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Implementing Evidence-Informed Practices to Make Schools Safer and More Supportive of Sexual and Gender Minority Youth

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The importance of safe and supportive school climates to the well-being of sexual and gender minority (SGM) youth— those that identify as lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ+)—is undisputed.[1] Public health, adolescent health, and school health authorities[2–4] have identified evidence-informed practices to create safer and more supportive school environments for SGM youth, but implementation efforts have lagged in the United States.[5,6] A review of national trends found that secondary schools had made little progress from 2008 to 2014, with only 1 of 8 practices examined, the creation of safe spaces, having increased implementation over the years.[7]

In 2015, we initiated the Implementing School Strategies to Reduce LGBTQ+ Adolescent Suicide (RLAS) study[8] to address the gap between the identification of evidence-informed school practices that support SGM youth and their implementation in school settings. The RLAS study[8] is a cluster randomized controlled trial that enrolled 42 public high schools in a southwestern US state.

In 19 intervention schools, study coaches supported teams (typically 3–5 school employees) that championed the implementation or scale up of 6 evidence-informed school practices supportive of SGM youth: (1) professional development on safe and supportive school environments for SGM students; (2) “safe spaces” at schools where SGM youth can receive support; (3) prohibitions of harassment and bullying based on a student’s perceived or actual

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Human Subjects Approval Statement

Preparation of paper did not involve research with human subjects.

sexual orientation or gender identity; (4) health education curricula relevant to SGM youth; (5) access to community providers with experience delivering sexual and reproductive health services to SGM youth; and (6) facilitating access to community providers with experience in providing social and psychological services to SGM youth. The remaining delayed intervention schools receive support from coaches in the final year of the study.

In this paper, we report on lessons learned from 3 years of supporting intervention schools and offer practical suggestions for implementing these practices based on individual, school, and community factors found to influence their implementation. Our lessons learned may have applicability beyond SGM youth health to support other efforts to implement health interventions in the school setting.

KEY ELEMENTS FOR SUCCESS

Involve School Health Professional Leadership

The state school nurse association and the state department of health were actively involved in the RLAS project, including prior to implementation. These stakeholders were crucial in raising awareness about the importance of school climate to adolescent health, normalizing conversations about SGM health risks in socially conservative environments, and promoting understanding of the roles and responsibilities of school nurses and other school health professionals in addressing SGM students' needs. The state school nurse association has been such a key collaborator that our trainings for the study have been held in partnership with their annual conference.

Leverage Support of School Administrators

Support from school administration was critical for successful implementation. Administrators set expectations for staff by explicitly stating that the wellbeing of LGTBQ+ youth was a priority for their schools. Particularly impactful demonstrations of support included direct involvement with school teams, personally introducing and attending SGM focused staff professional development (PD) sessions, and making PD mandatory. Regardless of administrators' level of active participation, school teams needed to ensure that administrators were informed of efforts and supportive of policy and practice changes.

Build Effective School Teams

Optimal school teams benefited from diverse membership, including school health personnel, those with influence within schools and, when possible, those who self-identified as SGM. School teams with school health professionals (eg, nurses, health educators, and counselors) were able to capitalize on their authority in promoting health-related school changes. "Influencers" within schools (eg, staff with long-standing tenure) had the knowledge, relationships, and power necessary to accomplish action items. Members of the SGM community brought experience and passion that was often motivating. In our study, school teams included representatives from a variety of school sectors ranging from teachers, administrators, counselors, health educators, librarians, school nurses, school social workers, community members, parents, and students.

Structure Team Meetings

Regular meetings were critical for planning, problem-solving, and sustaining momentum. Annual assessments and planning sessions took up to 2 hours, and subsequent team check-ins and problem-solving meetings as little as 30 minutes. School teams able to meet at least monthly accomplished more. Administrators were helpful in establishing set times, allocating space, and protecting staff time for meetings. Some teams met during allocated monthly PD times. To overcome scheduling challenges, other teams organized monthly meetings with smaller team sub-groups. Regular contact with the research coaches (in person or via phone) helped sustain momentum. Regular engagement also ensured continued involvement of team members and increasing their capacity to distribute responsibility for action items. Teams that were able to delegate specific tasks were more effective at accomplishing goals.

Prioritize Youth Voice

Youth input was critical to ensure that school activities addressed issues relevant to SGM youth. Often administrators and staff had unrealistically positive views of SGM student safety at their schools. At one school, teachers implemented changes to health curricula based on feedback from the Gender Sexuality Alliance (GSA), a student peer support and advocacy group. Youth suggested effective ways to engage students (eg, changing backgrounds on library computers to feature hotlines, using social media, etc.) and increased the impact of PD on staff when they voluntarily spoke about their experiences.

Together, diverse school teams with shared knowledge and responsibilities, regular meetings, and administrative and youth involvement help mitigate the negative impacts of inevitable school turnover—an on-going problem that can undermine the successful implementation of any new school health initiative.

IMPLEMENTING PRACTICE CHANGES

Based on our experiences, practice changes attempted by schools fit into 2 broad categories. Foundational practice changes were easier actions to implement, made a strong impact, and paved the way for future practice changes. More challenging practice changes were those schools struggled with most because they relied on district or state level changes as well as broader community resourcing.

Foundational Practice Changes

Most schools benefitted from several early steps. First, a self-assessment allowed schools to evaluate their status *vis-à-vis* evidence-informed supportive school practices and assisted in action planning. Second, providing PD for staff laid the educational groundwork for further action. Third, Safe Zones programs and GSAs communicated to students that staff were actively working to improve the school culture and climate.

Self-Assessment.—During the first year, school teams worked with RLAS coaches to conduct detailed school self-assessments to gather data on the current state of each school-based practice supportive of SGM youth at their schools. The self-assessment

instrument was based on published research, instilling authority that helped some reluctant administrators support the effort. Team members rated each item as either present, absent, or unknown. The unknown elements prompted team members to collaborate with others at their schools to find answers. The initial self-assessment was supported by annual re-assessments that allowed schools to monitor progress toward goals.

Providing PD.—Most school teams started with providing PD for their school staff. Trainings like LGBTQ+ 101, Transgender 101, and suicide prevention trainings were foundational in inspiring school staff to make further changes varying from personal language use to school policies. Professional development that was mandated communicated the importance of the content and that shifts in climate and culture were needed. Optimal PD went beyond familiarizing staff with SGM terminology, to prioritizing practical ways schools could address health disparities. It was important to schedule PD at the beginning of the school year. PD scheduled at regular intervals buffered against staff turnover and when all support staff were included (eg, custodians, bus drivers, etc.), PD reinforced best practices and helped ensure that students might have support and safety no matter where they were at school. School staff, including administrators, were sometimes unaware of the benefits of PD related to SGM topics. Team members who anticipated possible reluctance and communicated the benefits of PD helped reduce any negative feedback.

Safe zones and GSAs.—Schools chose early to focus on creating safer spaces for SGM students, which included implementing safe zones[9] or other similar programming, creating or strengthening their GSAs, or making sure SGM representation was evident throughout the school such as in library materials or on public-facing bulletin boards.

Developing a safe zones team engaged interested staff in assuring that safe spaces were available for SGM and other marginalized students. Safe zones[9] is a training program designed to recognize volunteers who self-identify as “safe” people or resources for SGM or other marginalized student groups. Those individuals post flyers, stickers, or other visual markers within their classrooms, or offices or on the doors to their spaces to notify students of their participation as a safe zone.

GSAs varied from informal lunch gatherings to robust clubs that participated in community advocacy activities. Schools made sure that SGM safe spaces were in multiple locations throughout the schools. SGM affirming books in the libraries, making sure single use bathrooms were gender neutral, and displaying SGM affirming and supportive information (including crisis or suicide helplines) on school billboards were high impact steps that schools took.

More Challenging Practice Changes

A majority of schools faced difficulty implementing practice changes where the locus of change was rooted in district, community, and state level contexts often outside of individual teams’ spheres of influence.

Prohibiting bullying and harassment.—School policy changes prohibiting bullying and harassment to protect students’ actual or perceived sexual orientation or gender identity

were controlled at the district level. School teams had limited influence at the district level; however, district leadership at one school supported district-wide policy changes. Fortunately, during the RLAS study, our state passed legislation requiring comprehensive bullying prevention policies at all school districts and charter schools. These changes included ensuring protections for sexual orientation and gender identity. Our study coaches helped school teams navigate the implementation of best practices in accordance with the policy.

Implementing inclusive health education.—In our state, schools do not have required health education curricula. Instead, the interpretation of state health education standards and benchmarks and the choosing or designing of educational material is left up to individuals at the schools who are responsible for teaching health education. While changing health curriculum in a sustainable manner across schools requires changing state policy, the RLAS coaches helped health education staff assess curricula and inclusive resources and trainings.

Facilitating access to SGM affirming and competent services.—By far the most difficult practices to implement were those that focused on facilitating access to SGM affirming and competent community services. School teams have no control over what community resources are available or how SGM friendly those resources might be. For schools located in rural and underserved areas, the lack of services and health care providers was a major obstacle. To assist schools in facilitating access, the coaches developed a guidance document to help school personnel vet health care providers in their communities, and direct students to affirming and competent care.

IMPLICATIONS FOR SCHOOL HEALTH AND EQUITY

In this paper, we report lessons learned over 3 years of supporting schools in their implementation of evidence-informed practices to make schools safer and more supportive of SGM youth. We identified key elements for success, steps for initiating change, more challenging aspects, and practice-specific considerations.

It is important to recognize that not all schools progress at the same pace; however, patience and persistence yield results. Whereas some participating schools, especially those in socially conservative communities, struggled to implement changes to support SGM youth, all made substantial shifts over time. It was critical for teams to work through resistance, address barriers, and challenges as they arose, and have a wide variety of people involved in the efforts.

These findings may aid other schools and school districts who wish to implement evidence-informed practices. Although these tips are specific to innovations focused on SGM youth, they have universal foundations in how schools might approach sustainable change at multiple levels to better support all students.

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