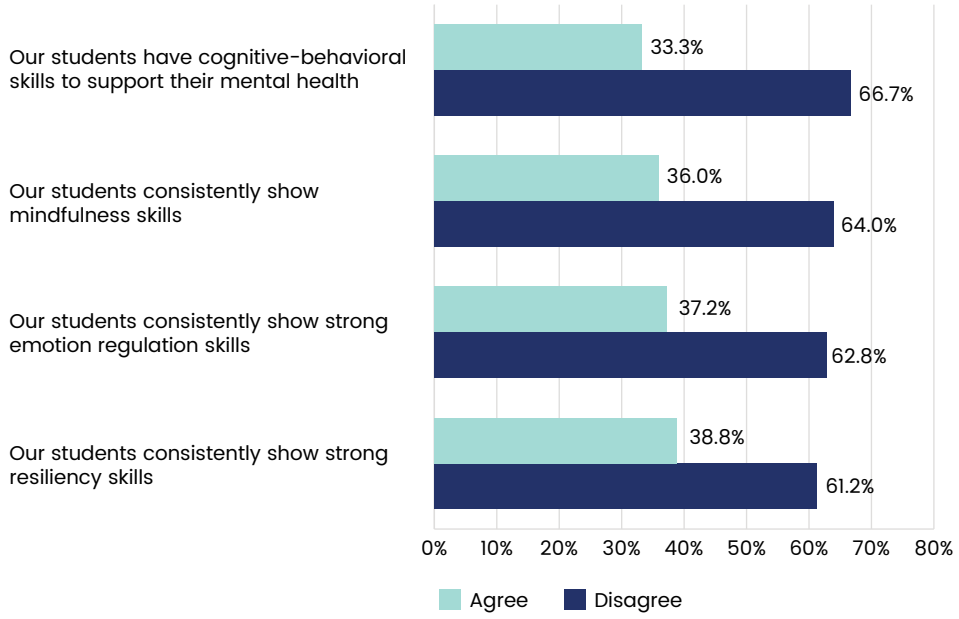
When asked about staff approaches to being responsive to student needs and practicing resiliency skills, respondents were less likely to agree that their colleagues, compared to them, incorporated trauma-responsive and culturally responsive approaches with students. They were similarly less likely to agree that their colleagues, compared to them, practiced resiliency skills to maintain a high level of well-being. See Figure 2 below.

Figure 2. Baseline Needs Assessment Results on Staff Approaches & Resiliency Skills



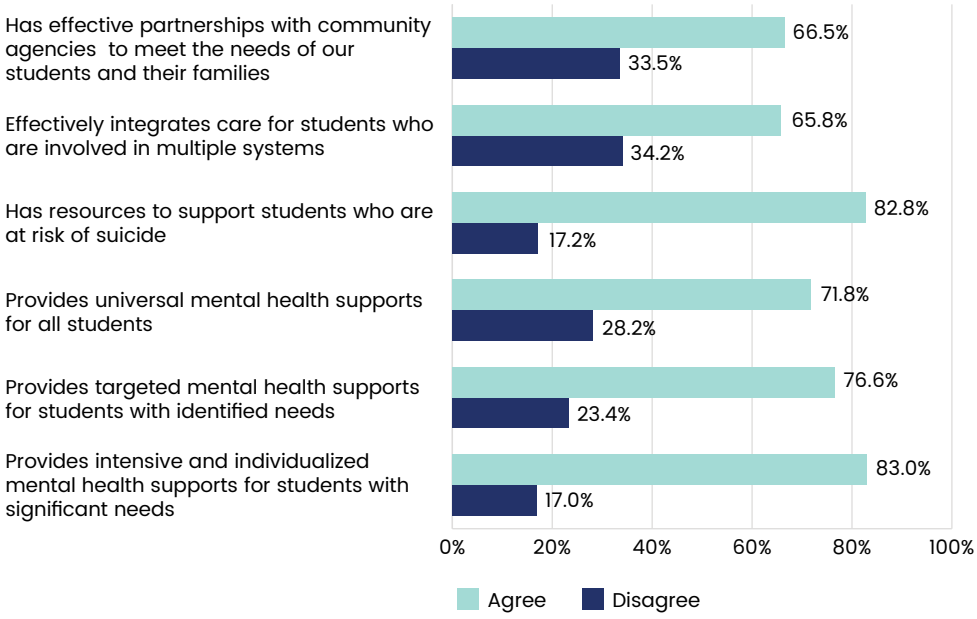
As seen in Figure 3, respondents were more likely to disagree than agree that students have cognitive-behavioral, mindfulness, emotional regulation, or resiliency skills.

Figure 3. Baseline Needs Assessment Results on Student Skills



Responses to the needs assessment based on school readiness indicated that respondents were more likely to agree than disagree that their school had effective partnerships, effective care coordination, access to resources related to suicide risk, and alignment with the MTSS framework. See Figure 4 below.

Figure 4. Baseline Needs Assessment Results on Schools



Participation and Reach

According to data from the implementers, the SMHSP program did a good job of reaching a wide variety of individuals and organizations across a broad section of Colorado especially as this was the first year and initial implementation phase and the SMHSP program was new in the state. Participation data indicates that a total of 568 people participated in SMHSP during the first year of the program in a variety of capacities. This includes 162 people who created an account with the Learning Management System. The virtual Kickoff Event in February 2026 had 79 attendees, and the virtual Spring Summit in May 2026 had 96 attendees. Participation was operationalized broadly and included people who participated in activities, completed the needs assessment, created an account with the Learning Management System, and/or attended virtual events as well as those who registered for an activity or event but may not have attended. There are additional participants unaccounted for in this analysis who attended activities hosted by partners (for example, webinars and the Community of Practice sessions).

A total of 148 organizations were represented among all participants, including 82 school districts (across 44 counties), BOCES, private schools, mental health service organizations, non-profits, and other partners (including medical, government, academic, and tribal). There was a participant from an out-of-state school and an international school. In terms of Colorado schools, participation data indicates 352 specific schools that were reached with some participants working at more than one school.

Participants included educators (e.g., teachers and paraprofessionals), school staff (e.g., school nurses and family liaisons), mental health professionals (e.g., school counselors, school psychologists, and school social workers), leaders (e.g., administrators and principals), and community partners (e.g., program specialists and advocates). Of the participants, 380 identified as female, 19 as male, one as gender queer, and four as 'other.' Among the participants who shared their race/ethnicity, approximately 71% identified as White, non-Hispanic.

Responses to the program evaluation survey came from an equally broad and diverse group of education and behavioral health professionals, reinforcing the diversity of professionals reached by the SMHSP program. Surveys were completed mostly by school mental health professionals (58.8%), followed by school staff (8.8%), district-level employees (7.4%), school administrators (4.4%), community partners (4.4%), and state-level employees (4.4%). Fewer respondents were nursing staff, classroom educators, and other roles.

Survey respondents represented a range of professional experience levels. Approximately 40.3% reported having one to three years of experience in their current role, 23.9% had eight to fifteen years, and 16.4% had more than fifteen years.

Activities and Resources

The SMHSP implementation featured a variety of activities and resources. The implementers facilitated statewide webinars and application to practice sessions with topics focused on suicide risk, mental health and well-being, resiliency skills, culturally responsive environments, mindfulness, and more. Various partners presented live webinars, and the implementers typically offered a follow-up application to practice session, generally one to two weeks later.

As seen in Table 1, the most highly attended webinars and application to practice sessions were: how **Response to Intervention**, targeted school-level implementation that creates systems and structures focused on giving all students high-quality instruction and individualized tiered support, functions within the Colorado MTSS framework; supporting students with anxiety through appropriate accommodation plans; an overview of the **Colorado Suicide Risk Assessment Toolkit**; and tips and best practices for collaboration between schools and community agencies.

Table 1. Webinars and Application to Practice Sessions Offered in the 2025-2026 School Year

Topic	Format	Partner	Date	Number of Attendees
Colorado's New Optional Suicide Prevention Policy	Webinar	Project AWARE	August 2025	*
	Application to Practice		September 2025	8
Response to Intervention Within the Colorado MTSS Framework	Webinar	Colorado Department of Education	September 2025	*
	Application to Practice		September 2025	13
Navigating Life Transitions	Webinar	Pediatric Mental Health Institute at Children's Hospital Colorado	September 2025	4
	Application to Practice		September 2025	0
Culturally Responsive Mental Health Support for Latino Students: Integrating Evidence-Based and Practice-Informed Approaches in Schools	Webinar	Hispanic/Latino Behavioral Health Center of Excellence	September 2025	*
	Application to Practice		October 2025	1
Cultivating Mental Health Awareness	Webinar	Colorado Department of Education's Office of Learning Supports	October 2025	*
	Application to Practice		October 2025	5
Anxiety and Accommodations	Webinar	Pediatric Mental Health Institute at Children's Hospital Colorado	November 2025	10
	Application to Practice		November 2025	7
Supporting Foster and Kinship Youth in Colorado Schools: Mental Health, Consent, and Classroom Impact	Webinar	School Administrator (and Foster Parent)	December 2025	9
Mindfulness Strategies for Stressful Times	Webinar	Presented by the implementers	December 2025	2
Data Literacy for Response to Intervention	Webinar	Colorado Department of Education	November 2025	*
	Application to Practice		December 2025	1
Integrating Universal Design for Learning within Response to Intervention	Webinar	Colorado Department of Education	January 2026	*
	Application to Practice		January 2026	0
Belonging to Blooming: Creating the Conditions Where Bullying Doesn't Live	Webinar	Colorado Department of Education	January 2026	*
	Application to Practice		January 2026	3

Topic	Format	Partner	Date	Number of Attendees
Mental Health Awareness for Safer, Stronger Schools	Webinar	Colorado Department of Education	February 2026	*
	Application to Practice		February 2026	1
The Intersection of Adolescent Mental Health and Substance Use	Webinar	SBIRT in Colorado	March 2026	2
	Application to Practice		March 2026	Canceled
The Secret Sauce to Success: How Family Partnerships Promote School Safety	Webinar	Colorado Department of Education	March 2026	*
	Application to Practice		March 2026	3
Supporting Student Safety: An Overview of the Colorado Suicide Risk Assessment Toolkit	Webinar	The Office of School Safety	April 2026	13
Permission to Collaborate: Best Practices for School Community Partnerships	Webinar	Youth Healthcare Alliance	May 2026	10

*Number of attendees not included because partners rather than the implementers were the host

The implementers also facilitated two statewide monthly learning series. One was designed for educators and focused on student mental health by providing practical strategies for creating safe and supportive classrooms, reducing stigma, and understanding how trauma, adversity, and developmental stages impact learning and behavior. The other supported educators and focused on how professionals can strengthen their own wellness and resiliency. Both learning series had approximately one to three attendees at each monthly session, and each session topic was offered typically at least three times.

In partnership with other organizations, the implementers supported the 2025-2026 **Colorado School Mental Health Community of Practice**. These monthly sessions, promoted via the SMHSP newsletter, brought together school mental health professionals and community members throughout the state to engage in shared learning, conversation, and collaboration to advance school mental health practices. On average, these sessions had around 39 attendees.

Self-paced eLearning courses were made available on the Learning Management System when it was launched in March 2026: a four-part series on Trauma-Informed Practices in Education and a module covering Culturally Responsive Practices to Support Student Mental Health. Available participation data suggest that while completion rates for these courses were low between March-June 15, 2026 (fewer than 10 people completed each module), most who started the modules completed them.

Resources on eight topics related to school mental health were also made available on the Learning Management System when it launched in March 2026: Cognitive-Behavioral Skills; Culturally Responsive Environments; Educator Wellness & Resiliency; Mental Health & Well-Being; Mindfulness Skills; Self-Regulation & Resiliency Skills; Suicide Risk; and Trauma-Informed Practices. Available participation data suggests that between 4-13 people accessed various resources between March and June 15, 2026, with the Cognitive-Behavioral Skills resources being the most highly accessed.

During the 2025-2026 school year, the implementers facilitated training sessions with six organizations, meaning these sessions were organization-specific rather than offered statewide. Two of these organizations participated in *Intensive Implementation Support* activities. An additional five organizations committed to *Targeted Skill Development* participation but had not yet participated in trainings during this school year. Two of these organizations, however, had trainings scheduled for the 2026-2027 school year. Organizations that committed to *Targeted Skill Development* had an implementation team that met with the implementers. As seen in Table 2, someone in a leadership position at the organization was often involved in the implementation team.

Table 2. Trainings and Implementation Teams in the 2025-2026 School Year

Organization Type	Number of Trainings	Number of Attendees at Trainings	Implementation Team Composition	Number of Meetings with Implementers
School District	3	First Training: 21 Second Training: 17 Third Training: 16	Executive Director; Program Manager	4
BOCES	2	First Training: 35 Second Training: 41	Executive Director; Director	6
Agency	1	15	Counselor; Director; Educator	4
Agency	1	10	Social Worker	2
School*	1	6	School Social Worker; School Psychologist, School Counselor; School Nurse; Restorative Justice Coordinator; 2 Deans	4
School District*	1	6	District Mental Health Lead; ~6 School Social Workers	8
School District	0	N/A	Director; School Health Professional	2
School District	0	N/A	School Based Therapy Program Supervisor	2
BOCES	0 (5 scheduled for 2026-2027 school year)	N/A	Director of Special Education	3
School	0 (4 scheduled for 2026-2027 school year)	N/A	Principal; School Social Worker; School Counselor	3
School	0	N/A	Assistant Principal; Principal	4

*Participated in *Intensive Implementation Support* activities

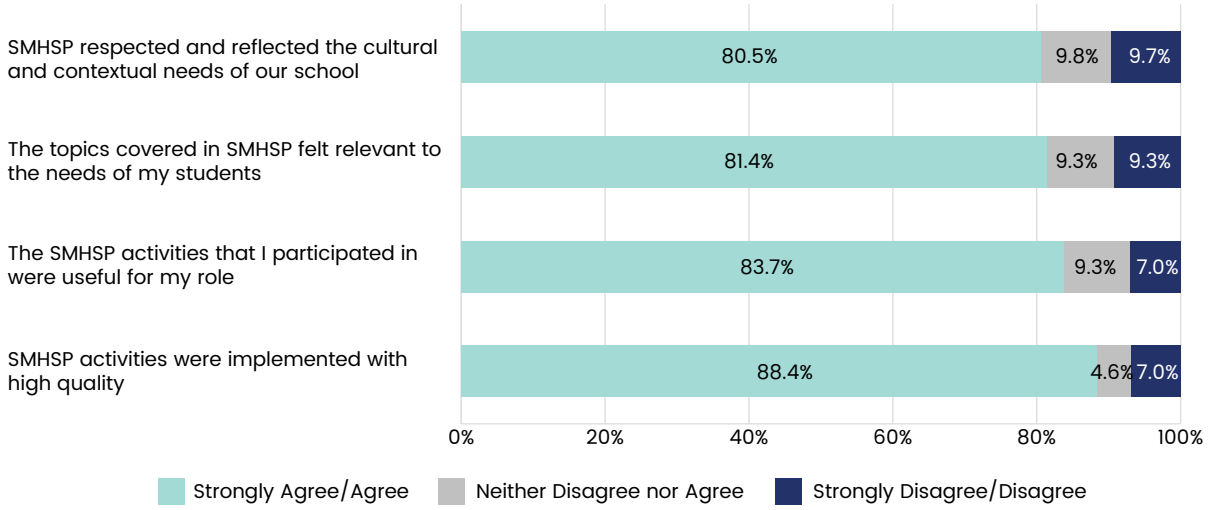
Respondents to the program evaluation survey reported participating in a variety of SMHSP activities. The most frequently reported activities included attending synchronous training sessions (37.7%), participating in the community of practice (27.9%), attending learning series sessions (23.0%), accessing behavioral health resources (19.7%), and receiving implementation support (13.1%). Respondents also reported varying levels of engagement, with most spending between one and seven hours participating in SMHSP activities.

Focus group participants also described engaging with SMHSP in a variety of ways, including organization-specific trainings, statewide events and summits, webinars, needs assessments, and implementation planning. Several participants explained that they first learned about SMHSP through newsletters, professional networks, or outreach from program staff. Participants from schools and other organizations noted that they initially engaged because the program offered free, high-quality mental health resources and supports tailored to their needs. Participants described expanding their involvement over time by sharing the SMHSP newsletter and training opportunities with colleagues or bringing information back to their schools and districts.

Program Efficacy

Findings from the program evaluation survey suggest that participants generally viewed SMHSP activities as being implemented effectively and with attention to local needs. As seen in Figure 5, the vast majority of respondents (88.4%) agreed or strongly agreed that SMHSP activities were implemented to a high standard. Similarly, 83.7% agreed or strongly agreed that the activities they participated in were useful for their professional role. Respondents also reported that SMHSP content was relevant and responsive to school needs. Around 82% of respondents agreed or strongly agreed that the topics covered were relevant to students' needs at their schools, while 80.5% agreed or strongly agreed that SMHSP respected and reflected the cultural and contextual needs of their school communities.

Figure 5. Program Evaluation Survey Results on Program Efficacy



Focus group participants reinforced these findings, consistently describing SMHSP activities as responsive to local needs and as implemented collaboratively. Rather than providing standardized training, participants reported that SMHSP staff first sought to understand their schools' priorities and used the needs assessments to guide implementation. Schools also described using the needs assessment as a roadmap for identifying priorities and selecting professional development. One participant explained that staff asked, *"What type of training are you all needing?"* before developing content, while another noted that the needs assessment helped them *"build out what supports we need."*

Participant Satisfaction and Training Quality

There were 268 responses available for the evaluation of implementer activities: 100 from webinars, 16 from eLearnings, and 152 from trainings. While the evaluation questions varied by activity, respondents provided open-ended answers to the question, "What was most effective about the session or training?" Overall, the respondents were very positive about and appreciative of the activity. Multiple responses referenced collaboration and learning what other organizations are doing; the accompanying visuals, resources, and handouts; the discussion; and the ability to reflect and apply this information to their work.

Open-ended feedback from the evaluation of implementer activities highlighted several recurring strengths. Participants valued the practical examples and resources provided, the expertise of facilitators, opportunities for discussion and reflection, and the collaborative learning environment. Many respondents appreciated learning from peers across schools and organizations, noting that hearing how others approached similar challenges helped them identify new ideas and strategies for their own practice.

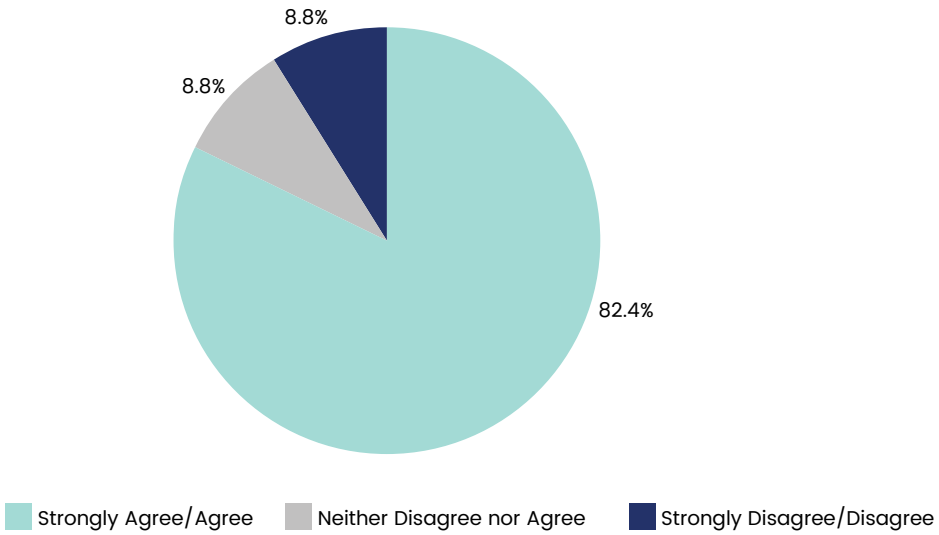
As one respondent shared, *"Hearing from other people about what they're doing definitely helped me for my practice,"* while another appreciated *"collaborating and sharing ideas with others from schools."* Participants also highlighted the interactive nature of the activities, noting the value of *"guiding questions for discussion," "table talks and reflections,"* and *"the opportunity to personalize the information and it feeling like a safe space to be interactive."*

Respondents also praised the quality of the content and facilitation. Practical examples, real-world scenarios, and the expertise of presenters helped participants better understand and apply new concepts. One participant commented, *"The examples were great, it really made me imagine the scenarios, situations, etc. & it made me understand better,"* while another simply identified *"the knowledge the presenter had on the topic"* as the most effective aspect of the session.

Many participants appreciated receiving practical resources they could continue using after the activity. Respondents noted the value of *"having a document I can share with staff"* and commented, *"Thanks for the PDFs! A good presentation has handouts!"* Others described leaving the sessions with knowledge they could immediately apply in their work, including learning *"new strategies for oneself in being able to manage emotions and communication better in the office"* and gaining terminology that helped them understand *"how to use it in our roles of work."*

Findings from the program evaluation survey similarly reinforce the value of SMHSP participation. As seen in Figure 6, more than four-fifths of respondents (82.4%) agreed or strongly agreed that participation in SMHSP was valuable. Only 8.8% disagreed or strongly disagreed, while 8.8% neither agreed nor disagreed.

Figure 6. Program Evaluation Survey Results on Program Value



Focus group participants echoed the positive survey findings, describing SMHSP activities as engaging, practical, and well-facilitated. Participants consistently praised the expertise of presenters and appreciated that sessions were adapted to their organizational context. One participant described the trainer as very well informed and noted that the training included *"good examples tailored to our needs."* Others valued the program's flexibility and the opportunity to access both local support and statewide learning.

Knowledge and Skill Development

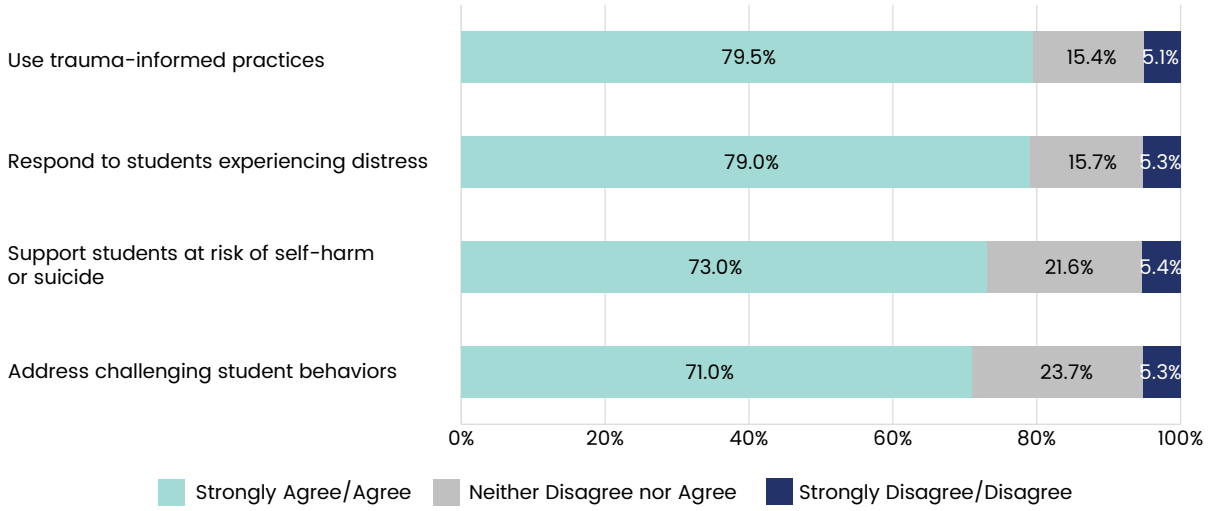
Implementer activity evaluation data showed that respondents left the activities with practical strategies they intended to incorporate into their work and daily practice. Many described plans to strengthen trauma-informed approaches, improve their ability to recognize signs of trauma, and use co-regulation and self-regulation techniques when supporting students. One respondent shared that they planned to focus on *"being able to notice or spot signs of trauma"* and apply *"trauma informed practices with youth,"* while another noted, *"I will try to use the co-regulation technique with students."*

Participants also reflected on the importance of applying these concepts to their own well-being and professional practice by becoming more intentional about recognizing their own emotional responses, practicing mindfulness, and regulating their own emotions before supporting others. As one participant explained, *"It's important to know what zone I am in first,"* adding that they planned to identify their physical reactions and use strategies to return to a calm state. Another respondent similarly noted that they would *"pay attention to my own needs, triggers, and patterns"* in order to self-regulate more effectively.

Many participants also described plans to apply what they learned more broadly within their schools by strengthening relationships with students and colleagues. Responses included using the 4Rs *"to build a lasting relationship with our students," "practicing patience with students,"* and *"sharing information about trauma informed practices with colleagues."* Together, these responses suggest that participants viewed the trainings as providing both practical strategies for supporting students and opportunities to strengthen their own professional skills and well-being.

Respondents to the program evaluation survey reported improvements in their perceived ability to support students' mental health after participating in SMHSP activities. As seen in Figure 7, the strongest reported gains were in the use of trauma-informed practices, with 79.5% of respondents agreeing or strongly agreeing that participation improved their ability to use these approaches. Similar proportions reported improvements in their ability to respond to students experiencing distress (79.0%) and to support students at risk of self-harm or suicide (73.0%). Participants also reported increased capacity to address challenging student behaviors, with 71.0% agreeing or strongly agreeing that participation in SMHSP improved their skills in this area. Overall, the findings suggest that participants perceived meaningful improvements in their knowledge and practical skills related to student mental health, trauma-informed care, crisis response, and behavioral support.

Figure 7. Program Evaluation Survey Results on Improvements in Ability to Support Student Mental Health

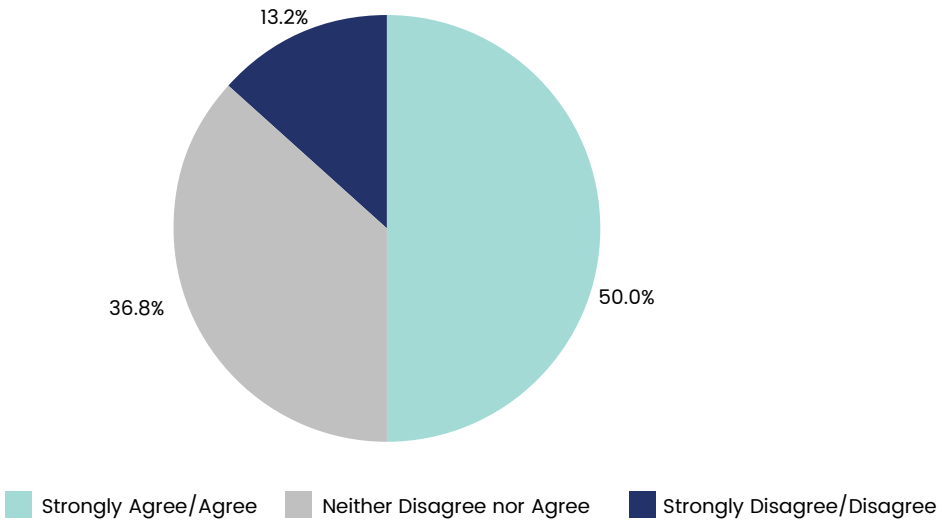


Focus group findings help explain how these perceived improvements translate into practice. Participants described using trauma-informed concepts, boundaries training, and practical strategies from SMHSP sessions to better support students, train colleagues, and strengthen school practices. Several respondents emphasized that the program not only introduced new approaches but also reinforced and expanded practices they were already using. One participant explained that the training helped staff move beyond simply describing their work as trauma-informed and toward identifying specific interventions they could consistently implement. Another noted that they had already begun applying concepts from the boundaries training in their work with students.

Educator Well-being and Workforce Retention

When asked whether participation in SMHSP helped reduce their stress and burnout, respondents in the program evaluation survey reported mixed experiences. As seen in Figure 8, half of the respondents (50.0%) agreed or strongly agreed that SMHSP had a positive effect on their stress and burnout, while 36.8% neither agreed nor disagreed, and 13.1% disagreed or strongly disagreed. These findings suggest that SMHSP may have contributed to improved well-being for some participants, although the impact was not consistent across respondents.

Figure 8. Program Evaluation Survey Results on Improvements in Stress and Feelings of Burnout

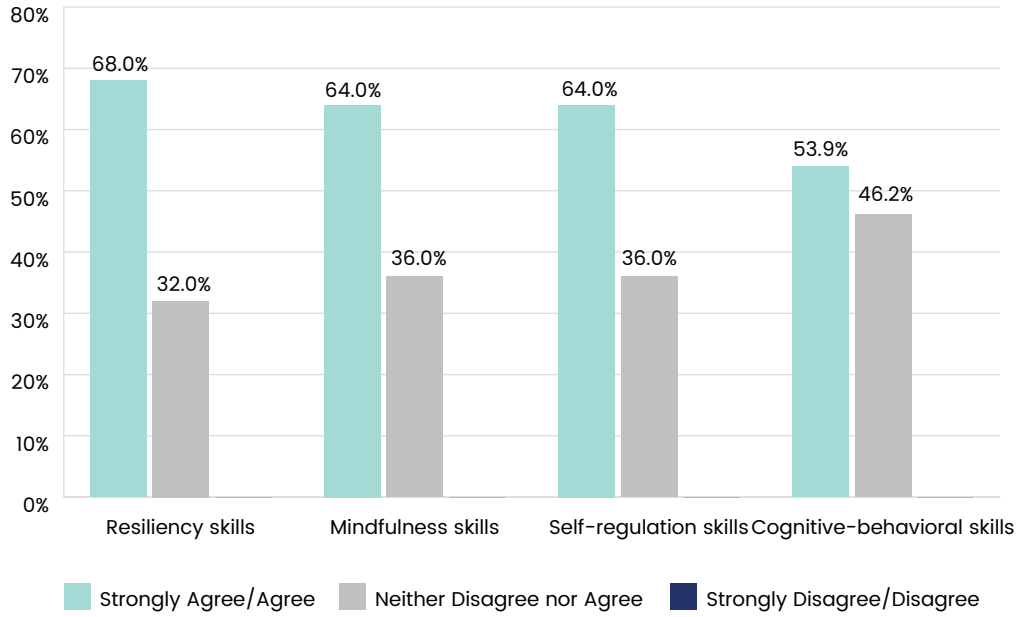


Focus group discussions suggest that one of SMHSP's greatest contributions to educator well-being was reducing professional isolation and providing opportunities for collaboration and validation. Participants frequently described feeling more supported through access to consultation, networking, and implementation support. One participant referred to SMHSP as a *"lifeline"*, while another explained that the program had *"grown some confidence,"* provided validation, and connected them with professionals facing similar challenges. Participants also noted that trainings on boundaries reinforced the importance of maintaining healthy professional boundaries to prevent burnout. At the same time, participants recognized that educator well-being is influenced by broader workforce challenges, staffing shortages, competing priorities, limited time and capacity, and staff turnover, all of which extend beyond the scope of SMHSP.

Perceptions of Student Outcomes

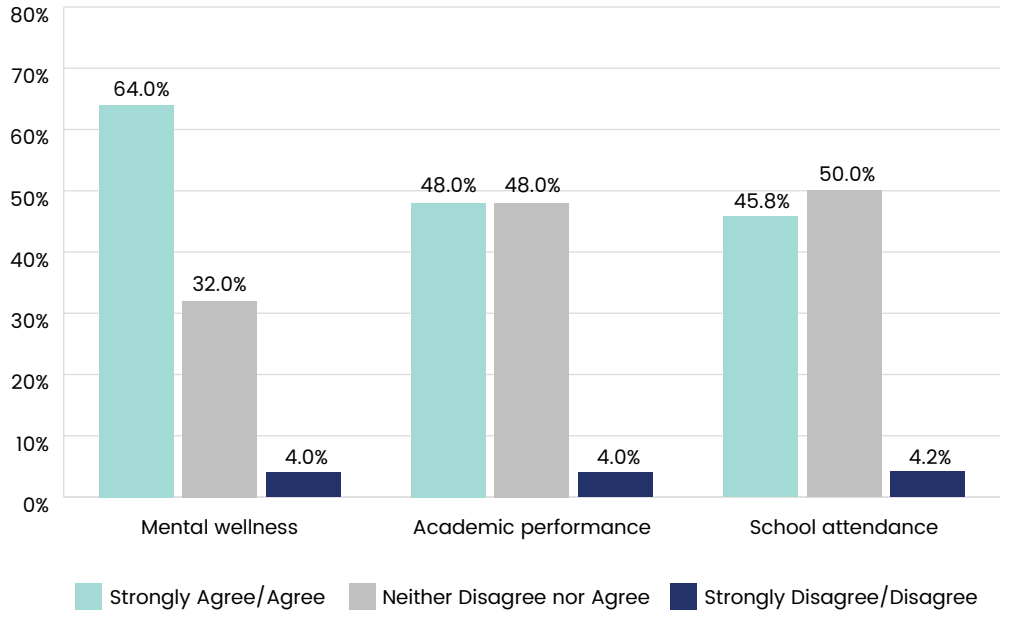
While challenging to measure, program evaluation survey respondents were asked to report on the impact of the SMHSP program on their perceptions of student outcomes. Participants reported positive perceptions of changes in student social-emotional skills following participation in SMHSP. As seen in Figure 9, the largest reported improvements were observed in student resiliency, with 68% of CPR's survey respondents agreeing or strongly agreeing that students demonstrated gains in this area. Similar proportions reported improvements in mindfulness (64%) and self-regulation (64%) skills. Slightly more than half of respondents (53.8%) agreed or strongly agreed that students demonstrated improvements in cognitive-behavioral skills. There were no respondents who disagreed or strongly disagreed with the statement that there were improvements in student skills, and all respondents saw some value in student outcomes.

Figure 9. Program Evaluation Survey Results on Improvements in Student Skills



Participants also reported positive changes in broader student outcomes. As seen in Figure 10, nearly two-thirds (64.0%) agreed that student mental wellness had improved. Smaller proportions reported improvements in academic performance (48.0%) and school attendance (45.8%). Across these outcomes, a substantial proportion of respondents selected neutral response options, suggesting that some participants may not have observed sufficient change or had enough information to assess student outcomes.

Figure 10. Program Evaluation Survey Results on Improvements in Student Outcomes



Focus group participants also perceived positive changes in how schools supported students following participation in SMHSP. Participants described increased use of trauma-informed interventions, mindfulness, and co-regulation strategies, as well as shifts in how educators understood and responded to student behavior. One participant observed *that "a lot more teachers are doing mindfulness and co-regulation in their classes,"* while another noted that trauma-informed practices had become integrated into student support discussions. A participant from a rural area also reported improvements in attendance, engagement, and school climate over the past several years. However, they emphasized that these changes reflected broader regional efforts and could not be attributed solely to SMHSP.

Rural and Underserved Communities

Of the 82 school districts that participated in SMHSP in some capacity, 21 (26%) are considered 'rural' and 30 (37%) are considered 'small rural,' by the Colorado Department of Education's **Rural and Small Rural Designation**. A Colorado school district is determined to be rural based on the district's size, the distance to the nearest large urban/urbanized area, and a student enrollment of 6,500 or fewer. A small rural district meets those same criteria but has fewer than 1,000 students.

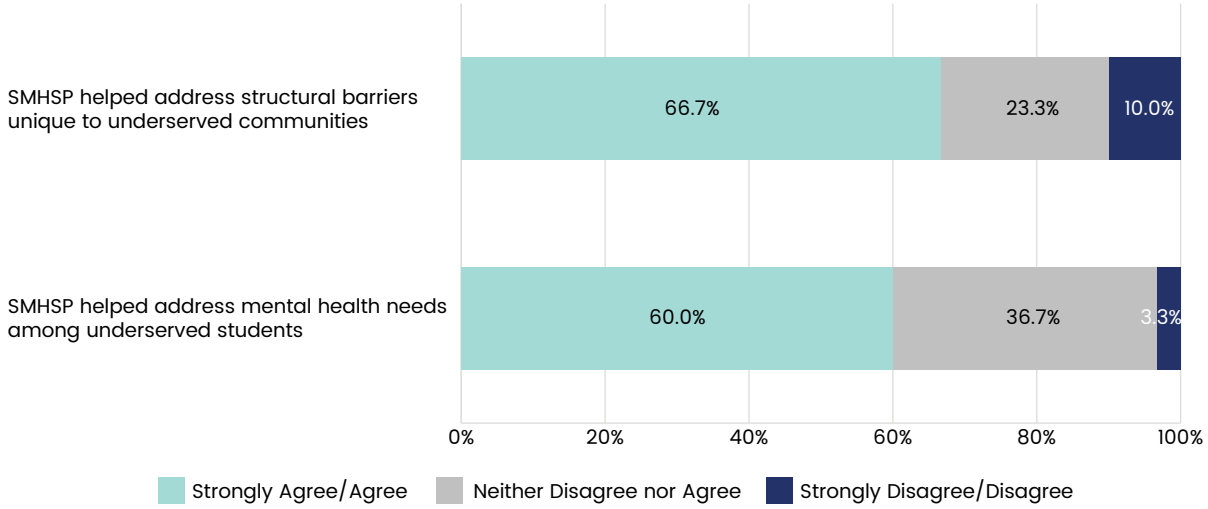
The school district that completed three trainings with the implementers is designated as a rural district. The school district that completed one training with the implementers, and participated in *Intensive Implementation Support* activities, is not designated as either. Over 62% of the school districts that had at least one person participate in SMHSP during the 2025-2026 school year are designated as either rural or small rural. Of the two school districts that had committed to argeted *Targeted Skill Development* participation but had not yet completed training with the implementers, one is designated as a rural district and the other as a small rural district.

The National School Lunch Program (NSLP) provides eligible students with free or reduced-price lunch (FRPL), and the percentage of eligible students in a school serves as a proxy measure of the concentration of low-income students. Public schools are divided into categories by **FRPL eligibility**: low-poverty schools are those where 25% or less of the students are eligible; mid-low poverty schools are those where 25.1% to 50% of students are eligible; mid-high poverty schools are those where 50.1% to 75% of the students are eligible; high-poverty schools are those where more than 75% of the students are eligible. The **percentage of FRPL eligible students** is available from the Colorado Department of Education for 302 of the 352 specific Colorado schools that participated in SMHSP in some capacity. Of these 302 schools, 39 (12.9%) are considered low-poverty; 101 (33.4%) are considered mid-low poverty, 106 (35.1%) are considered mid-high poverty; and 56 (18.5%) are considered high-poverty.

The school that completed one training with the implementers is considered a high-poverty school. Of the two schools that committed to *Targeted Skill Development* participation but had not yet completed training with implementers, one is considered low-poverty and the other high-poverty.

Program evaluation survey respondents generally perceived that SMHSP was responsive to rural and underserved populations. As seen in Figure 11, 60% agreed or strongly agreed that SMHSP helped address the mental health needs of underserved students, and 66.7% agreed or strongly agreed that the program helped address structural barriers affecting students in their communities.

Figure 11. Program Evaluation Survey Results on Responsiveness to Rural and Underserved Populations



Survey respondents also identified opportunities to further strengthen the program's relevance for rural and underserved populations. More than one-third (37.0%) indicated that increasing the relevance of SMHSP for rural and underserved communities was an area for improvement. These findings suggest that participants viewed SMHSP as responsive to equity-related needs while recognizing opportunities to better tailor supports to the unique contexts of rural and underserved communities.

Focus group participants added important context to these findings by describing the structural barriers that continue to affect implementation, particularly in rural communities. Participants identified workforce shortages, provider turnover, limited access to behavioral health services, competing school priorities, budget constraints, geographic isolation, and limited time for professional development as persistent challenges. As one participant summarized, schools often face "*not enough money, not enough time, and not enough people.*" These findings suggest that while participants viewed SMHSP as responsive to the needs of rural and underserved communities, broader systemic barriers continue to affect schools' ability to implement and sustain school mental health initiatives.

Opportunities for Improvement

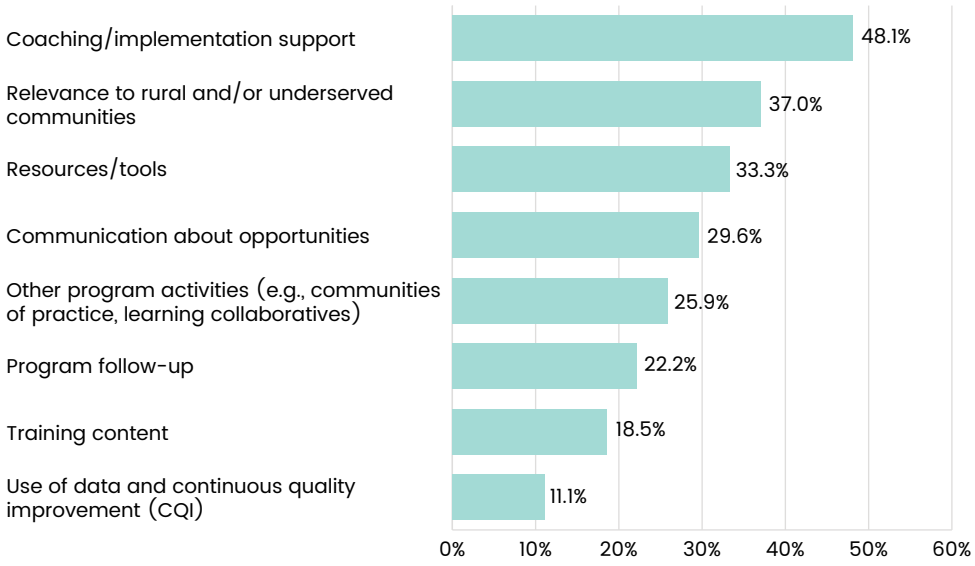
Areas for Improvement

The evaluation of implementer activities asked respondents to provide recommendations for improving the sessions. The most common recommendation was to make sessions even more practical and interactive. Respondents expressed interest in additional real-world examples and classroom-based scenarios, with one participant requesting *"more examples that are relevant to work settings and structures,"* and another suggesting *"scenarios and examples of behaviors in the classroom and how to deal with them."* Others recommended incorporating *"more hands-on activities," "more movement breaks,"* and additional visuals to support learning.

Focus group participants reinforced these findings, emphasizing that they valued the quality of the activities but would benefit from additional opportunities to apply what they learned. Participants suggested incorporating more implementation support following trainings, including coaching, consultation, and opportunities to discuss challenges with peers. As one participant noted, *"Once practitioners try something, how can we embed some follow up?"* Others emphasized that ongoing support would help educators translate training concepts into sustained practice.

When asked where SMHSP could improve, as seen in Figure 12, nearly half of program evaluation survey respondents (48.1%) identified coaching and implementation support as a priority area. More than one-third (37.0%) indicated that additional attention should be given to ensuring relevance for rural and underserved communities. Participants also identified a need for more resources and tools (33.3%), improved communication about available opportunities (29.6%), stronger learning collaboratives and communities of practice (25.9%), and increased follow-up support after activities (22.2%). When asked if there was anything else that they would like to share, one respondent wrote in that *"I really like these trainings however I struggle to be available in the times they are offered and feel that recordings of sessions available on a sign in…would be helpful for me if I started a session and had to leave"*. These findings suggest that participants value SMHSP resources and training opportunities but would benefit from additional implementation-focused supports and ongoing engagement.

Figure 12. Program Evaluation Survey Results on Areas for Improvement



Focus group participants reinforced these priorities by emphasizing the importance of ongoing engagement beyond one-time trainings. Participants recommended expanding coaching, peer learning opportunities, and implementation consultation to help schools sustain new practices. They also suggested strengthening communication and outreach through concise, visual materials and providing tools to help schools document and communicate the impact of school mental health initiatives. These findings suggest that participants view SMHSP as a valuable resource and would benefit from continued support in implementing school mental health practices.

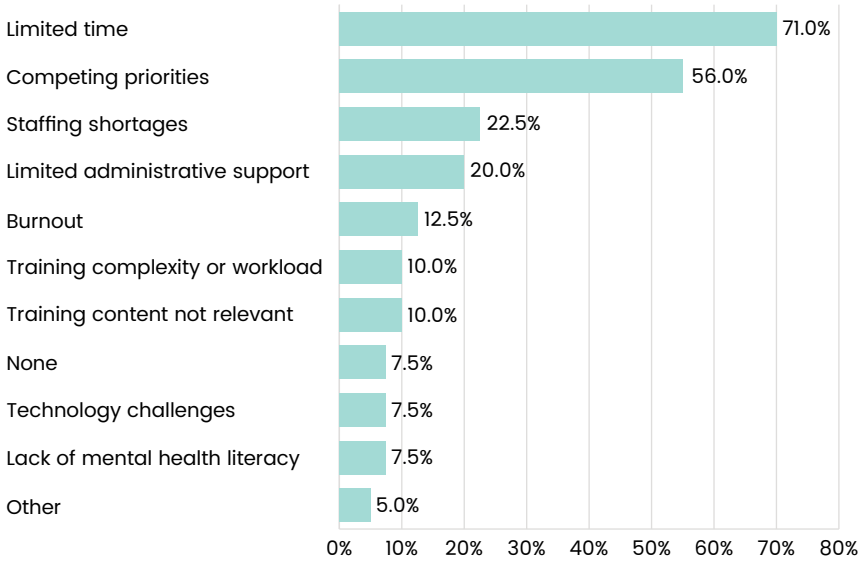
Participants also provided suggestions for new or missing topics for the training sessions. Respondents to the evaluation of implementer activities identified several topics they would like future SMHSP offerings to address. Trauma remained the area of greatest interest, with respondents requesting opportunities to explore the topic in greater depth. One participant stated they wanted to learn *"just trauma in a deeper level."* Participants also expressed interest in practical resources and emerging issues, including *"more behavioral accommodations," "resources for rural areas for mental health supports,"* and information about grants to increase school counseling capacity. Others suggested expanding training to address new challenges affecting youth, such as understanding *"AI companionship/relationships and the challenges and strengths of these types of relationships."* Collectively, these responses suggest that participants value the current training offerings and are interested in building on them with more advanced, practice-oriented content tailored to evolving school mental health needs.

Focus group participants similarly expressed interest in continuing to build their knowledge beyond introductory trainings. Rather than requesting entirely new topics, participants emphasized the value of expanding existing content through more advanced, practice-oriented learning and implementation support. Several also highlighted the need for practical tools that educators could use directly with students and staff, as well as opportunities to revisit concepts over time.

Identified Challenges

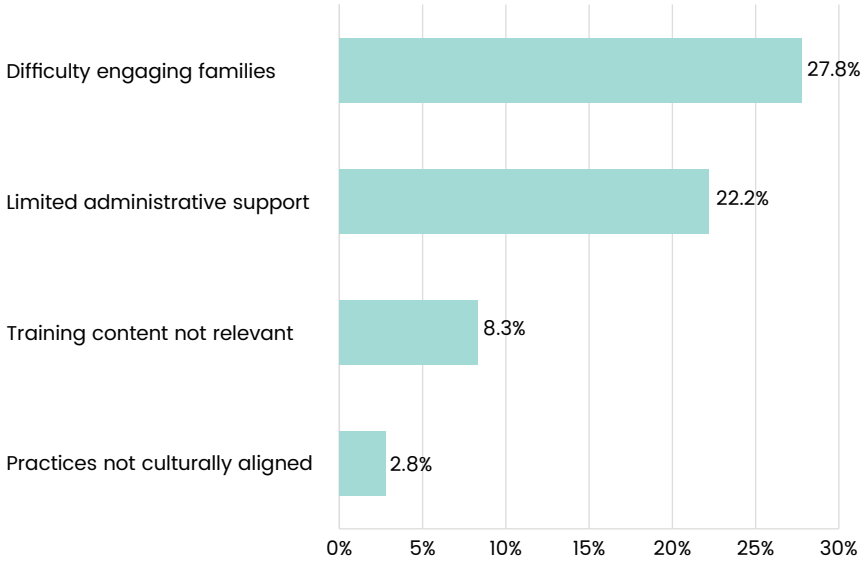
Respondents to the program evaluation survey identified several challenges that limited their ability to fully engage in SMHSP activities. As seen in Figure 13, the most commonly reported barrier was limited time, cited by 70.0% of respondents. More than half (55.0%) reported competing priorities as a barrier to participation. Other commonly reported barriers included staffing shortages (22.5%), limited administrative support (20.0%), and burnout (12.5%). These findings suggest that educators and school staff often face competing demands, making it difficult to participate consistently in professional learning and implementation activities.

Figure 13. Program Evaluation Survey Results on Barriers to Participation



Participants also identified challenges to implementing SMHSP practices within their schools. As shown in Figure 14, the most frequently reported barrier was difficulty engaging families, identified by 27.8% of respondents in the program evaluation survey. Limited administrative support was reported by 22.2% of respondents. Smaller proportions indicated that training content was not relevant to their needs (8.3%) or that practices were not culturally aligned with their communities (2.8%). Overall, the findings suggest that implementation challenges were more often related to school and community contexts than to the content of the program itself.

Figure 14. Program Evaluation Survey Results on Barriers to Implementation



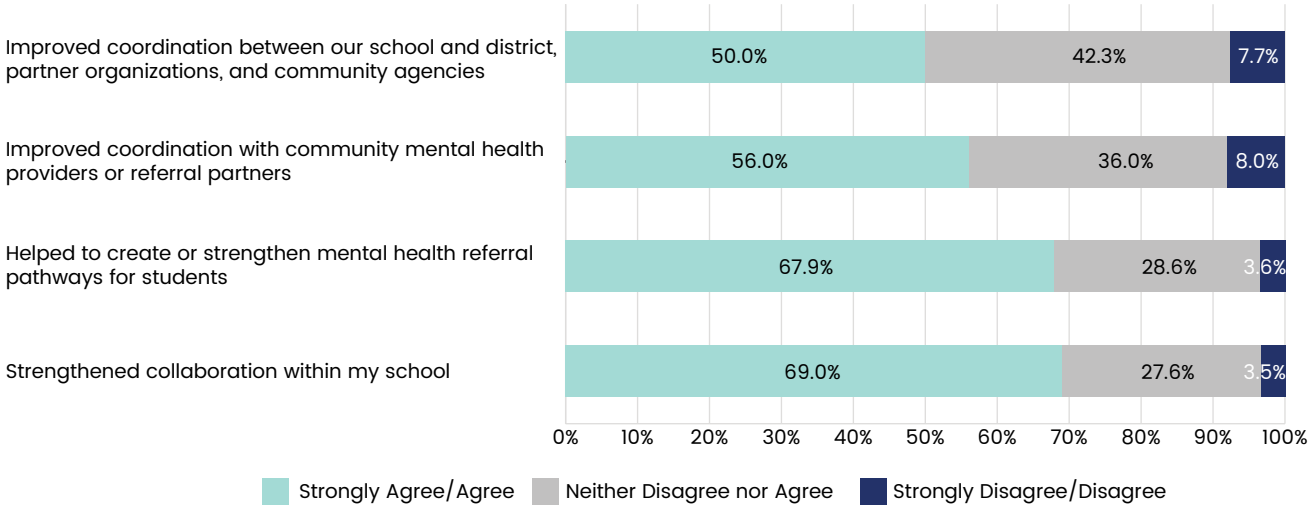
Focus group participants also described implementation challenges that extended beyond the content of the trainings. Educators emphasized that sustaining new practices requires administrative support, dedicated time, and ongoing coaching. Several noted that implementing school mental health initiatives can be difficult amid competing school priorities and limited staff capacity, particularly when schools are already responding to significant student needs.

Partnership Effectiveness

As previously mentioned, participants were appreciative of the implementers. When asked in the evaluation of implementer activities to provide open-ended responses about how the facilitator could improve future sessions, multiple participants said the facilitator was great, professional, and/or knowledgeable. A respondent to the program evaluation survey, when asked if there was anything else that they would like to share, wrote in that *"because of this partnership I have been able to feel less alone in this work and always had access to a thought partner and encouragement"*.

The program evaluation survey respondents also reported generally positive perceptions of collaboration and coordination associated with SMHSP participation. As seen in Figure 15, around 69% of respondents agreed or strongly agreed that participation in SMHSP strengthened collaboration within their school or organization. Respondents also reported improvements in referral pathways, with 67.9% agreeing or strongly agreeing that participation strengthened connections between students and appropriate supports and services. Perceptions of coordination across organizations were somewhat more mixed. Half of respondents (50.0%) agreed or strongly agreed that SMHSP improved coordination between schools, districts, and partner organizations, while 56.0% agreed or strongly agreed that participation improved coordination with community mental health providers. A substantial proportion of respondents selected neutral response options for these items, suggesting that some participants may have had limited opportunities to observe changes in cross-system collaboration.

Figure 15. Program Evaluation Survey Results on Collaboration and Coordination



Focus group participants suggested that the value of these partnerships extended beyond formal coordination. Participants explained that SMHSP brought additional credibility to school mental health efforts by reinforcing priorities that staff had already identified. One participant noted that the program helped validate concerns and recommendations they had been raising for years, making it easier to build buy-in among colleagues and administrators. Participants also expressed interest in expanding opportunities for collaboration among participating schools and districts, suggesting that peer learning and cross-site networking could further strengthen implementation.

Overall, the survey and focus group findings suggest that participants perceived improvements in collaboration, coordination, and referral pathways. At the same time, the qualitative findings indicate that participants valued SMHSP not only for strengthening partnerships across organizations but also for serving as a trusted thought partner that supported planning, problem-solving, and implementation within the school.

Conclusion

SMHSP had a broad reach across the state in its first year especially considering this was the initial implementation phase and the SMHSP program was new to Colorado. There were 568 individuals who participated in the program in various capacities, representing 148 organizations, including 82 school districts (across 44 counties), BOCES, and other agencies. Over 62% of the school districts with at least one person participating in SMHSP during the 2025-2026 school year are designated as either rural or small rural. The program reached 352 specific Colorado schools. Based on available data on the percentage of students eligible for Free and Reduced-Price Lunch, 12.9% of these schools are considered low-poverty, 33.4% mid-low poverty, 35.1% mid-high poverty, and 18.5% high-poverty.

The implementers offered a variety of activities and resources with varying levels of attendance and utilization. This is partly because it is the first year of the program. The implementers had to establish relationships with participants, schools, and other organizations, and set up the program infrastructure (for example, the Learning Management System, launched in March 2026, which had limited reach in the 2025-2026 school year).

The evaluation findings indicate that SMHSP was successfully implemented in its first year and was perceived as a valuable, high-quality resource for educators and school mental health professionals. Participants reported improvements in educators' knowledge, confidence, and capacity to support student mental health, as well as stronger implementation of trauma-informed practices within their schools and organizations. Participants identified several opportunities to strengthen the program. The most common recommendations were to make trainings more practical and interactive, expand implementation support through ongoing coaching and follow-up, and strengthen communication and outreach. Participants consistently described positive experiences with the implementers and perceived improvements in collaboration, coordination, and referral pathways. They also noted that SMHSP brought credibility to school mental health efforts, helped build buy-in among colleagues and administrators, and created opportunities for stronger collaboration across schools and organizations.

Overall, the evaluation findings indicate that SMHSP established a strong foundation for supporting school mental health across Colorado. Despite ongoing workforce and resource challenges, participants consistently viewed the program as relevant, responsive, and valuable for strengthening educator capacity, partnerships, and school mental health systems.

Although the program ended earlier than anticipated due to a state funding error, plans were already underway to expand participation during the 2026-2027 school year, including an additional five organizations committed to *Targeted Skill Development* participation and new learning collaborative activities. To help sustain the program's impact, the implementers plan to maintain access to the Learning Management system through the end of 2026 and to add new eLearning courses on Building Students' Self-Regulation and Resiliency Skills; Mindfulness and Stress Management Skills to Strengthen Educator Resiliency; and Trauma-Responsive Guidelines for Classroom Management Systems and Behavioral Intervention Plans. The learning series on educator wellness and resiliency will also continue, as scheduled, throughout the summer of 2026.

This evaluation report was intended to provide results from the implementation of SMHSP in the 2025-2026 school year to inform the statewide expansion of the program in future years. Should similar programming be implemented in the future, several lessons learned from this evaluation can guide expansion:

- Allowing for longer timeframes for program implementation and start-up activities, including the onboarding and recruitment of schools and participants, will bolster participation and reach.
- Encouraging stronger participation in pre- and post-surveys, by embedding evaluation measures throughout activities, will help to measure program impact. For example, in the 2025-2026 school year, 14 participants completed knowledge tests that corresponded to an eLearning course. The knowledge tests included factual questions specific to each eLearning module, and participants completed a pre-test before taking the course and a post-test after completing it. A larger sample size is needed to draw any conclusions regarding the impact of the eLearning courses on participant knowledge.
- Linking administrative data from schools and other available sources can provide additional insight into student outcomes and the long-term impacts of SMHSP on student mental health.

SMHSP was a critical program intended to expand and provide needed school-based mental health services to students, particularly in rural and underserved schools across Colorado. Educators, school staff, and mental health professionals across Colorado responded positively to the activities, resources, and supports provided through SMHSP. Participants viewed SMHSP as a valuable resource and would benefit from ongoing support and further expansion to support school mental health practices across Colorado. Together, these findings suggest that the need for a coordinated statewide initiative to strengthen school mental health remains strong.

Appendix A: Services Menu

SCHOOL MENTAL HEALTH SUPPORT PROGRAM

What does the SMHSP focus on?

Training, resources, and activities focus on:

- **Mental Health and Well-Being**
- **Self-Regulation and Resiliency Skills**
- **Culturally Responsive Environments**
- **Mindfulness Skills**
- **Cognitive-Behavioral Techniques (CBT)**
- **Educator Wellness and Resiliency**
- **Trauma-Informed Practices**
- **Individualized Mental Health Plans**
- **Suicide Risk**

What activities does the SMHSP offer for schools?

Application to Practice Sessions - Our partners and team offer live webinars of various lengths on different school mental health and wellness topics. Follow-up Application to Practice Sessions are offered the following week to provide opportunities to ask questions and have deeper discussions about how to apply the learning or implement new strategies.

eLearning Modules - Self-paced, on demand training, available anytime, anyplace, through the SMHSP Learning Management System (LMS). Modules typically take between 30 minutes to 1 hour to complete. CE credits and certificates available.

Learning Series - Each yearlong series covers different aspects of a topic. Sessions are 45 minutes on Zoom, once a month, offered 3 times each month on various times and days. Each month's session will present new information on the topic and build upon the previous month's content. This may use a flipped classroom model or include content to review between the monthly sessions. CE credits and certificates available.

Communities of Practice - The Communities of Practice focuses on sharing best practices and creating new knowledge to advance professional practice. Presenters are representatives of schools/districts who share lessons learned from their experience. Meets monthly September to May (no meeting in December or March).

Synchronous Training - In-person or virtual trainings for partner schools, districts, and agencies. Length can vary from less than an hour to full day depending on individual needs (for example, staff meetings vs. in-service days). Topics can be chosen in partnership with SMHSP team and the implementation team, connected to the goals set through the needs assessment process.

Learning Collaboratives - Structured groups of schools, districts, or professionals who come together regularly to share experiences, apply evidence-based practices, and learn from one another. Learning collaboratives foster peer-to-peer exchange, collective problem-solving, and continuous improvement toward shared goals.

Implementation Support - In-person or virtual coaching, consultation, and technical assistance to assist schools in planning, executing, reflecting on, and building strategies to embed program practices in school operations. Coaching can be provided in conjunction with other mental health-related initiatives, even if not offered by SMHSP.

Needs Assessment - Assessment of staff perspectives of the needs and strengths of each school, district, or agency. The SMHSP team will work with you to turn the needs assessment results into actionable steps.

What can participation in SMHSP look like?

		Flexible Learning Opportunities	Targeted Skill Development	Intensive Implementation Support
Flexible Learning Opportunities Focus: Skills and knowledge for any interested school staff across all roles to promote student mental health, staff well-being, trauma-informed practices, and positive school climate.	Application to Practice Sessions and professional development webinars	✓	✓	✓
	eLearning	✓	✓	✓
	Learning Series	✓	✓	✓
	Communities of Practice	✓	✓	✓
	Toolkits, tip sheets, and micro-learning library	✓	✓	✓
+ **Targeted Skill Development** Focus: Targeted skill development to support collaborative growth for staff seeking deeper knowledge in specific focus areas.	Synchronous in-person training and workshops on requested topics		✓	✓
	Ongoing Learning Collaboratives		✓	✓
	Consultation and technical assistance		✓	✓
	Data-informed action planning		✓	✓
	Skill-building lesson plans for educators to use with students		✓	✓
	Needs assessment/data collection analysis support		✓	✓
+ **Intensive Implementation Support** Focus: Intensive individualized support for schools, districts, partner agencies, and BOCES committed to systemic practice change.	Ongoing implementation team meetings, with support from SMHSP for implementation and long-term sustainability			✓
	Tailored specialized in-person or virtual training + follow-up modeling, one-on-one			✓
	Support with integrating mental health and behavioral supports into MTSS & SEL systems			✓
	Support to expand external community partnerships with mental health and health agencies			✓

Flexible Learning Opportunity activities are open free of charge to all Colorado educators and related professionals. Targeted Skill Development and Intensive Implementation Support are available free of charge to Colorado schools, districts, BOCES, and partner agencies serving grades 6-12.

SCAN TO LEARN MORE!

SMHSP School Mental Health Support Program · Colorado Behavioral Health Administration · The Kempe Center · Butler Institute for Families, University of Denver

Appendix B: Program Evaluation Survey

Program Evaluation Survey

Thank you for completing this brief survey on your participation in the School Mental Health Support Program (SMHSP) during the 2025-2026 school year. The Center for Policy Research (CPR) is a non-profit research evaluation firm conducting an external evaluation of the program, funded by the Behavioral Health Administration (BHA). Your response helps us to better understand the program, its effectiveness, and opportunities for improvement. Your answers are confidential, and the survey is voluntary – you can skip any question and can stop at any time.

I. DEMOGRAPHICS AND BACKGROUND

1. **What is your role?** *(Select all that apply)*
    a. Classroom educator (e.g., teacher)
    b. School staff (e.g., support staff, office staff)
    c. School administrator
    d. School mental health professional (e.g., counselor, psychologist, social worker)
    e. Community partner
    f. Other (please specify): _____

2. **Which school do you currently work in?**
    a. [drop down of schools where SMHSP is being implemented]

3. **How long have you worked in your current role?**
    a. Less than 1 year
    b. 1–3 years
    c. 4–7 years
    d. 8–15 years
    e. More than 15 years

II. PARTICIPATION IN SMHSP

4. **Which SMHSP activities have you participated in?** *(Select all that apply)*
    a. Attending application to practice sessions
    b. Completing eLearning modules
    c. Attending a learning series
    d. Participating in a community of practice
    e. Attending synchronous training (in-person or virtual)
    f. Participating in a learning collaborative
    g. Receiving implementation support (in-person or virtual)
    h. Completing the needs assessment
    i. None [-> end survey]
    j. Other (please specify): _____

5. **Approximately how many hours of SMHSP activities have you participated in this school year?**
    a. Less than 1 hour
    b. 1–3 hours
    c. 4–7 hours
    d. 8–15 hours
    e. More than 15 hours
    f. Not sure

6. **Have you received or engaged with any SMHSP resources?** *(Select all that apply)*
    a. The SMHSP newsletter
    b. The SMHSP website
    c. Topic-specific resources
    d. None
    e. Other (please specify): _____

III. PROGRAM EFFICACY

7. In my opinion…

	Strongly Disagree	*Disagree*	*Neither Disagree nor Agree*	*Agree*	*Strongly Agree*
SMHSP activities were implemented with high quality.	☐	☐	☐	☐	☐
The SMHSP activities that I participated in were useful for my role.	☐	☐	☐	☐	☐
The topics covered in SMHSP felt relevant to the needs of my students.	☐	☐	☐	☐	☐
SMHSP respected and reflected the cultural and contextual needs of our school community.	☐	☐	☐	☐	☐

8. Participation in SMHSP has increased my capacity to….

	Strongly Disagree	*Disagree*	*Neither Disagree nor Agree*	*Agree*	*Strongly Agree*
Use trauma-informed practices.	☐	☐	☐	☐	☐
Address challenging student behaviors.	☐	☐	☐	☐	☐
Respond to students experiencing distress.	☐	☐	☐	☐	☐
Support students at risk of self-harm or suicide.	☐	☐	☐	☐	☐

9. Participation in SMHSP has helped my stress or feelings of burnout.

a. Strongly disagree
b. Disagree
c. Neither disagree nor agree
d. Agree
e. Strongly agree

10. Since participating in SMHSP, I have noticed improvements in student…

	Strongly Disagree	*Disagree*	*Neither Disagree nor Agree*	*Agree*	*Strongly Agree*
Cognitive-behavioral skills.	☐	☐	☐	☐	☐
Mindfulness skills.	☐	☐	☐	☐	☐
Self-regulation skills.	☐	☐	☐	☐	☐
Resiliency skills.	☐	☐	☐	☐	☐

11. Since participating in SMHSP, I have noticed improvements in student…

	Strongly Disagree	*Disagree*	*Neither Disagree nor Agree*	*Agree*	*Strongly Agree*
School attendance.	☐	☐	☐	☐	☐
Academic performance.	☐	☐	☐	☐	☐
Behavioral outcomes.	☐	☐	☐	☐	☐

12. Overall, my participation in SMHSP has helped me better support my students' mental health.

a. Strongly disagree
b. Disagree
c. Neither agree nor disagree
d. Agree
e. Strongly agree

IV. OPPORTUNITIES FOR IMPROVEMENT

13. What barriers, if any, made it difficult for you to participate in SMHSP activities?
(Select all that apply)

a. Limited time
b. Staffing shortages
c. Competing priorities
d. Limited administrative support
e. Technology challenges
f. Training content not relevant
g. Training complexity or workload
h. Practices not culturally aligned
i. None
j. Other (please specify): _____

14. What barriers, if any, made it difficult for you to use SMHSP practices in your work? *(Select all that apply)*

a. Limited administrative support
b. Technology challenges
c. Training content not relevant
d. Difficult engaging families
e. Practices not culturally aligned
f. None
g. Other (please specify): _____

15. Which SMHSP components should be strengthened or improved?
(Select all that apply)

a. Training content
b. Coaching/implementation support
c. Other program activities (e.g., communities of practice, learning collaboratives)
d. Resources/tools
e. Communication about opportunities
f. Use of data and continuous quality improvement (CQI)
g. Program follow-up
h. Relevance to rural and/or underserved communities
i. Other (please specify): _____

16. What additional supports or resources would help you use SMHSP practices more effectively?

V. PARTNERSHIP EFFECTIVENESS

17. SMHSP has...

	Strongly Disagree	*Disagree*	*Neither Disagree nor Agree*	*Agree*	*Strongly Agree*
Strengthened collaboration within my school (across staff, roles, or departments).	☐	☐	☐	☐	☐
Improved coordination between our school and district or BOCES partners.	☐	☐	☐	☐	☐
Improved coordination with community mental health providers or referral partners.	☐	☐	☐	☐	☐

18. How could partnerships across schools, districts, or community providers be strengthened to better support student mental health?

VI. EQUITY

19. SMHSP helped...

	Strongly Disagree	*Disagree*	*Neither Disagree nor Agree*	*Agree*	*Strongly Agree*
Address mental health needs among underserved students in my school (e.g., rural, low-income, students of color, multilingual learners).	☐	☐	☐	☐	☐
Our school address structural barriers unique to our community (e.g., staffing shortages, limited resources).	☐	☐	☐	☐	☐

VII. WRAP-UP

20. Is there anything else that you would like to share about SMHSP?

21. Please provide your email address if you are interested in being contacted to participate in a virtual focus group to share more about your experience with SMHSP.

Appendix C: Focus Group Guide

Focus Group Guide

Audience: Teachers, school staff, mental health providers, and other school personnel who participated in SMHSP

Length: 60–75 minutes

Mode: Virtual (Zoom)

WELCOME & INTRODUCTIONS (5 MINUTES)

Facilitator script:

Thank you for being here today. My name is _____ from the Center for Policy Research (CPR). We are conducting the external evaluation of the School Mental Health Support Program (SMHSP), funded by the Behavioral Health Administration. The purpose of today's conversation is to learn about your experiences with SMHSP—what has worked well, what challenges remain, and how the program could better support you, your students, and your school community.

Your participation is voluntary. You may skip any question, and you may stop at any time. Nothing you say will be shared with your school or administrators in a way that identifies you. Nothing you share will be linked back to you. We'll report only general themes and will remove all identifying details.

With your permission, we would like to record this session.

The recording is only for our internal note taking so we can make sure we accurately capture your ideas. It will not be shared outside the evaluation team.

Is everyone comfortable with us recording today's discussion?
(If yes, begin recording. If not, proceed without recording)

To help our conversation flow smoothly:

- We'll take turns so everyone can share.
- There's no pressure to agree; all perspectives are welcome.
- Please speak from your own experiences, whatever feels comfortable.
- And as a reminder, everything shared here stays within this group.

Warm-up question:

- Please introduce yourself: share your name, your role, how long you've been in education, and one word that describes this school year so far.

EXPERIENCES WITH SMHSP TRAININGS & SUPPORTS

1. **How did you first learn about and begin participating in SMHSP?**
    - What motivated you to participate?
    - How clear was the purpose of the program at the outset?

2. **How would you describe the overall quality of the SMHSP activities you participated in?**
    - What stood out as high-quality?
    - Where did quality feel uneven?

3. **What changes, if any, have you noticed in your own skills or confidence after participating in SMHSP?**
    - Trauma-responsive practices
    - Classroom management / addressing challenging behaviors
    - Managing student suicide risk

4. **Has SMHSP changed how prepared you feel to support students at risk of self- harm or suicide?**
    - What tools or guidance were most helpful?
    - What still feels challenging?

5. **How has SMHSP influenced your day-to-day work with students?**
    - Any specific practices you use more often now? Can you give me an example?
    - Any shifts in how you respond to student behavior or distress?

IMPACTS ON EDUCATOR WELL-BEING & RETENTION

6. **How has SMHSP influenced your well-being as an educator?**
    - Stress levels
    - Burnout
    - Feeling supported

7. **Has the program influenced your intentions around staying in or leaving the profession? If so, how?**

8. **What additional supports would help you feel more confident or sustained in your role?**

STUDENT IMPACTS

9. **Have you noticed changes in student behavior, engagement, or well-being that you attribute to SMHSP?** *Prompts:*
    - Emotion regulation
    - Use of CBT/mindfulness strategies
    - Peer relationships
    - Classroom behavior / de-escalation
    - Attendance or participation

IMPLEMENTATION EXPERIENCE & BARRIERS

10. **What made it easy to implement SMHSP practices in your school?** *Prompts:*
    - Support from SMHSP implementer
    - School buy-in to program
    - Time and capacity to participate in SMHSP
    - Time and capacity to implement the practices

11. **What made it difficult or created barriers?** *Prompts*:
    - Time
    - Competing priorities
    - Staff capacity
    - Administrative support
    - Technology
    - Parent/caregiver engagement
    - Cultural relevance

12. **What would make it easier for schools like yours to use SMHSP practices consistently?**

RURAL & UNDERSERVED CONTEXTS

13. **How well does SMHSP address the unique needs of rural or underserved schools?**
    - Staffing shortages
    - Limited access to providers
    - Technology challenges
    - Cultural or community-specific considerations

14. **Did your school face any structural barriers to participating in SMHSP?**

15. **How could the program better support rural or underserved communities?**

PARTNERSHIPS & COORDINATION

16. **Has SMHSP improved coordination within your school, your district, or with community mental health partners? Tell us how?**

17. **What additional partnership supports would be helpful?**

OVERALL REFLECTIONS & RECOMMENDATIONS

18. **What do you think is the biggest strength of SMHSP so far?**

19. **What is one thing you would change or improve?**

20. **What supports or resources would help SMHSP have a deeper impact on your school or community?**

21. **Anything else you want to add that we didn't touch on or ask about?**

Facilitator script (closing):

Thank you so much for your time and insight today. Your perspectives are incredibly valuable and will help strengthen future iterations of the SMHSP program. We'll be incorporating what we heard into the annual evaluation reports.

If you have any additional reflections or questions after today, please feel free to reach out, our email addresses are in the chat.