University of South Carolina

Scholar Commons

4-5-2022

A Mixed Method Study of Teachers' Appraisals of Student Wellness Services and Supports During COVID-19

Tasha M. Childs

Elizabeth Levine Brown

Naomi Brown

Aidyn Iachini Ph.D.

Kate Phillippo

See next page for additional authors

Author(s)

Tasha M. Childs, Elizabeth Levine Brown, Naomi Brown, Aidyn Iachini Ph.D., Kate Phillippo, Linda Galib, Audra Parker, and Ken Fujimoto

RESEARCH ARTICLE

A Mixed Method Study of Teachers' Appraisals of Student Wellness Services and Supports During COVID-19

TASHA M. CHILDS, MSW, LSW[a] (ID) ELIZABETH LEVINE BROWN, PhD[b] NAOMI BROWN, MA, LCSW[c] AIDYN L. IACHINI, PhD, MSW, LSW[d] (ID)
KATE PHILLIPPO, PhD[e] (ID) LINDA GALIB, MPH/MPP[f] AUDRA PARKER, PhD[g] (ID) KEN FUJIMOTO, PhD[h]

ABSTRACT

BACKGROUND: Understanding teachers' appraisals of student wellness services and supports during COVID-19 is essential to strengthening services and improving student health outcomes. This mixed-method study aimed to examine US PK-12 teachers' appraisals of student wellness services and supports during COVID-19.

METHODS: This study focuses on qualitative data from 291 teachers' open-ended responses to the question: "What do you wish your school leaders knew about this (wellness support) aspect of your work?" and whose responses described wellness services and supports. A qualitative content analysis was conducted by an interdisciplinary research team using open- and axial coding.

RESULTS: Three main themes emerged. (1) insufficient access to mental health professionals and programming at schools, (2) concern about the quality of available services, and (3) a need for teacher professional development and support on student wellness. Statistically significant differences in teacher appraisals of insufficient access to mental health professionals and programming were found based on grade level taught and percentage of immigrant students in the school.

CONCLUSION: With amplified student wellness needs, school personnel, including school leaders, must consider ways to allocate additional resources/staffing, assess the quality of services and supports, and design professional development opportunities to support teachers' involvement in supporting student wellness needs.

Keywords: student wellness; COVID-19; access; quality; teacher.

The COVID-19 pandemic profoundly disrupted the education and health of children and families across the nation.[1] Beyond widespread illness and death, other consequences associated with the ongoing pandemic include loss of family income, housing instability, isolation, and loss of routine and critical social services.[2] COVID-19 exacerbated the ongoing mental health and wellness needs of children and youth also,[3-4] with pediatric emergency room visits higher now due to mental health issues rather than physical injuries,[5] and schools reporting heightened rates of uncertainty, anxiety, and grief for children and youth.[3]

Teachers have always served as liaisons to school-based health and wellness services, often being the first ones to experience signs of student distress

[a] PhD Candidate, (tashah@email.sc.edu), College of Social Work, University of South Carolina, 1512 Pendleton Street, Columbia, SC 29209.

[b] Associate Professor, (ebrown11@gmu.edu), College of Education and Human Development, George Mason University, 4400 University Drive, 1804 Thompson Hall, MS 4B3, Fairfax, VA 22030.

[c] PhD Student, (nbrown27@gmu.edu), College of Education and Human Development, George Mason University, 4400 University Drive, 1804 Thompson Hall, Fairfax, VA 22030.

[d] Associate Professor, (iachini@mailbox.sc.edu), College of Social Work, University of South Carolina, 1512 Pendleton Street, Hamilton 332, Columbia, SC 29209.

[e] Professor, (kphillippo@luc.edu), School of Social Work and School of Education, Loyola University Chicago, 1 East Pearson Street, Fifth Floor, Chicago, IL 60611.

[f] PhD Student, (lgalib@luc.edu), School of Education, Loyola University Chicago, 820 North Michigan Avenue, 11th Floor, Chicago, IL 60611.

[g] Associate Professor, (aparke19@gmu.edu), College of Education and Human Development, George Mason University, Fairfax, VA.

[h] Associate Professor, (kfujimoto@luc.edu), School of Education, Loyola University Chicago, 820 North Michigan Avenue, 11th Floor, Chicago, IL 60611.

Address correspondence to: Tasha M. Childs, PhD Candidate, (tashah@email.sc.edu), College of Social Work, University of South Carolina, 1512 Pendleton Street, Columbia, SC 29209.

in the classroom.[6-7] However, during the pandemic more than ever, teachers are frontline responders identifying, reporting, and responding to students' wellness needs.[8-9] Especially during school lockdowns and virtual learning, teachers were often the only school staff who had direct contact with children and youth and who were in positions to observe and support students' wellness needs.

Recent studies have identified the types of wellness services and supports provided in schools during the pandemic (ie, school social workers).[10] However, few studies have examined teachers' appraisals of these wellness services and supports. While some districts offer support services to which teachers can refer students under current conditions,[11] others do not have sufficient support resources, reinforcing teachers' responsibility to address student wellness at an individual level, even as they too weather this crisis. As the pandemic continues, teachers' voices regarding wellness services and supports are critical to better address various components of the Whole School, Whole Community, Whole Child model (WSCC),[12-13] such as strengthening health services and psychological services to create healthy students, schools, and communities. The ecological lens of this model has implications for how schools and teachers can support student health.

Teachers' experiences with wellness services and supports may also differ based on school context (ie, type of school, type of community [ie, suburban, urban], etc.). For instance, students who may have limited access to health insurance and physical health care are most likely to access services in schools.[14] Similarly, students in need of mental health services and supports may be more likely to receive services in school than through any other service provider.[15] COVID-19 exacerbated structural inequalities for services in schools already existent, and placing these roles on teachers at times, making our understanding of teachers' appraisal of access and quality of student wellness services and supports even more important.[16]

This study drew from a larger (n = 2107) national mixed method study of US preschool through 12th grade (PK-12) teachers' experiences with student and teacher wellness needs during COVID-19.[17] In this study, we explore teachers' appraisals of student wellness services and supports during the pandemic through the following research questions: (1) What were teachers' appraisals of student wellness services and supports during the COVID-19 pandemic? and (2) Are there differences in teachers' appraisals of wellness services and supports based on the type of school, type of community, student enrollment demographics, and grade level they teach (e.g., PK-5, 6-8, 9-12)? This study was exploratory and descriptive in nature, and therefore no a priori hypotheses were examined.

METHODS

This study was conducted by an eight member inter-disciplinary research team with expertise in teacher education, social work, education policy, and clinical and developmental psychology. In summer 2020, following IRB approval, 2117 PK-12 teachers from 46 states completed an online survey. A convenience sampling method was used through distribution and subsequent recirculation of the survey link to teachers through national organization listservs, social media resources, university professional networks, state-level education department listservs, and local school district listservs. The survey took teachers approximately 20 minutes to complete and survey items focused on teacher and student health and wellness during the pandemic and demographic information.

One open-ended write-in question on the survey asked, ''What do you wish your school leaders knew about this (wellness support) aspect of your work?'' Of the 2117 teachers in the total sample, 1037 (49%) responded to this write-in question and 291 (28%) highlighted some aspect of wellness services and supports in their responses. Wellness services and supports were defined by the research team as any discussion of teachers': (1) request for help, (2) lack of confidence in student wellness supports, (3) quality of wellness professionals' work, (4) support of teachers' work, (5) professional guidance on wellness services, (6) mention of training or professional development, or (7) general reference of services or supports personnel or service (eg, social workers, counselors, mental health professionals, interventions, services). Remaining teacher respondents discussed other topics such as personal well-being, administrator competence, and systemic or ecological barriers. As such, these teacher responses were not analyzed for this study.

Participants

Of the 291 teachers who discussed wellness services and supports in the write-in question, the majority identified as white (75%, n = 219), followed by Latinx or Hispanic (12%, n = 33), African American or black (7%, n = 21), Asian (2.5%, n = 7), Native American or Alaskan Native (0.4%, n = 1), and Native Hawaiian or Pacific Islander (0.4%, n = 1). Most PK-12 teachers identified as female (87%, n = 248); male (11%, n = 30); Transgender, nonbinary or another gender (2%, n = 6). All the teachers were union members. Teachers ranged in age from 22 to 74 years old, with an average age of 44 years. Teachers taught across all grade levels with 36% teaching preschool to 5th grade (PK-5; n = 101), 30% teaching 9th to 12th grade (n = 85), 24% teaching 6th to 8th grade (n = 69), and about 10% teaching multiple grade levels (n = 28). Most teachers worked in traditional public schools

(74%, n = 213), followed by private schools (22%, n = 63), charter schools (2%, n = 7), and alternative schools (2%, n = 5). Teachers taught in a variety of school communities with 37% in large cities (n = 107), 29% in suburbs (n = 82), 20% in small cities (n = 56), and 15% in towns or rural areas (n = 42). On average, teachers had 15.5 years of teaching experience, ranging from 1 to 42 years.

Data Analysis

Open-ended survey responses and demographic data were entered into MaxQDA (Version 20.4.1).[18] To ensure we had a deep understanding of teachers' appraisals of wellness services and supports during the pandemic, we engaged in a multistaged analysis of the write-in responses. In stage one of our multistaged data-analysis process, the research team read all the responses to this open-ended survey question (n = 1037) to develop the initial codebook and began coding subsections of the data (eg, approximately 250-500 responses at a time). We reviewed 250 responses in dyadic teams and then regrouped as a full research team to confer on our initial codes from these first 250 responses. Dyads used coding software to assess inter-rater agreement of each dyad's codes, reviewing percent match of code application. We revisited codes with a high percent of mismatch, or low inter-rater agreement, to strengthen our initial code definition. Following we modified the codebook to reflect our preliminary structural coding process.[19] We conferred again as a whole team, reviewed reliability of results, consulted on any changes necessary to the modified codebook and finalized the codebook. Following, dyads analyzed the remaining 537 write-in responses.

In stage two of analysis, we sought to deepen our understanding of the Wellness Services and Supports code, beyond the general overall definitions to allow themes to emerge. Coding was conducted by an interdisciplinary dyad using LaRossa's open, axial, and selective coding model.[20] Open coding involved coding text representing teachers' knowledge, utilization, awareness, and access to wellness services and supports, which resulted in some of the initial codes. Thereafter, the dyad coders reviewed their open codes and developed a codebook for this subcode. Axial coding refined this Wellness Services and Supports codebook to collapse across open codes.[20] Coders kept memos for each coded response and when coding disagreements occurred, coders discussed those items (often related to discipline specific considerations) and agreed upon the code to apply. For example, team discourse led to the separation of the professional development and supports code into need for professional development and requests for mental health supports. Finally, selective coding involved taking the most robust codes to highlight the key ideas teachers shared about their experiences with wellness services and supports during the pandemic.

During these first two stages of analysis, we used several criteria (e.g., transferability, dependability, credibility, and confirmability) to ensure rigorous review of our qualitative data.[20] We used coders from different academic disciplines to ensure an interdisciplinary lens was reflected in the coding. We debriefed throughout the coding process and curtailed any emergent biases that informed analyses. We used memo writing[21] and consensus coding[19] during our final round of selective coding.

To answer our second research question, the team used crosstabs and typology analysis in MaxQDA within the Wellness Services and Supports qualitative subcode to examine any demographic differences across the subthemes. We used a Pearson's chi square to determine the association between membership to themes and school/community demographics and were calculated using MaxQDA Stats (Version 20.4.1).[18] Variables included school characteristics, such as the type of school (ie, private, public, charter, alternative), type of community (ie, suburban, urban), student enrollment, and grade level (eg, PK-5, 6-8, 9-12).

RESULTS

Appraisals of Student Wellness Services and Supports

Three main themes emerged regarding teachers' appraisals of student wellness services and supports. These included: (1) Insufficient access to mental health professionals and programming at schools (40%, n = 115), (2) Concerns about the quality of available services (31%, n = 91), and (3) Need for teacher professional development and support related to student wellness services and supports (25%, n = 70; Table 1). In addition to the 3 overarching themes, a smaller subtheme emerged in terms of teachers describing wellness services and supports as not their responsibility (10%, n = 30).

Insufficient Access to Mental Health Professionals and Programming at Schools

Insufficient access to mental health professionals and programming at schools (40%, n = 115) emerged as the most common theme among teachers' responses on the topic of wellness services and supports during the pandemic. Teachers described issues related to accessing resources, programs, and professionals for their students during the pandemic. Most often teachers expressed a need for additional staff (11%, n = 33), support in general (11%, n = 31), and programs, services, interventions, and resources (10%, n = 28). For instance, teachers named mental health professionals, guidance counselors, social workers,

Table 1. Wellness Services and Supports Definitions, Examples, and Number of Participants

Theme	Definition	Example	Participants
Insufficient access to mental health programming and professionals at schools			115 (40%)
Additional staffing	Any reference of one of these roles (any type of help—person, intervention, service, a talk). Includes mental health providers or workers, guidance counselor, counselors, social workers, and therapists.	"It is very VERY crucial for there to be more counselors in order to address the socio-emotional needs of our students to the best capacity, even more now with Covid & everything going on with racial injustices."	33 (11%)
Support	General "support" mentioned, excluding mentions of staff, funding, community partnerships, program/services/interventions, environmental influences.	"It is because we have tried everything that we know of and need more ideas or support."	31 (11%)
Programs, services, interventions, resources	A need for more programs, services, interventions.	"Our hands are tied a lot and even if we know of great resources, often cannot access them."	28 (10%)
Environmental influences	Family broader needs, issues, resources (ie, poverty, food, etc.), different systems at play influencing the family.	"…pockets of poverty that need to be focused on more closely so that we can close the achievement gap…getting the supports they need"	21 (7%)
Concerns about the quality of available services			91 (31%)
Quality of mental health programing and services	Programming and services (eg, interventions) are nonexistent or lacks consistency.	"I do not feel confident in our mental health programs that we have in place, nor do I feel that our guidance counselor understands how important their presence is every day, not just for a once-a-month lesson."	16 (5%)
Quality of mental health professionals	Mental health professionals (eg, guidance counselors, counselors, nurses). Mental health professionals are not available or "present" to do their jobs when needed.	"As teachers we often have to step in to help students immediately. I'm high school, the counselors and MHPs are so busy they may not be able to see students until the next day."	35 (12%)
Students lack relationships trust with MHPs	Students do not trust these professionals or do not have a relationship with them.	"Some kids will talk to me but do not want to be referred to someone they do not know or trust."	10 (3%)
MH prevention, assessment, identification, referral	More MH assessment for students and staff. Request for more formal assessments and fidelity in interventions.	"We need more formal assessments of mental health for ALL students and staff"	18 (6%)
Communication pathway or loop	Procedures known for seeking services as well as when students have been referred and "supported."	"There is a chain of command, teachers have to follow a certain protocol, and after we report things to the school counselors, it is out of our hands and confidential. When you love and care about these students, it is so hard to not know what is going on or if they are getting the help that they need."	30 (10%)
Need for teacher professional development and support on student wellness			70 (24%)
Teacher professional development	Request for more instruction, knowledge and training on mental health literacy.	"I think we need more professional development sessions in regards on how to handle this virtually."	58 (20%)
Teacher request for mental health supports	Teachers requesting or needing MHPs and programs (ie, interventions, services) for themselves.	"My principal has offered training over the last few years on supporting mental health of students, however, he seems to ignore the fact his staff can have the same issues, such as with referred pain."	15 (5%)

and therapists among the additional staff needed in schools. Additionally, teachers noted a need for access to programming and professionals that addressed wellness concerns such as environmental influences (eg, poverty, food insecurity, and trauma; n = 21). Teachers also mentioned that a lack of time (3%, n = 8), community partnerships (2%, n = 6), and funding (1%, n = 4) impacted access to these wellness services and supports.

Concerns About the Quality of Available Services

A second theme that emerged related to teachers' concerns about the quality of mental health programming and services (5%, n = 16). Teachers discussed negative (5%, n = 16) and some positive (1%, n = 3) aspects of the quality of programs and services (eg, counseling, mental health professionals). While a majority expressed a lack of confidence in their mental health professionals (11%, n = 32), with only 3 respondents stating they had confidence in them (1%, n = 3). Negative remarks about mental health professionals concerned those professionals' capacity, competence, and trustworthiness. Some teachers noted mental health professionals' heavy caseloads or capacity, while others shared remarks on school counselors, for instance, not being able to diagnose.

Relationships between mental health professionals and students was another subtheme that emerged related to the quality of mental health professionals (3%, n = 10). Teachers questioned the quality of mental health professionals' relationships with students. Further, many described the existing strength of teachers' relationships with students and the importance of these relationships in addressing student wellness concerns. Teachers also highlighted concerns surrounding quality in relation to understanding and utilizing communication (10%, n = 30), and supporting mental health prevention, assessment, identification, and referral (6%, n = 18). For example, some teachers expressed uncertainty or a lack of follow up after utilizing a wellness service or support in their school.

Need for Teacher Professional Development and Support Related to Student Wellness

A third theme that emerged was teachers' need for professional development and support to help with their students' and their own well-being. Respondents' ideas about teacher professional development opportunities (20%, n = 58) included instruction, knowledge, and training on topics such as mental health literacy and e-learning. Specifically, teachers expressed a need for more training to support students and identify mental health risk and protective factors and that mental health first aid training was not enough. In teachers' requests for professional development, a subtheme of requests was about teachers needing support for themselves (5%, n = 15). Similar to what teachers described within the access theme above, teachers described needing mental health professionals, interventions, and services for their own wellness.

Differences in Appraisals Based on School, Teacher and Community Characteristics

Teachers' appraisals within each of the three themes varied based on several school, teacher, and community characteristics of interest, including the type of school, type of community, student enrollment demographics, and grade-level taught in regard to insufficient access to mental health professionals and programming at schools, concerns about the quality of available services, and a need for teacher professional development and support on student wellness. Differences in belonging to each of the three main themes were examined based on the school, community, and student demographic characteristics reported by teachers. Table 2 provides detailed counts of participants in each theme based on their characteristics and illustrates whether the differences in distributions across themes were significant (Complete demographic information was not provided by all participants.).

In terms of insufficient access to mental health professionals and programming at schools, most teachers who cited insufficient access were from traditional public schools (n = 85, 76%), matching the overall distribution of the participants' characteristics in this study. The community type for each participant varied across all demographic options, including large city (n = 34), rural area (n = 10), small city (n = 26), suburb (n = 32), and town (n = 9). Additionally, student enrollment in terms of students' racial and ethnic majority at the teachers' schools showed that most of the participants who discussed access served primarily white schools, matching the overall school demographics reported by participants. There was a significant association between teachers' report of access to services and the percent of immigrant students in their schools, as respondents at schools with 20% or fewer immigrant students reported more concerns with insufficient access to services ($\chi^2(1) = 7.97$, p = 0.005). Finally, grade level was also significantly associated with increased reports of concern for access to services with teachers serving PK-fifth grade making up the largest percentage of respondents ($\chi^2(3) = 11.90$, p = 0.008).

In terms of concerns about the quality of available services and need for teacher professional development and support for student wellness variations related to the makeup of teachers' membership to each theme were not statistically significant. These concerns were discussed primarily by participants who worked

Table 2. Association Between Membership in Each Theme Based on Teachers' School and Community Characteristics

Characteristics	Theme (Number of Participants)		
	Insufficient Access to Mental Health Professionals and Programming at Schools (n = 112)	Mixed Quality of Available Services (n = 90)	Need for Teacher Professional Development and Support on Student Wellness (n = 70)
School type	p = 0.906	p = 0.0775	p = 0.504
Alternative	2	1	1
Charter	2	2	3
Private	23	17	18
Traditional public	85	70	48
Community type	p = 0.274	p = 0.937	p = 0.644
Large city	34	35	31
Small city	26	19	13
Suburb	32	25	17
Town	9	6	4
Rural area	10	5	5
Student enrollment racial demographics	p = 0.596	p = 0.160	p = 0.628
African American/black	16	11	7
Asian/Native Hawaiian/Pacific Islander	2	6	1
Latinx	33	19	19
Native American/Alaskan Native	0	2	0
White	96	38	35
Percentage of immigrant students	p = 0.005*	p = 0.206	p = 0.273
20% or fewer	67	68	53
More than 20%	43	22	17
Grade level	p = 0.008*	p = 0.142	p = 0.393
PK-5th	51	29	22
6th-8th	27	16	14
9th-12th	22	34	26
Multiple grades	10	109	8

*Denotes significance with p < .05.

in traditional public schools in a large city, with predominantly white student populations working across multiple grade levels. In terms of need for teacher professional development and support for student wellness, teachers working in a large city with 9th-12th graders called for more professional development than teachers from other communities and grade levels. The only statistically significant differences in teachers' appraisals of insufficient access to mental health professionals and programs were seen in a subgroup of teachers in schools with 20% or fewer immigrant students and in the grade-level teachers taught.

DISCUSSION

This study aimed to understand teachers' appraisals of student wellness services and supports during the COVID-19 pandemic, as well as any differences in these appraisals based on demographic data. Overall, approximately 40% of our national teacher survey's respondents reported insufficient access to mental health professionals and programming at schools to address student wellness needs. As current behavioral health and education workforce shortages continue to plague schools,[22] ensuring the accessibility

of quality wellness services and supports becomes even more consequential. This is concerning given the importance of access to mental health and psychological services, physical health resources, and overall social and emotional supports in schools.[13] Further, the WSCC model suggests that these services are critical components of students' health and learning experiences.[13] With health and mental health services in jeopardy at school sites and the exacerbation of these needed services since the pandemic, our findings necessitate access to these resources and supports.[15]

Another noteworthy finding from this study is that when student wellness services were available, teachers reported concern about the quality of those services. Some teachers reported confidence in the services and professionals, yet others reported greater concern with health professionals' ability to identify and address student wellness concerns. Schools should continue to promote and strengthen the quality of these services to meet students' wellness needs, potentially with consideration of expanded school models, like WSCC, which focus on the interdisciplinary stakeholders involved in supporting student wellness.[13] Bolstered quality of services and supports in schools becomes even more noteworthy

with higher proportions of students and families facing economic and food insecurity since the onset of the pandemic.[2] This is especially consequential for students and families from marginalized populations who are often less likely to access services and supports in a community or other nonschool setting.[14-15]

Another key finding that has formidable implications for student health showed that teachers wanted additional resources and professional development to support their efforts to provide student wellness services (eg, mental health literacy, virtual services) and to feel more prepared to evaluate student wellness needs. This finding aligns with existing research pointing to teachers' active role in student wellness promotion and their desire for more preparation to engage in this work.[3-4] To do this work, however, teacher preparation programs would need to expand their curricula and development resources to provide the knowledge, skills and practices necessary to promote quality wellness services and supports.[23] Schools cannot expect teachers to identify student wellness needs or know how to refer to other helping professionals if they do not receive clear guidance about what to identify, how to collaborate, or what resources are available. As earlier research indicates, teachers can benefit from professional learning opportunities that both respect and address their unique roles in expanded school health networks.[9] This also ensures that teachers and students have access to specialized wellness supports so that teachers do not become overwhelmed by their vast instructional and wellness support responsibilities.

While we did not identify substantial variation across teacher subgroups, we do note differences in access to mental health professionals and programming for those teachers in schools with 20% or fewer students identifying as immigrants and for those who teach grades PK-5. Former research shares differences in wellness service access for immigrant students due to residency requirements, linguistic accessibility, and discrimination.[24] While our survey responses do not afford us the capacity to understand why differences in teacher appraisal of access to wellness services was more negative among teachers in schools with 20% or fewer immigrant students, we remark strongly on the importance of further exploration here with particular focus on whether these teacher respondents were located in schools or communities that had fewer wellness supports in general.

Similarly, why PK-5 teachers reported more access concerns than teachers in other grade levels remains relevant for future research and practice. These findings lead us to consider whether fewer student wellness services are available across PK-5 school settings in comparison to middle and high schools or whether expanded school health services are not as clearly defined in elementary schools. Similarly, it is possible that teachers develop closer relationships at the PK-5 grade levels given smaller class sizes, and often single classes, in comparison to middle and high school settings where students rotate classes and teachers serve more students daily. However, this finding is troubling given the heightened rates at which young children are facing more wellness concerns,[5] and thus signal the need for access to high quality supports at prevention and early intervention stages in primary grades along with more promotion of professional development for teachers.

Although this study provided insights from a sample of PK-12 teachers closely mirroring the population demographics of US teachers, the sample is not large enough to generalize results across all school and community settings. Our findings are limited by the under-representation of both teachers of color and teachers at schools with large enrollments of students of color. Future research should consider how teachers' appraisals may vary by state and geographic region in the United States, particularly as this could help inform future state-level policy decisions for expanded health services and supports in schools. Additionally, researchers used consensus coding to come to agreement on overall themes but were unable to member check the results to increase validity due to the anonymous nature of the online survey method used.[21] It is also not possible to assess whether teachers' current appraisals of wellness services and supports were changed due to the COVID-19 pandemic or workforce shortages,[25] as perceptions prior to COVID-19 were not captured.

IMPLICATIONS FOR SCHOOL HEALTH

With growing health concerns for our children and youth,[3-4] particularly those living in our most vulnerable populations,[15] school leaders and districts should prioritize allocating fiscal resources and staff to ensure access to and quality of student wellness services and supports in schools.[14-15] Schools should evaluate the level of services and supports available to address students' health and wellbeing, inclusive of physical and mental health. In doing such, schools may gain a better understanding of the areas in which additional support staff, mental health professionals and programming, and interventions are needed. Evaluation of current wellness services and supports should examine the quality of both the professionals and programs themselves, as our study highlighted concerns about the quality of services and supports when they were available in the school. In addition, given the shortage of behavioral health professionals, school leaders should employ strategies to engage and retain high quality behavioral health staff in their schools.[25] Building from our findings, schools may consider the ways in which they foster student relationships

with school health staff and accountability measures for assessing the quality of professionals and services in their schools. Because teachers serve a critical role in identifying and referring students for wellness concerns, school leaders should advocate for and allocate time to provide teachers with ongoing professional development regarding student wellness. We also need to deepen conversations in teacher education to prepare future teachers for these growing expectations of the practice along with examining student wellness supports and services on an ongoing basis to make real-time adjustments to the allocation of resources and staff to address student wellness concerns.

The pandemic disrupted conventional streams of student wellness services and support in schools (eg, school-based health centers, mental health services).[14-15] Now more than ever, teachers' unique appraisals of student wellness services and supports is essential, particularly their gatekeeping roles for identification, referral, and support of students, with wellness needs.[6-7] Framed within the WSCC,[12-13] and further referenced in the striking health challenges faced by our children and youth today,[3-5] these findings speak to the critical roles that teachers play in supporting students' health and the importance of strengthening health and psychological services in our schools to promote optimal development and learning for our PK-12 students.

Teachers in this study shared a need for additional access to mental health and wellness support staff, additional teacher professional development and support for student wellness needs, and improved quality of existing supports and services. School leaders should assess the alignment of professionals, programs, and professional development opportunities to address students' wellbeing as part of their overall school health priorities. The National Center for School Mental Health[25] and CDC Healthy Schools[26] offer free teacher and school stakeholder professional development training modules that may be used to begin or foster ongoing support for teachers in addressing student well-being.

Human Subjects Approval Statement

The principal investigators institutional review boards approved this study (#3024). This study was deemed exempt and therefore participants were not required to provide verbal or written consent.

Conflicts of Interest

All authors have no conflicts of interest to disclose.

REFERENCES

1. Golberstein E, Wen H, Miller BF. Coronavirus disease 2019 (COVID-19) and mental health for children and adolescents. *JAMA Pediatr*. 2020;174(9):819-820. https://doi.org/10.1001/jamapediatrics.2020.1456.

2. Belot M, Choi S, Tripodi E, van den Broek-Altenburg E, Jamison JC, Papageorge NW. Unequal consequences of Covid 19: representative evidence from six countries. *Rev Econ Househ*. 2021;19(3):769-783. https://doi.org/10.1007/s11150-021-09560-z.

3. Hamoda HM, Chiumento A, Alonge O, et al. Addressing the consequences of the COVID-19 lockdown for Children's mental health: investing in school mental health programs. *Psychiatr Serv*. 2021;72(6):729-731. https://doi.org/10.1176/appi.ps.202000597.

4. Rahman AM, Chandrasekaran B. Estimating the impact of the pandemic on Children's physical health: a scoping review. *J Sch Health*. 2021;91(11):936-947. https://doi.org/10.1111/josh.13079.

5. Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental health-related emergency department visits among children aged <18 years during the COVID-19 pandemic - United States, January 1-October 17, 2020. *MMWR Morb Mortal Wkly Rep*. 2020;69(45):1675-1680. https://doi.org/10.15585/mmwr.mm6945a3.

6. Kidger J, Gunnell D, Biddle L, Campbell R, Donovan J. Part and parcel of teaching? Secondary school staff's views on supporting student emotional health and well-being. *Br Educ Res J*. 2009;36(6):919-935. https://doi.org/10.1080/01411920903249308.

7. Roth̀i DM, Leavey G, Best R. On the front-line: teachers as active observers of pupils' mental health. *Teach Educ*. 2008;24(5):1217-1231. https://doi.org/10.1016/j.tate.2007.09.011.

8. Michie G. *We Don't Need Another Hero: Struggle, Hope, and Possibility in the Age of High-Stakes Schooling*. Columbia University: Teachers College Press; 2012.

9. Phillippo KL, Stone S. Teacher role breadth and its relationship to student-reported teacher support. *High Sch J*. 2013;96(4):358-379. https://doi.org/10.1353/hsj.2013.0016.

10. Kelly MS, Benbenishty R, Capp G, Watson K, Astor R. Practice in a pandemic: school social workers' adaptations and experiences during the 2020 COVID-19 school disruptions. *Fam Soc*. 2021;102(3):400-413. https://doi.org/10.1177/10443894211009863.

11. Javier, C. How can I help you? Schools try to reach students struggling with mental health during coronavirus. LAist. Available at: https://laist.com/news/school-mental-health-hotline-coronavirus. Accessed November 3, 2021

12. Center for Disease Prevention and Control. Whole School, Whole Community, Whole Child (WSCC). Center for Disease Prevention and Control. Available at: https://www.cdc.gov/healthyschools/wscc/index.htm. Accessed November 3, 2021.

13. Lewallen TC, Hunt H, Potts-Datema W, Zaza S, Giles W. The whole school, whole community, whole child model: a new approach for improving educational attainment and healthy development for students. *J Sch Health*. 2015;85(11):729-739. https://doi.org/10.1111/josh.12310.

14. Habiyaremye MA, Clary K, Morris H, Tumin D, Crotty J. Which children use school-based health services as a primary source of care? *J Sch Health*. 2021;91(11):876-882. https://doi.org/10.1111/josh.13085.

15. Ali MM, West K, Teich JL, Lynch S, Mutter R, Dubenitz J. Utilization of mental health services in educational setting by adolescents in the United States. *J Sch Health*. 2019;89(5):393-401. https://doi.org/10.1111/josh.12753.

16. Crutchfield J, Phillippo KL, Frey A. Structural racism in schools: a view through the lens of the National School Social Work Practice Model. *Child Sch*. 2020;42(3):187-193. https://doi.org/10.1093/cs/cdaa015.

17. Brown, E, Phillippo, K, Parker, A, Fujimoto, KA, Iachini, AL, Maras, M, et al. Teaching in 2020: Supporting

teacher and student wellness. Available at: http://education
.gmu.edu/assets/docs/soed/TeacherWellnessSurvey.pdf?
fbclid=IwAR1iLqUvqVhVHwdeUXsfZwVlYzgbtNAMOiX_A-
8cENKtUSi9EO5MMfrgk9o. Accessed November 3, 2021.

18. MAXQDA. All-in-One Qualitative & Mixed Methods Data Anal-
ysis Tool. Available at: https://www.maxqda.com/. Accessed
November 3, 2021.

19. Saldana J. *The Coding Manual for Qualitative Researchers*. 3rd ed.
Los Angeles: Sage Publications; 2015.

20. LaRossa R. Grounded theory methods and qualitative family
research. *J Marriage Fam*. 2005;67(4):837-857. https://doi.org/
10.1111/j.1741-3737.2005.00179.x.

21. Maxwell JA. *Qualitative Research Design: An Interactive Approach*.
3rd ed. Los Angeles: SAGE Publications; 2013.

22. Health Resources and Services Administration (2020). Health
Resources and Services Administration Behavioral Workforce
Projections for 2017-2030. Available at: https://bhw.hrsa.gov/
data-research/projecting-health-workforce-supply-demand/
behavioral-health

23. Brown EL, Phillippo KL, Weston K, Rodger S. United States
and Canada pre-service teacher certification standards for
student mental health: a comparative case study. *Teach
Educ*. 2019;2019(80):71-82. https://doi.org/10.1016/j.tate.2018
.12.015.

24. Teasley ML, Nevarez L, Frost CJ. Bringing attention to
issues related to school social work practice with immigrant
children and children of undocumented parents. *Child Sch*.
2017;39(4):195-199. https://doi.org/10.1093/cs/cdx022.

25. National Center for School Mental Health (n.d.). Train-
ing & Technical Assistance. Available at: https://www
.schoolmentalhealth.org/Our-Work/Training--Technical-
Assistance/

26. Center for Disease Control (n.d.). Healthy Schools. Available at:
https://www.cdc.gov/healthyschools/index.htm