American Journal of Industrial Medicine

WILEY

AMERICAN JOURNAL OF INDUSTRIAL MEDICINE

BRIEF REPORT

Psychological Well-Being of US Educators Remains a Post-Pandemic Concern: Findings From a Cross-Sectional Study

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Received: 5 December 2024 | **Revised:** 2 April 2025 | **Accepted:** 22 April 2025

Funding: This publication was supported by Grant Number U19 OH012299 from the National Institute for Occupational Safety and Health (NIOSH). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of NIOSH.

Keywords: anxiety | depression | educators | intention to quit | stress

ABSTRACT

Background: Educator mental health plays an important role in schools, yet the long-term impacts of the COVID-19 pandemic remain unknown. We sought to estimate the prevalence of school employee stress, anxiety, and depression in the 2022–2023 school year within two school districts in the Northeastern United States.

Methods: An electronic survey was distributed to school employees. Stress was assessed with the 10-item Perceived Stress Scale with scores 0–13, 14–26, and 27–40 representing low, moderate, and high stress. The Generalized Anxiety Disorder 7-item scale and the Center for Epidemiologic Studies Depression 10-item scale were used to assess clinically significant anxiety and depressive symptoms, with a cut-point of 10 applied to the total summed score of each scale. We used log-binomial regression models to estimate prevalence ratios (PR) and 95% confidence intervals (CI).

Results: The majority (76.0%) of the 725 school employees surveyed reported moderate to severe stress with 31.2% and 49.5% reporting clinically significant anxiety or depressive symptoms, respectively. A significantly higher prevalence of anxiety was reported among females (PR = 1.15 (CI: 1.02, 1.30)), instructional staff (PR = 1.15 (CI: 1.02, 1.30)), and employees reporting financial insecurity (PR = 1.18 (CI: 1.10, 1.27)). Likewise, a significantly higher prevalence of depression was reported was reported among women (PR = 1.24; CI (1.00–1.52)), instructional staff (PR = 1.31; CI (1.06–1.62)), and employees reporting financial insecurity (PR = 1.38; CI (1.19–1.60)). Stress, anxiety, and depression were each associated with employees' intention to quit.

Conclusions: The residual effects of the pandemic remain prevalent among school employees. Improving school employees' mental health is crucial for the well-being and retention of educators.

1 | Introduction

1.1 | The Importance of Educator Mental Health

Promoting educator mental health is crucial because it has a trickle-down effect, affecting not only teachers themselves but also their students and the entire school community. At the individual level, research suggests that teachers' work-related anxiety spills over into their personal lives [1]. Workplace stressors also increase educators' poor sleep habits and symptoms of burnout [1, 2]. A systematic review of secondary school teachers found that 28.1% of educators suffer from severe emotional exhaustion, 37.9% have high levels of depersonalization, and 40.3% have low levels of personal accomplishment, all components of burnout [2]. These high levels of occupational stress have also been associated with a wide range of adverse health outcomes such as fatigue, hormonal changes, anxiety, and depression [3]. In the classroom, teachers' work-related stress has been linked to students' physiological stress response with classroom teacher burnout symptoms predicting children's stress response [4]. Teachers' stress is also associated with poorer student outcomes in behavior, concentration, and academic achievement [1]. Teacher burnout is correlated with lower levels of effective learning and lower motivation in students [5].

High stress environments have led to increased turnover rates with new teachers more likely to leave the field in their initial years of teaching compared to veteran teachers [1, 3]. Turnover rates show that 10% of teachers leave the profession after a year and 17% leave within 5 years [5]. These high rates of educator turnover reduce social resources with colleagues (i.e., relationship quality and structure), student performance, and district finances [1].

1.2 | COVID-19 Pandemic and Educator Mental Health

The COVID-19 pandemic introduced unprecedented work-related stressors for educators, worsening their already declining mental health [1]. The pandemic was not a discrete event, but rather a series of shifting hazards and challenges each with new or varying stressors and mental health consequences for educators.

In the US, at the start of the pandemic, the 2019–2020 school year was marked by abrupt closings and remote learning for the majority of educators. In addition to the stress posed by the pandemic itself, educators also reported stressors due to lack of connection, online teaching challenges, lack of student and family resources as well as work-life conflict due to the challenge of simultaneously teaching and caring for one's family during the lockdown [6]. In this acute phase in Wisconsin urban districts, for example, the majority of surveyed US school system employees reported moderate or higher symptoms of depression (53.3%) and anxiety (77.6%) [7]. A survey of US teachers in May through June of 2020 also found that 53% of teachers reported moderate or higher symptoms of depression [8].

In the following school year (2020–2021), many US educators experienced remote or hybrid learning. Without a vaccine available, prevention measures including masking and social distancing were implemented. Technological stressors due to hybrid teaching and health concerns continued during this period [9]. In a study of US educators in January and February of 2021, 78% of teachers reported job-related stress with 27% indicating symptoms of depression [9]. Higher levels of depression were observed in a survey of US educators recruited through social media; 64.8% had clinically significant depression levels, and 18.6% would likely be diagnosed with a major depressive disorder [10]

By the 2021-2022 school year, classrooms in the US had returned to in-person learning with changing isolation and quarantine periods as well as vaccination and continued prevention measure requirements, including masking [11]. During this period, educators faced numerous stressors, including student challenges with behavior management, staff shortages, and communication difficulties, including unclear and inconsistent information from school administration regarding COVID-19 protocols and exposures, as well as limited opportunities for input [12]. A survey of US teachers in the fall of 2021 found stress levels elevated at a moderately high level [13].

By the 2022–2023 school year, while the risks associated with SARS-CoV-2 infection had waned, the impacts of the pandemic were still being felt by educators. Academic recovery efforts were in full effect as was addressing the social-emotional health of students, all while dealing with new protocols for SARS-CoV-2 infection and prevention [14]. In this new post-pandemic stage, new and varying stressors continued to affect educators who had been weathering pandemic-related work stressors since the initial phase of COVID-19. Despite the importance of educator mental well-being, we have yet to fully characterize educator mental health in the post-pandemic period, including the 2022–2023 school year.

1.3 | The Present Study

We sought to estimate the prevalence of educator stress, anxiety, and depressive symptoms in the 2022–2023 school year. Furthermore, we sought to examine which educators had the highest prevalence of stress, anxiety, and depressive symptoms and the impact of these symptoms on educators' intention to quit.

2 | Materials and Methods

We performed a cross-sectional study among educators within two suburban school districts in the same New England state, USA. The school districts were recruited to participate in the Total Teacher Health research study that adapts, implements, and evaluates the participatory Educator Wellbeing Program to improve educator well-being [15]. The Educator Wellbeing Program uses a holistic approach to well-being, operationalized through the Center for the Promotion of Health in the New England Workplace's Healthy Workplace Participatory Program [16]. One of the initial program activities is a well-being and risk factor assessment that was used as a basis for the current analysis. All research protocols were reviewed and approved by the UConn Health Institutional Review Board and

deemed exempt. Participants were provided with an information sheet about the study at recruitment and provided the opportunity to ask questions to research personnel before, during, or after taking the survey.

2.1 | Schools

The two recruited school districts served similar-sized towns each with a population of approximately 30,000 households. However, the two community demographics differed; within one community 47% and 37% of residents identified as White or Black/African American, while within the other community 77% and 6% of residents identified as White or Black/African American, respectively. Each school district had one high school, one middle school, and four or five elementary schools; all 13 schools were surveyed. The schools ranged in size from 186 to 1072 students, with an average rate of 46% of students qualifying for free or reduced lunch.

2.2 | Survey Period and COVID-19 Context

Schools were surveyed between October 2022 and May 2023. At this time, participating schools had fully returned to in-person learning with waning COVID-19 restrictions and protocols. Strict testing and vaccination requirements were removed, though continued to be highly encouraged, and operational strategies and guidance were provided to school districts to maximize in-person learning and minimize disruptions for families (e.g., childcare) [17].

2.3 | Participant Recruitment

Working with school administrators, each school was visited by researchers during staff meetings and professional development days to describe the research survey and provide an opportunity for questions. Participants were provided with an electronic survey link, which remained active for at least one week. At each school, survey participants were provided an information sheet and given the opportunity to enter a drawing for a $50 gift card.

2.4 | Survey Measures

The electronic well-being and risk factor assessment survey consisted of approximately 50 survey items and took approximately 45 min to complete. Only measures related to the current analysis are described. The 10-item Perceived Stress Scale (PSS) was selected to assess psychological stress over the prior 30 days [18]. Participants were asked to indicate the frequency of feelings or thoughts for each of the items using a 5-item scale from 0 to 4 (never to very often, respectively). For example, participants were asked, "In the last month, how often have you felt that you were unable to control the important things in your life?" Ratings for all 10 items were summed (Cronbach's α of 0.88) and categorized with PSS scores 0–13, 14–26, and 27 or higher representing low, moderate, and high stress levels, respectively [19]. Anxiety symptoms over the last 2 weeks were assessed using the Generalized Anxiety Disorder 7-item scale (GAD-7 [20]). Participants were asked to rate the frequency across a 4-point scale from 0 to 3 (not at all to nearly every day) that they felt symptoms. For example, "Not being able to stop or control worrying." Depressive symptoms were assessed over the past week using the Center for Epidemiologic Studies Depression 10-item scale (CES-D 10 [21]). Participants were asked to rate on a 4-point scale from 0 to 3 (rarely or none of the time [less than 1 day per week] to all of the time [5–7 days per week]) how often they experienced each of the 10 symptoms. For example, "I felt that everything I did was an effort." The turnover intention was assessed using 1 item ("I often think about quitting my job") assessed across a 5-point Likert scale from strongly disagree to strongly agree. Additional details on the scales used can be found in Table S1. Additional sociodemographic variables collected included age, gender identity, race, financial situation, job title, tenure working in education, and school type.

2.5 | Data Analysis

We calculated descriptive statistics, including means, standard deviations, and frequencies, for the demographic and occupational variables across the full population and by each mental health outcome. We collapsed categorical mental health outcomes and covariates into dichotomous variables to maximize statistical power. Stress was dichotomized at the cut-point of 27, to compare high versus low stress. For anxiety and depression, clinical symptomology was defined at a cut point of 10 or greater [20, 21]. Age was dichotomized with a cut point of 40 which provided a similar number of respondents in each group. Gender identity was dichotomized by cisgender female. Self-identified race was dichotomized by combining White and unknown race. Financial situation was dichotomized with financially insecure representing respondents who selected "don't even have enough to meet basic expenses" or "just meet basic expenses categories." School type was dichotomized into elementary and middle school versus high school. Educational tenure was dichotomized at more than 10 years, to allow for even distribution of respondents. Job title was dichotomized into instructional staff which included classroom teachers, specialists, and assistants versus non-instructional staff that included administrators/supervisors, student support services, and school support personnel.

Data analysis was conducted on participants who completed at least 70% of the survey items. Missing data were minimal for mental health outcomes, with no missing responses for stress and intention to quit, and depressive and anxiety symptoms missing for only one participant. Covariate missing data were as follows: none for race and school type, one for employment category, two for education tenure, four for gender, six for financial situation, and 25 for age.

We calculated the prevalence ratio (PR) between each outcome (high stress, clinical anxiety symptoms, clinical depressive symptoms, and intention to quit) and each sociodemographic and occupational characteristic. We used ANOVA to test the statistical significance of each prevalence ratio.

We used log-binomial regression models to estimate PRs and 95% confidence intervals (CI) of each covariate for the three mental health outcomes in fully adjusted models. The Pearson correlation between each of the covariates was assessed to select

the variables for inclusion in the final model. The correlation between covariates ranged from 0.001 to 0.16, with the exception of age and educational tenure, which had a Pearson correlation coefficient of 0.58. Due to this moderate correlation, age, not educational tenure, was considered in the regression analysis. We also used log binomial regression models to estimate the relationship between intention to quit and covariates and each mental health outcome in separate models. Statistical significance was assessed at $p < 0.05$ for univariate and log-binomial regression analyses.

3 | Results

A total of 839 consented participants completed the survey, with 724 (86.3%) completing at least 70% of the survey items. Table 1 summarizes the mental health outcomes, intention to quit, demographic, and occupational variables. The average school employee stress (18.76, SD = 7.04) was moderate with 62.6% and 13.4% in the moderate and severe categories, respectively. The average anxiety symptom score was 7.22 (SD = 5.35) with 31.2% meeting the criteria for clinically significant anxiety symptoms (GAD > 10). The average depressive symptom score was 9.80 (SD = 5.69) with 49.5% meeting the criteria for clinically significant depressive symptoms (CSE-D 10 > 10). A total of 198 (27.4%) educators presented with both clinically significant anxiety and depression scores. A total of 37.1% of respondents agreed or strongly agreed with a statement indicating their intention to quit.

The majority of respondents were older than 40 years (51.1%), identified as female cisgender (77.4%), self-identified as White (77.2%), able to meet basic expense with a little extra or live comfortably (81.2%), and instructional staff (76.0%) at the elementary level (48.1%) with an educational tenure of 11 or more years (58.0%).

The prevalence ratios and univariate analysis results are presented in Table 2. A statistically significant higher prevalence of high stress was observed among school employees who were aged 40 or less (PR = 1.15), identified as cisgender female (PR = 1.17), reported an insecure financial situation (PR = 1.27), had an educational tenure of less than 11 years (PR = 1.11), or were instructional staff (PR = 1.23). The same covariates were statistically significant for clinically significant anxiety symptoms (age PR = 1.40, female PR = 1.52, insecure financial situation PR = 1.65, low educational tenure PR = 1.29, and instructional staff PR = 1.60) and clinically significant depressive symptoms (age PR = 1.22, female PR = 1.28, insecure financial situation PR = 1.50, low educational tenure PR = 1.20, and instructional staff PR = 1.43). A statistically significant higher prevalence of an intention to quit was also observed among school employees reporting financial insecurity (PR = 1.33) as well as instructional staff (PR = 1.47). Furthermore, school employees reporting high stress (PR = 4.41), clinically significant anxiety symptoms (PR = 2.00), or clinically significant depressive symptoms (PR = 2.54) also reported a statistically significant higher prevalence of an intention to quit.

Results of the fully adjusted models examining mental health outcomes are displayed in Figure 1 and presented in Table S2. In the

TABLE 1 | Population characteristics of educators from two US school districts surveyed between October 2022 and May 2023.

Mental health and work outcomes	***n* (%)**
Stress	
Low	174 (24.0)
Moderate	453 (62.6)
Severe	97 (13.4)
Anxiety symptoms	
Low/moderate	497 (68.7)
Severe/clinically significant	226 (31.2)
Depressive symptoms	
Low/moderate	365 (50.5)
Severe/clinically significant	358 (49.5)
Intention to quit	
Strongly disagree to neutral	455 (62.9)
Agree or strongly agree	269 (37.1)
Covariates	***n* (%)**
Age	
40 years or less	342 (48.9)
Older than 40 years	357 (51.1)
Gender	
Female (cis-gender)	557 (77.4)
Male (cis-gender)	143 (19.9)
Non-binary, trans-gender or other designation	4 (0.6)
Prefer not to say	16 (2.2)
Race	
American Indian or Alaska Native	4 (0.6)
Asian	8 (1.1)
Black or African American	53 (7.3)
Middle Eastern or North African	3 (0.4)
White	559 (77.2)
Prefer not to say	84 (11.6)
Two or more races selected	13 (1.8)
Financial situation	
Able to live comfortably	281 (39.1)
Meet basic expenses with a little left over for extras	302 (42.1)
Just meet basic expenses	101 (14.1)
Don't even have enough to meet basic expenses	34 (4.7)
Employment category	
Instructional staff	*551 (76.0)*
Classroom teachers	415 (57.4)
Specialists	99 (13.7)
Assistants	37 (5.1)

(Continues)

TABLE 1 | (Continued)

Mental health and work outcomes	*n* (%)
Non-instructional staff	*172 (23.8)*
Administrators or supervisors	32 (4.4)
Student support	116 (16.0)
School support	24 (3.3)
Educational tenure	
0–5	159 (22.0)
6–10	144 (19.9)
11–20	221 (30.6)
21+	198 (27.4)
School type	
Elementary	348 (48.1)
Middle	154 (21.2)
Highschool	222 (30.7)

fully adjusted models, we observed a statistically significant higher prevalence of stress across school employees who identified as cisgender female (PR = 1.15; CI (1.02–1.30)), reported financial insecurity (PR = 1.18; CI (1.10–1.27)), and were instructional staff (PR = 1.14; CI (1.01–1.28)) (Figure 1A). With respect to clinically significant anxiety symptoms, in fully adjusted models we observed a statistically significant higher prevalence among school employees who were aged forty or less (PR = 1.29; CI (1.04–1.61)), identified as cisgender female (PR = 1.51; CI (1.09–2.09)), reported financial insecurity (PR = 1.58; CI (1.26–1.96)), and were instructional staff (PR = 1.43; CI (1.05–1.96)) (Figure 1B). Similar associations were observed with respect to clinically significant depressive symptoms where we observed a statistically significant higher prevalence among school employees who identified as cisgender female (PR = 1.24; CI (1.00–1.52)), reported financial insecurity (PR = 1.38; CI (1.19–1.60)), and were instructional staff (PR = 1.31; CI (1.06–1.62)) (Figure 1C). As compared to univariate results, we observed decreased prevalence ratios for each statistically significant predictor in the fully adjusted models. A higher prevalence of intention to quit was observed among school employees reporting higher stress (PR = 3.93; CI (2.51–6.16)), clinically significant anxiety symptoms (PR = 1.93; CI (1.59–2.34)), and clinically significant depressive symptoms (PR = 2.38; CI (1.90–2.99)) in the fully adjusted models (Table 3).

4 | Discussion

4.1 | Prevalence of Mental Health Symptoms

In the 2022–2023 school year, we observed that school employees continued to experience poor mental health with nearly one-third presenting with clinically significant anxiety and nearly half presenting with clinically significant depression. In comparing the current (2022–2023) school employees survey to a prior year's (2021–2022) school employees survey [7], we observed a similar percentage of school employees experiencing moderate to severe levels of stress (76.0% vs. 80.0%) with a larger percent in the high category (13.4% vs. 8.0%). Although different scales preclude a one-to-one comparison of the prevalence of anxiety and depression symptoms, there appear to be lower levels of anxiety symptoms (31.2% vs. 47.8%) and depressive symptoms (49.5% vs. 53.3%) in considering a cut-point of moderate or higher symptoms as clinically significant for the prior study [7]. Likewise, declines in clinically significant depressive symptoms were also observed as compared to an online survey of educators in fall of 2020 (49.5% vs. 64.8%) [10]. This is consistent with the trends observed across the United States, whereas compared to 2020, decreasing levels of depression and anxiety symptoms were observed in a population study by spring of 2022 [22]. Although the acute phase of the pandemic had receded by 2022–2023, teachers continued to experience COVID-19 isolation protocols, challenging student behaviors, and pandemic-related learning losses and these continued stressors put them at higher risk for stress and poor mental health.

4.2 | Predictors of Mental Health

Few studies examine the mental health of all employees, including administrators and support staff. Notably, for predictors of poor mental health, we observed an association between instructional staff with a statistically significant higher prevalence of high stress, anxiety, and depressive symptoms, which had not been observed in a 2021–2022 survey of school employees [7]. Since the beginning of the pandemic, stressors may have shifted from COVID-19-related effects back to ongoing, and potentially exacerbated, school-related challenges. Teachers in instructional positions face diverse challenges such as managing students' various learning needs, limited resources to support students, behavioral problems, and meeting the pressures of standardized testing expectations [23]. As a result, they may be at greater risk for poor, stress-related health outcomes compared to school staff who are not frequently engaged in direct instruction of students, such as administrators or office personnel.

Within this population, we also observed a higher prevalence of anxiety and depressive symptoms among educators who were40 years old or younger. This is consistent with studies demonstrating increased vulnerability to anxiety and depression among younger adults [24] and teachers, specifically [25]. Due to the correlation between age and tenure, we were unable to examine the independent links of each, although research suggests that teachers in their early careers are more likely to experience anxiety disorders [26]. We also observed an association between school employees identifying as female and higher symptoms of anxiety and depression, as with the analysis of school employees in 2021–2022 [7]. This is also consistent with studies of adults during the pandemic where increased prevalences of depression [22, 27] and anxiety [27] were reported for women. Women's increased susceptibility may be due in part to increased at-home stressors during the pandemic including work-life conflict, childcare/virtual learning, and elder care [28], which may have exacerbated pre-pandemic gender inequalities in both anxiety and depression [29].

After adjusting for covariates, we also found that finances played a role in stress, anxiety, and depressive symptoms. The link between anxiety and financial insecurity was also observed in the initial phase of the pandemic more broadly across the US

TABLE 2 | Frequency and prevalence of mental health and work outcomes by demographic and mental health outcomes.

	Stress				Anxiety symptoms				Depressive symptoms				Intention to quit			
	Low[a]	High[b]	PR	*p* value	Low[a]	High[b]	PR	*p* value	Low[a]	High[b]	PR	*p*-value	No	Yes	PR	*p* value
Age			1.15	0.0013			1.40	0.0025			1.22	0.0082			1.08	0.4082
40 or less years	64	278			215	126			155	187			210	132		
over 40 years	104	253			263	94			197	159			230	127		
Female, cis-gender			1.17	0.0021			1.52	0.0045			1.28	0.0095			1.25	0.0666
Yes	119	438			368	189			266	290			340	217		
No	55	112			129	37			99	68			115	52		
Race			1.07	0.3296			1.36	0.1245			1.13	0.3327			1.29	0.1370
White or not shared	151	492			436	207			320	322			398	245		
Person of color, multi-racial	23	58			61	19			45	36			57	24		
Financial Situation			1.27	< 0.0001			1.65	< 0.0001			1.50	< 0.0001			1.33	0.0114
Insecure	11	124			72	62			43	92			72	63		
Secure	161	422			420	163			317	265			379	204		
Educational tenure			1.11	0.0163			1.29	0.0197			1.20	0.0159			0.97	0.7681
less than 11 years	59	244			193	109			137	166			192	111		
11 years or more	114	305			302	117			227	191			261	158		
School type			1.06	0.2099			1.25	0.0706			1.15	0.0922			1.03	0.8046
Elementary or middle	114	388			334	167			243	259			314	188		
High	60	162			163	59			122	99			141	81		
Staff			1.23	< 0.0001			1.60	0.0015			1.43	0.0002			1.47	0.0024
Instructional staff	113	438			361	189			257	293			330	221		
Non-instructional staff	61	111			135	37			108	64			125	47		
Stress															4.41	< 0.0001
Moderate/high													299	251		
Low													156	18		
Anxiety															2.00	< 0.0001
Clinically significant													98	128		
Low/moderate													356	141		
Depression															2.54	< 0.0001
Clinically significant													166	192		
Low/moderate													288	77		

Abbreviation: PR, prevalence ratio.

[a]The low (reference) categories include respondents with stress scores below 27 for stress and anxiety or depressive symptoms scores below 10.

[b]The high categories include respondents with stress scores of 27 or higher and anxiety or depressive symptoms scores of 10 or higher, indicating clinically significant symptomology.

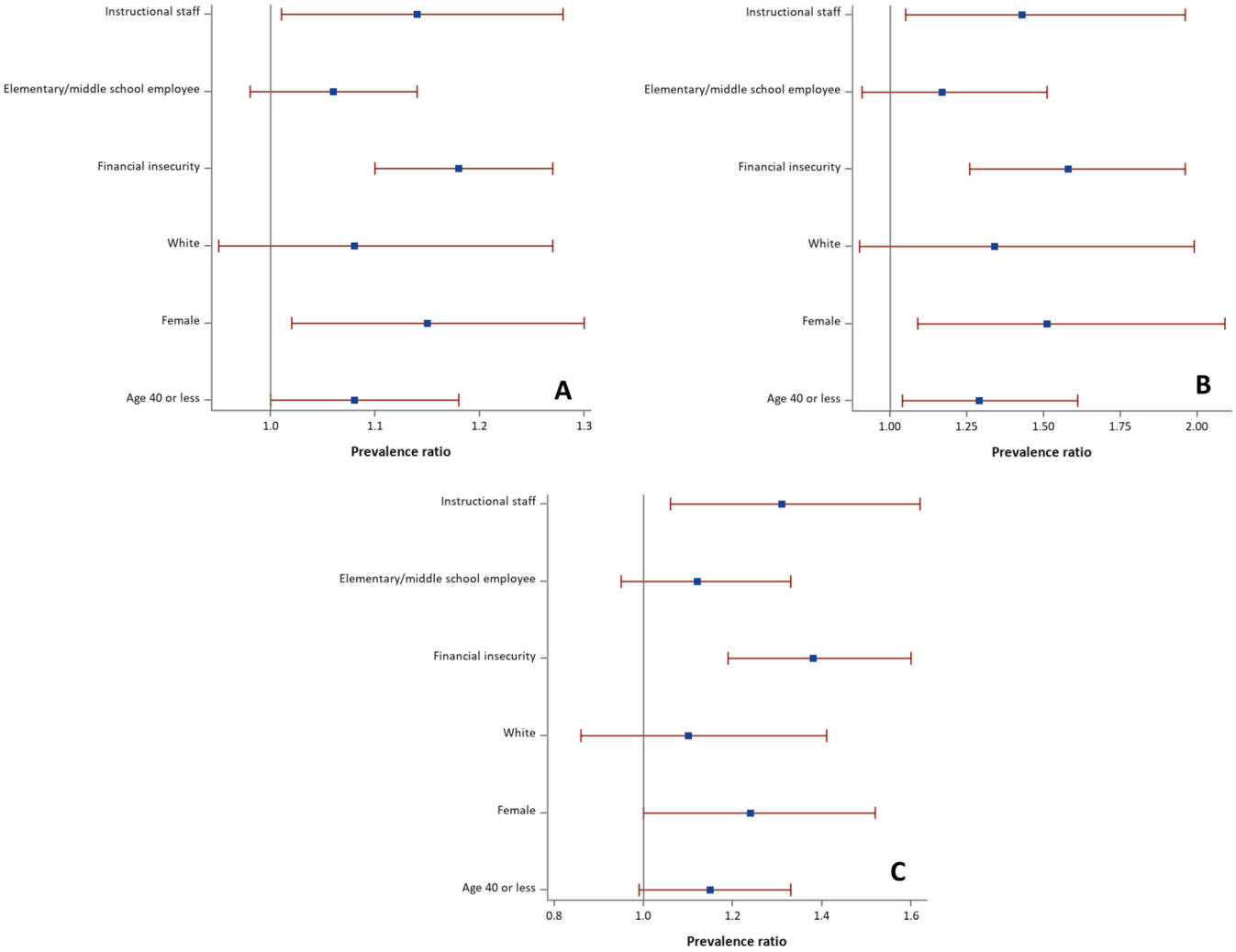

FIGURE 1 | Prevalence ratios of high stress (A), clinically significant anxiety symptoms (B), and clinically significant depressive symptoms (C). Prevalence levels greater than 1 indicate a higher prevalence as compared to referent and 95% confidence intervals that do not cross 1.0 indicate statistical significance ($p < 0.05$).

TABLE 3 | Adjusted prevalence ratios predicting intention to quit after adjusting for age, female, race, financial situation, school type, and instructional staff.

	Intention to quit			
	PR	95% CI		*p* value
High stress	3.93	2.51	6.16	< 0.0001
Clinical anxiety symptoms	1.93	1.59	2.34	< 0.0001
Clinical depressive symptoms	2.38	1.90	2.99	< 0.0001

Abbreviations: PR, prevalence ratio; CI, confidence interval.

population [30]. School employees with insecure finances were more likely to be 40 years old or younger and to have worked within the school system for less than 11 years, suggesting they are early-career employees. This highlights the need to address the financial challenges faced by new educators, includinglow pay and student or other debts.

4.3 | Predictors of Intention to Quit

For factors predicting intention to quit, our results are consistent with a survey of educators from the 2021–2022 school year, which identified a statistically significant association between high stress and the intention to quit [7]. Furthermore, we observed statistically significant associations between clinically significant anxiety and depressive symptoms and the intention to quit. This relationship is consistent with studies in which workplace psychological conditions, including stress, depression, and anxiety are predictors of turnover [31, 32]. More specifically, previous studies have found that teachers who have met the criteria for an anxiety disorder or major depression have a higher intent to quit [26, 33].

4.4 | Limitations

Given the heterogeneity of COVID-19 protocols, impacts, and school-level stressors across the United States, the prevalence of poor mental health among school employees observed in this study should be interpreted within the context of regional and school-specific factors. Small sample size did not allow us to

fully examine vulnerabilities amongst certain educator groups. Although the survey attempted to reach a broad range of school employees, the majority of respondents were classroom teachers (57.24%). Additional research should examine the unique risk factors for other staff including administrators who have also experienced poor mental well-being [34] as well as education support staff who report numerous stressors [35]. Prior research has shown that increased discrimination among educators of color can lead to poor mental health outcomes [34] and should be further monitored for unique stressors and vulnerabilities.

4.5 | Implications

Assessing and addressing school employees' mental health is crucial for the success of our students and the preservation of our school employee workforce. These data suggest that school employees' stress remains elevated, especially for instructional staff. Continued surveillance of school employees' mental health and improvement of psychosocial hazards are paramount to identifying and addressing risks [36]. Programs that take an integrated approach to school employees' mental health - recognizing that both individual and workplace level changes are needed [15] - can improve employees' well-being and help prevent premature exit from the educator workforce.

Author Contributions

Jennifer M. Cavallari, Alicia G. Dugan, Lisa M. H. Sanetti, Matthew Brennan, Megan N. Miskovsky created the study methods and identified survey items. Jennifer M. Cavallari, Natalie R. Charamut, Sierra M. Trudel, Alicia G. Dugan, Megan N. Miskovsky identified the study hypotheses. Megan N. Miskovsky, Matthew Brennan, Natalie R. Charamut, Amanda J. L. Hiner created and implemented the online survey. Jennifer M. Cavallari, Rebecca J. Gore, Sierra M. Trudel, Amanda J. L. Hiner, Megan N. Miskovsky, and Natalie R. Charamut conducted data cleaning and analyses. All authors contributed to the interpretation of the results. Jennifer M. Cavallari, wrote the manuscript with input from all authors. All authors read and approved the final manuscript.

Acknowledgments

We gratefully acknowledge the support and assistance from educators. We particularly appreciate the assistance of Drs. Jennifer Garza and Rick Laguerre for their initial work on the survey design.

Disclosure

The authors have nothing to report.

Disclosure by AJIM Editor of Record

John Meyer declares that he has no conflict of interest in the review and publication decision regarding this article.

Ethics Statement

This research was approved by the UConn Health Center Institutional Review Board (22X-123-2) and was conducted in accordance with the Declaration of Helsinki.

Consent

The study was deemed exempt, and information sheets were provided to study volunteers before participation.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.