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Factors Impacting Implementation of Evidence-Based Strategies to Create Safe and Supportive Schools for Sexual and Gender Minority Students

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A B S T R A C T

Purpose: The Centers for Disease Control and Prevention recommends six evidence-based strategies to improve safety and support for sexual and gender minority (SGM) youth in U.S. schools. However, only a small minority of schools implement all strategies. This study draws on implementation science to assess contextual challenges to strategy implementation.
Methods: Semistructured interviews were conducted with at least two stakeholders at each of 42 high schools in New Mexico. Interviews consisted of open-ended questions centered on attitudes toward, access to, and availability of school and community supports for SGM youth, school policies, and practices, and organizational factors believed to impact implementation. Transcripts were imported into NVivo 11 for iterative coding and qualitative analysis.
Results: We identified eleven overarching sets of factors related to the preparedness of schools to implement the evidence-based strategies: (1) political climate; (2) community context; (3) community resources; (4) policies and practices; (5) staff knowledge and exposure to SGM issues; (6) training deficits; (7) prevalence of neutrality discourses suggesting SGM students should not be singled out for "special treatment" or intervention; (8) student attitudes and support; (9) *de facto* safe spaces; (10) health education curricula; and (11) pragmatic considerations, such as time, staff turnover, and workloads. Key factors believed to hinder implementation included lack of resources, staffing concerns, and knowledge deficits.
Conclusions: These results can be used to inform the development of implementation strategies to modify school health systems from within to best support evidence-based practices for SGM youth and other stigmatized populations.

IMPLICATIONS AND CONTRIBUTIONS

Sexual and gender minority youth suffer from many health disparities. Qualitative interviews with school staff identified key factors believed to impact schools' abilities to implement evidence-based strategies to better support sexual and gender minority youth. Increased attention to these factors as part of implementation readiness assessment and planning is essential.

Sexual and gender minority (SGM) youth—lesbian, gay, bisexual, and transgender and queer, questioning, two-spirit, and gender nonconforming adolescents—are at increased risk for negative mental health outcomes, including depression, suicide, and substance use, compared to their heterosexual and cisgender counterparts [1–6]. Youth who are SGM report high levels of family and peer rejection [7] and are less likely to receive support from

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teachers [8]. They also experience higher levels of harassment, victimization, and violence [9–11].

Interventions to improve SGM youth outcomes are more likely to exert an impact when considering the context in which risk occurs [12–14]. A supportive, safe school environment is imperative to a comprehensive public health approach for SGM youth [6], and the United States Centers for Disease Control and Prevention recommends six evidence-based strategies [15,16]. These strategies include: (1) "safe spaces" on campus [16]; (2) policies prohibiting harassment and bullying based on sexual orientation or gender expression [17]; (3) facilitating access to medical providers experienced in services for SGM youth [18]; (4) facilitating access to behavioral health providers experienced in services for SGM youth [19]; (5) staff professional development on safe, supportive school environments [20]; and (6) SGM-relevant health education curricula [21]. Despite evidence that these strategies enhance youth outcomes, only 12% of secondary school administrators nationwide report implementing all six [15]. This study examines factors impacting the readiness of schools to implement these Centers for Disease Control and Prevention strategies.

Successful integration of evidence-based practice and policies into real-world settings requires consideration of contextual factors at multiple levels (e.g., students, teachers, administrators, community) [13]. Across implementation science (IS) frameworks [22–24], these factors are categorized as occurring in the "inner context" (e.g., school staff and students) and "outer context" (e.g., the community in which a school is located and attendant policies and resources). The exploration, preparation, implementation, sustainment (EPIS) framework (Figure 1) was designed for public sector settings and frames implementation as a multiphased process, emphasizing the role of outer- and inner-context factors throughout each phase [24]. Despite a high degree of overlap across IS frameworks [22], there is limited research applying them to interventions to reduce disparities among stigmatized populations. Stigma and discrimination toward SGM people can derail the implementation of supportive strategies. Therefore, there is a need to better understand how contextual factors common to IS frameworks (e.g., staff attitudes, leadership buy-in, community advocacy, policies) operate when applying evidence-based practices to stigmatized populations. More specifically, there is a need to better understand how stigma and discrimination impact implementation readiness (i.e., the exploration and preparation processes that occur before active implementation begins), as contextual factors during this period can significantly impact implementation success [25].

This qualitative study is part of a larger cluster-randomized trial in New Mexico [26] that randomized high schools to an intervention condition in which school health professionals received training and support to lead their school's implementation of the six strategies or a waitlist control condition. Interview data were collected during the Exploration/Preparation phase to address the following research question: How do implementation challenges for SGM guidelines in schools align with, expand on, and contrast with existing knowledge of contextual factors at the inner and outer context of implementation?

Methods

Public high schools in New Mexico were contacted by email and phone to request participation in the larger cluster-randomized trial. Figure 2 offers recruitment and enrollment details. A total of 42 high schools, representing 22 school districts, ultimately enrolled in the study. Forty-percent of schools were in rural areas. No statistical differences were found in the participation rates of public schools across the four public health regions of the state.

Using purposive sampling, three anthropologists administered 45–60-minute semistructured interviews with at least two stakeholders at each high school prior to randomization to intervention or control conditions. School administrators were selected as they were responsible for their school's decision to participate in this project. School health professionals were selected as they were the individuals charged with leading or co-leading the implementation as part of the study protocol. Ninety-six interviews were conducted with school administrators (n = 41; e.g., principal, vice principal) and school health professionals (n = 55; e.g., school nurse, social worker, counselor) in their offices during the 2016–2017 school year. Participants averaged age 47 with 7 years of employment at their schools. Two-thirds of participants were female, with one transgender female participant. Participant race was reported as white (81%), Native American (9%), and black (3%). Forty-four percent reported Hispanic/Latino ethnicity.

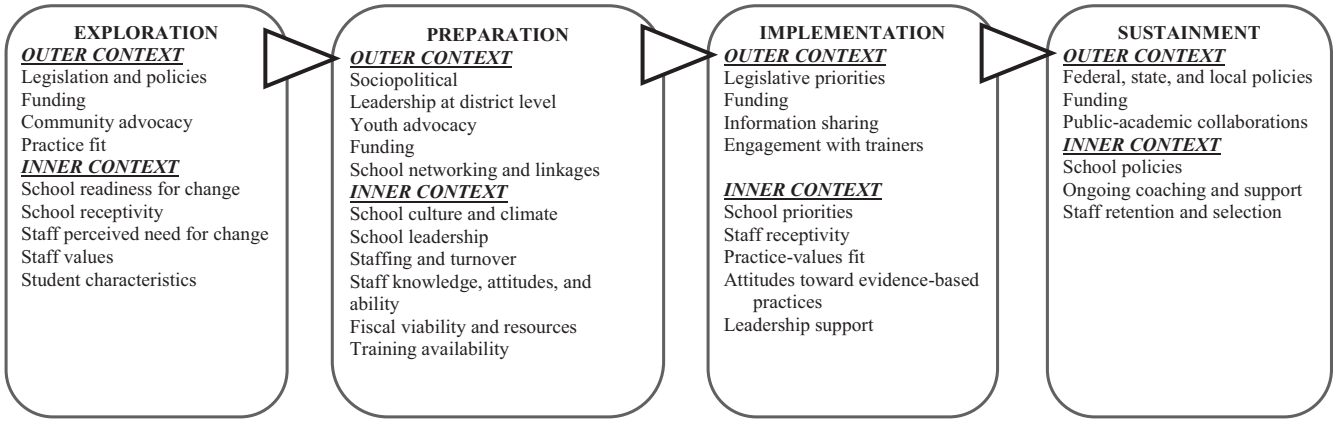

Figure 1. This adapted figure [24, 38] depicts examples of factors in the outer- and inner-contexts to be considered in each phase of the exploration, preparation, implementation, sustainment framework.

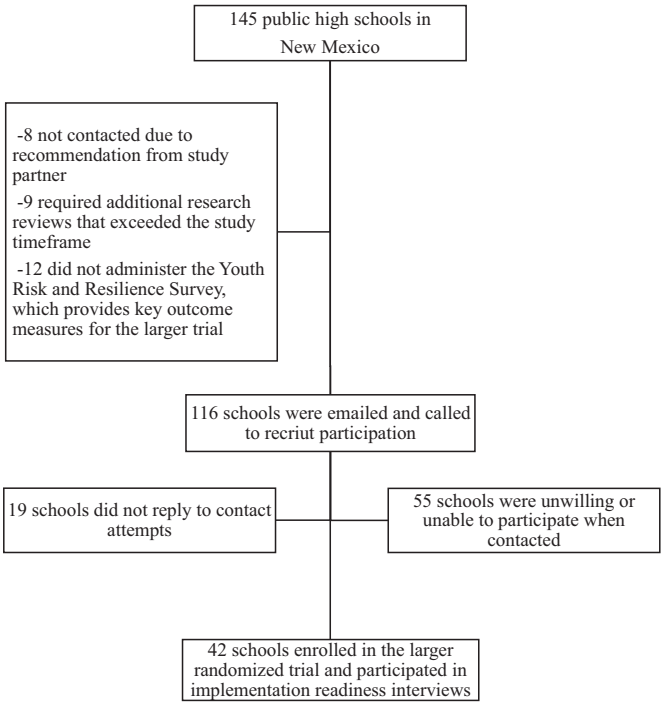

Figure 2. High school recruitment and enrollment.

Interview guides covered key inner- and outer-context factors identified in the Exploration/Preparation phases of the EPIS framework (e.g., attitudes, school policies and practices, organizational factors, leadership support) as well as school and community supports and barriers to support for SGM youth.

We digitally recorded and professionally transcribed the interviews, importing transcripts into an NVivo database for analysis via iterative readings or codings using grounded theory methods [27]. To ensure reliability and rigor in the identification of themes, two members of the research team independently coded sets of transcripts, creating a codebook to guide this process and detailed memos describing and linking codes to each theme. These codes centered on key inner- and outer-context factors (e.g., "staff turnover," "political climate," and "lack of knowledge"). During the transcript review, new codes were subsequently identified and defined to capture information on emergent issues (e.g., "special treatment of SGM youth" and "anti-SGM stigma among staff"). Focused coding was then used to determine which issues surfaced frequently and which represented concerns of the individual research participants [28]. The final codes, constructed through a consensus of the coders and authors, consisted of sets of inner and outer-context factors believed to impact the ability to implement the six evidence-based strategies. The Human Research Protections Program of the Pacific Institute for Research and Evaluation approved the study protocol and informed consent procedures.

Results

We derived eleven factors related to school readiness to implement strategies to support SGM youth. Outer-context factors included: (1) political climate; (2) community context not accepting of SGM issues; (3) community resources; and (4) policies and practices. Inner-context factors included: (5) knowledge and exposure to SGM issues among school staff; (6) training deficits among school staff; (7) prevalence of neutrality discourses suggesting SGM students should not be singled out for "special treatment" or intervention; (8) student attitudes and support; (9) *de facto* safe spaces; (10) health education curricula; and (11) pragmatic considerations. We provide quotations exemplifying the views and experiences of the participants to illuminate each set of factors, editing some quotations to enhance readability.

Outer-context factors

Political climate. Participants pointed to a fear of potentially hostile political ideologies that present challenges to implementing positive changes for SGM youth. Much of this fear was shaped by recent media coverage of SGM issues and a tumultuous political campaign season at both state and national levels, and by personal observations locally. One principal explained,

> "The political climate of the nation. . .[is]. . .trickling down. I have felt and seen some changes that aren't so positive. Just some heaviness—where people were feeling a little bit more confident to go forward, I think they're retreating into their isolations. That hurts my heart."

A second principal described rights for SGM individual as the major "civil rights struggle" of our day, while expressing concern about how political changes nationally might impact progress:

> "Legally there must be some protection—a way of ensuring that this is a recognized legal issue process that protects SGM people equally as others because there is such a frustration right

now because of the politics that we have seen develop this last election cycle... Potentially, legally, and otherwise, we need to ensure that we create environments that will permit students to be comfortable."

Community context. Among our participants there was alarm expressed about socially conservative orientations within the surrounding community, including the perception that the community lacked understanding of what it means to be SGM. As one nurse stated,

"There's a lot of our community that still feels like you can just learn how to be a different way because they just don't understand.... Until you've had that experience where someone close to you has gone through it, it's hard for you to understand."

Participants also brought up concerns about how parents and caregivers would respond to changes in the schools aimed at supporting and including SGM youth. One nurse described parents in the community as, "very, very old school.... A lot of the kids here identify at school but not at home..." Participants living in smaller, tight-knit rural communities where their families had lived and worked for generations also expressed concern that they might be criticized or even ostracized by others locally for championing SGM issues in schools.

Community resources. Outside of metropolitan areas, participants noted there was minimal choice regarding medical or behavioral health providers. Some referred to a school-based health center or public health office as receptive spaces for SGM youth, but not all communities had access to such a center/office, or the local center/office was understaffed. Participants stated that although they expect providers to be affirming of SGM individuals, they were unsure whether this is the case. In general, participants had little awareness of SGM resources, including advocacy organizations. For example, when asked about community resources to support SGM youth, one principal stated, "I have no knowledge on that."

Policies and practices. Participants (including principals) often thought school and district policies were inclusive of SGM students, but could rarely say for sure. Policies affecting transgender and gender nonconforming students were of paramount concern particularly as they related to bathroom usage and physical education. One nurse clarified,

"We do not have a genderless bathroom. For some of our kids changing for physical education because they don't have locker rooms or just even going to the bathroom throughout the day, we want to make sure that they have a place where they feel safe."

Media coverage was again implicated in shaping the general understanding of participants regarding school policy issues impacting transgender and gender nonconforming students.

Inner-context factors

Staff knowledge. There was a consensus that staff lacks knowledge and awareness of SGM issues. In places where knowledge was reported, it was often limited to one or a few individuals, usually the SGM-identified school staff. As one nurse noted,

"You had five professionals in the room this morning and two had to get clarification before you had come and definitions and the other three had no exposure and those are the people that we've identified as probably the best to support these children...."

There were also instances where participants suspected that they did not have any of "those" students at their school, and thus did not think the strategies would apply to their school community. The lack of knowledge also related to identified training and education needs among school staff in SGM youth issues.

Training deficits. Few participants reported regular schoolwide training to staff on bullying and harassment. Similarly, few schools offered schoolwide training in suicide prevention. When asked about training on safe school environments, most participants described training on natural disasters or violent attacks. Outside the state's largest metropolitan area, no schools had sponsored training on SGM issues.

Neutrality discourses. Several participants expressed hesitation at the concept of singling out SGM students for "special treatment" or intervention, often stating they "treat all students the same." These participants called attention to the belief that school staff should be able to treat SGM students just like all other students and that, accordingly, there was no need to provide additional support that other students would not receive. Such views were reinforced by the reportedly common perception that SGM youth did not warrant the additional expenditures of time, effort, and resources because they represented such a small proportion of the overall student body.

Student attitudes and support. There was a general sentiment held by participants across schools that students were more affirmative toward their SGM peers than were fellow staffs. Participants discussed students' ability to advocate for each other and stated that "it's the adults" who have the problems with the SGM population rather than students. One nurse described an instance when students advocated for one of their transgender peers.

"Our students are really good at standing up for each other. We have a student who is trans.... The Spanish teacher kept wanting him to use female pronouns because that's how the teacher was perceiving him and the other students were like, "Hey you might think that he's a girl but he's not and he wants to use the male pronouns." That's really cool to see the other students stand up for that."

De facto safe spaces. Offices of school nurse, counselors, and social workers were portrayed as the main "safe spaces" for SGM students on campus. Participants explained that students came to these offices through informal channels, mostly by "word of mouth." A few principals claimed their offices were safe spaces, but also confided that students were not coming to them to address SGM issues. Safe Zone emblems to identify safe spaces were mostly observed in schools in metropolitan areas, or in school-based health centers. Similarly, there was a dearth of genders and sexualities alliances outside these areas. Regarding a recently dissolved GSA, a nurse stated, "The administration required a sign in sheet so [club sponsor] didn't feel comfortable writing their names down. I understand where he's coming from."

Health education curricula. Participants were often unsure whether their current health education curricula were inclusive of information relevant to SGM students or addressed SGM concerns. Most believed that curricula were not inclusive and that health educators would welcome assistance in determining changes for existing curricula and texts. A minority speculated that students could access SGM-relevant health education materials from the nurse's office or the school-based health center.

Pragmatic considerations. Participants raised apprehensions related to school leadership, workplace, and workforce issues, noting that staff had excessive workloads and time constraint that would limit their ability to implement the strategies in their schools. Turnover of staff and leadership would also imperil prospects of lasting changes, with one counselor remarking, "Last year we had two different principals. . .Over the past 10 years we've gone through 12 principals" More specifically, turnover could disrupt school change initiatives that take time, dedication, and local buy-in and support to achieve.

Discussion

Evidence-based strategies to ensure school safety and supports for SGM youth in the U.S. remain underutilized nationwide [15]. This qualitative study highlights several outer- and inner-context factors impacting the ability of high schools and their staff to implement these evidence-based strategies. Concerns relating to stigma associated with the target population were prominent throughout the findings and have implications for enhancing the readiness of schools to undertake changes in policy and practice.

Nonstigma factors at the outer context included lack of availability and knowledge of existing community resources. This dearth of resources was compounded by stigma-related concerns of a community ideology that was unaccommodating of SGM people and worries about the safety of SGM youth outside school milieus. An additional outer-context factor related to the almost ubiquitous unfamiliarity with school and district policies among participants. This lack of staff awareness regarding existing school policies replicates past findings [29,30], and lessens the impact of policy implementation. In addition to enacting policies to support SGM youth, school leaders should regularly remind staff and provide training on how to implement them appropriately. Echoing past findings [31], stigma-related policy concerns were especially prevalent and focused on apprehension that the community would respond negatively to school policy and practice changes that support SGM youth. As others have suggested [31–33], framing policy change within a social justice lens that allows schools and communities to examine the injustice in current policies and work to reduce disparities for the population is a promising approach. Notably, there was little discussion among our 96 stakeholders related to referrals to SGM-appropriate health and behavioral health providers. This may imply a lack of knowledge and awareness among these stakeholders or perceptions that they are not available or needed

Similarly, inner-context barriers to implementation included a mix of nonstigma factors that could hinder practice changes in schools and challenges directly germane to anti-SGM stigma. Time constraints, staff and leadership turnover, and other pragmatic considerations highlighted in the EPIS model [24] strongly emerged as did a lack of knowledge of behavioral health issues and the health education curriculum, and insufficient school training in bullying, harassment, and suicide prevention and intervention. Stigma-related concerns centered on the negative attitudes of school staff and leadership toward SGM youth. Stigma likely contributed to the invisibility of SGM youth among staff who believe such students are not attending their and can hinder motivation to collaborate on initiatives to reduce SGM disparities.

Our study points to several facilitators to support SGM youth in schools. Of note, metropolitan areas of the state were most likely to have resources, including training and knowledgeable staff. Student bodies were often portrayed as having more positive attitudes toward SGM youth than staff. School-based health centers were also recognized as supportive places and as venues where students may be able to access health education materials inclusive of SGM issues. Our findings suggest that youth may have roles to play in implementing evidence-based school practices to support SGM students, as do school-based health center staff.

However, we found a high degree of interest among school administrators and school staff in policies and practices supportive of transgender and gender nonconforming youth, in addition to a sense that their awareness of these policies, practices, and students more generally was still emergent and largely shaped by media portrayals of public debates concerning this population. Most comments pertaining to these students largely focused on school policies related to use of bathrooms and physical education. This finding does suggest a readiness on the part of schools to address school supports for transgender and gender nonconforming students.

Finally, as school administrators and staff proceed with implementing the evidence-based strategies, they must strive to challenge discourses that call for all students to be treated the same, regardless of sexuality or gender. While often invoked for well-intentioned purposes, i.e., to affirm all students are equal regardless of personal characteristics, such discourses can be harmful by masking stakeholder biases, contributing to continued minority stress and health disparities for SGM youth, and deterring attention from power imbalances that enable anti-SGM attitudes and behaviors, including stigmatization and discrimination, to proliferate in schools [34].

In terms of limitations, schools and staff taking part in this study likely face different challenges and embody different opinions compared to those in schools that did not elect to participate in the larger cluster-randomized trial. Although our participants may have already been more supportive of SGM students or had vested interests in portraying themselves and their schools in a positive light, the majority conceded their own dearth of knowledge and experience in addressing issues of sexuality and gender. Such admissions clarify the need to prioritize professional staff development and education to make schools safer. Additionally, our study would have been strengthened through inclusion of student voice. Our study protocol ensured that no data would be collected from individual students, a process which would have required parental notification and limited school participation.

Research on improving school environments through policies, programs, and interventions that enhance system-level protective factors for SGM students is essential [6]. Per IS frameworks, a multilevel approach to implementation readiness should be employed [22–24]. Our study illuminates key factors across multiple levels of influence that can thwart initiatives to implement these strategies. A number of implementation strategies can be employed to help schools succeed in creating a positive school climate for SGM youth [35]. For example, to enhance the likelihood of implementation success [25], we suggest that school personnel dedicate time

to assess the readiness of their schools to implement policies and practices to support SGM youth prior to adoption. We also suggest that school personnel identify school champions and advocates for SGM youth and enlist their support to lead implementation efforts. A coalition approach that recruits and cultivates relationships with supportive partners and includes school leadership representation can also enhance implementation efforts [36]. Through this approach, coalition members can plan and enact "action plans" to assist schools in implementation. Action plans incorporate strategies to address implementation barriers and facilitators derived from school readiness assessments, prioritize goals, create actionable steps toward goals, and delineate roles and responsibilities [26]. For example, schools with strong alliances from heterosexual, cisgender peers may involve these youth in action planning and implementation to facilitate wider buy-in. Moreover, schools reporting a dearth of community resources can start with school-level changes, such as cultivating safe spaces and implementing supportive school policies, while providing a social justice framing of such initiatives for concerned community members [33]. Attending to stigma and nonstigma factors spanning inner- and outer-contexts as part of implementation readiness is as crucial as the evidence-based strategies themselves. Without proper preparation, most change initiatives fail [37]. Careful attention to factors believed to impact the implementation of change is vital to advancing safer school environments for SGM students [26].

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