

AN ABSTRACT OF THE THESIS OF

PAUL HANS TEMPLIN for the degree Doctorate of Education  
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Title: EXPERT OPINION REGARDING PROGRAM ACTIVITIES  
AND RESOURCES LEADING TO AND SUPPORTING  
DISTRICTWIDE, COMPREHENSIVE SCHOOL HEALTH  
INSTRUCTION PROGRAMS

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Abstract approved: \_\_\_\_\_  
Dr. Arthur Koski

This study was concerned with identifying the program activities and resources believed necessary to support a districtwide, comprehensive school health instruction program and investigated the perceptions of an expert committee composed of persons involved in school health instruction in the State of Washington.

A questionnaire, developed after extensive review of related literature and a field test involving state and national health educators, was mailed to members of the expert committee on two separate occasions. Information received from the first questionnaire returns was furnished with the second mailing. The questionnaire contained 80 scaled-response activity/resource statements grouped into five areas: (1) Personnel; (2) Inservice; (3) Community

Involvement; (4) Written Guidelines; and (5) Evaluation.

A t test comparison between the sample mean obtained from responses of the expert committee and the population mean of 3.5 on a six-point response scale was made for each of the activity/resource statements. In addition, a two-tailed t test for testing independent means was used to test the significance of mean differences between sub-group pairings found within the membership of the expert committee. Sub-group comparisons included: (1) Metropolitan-Smaller cities; (2) Supervisors-Classroom personnel; and (3) Health educators-Non-health educators.

The results of this study revealed that the members of the expert committee agreed that 78 of the 80 activity/resource statements were important in leading to and supporting districtwide, comprehensive school health instruction programs in the State of Washington. Of the statements classified as important, 74 were found to have differences which were statistically significant at the .001 level, three had differences which were statistically significant at the .01 level, and one had a difference which was statistically significant at the .05 level. Mean values obtained on each item indicated that five of the 80 items fell within the "strongly agree" range on the six-point response scale, 69 items fell within the "agree" range, and six items fell within the "agree with reservation" range.

It was found that expert committee members from metropolitan

areas differed from the members of the expert committee from smaller cities at a significant level for four items related to in-service programs, for two items related to community involvement, for three items related to written guidelines, and for one item related to evaluation. When grouped according to supervisory or classroom responsibility, a significant difference of opinion was noted on two items. One of these items dealt with personnel, and the other dealt with written guidelines. Separation of the expert committee into two groups, one composed of health educators and the other composed of non-health educators produced a significant difference of opinion about one item each in the sections on personnel, in-service programs, and evaluation.

Expert Opinion Regarding Program Activities  
and Resources Leading to and Supporting  
Districtwide, Comprehensive School  
Health Instruction Programs

by

Paul Hans Templin

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APPROVED:

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Professor of Health Education  
in charge of major

Redacted for Privacy

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Head of Department of Health Education

Redacted for Privacy

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Dean of the School of Education

Redacted for Privacy

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Dean of Graduate School

Date thesis is presented

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Typed by Opal Grossnicklaus for Paul Hans Templin

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EXPERT OPINION REGARDING PROGRAM ACTIVITIES  
AND RESOURCES LEADING TO AND SUPPORTING  
DISTRICTWIDE, COMPREHENSIVE SCHOOL  
HEALTH INSTRUCTION PROGRAMS

I. INTRODUCTION

In 1970, the American Association for Health, Physical Education and Recreation issued the following position statement:

Health education - particularly that aspect identified as health instruction - is of greater concern in contemporary society than ever before . . . A unified approach to health teaching - that is, planned, sequential curriculum in health education throughout the school years - is necessary to help attain the objective of education, the healthy, educated man (2).

Others have taken a similar position with regard to health instruction in the public schools. Within the past decade at least two important statements have appeared in writing. A joint committee of the National School Boards Association and the American Association of School Administrators, reporting in 1968, affirmed that:

The Committee is unanimous in its firm belief that the only effective way in which the school can fulfill its responsibility for meeting the health needs of youth is through a comprehensive program of health education in grades K through 12 (23).

Echoing this position:

The National Congress of Parents and Teachers supports the concept of comprehensive health education programs and believes these programs should be given higher priority at national, state, and local levels (16).

A concern for promoting comprehensive health instruction in the public schools has not been confined to the past few years. Strong supportive statements were made as early as 1850 (53). Schlaadt (48) has identified statements made since the turn of this century. From the Seven Cardinal Principles of Education to the report from the National Education Association's Project on Instruction many governmental and professional organizations have recognized health as an important objective of the educational process. It has been concluded that:

... unless we had a completely false premise all these years and in recent research it is the job of every school to have a broad and effective health program taught by competent instructors (10).

The School Health Education Study (51), conducting a national survey on the status of health education in elementary and secondary schools, found that most schools did not have a satisfactory health education program. School health education studies on the status of existing programs in the school districts of several states (34, 37, 54) revealed similar findings. The President's Committee on Health Education, a year-long task force, found little change today. The Committee, in its 70-page report, indicated that school health education does not exist in most schools, and when it is attempted it is not effective (44).

A comparison of the findings from two studies conducted in Washington seems to indicate little progress in the implementation

of comprehensive health instruction programs in this state over the past decade. In 1958, Mills (37) studied health education programs of the public secondary schools. The study indicated a wide variation in subject matter covered, teacher preparation, and organizational patterns. More recently, a health education survey conducted among 4,500 public elementary and secondary schools throughout Washington State (38) indicated a need for more health specialists, better facilities, more financing, better planned programs, revised textbooks and other instructional materials, and total evaluation and revision of curriculum.

The majority of expressed opinions seem to indicate a positive attitude toward health instruction, but observation suggests that many schools do not often take action to implement these opinions (45).

If health instruction is as valuable as has been suggested, school districts should be encouraged to make new efforts to plan and implement comprehensive programs having the best chance of reaching the ultimate objective of education, the healthy, educated man. Getting (20) indicated that it is wise to begin new program efforts with a program development, or planning phase.

"To be perceived as a whole, a program must be reduced to writing and made available to all who are to play a part in its implementation and evaluation." (20). The development, or planning, phase, ". . . should include a clear definition of the innovation, the identification of its essential elements, and a description of its

operational characteristics" (60). More specifically this might include: (a) a determination of the program objectives and sub-objectives deemed necessary and sufficient for attaining the program objective; (b) a selection of one or more activities believed to have a high probability of resulting in attainment of each sub-objective; and (c) a determination of the kind and amount of resources needed to support the performance of the planned activities. "The logic of program operation is to expend resources to support the performance of activities and thereby to attain sub-objectives and the program objectives" (13).

Planning comprehensive health instruction programs has not proven easy for most school district leaders. Administrators have recognized that school-aged youth are confronted with a variety of health problems and have developed a variety of educational responses to deal with these problems. However, administrative decisions to resolve the problems, ". . . have generally resulted in poor quality instructional programs" (11). Cornacchia feels that, ". . . administrators need, want, and should receive help to better understand the nature and organization of health instruction programs" (11). The initial help might well be to provide insight into the resources that need to be expended and the specific activities that need to be carried out if there is to be a successful attempt to establish and maintain a comprehensive health instruction program.

School district administrators, seeking to identify specific resources and activities for health instruction, are looking for program improvements.

Truly professional administrators, regardless of how well the organization may be flourishing, continually seek improvement and above all else are deeply committed to building a better tomorrow. Decisions in this area are critical because they establish the targets, define the resources needed, and determine their allocation (43).

#### Significance of the Study

There has been little available information to help public school administrators in the State of Washington to plan and implement comprehensive programs of health instruction. The apparent results of this lack of guidance for public school administrators are discussed by Mayshark and Shaw:

The reason why schools have not been utilized to their fullest potential includes the fact that school health programs have, for the most part, been administered in a directionless manner with no vision for the health education concept. The variety of patterns, whereby school health programs are organized is evidence that there does not exist widespread agreement as to the most effective organizational pattern and only occasional school health programs appear to be even vaguely successful (35).

As decision-makers who have responsibility for school health instruction search for answers to program improvement questions they will need to seek input from others. Rasp (43) has indicated

at least two reasons for this involvement: (1) because mistakes are costly and decisions have a way of directly reflecting the input and information upon which they are based; and (2) because the decisions require involvement beyond the decision maker for implementation. There should be some way for those who are expected to implement a decision to have a voice in what that decision will be.

The Supervisor for Health Education, State Office of Public Instruction, Washington State, has taken steps to involve a variety of people in the process of providing input about the future of health education in Washington. In June of 1973 six task force groups met in Olympia for ten days to begin identifying health education priorities. There is a need to get further information about these initial efforts. This study has been designed to provide data about one area of the State project; i. e. , the area of health instruction.

This study will identify for school district administrators the thinking of an expert panel of jurors about the kinds and number of resources to provide in supporting the program activities believed to lead to comprehensive health instruction. Knowledge of the resources considered most essential could help school district administrators make budget decisions for initial phases of program implementation. Such knowledge could also provide insight into future budget decisions related to the continuing health instruction program.

The data collected in this study will also identify those activities

deemed essential in implementing a comprehensive program of health instruction. Such information might provide school district administrators with the guidance they need to take action leading to the establishment of successful programs.

The results of this study will also identify where there was consensus, disagreement, or conflict in opinion between members of an expert panel of jurors about resources and activities leading to and supporting a comprehensive program of health instruction. An expert panel involved in implementing health instruction should be in a position to provide specific guidance to school administrators about such programs. This study will provide data which will help these panel members identify areas of professional conflict or disagreement. These data could lead to discussions at the professional level to resolve areas of conflict for purposes of program planning.

Development of an instrument to measure the degree of program implementation could be a long-range benefit resulting from the collection of data in this study. Determining the extent to which the program as planned is actually in effect is an important aspect of evaluating program effectiveness. Fox (18), in his evaluation of the More Effective Schools program in New York, concluded that evaluators should know the extent to which the program under consideration actually exists before determination of program can take place. This conclusion was reached when it was learned:

that those parts of the planning committee report concerned with process and program had either not been implemented at all, or else implemented so slightly as not to have any significant impact (18).

### Statement of the Problem

The purposes of the study are to:

1. Identify program resources believed necessary to support a districtwide comprehensive health instruction program.
2. To identify program activities believed necessary to support a districtwide comprehensive health instruction program.
3. To provide information which may be used by school districts in the State of Washington to evaluate progress towards a comprehensive program of health instruction.

As a means of identifying the activities and resources necessary to lead to and support districtwide comprehensive health instruction programs, the following questions will be considered:

1. What are the program activities and resources necessary to insure adequate health instruction personnel to administer and carry out a districtwide, comprehensive school health instruction program?
2. What are the program activities and resources necessary to be provided by a school district to meet the in-service needs of school health instruction personnel?

3. What are the program activities and resources needed to insure positive interrelationships between school health instruction personnel and the community?
4. What are the program activities and resources involved in providing written guidelines for the operation of a districtwide school health instruction program?
5. What are the program activities and resources needed to develop an evaluation process which involves assessment of planning, implementation, program outcomes, and feedback?

#### Method of Attacking the Problem

This study was undertaken in cooperation with the Supervisor for Health Education, State Office of Public Instruction, Olympia, Washington. A modified Delphi survey method was employed, focusing on the use of two questionnaires sent to a 24 member committee of recognized experts in school health instruction. Questionnaire items were developed after an extensive survey of related literature. The preliminary questionnaire items were then submitted to a task force of state and national health educators for their reactions.

The final form of the questionnaire submitted to the expert committee was used to identify areas of agreement about the program resources and activities believed to be necessary to lead to and support a comprehensive program of school health instruction on

a districtwide basis. A detailed description of this procedure is included in Chapter III, Method of Investigation.

#### Limitations of this Study

1. This study was limited to program resources, activities, and objectives for school health instruction in Washington. No attempt was made to determine program outcomes.
2. This study was limited to districtwide programs.
3. This study was limited to judgments of the expert panel of jurors. The panel was selected from individuals currently involved in coordinating or implementing school health instruction programs in Washington. Selections were made in consultation with the Supervisor for Health Education, State Office of Public Instruction.
4. Since the procedure used in this study involved determining the opinions of a select committee of individuals involved in school health instruction programs, others interested in health education; i. e., students, parents and community health personnel; were not involved in this study as respondents.

#### Basic Assumptions

1. It is necessary to provide both elementary school and secondary school health instruction if there is to be a comprehensive

program.

2. School districts generally recognize the need to include comprehensive programs of health instruction in their curriculum offerings.
3. Although there is a certain degree of self-identity, all school districts share some common characteristics of program development and implementation.
4. Professionals working with school health instruction are capable of determining the program resources which must be provided and the program activities which must be conducted by a school district to implement and maintain a comprehensive school health instruction program. The Delphi technique can be used for this purpose (43).

#### Definition of Terms

The following list defines various concepts as they are used in the context of this study:

1. Comprehensive Programs: Programs may be considered comprehensive when they have reached or have surpassed the objectives which form the standard or baseline established for that program.
2. Coordinator of Health Instruction: The individual in a school district who has major responsibility for actively developing

and improving health instruction.

3. Delphi Survey Technique: A method developed by Rand Corporation to circumvent problems associated with committees reaching consensus; technique utilizes an expert panel of jurors and a series of three or four questionnaires with controlled feedback (43).
4. Development: That phase of establishing educational programs which involves planning the program and developing procedures for putting the plan into effect.
5. Educational Innovation: Any concept, program, or process in the field of education which is not currently in widespread use.
6. Health Instruction: The process of providing a sequence of planned and spontaneously originated learning opportunities comprising the organized aspects of health education (40).
7. Implementation: Those activities which are carried on by a school district in putting into operation a previously planned program.
8. Program Activities: Specific activities which research and theory suggest must be carried out by those involved in every aspect of an educational program to insure the program's success.
9. Program Resources: Those personnel, materials and finances which research and theory suggests must be provided in order to carry out program activities.

## II. REVIEW OF RELATED LITERATURE

A comprehensive review of the literature, by manual methods and by computer assistance through ERIC's Information Retrieval Center, Boulder, Colorado, failed to uncover research duplicating the intended purpose of this study. There have been, however, studies which contribute to the development of the current investigation.

One of the earlier research projects was conducted by Nix (41) who used the review of literature procedure to extract criteria for a school health program. She submitted the criteria to a panel of American and Canadian experts for judgment. Using the panel's responses, Nix developed a final interview schedule. The interview schedule was used to determine how teachers' concepts of a school health program agreed with the judgments of a panel of experts, and whether length of teaching experience and type of professional preparation were factors in this agreement. Nix concluded that there was a general lack of understanding of the comprehensiveness of a modern school health program by teachers.

A scale for evaluating all aspects of the school health program was developed at Oregon State University under the direction of Anderson (3). The scale was based on recognized procedures, practices, standard facilities and activities.

After the scale was developed and each item weighted, the scale was submitted to a board of 24 experienced health educators. Information received from the analysis conducted by this board of health educators was used to revise the original draft of the scale.

This instrument was designed to be used as a self-appraisal instrument or as an instrument that could be used by an evaluation team from outside the school.

A scale of this type was not seen as a final product. Anderson (3) suggested that the scale should be modified as changes occurred in the school health program.

An instrument for evaluating health instruction in secondary schools was developed by Wilson (59). The author developed a rating scale, submitted the scale to a jury of experts, refined the scale, and tested the validity and reliability of the results. In 1965-1966 the Wilson study, along with studies completed by Watters (57) and Kirk (30) each of whom used similar research procedures to develop instruments for evaluating health services, were brought together into an appraisal schedule for American school and college health programs (42).

There have been other studies whose purposes have been to establish, or identify, a method of evaluating health education at the secondary level. Smith (52) developed a set of established principles for secondary health education by reviewing literature

in the field. Data obtained from a questionnaire mailed to 85 accredited Negro high schools in Georgia was compared to the established principles as a basis for suggesting program improvements.

An instrument to evaluate health education in the secondary schools of Kentucky was developed by Gentry (19). The author selected items for the instrument from the literature and submitted these to a panel of health education experts. The revised instrument was then field tested in several public secondary schools to determine its ability to select between poor and good health education programs. A similar process was used to develop a score card for evaluating the processes of health instruction programs in high schools. Carpenter (6) used a review of the literature and a jury of national and local experts in the field to develop the final form of the score card. The validity of the instrument was determined by use of the score card in a number of high schools. A person from the school who would rate the program and an outside rater used the score card in each situation with a test-retest format.

One of the most recent studies to develop an instrument to evaluate secondary school health instruction programs seems most nearly aligned with the purpose of this paper. Collins (9) developed and validated an instrument to be used by self-evaluators in order to identify the strengths and weaknesses in health instruction

programs in secondary schools. A preliminary instrument containing 142 items was developed and submitted to a jury of ten experts. Each expert reacted to each item on the basis of a five point Likert-type scale and also weighted each item on the basis of 100 total points according to that item's value or relevance. A final instrument containing 100 items was then used in selected schools in Indiana and Kentucky by two self-evaluators from each school and the author. Correlations between the three evaluators were used to determine internal consistency and reliability.

Although the above studies have been useful in preparing this current effort, none of the studies attempted to cover a districtwide school health instruction program. All have been limited to the study of secondary school health instruction programs.

An example of one of the more comprehensive studies designed to develop criteria for health programs is the School Health Education Evaluative Study, Los Angeles, California (27). This study developed separate sets of criteria for evaluating school health education at the elementary school, the high school, and the junior college levels. Each set of criteria was organized into four divisions: administration, health instruction, health services, and healthful school environment. Each set of criteria was field tested in a sampling of schools throughout the state of California. In addition each set was reviewed by a group of curriculum specialists and school health personnel.

A project with a purpose similar to that of the Los Angeles study has been reported by Cahoon (5). This study attempted to develop principles and criteria that would guide health education in Canadian Schools.

General principles, guiding principles, and criteria for health programs were identified by an extensive review of both Canadian and American literature. A combination interview schedule - questionnaire instrument was developed from the list of guiding principles and criteria. This instrument was administered to leaders in both Canadian education and public health. From the responses, a final list of guiding principles and criteria for health programs in Canadian schools was developed.

Cahoon concluded that further investigation was indicated. This conclusion was based on the ambivalence of the respondents' reactions about program activities, program organization, as well as communication problems, coordination of programs and other items.

Although not a research project in the true sense of the word, Cornacchia (11) did develop administrative guidelines for secondary school health education for California schools that were designed to aid in the increase of, and to lead to, quality instructional programs. Administrative guidelines were established by a conference of 45 selected educational leaders. The conference participants included principals, physicians, school board members, health educators,

and professors of education administration. The conference developed guidelines in the areas of program, curriculum, time, teachers, coordination, community, financing, facilities, and evaluation.

Guiding principles and/or criteria established in these studies follow the same pattern. That is, guidelines are stated in general, rather than measurable terms. The guidelines force each individual, school district, or other group to interpret the meaning of each guideline in terms of their own experiences and allows for a good deal of bias.

#### Status Studies

Several status studies have already been discussed in this paper (37, 38, 51, 54). Another example of this type of research is, "The Status of Health and Family Life Education in Connecticut Public Schools" (55). The Connecticut study used questionnaires sent to principals of elementary and secondary schools and regional vocational technical schools to determine the status of the program in health and family life at a given point in time. The Oregon School Health Education Study (48) is patterned somewhat after the National School Health Education Study, and was used to determine the standing of health education in that state.

There have been other status studies in health education. Those presented here should serve to indicate the nature of such research.

Status studies can provide some insight into the program components the researcher considers to be of importance when evaluating health education. This evaluation should indicate at least a partial list of those factors comprising the health instruction program.

Some studies have focused on the administrative aspects of school health programs. In a study of 2,886 city school systems Kilander (29) gathered data about the administration and the financing authority of school health services programs. Although the study was confined to health services it does provide information about procedures to use in assessing programs.

Neilson and Irwin (39) also used the questionnaire method to obtain information about school health practices. The majority of their findings, as in previous studies, were related to the health services aspect of a total school health program.

In one of the more comprehensive studies of administrative practices in school health programs Mayshark (34) used a closed-end interview schedule sent to 46-60 respondents in each of six school districts. The respondents represented a cross section of the district's administrative and teaching staffs and local public health officials. This initial method was followed by personal interviews with 20 or more respondents in each of the six communities.

Studies of the administration of school health programs or of some specific segment of a total program does provide a basis for

formulating the proposed research. However, as in the case of status studies, most of the current research deals with programs as they now exist rather than with programs in the future. To establish standards for improving school health instruction programs there seems to be some value in looking toward the ideal.

### III. METHOD OF INVESTIGATION

This section contains a description of how the individuals were selected for the expert committee, a discussion of the development of the instruments used, and an explanation of collection and statistical treatment of data.

#### Selection of the Expert Committee

Data for this study has been obtained from a highly select, expert committee consisting of 24 individuals. The committee members were asked to make judgments about the program resources and program activities which are believed to be important to develop and maintain a comprehensive school health instruction program. The selection of specific individuals to participate in this study was accomplished in consultation with the Supervisor of Health Education, State Office of Public Instruction, Olympia, Washington, and was based on the following criteria:

1. The committee should be composed of individuals who are working with various aspects of the school health instruction program.
2. Although there are more small districts in the State, a large percentage of the student population attends schools in large metropolitan districts. Individuals for the committee should

- be representative of both small and large districts selected on a fairly equal basis.
3. Approximately half of the committee should be selected from groups whose responsibility it is to administer the school health instruction program. The other half of the committee should come from those who work in various ways in classroom situations.
  4. Involvement in professional activities, research, writing for publication, conducting workshops, and guiding curriculum development should be used to determine selection of committee members.
  5. Individuals to serve on the expert committee should be chosen because of a sincere interest in the field of health education as well as for their experience within the field.

The names of several potential committee members were identified in cooperation with the Health Education Supervisor, State Office of Public Instruction. A final selection of the 24 committee members was made from the names identified. At least two alternates were selected for each of the sub-groups involved in the initial committee. Alternates were to be contacted in the event a member of the original committee could not, or did not, wish to participate in this study. The final size of the committee was determined by two considerations: (1) the expert committee should be large enough to

analyze statistically, and (2) it should be small enough so that time and economics do not interfere with the completion of the study.

The areas represented on the expert committee, the number of individuals from each area, and the rationale for their selection are included in the following:

1. Coordinators of Health Education - 4 members

Although few in number, the health education coordinator has direct responsibility for the school health instruction program.

Two coordinators were selected from those individuals who have the dual responsibility of health and physical education.

Two coordinators were selected whose sole responsibility is the school health instruction program. Training and experience are both factors in selecting these individuals.

2. Principals - 4 members

Some principals have been assigned curriculum and administrative responsibility for school health instruction in the absence of a districtwide coordinator. Selection was from both the elementary and secondary principals who have this responsibility. Experience and interest were expected to make the few principals, who participate in school health instruction in this way, valuable to the study.

3. Curriculum Directors - 4 members

Curriculum directors have responsibility for all discipline

areas. Some of these individuals have demonstrated leadership in the area of school health instruction and serve in the absence of a Coordinator of Health Education. Priority was given to those who have curriculum responsibility for K-12 programs.

4. Health Educators - 10 members

There are many more health education specialists who serve in teaching roles than in administrative capacities. Many of these individuals have demonstrated expertise in curriculum development, in-service training, and other phases of the school health instruction program. Selection was made from both large and small districts.

5. School Nurses - 2 members

School nurses have long taken an active role in the school health instruction program. They serve both as teachers and as program developers. One nurse was selected from a large metropolitan district and the other was selected from a smaller district.

### Data Collection

#### Using the Delphi Technique

There have been a number of techniques used to collect opinions and judgments which can serve as a basis for decision making.

Rasp (43) discusses three which are used most frequently. A single expert is sometimes consulted. This may be satisfactory if the expert is clearly the most knowledgeable in the field of concern, or if everyone knows the same thing about the question under consideration so that the answer would be the same regardless of who was asked. "Neither of these conditions exists in education today and the single input approach to decision making is seldom the most fruitful" (43).

A second technique which might be used is to consult several experts and then to average the results.

The problem is that the individuals consulted have not been given the opportunity to provide their most thoughtful input. In addition, they have not had the benefit of seeing or hearing other responses which might encourage a refinement of their own contributions (43).

Sometimes a group is brought together for a round table discussion. The purpose is to develop a consensus of opinion about a certain subject. This kind of approach has certain weaknesses.

Evidence suggests that group decisions get made faster as the dinner hour approaches, are influenced disproportionately by the group member holding the highest status, frequently reflect a desire for group approval, and represent conformity more than objective truth (43).

Each of the three techniques discussed above have uses in specific situations. The limitations of each technique have been described.

The Delphi is a technique for collecting judgements that attempts to overcome the weaknesses implicit in relying on a single expert, a one shot group average, or round table discussion (43).

The original Delphi technique was defined as a means of substituting for face-to-face group activity a method of getting feedback from individuals through the use of questionnaires and information about the opinions of others who are answering the same instruments.

The Delphi technique generally uses a series of four questionnaires (43):

1. The first questionnaire asks a select group for some initial input about the topic to be studied.
2. Items are developed from the first round responses to form a second questionnaire. The second questionnaire requests individual judgments in the form of priority ratings on each item.
3. The next questionnaire provides an average of the second round responses on each item. Each respondent is asked to reconsider his second round response in light of this information and either move to the group judgment or state a reason why he feels a minority position is in order.
4. The final questionnaire provides each participant with new consensus data, a summary of minority opinions and asks for a final revision of responses.

In this study a modification of the classic Delphi, described above,

was used. The first and fourth questionnaires of the original technique were omitted.

The formulation of the second questionnaire in the classic Delphi process is quite critical according to Rasp (43). There must be a sufficient range of items so that no serious omissions exist when data is collected. Uhl (56) points out that it is difficult to combine individual lists, such as those produced by the first step in the classic Delphi process, into clear goal statements. One method of dealing with this problem employs an extensive review of the literature to help identify the range of items that should be included in the final form of a questionnaire that will be submitted to an expert committee. Frequently a field test, or a review by a panel of judges, is used to insure that the review of literature has helped eliminate omissions in the formulation of the questionnaire. A review of the literature and the review by a panel of judges was used to develop the final form of the questionnaire used in this study.

The above procedure has its limitations. It is possible that not all of the innovative ideas about a districtwide, comprehensive school health instruction program have appeared in the literature. Without information from the expert committee in the initial stages of the questionnaire's development some areas of importance may still be omitted. A second factor may influence the development of the questionnaire. Failure to involve those persons who will

participate in the study in the process of developing the questionnaire reduces the ability of the writer to pick up phrasing and terminology that could make the final product more acceptable when it is sent to the respondents.

The fourth questionnaire has not proven to be of great value in the Delphi process. For example, one investigation determined that:

virtually all (99%) of the respondents' changes in opinion occurred on Questionnaire III which informed them of the first 'consensus' reached by the group. With hindsight, one can seriously question the need for going beyond Questionnaire III (12).

In a similar vein, Rasp (43) found that many Delphi surveys omit the fourth questionnaire. Little change occurs from that received on the previous questionnaire and insufficient additional data are generated to warrant the effort.

### Questionnaire Development and Processing

Two questionnaires were developed and sent to members of the expert committee for their feedback. The following steps were taken:

#### Step I Preparation of Questionnaire #1

An extensive review of the literature was conducted. Particular attention was given to research and theory which had as its purpose the establishment of guidelines or criteria for health instruction. Research and theory pertaining to organization

for effective health instruction was also reviewed. Additional background was obtained from status studies in health education.

The review of literature was used to identify specific or implied statements about resources and activities needed to lead to and support a comprehensive health instruction program. These statements were used to formulate a preliminary form of the first questionnaire.

As indicated above, the preliminary questionnaire was submitted to a task force of state and national health educators. (See Appendix A.) The task force members met in Olympia, Washington during June 1973. Each task force participant was asked to review the preliminary questionnaire for clarity, possible omissions, possible additions and readability. The information received from members of the task force was used to formulate the final form of Questionnaire #1 of this study. The questionnaire in its final form consisted of 80 activity resource statements grouped into the following five sections:

- A. The school district employs and supports competent health instruction personnel in sufficient numbers to administer and to carry out a comprehensive health instruction program.
- B. The school district provides planned, continuous opportunities for in-service to increase the knowledge and

skills, and to improve the attitudes of those individuals responsible for conducting the health instruction program.

- C. The school district encourages cooperative involvement between the community and school health personnel.
- D. The school district has written guidelines which provide direction for the school health instruction program.
- E. The school district, working with the district health education coordinator, had developed and published a plan for the continuing evaluation of all phases of the school health instruction program, including an assessment of planning, implementation, program outcomes and feedback processes.

### Step II Selection of Committee

An expert committee was selected with the cooperation of the State Office of Public Instruction, Health Education Office.

Alternate members were selected at the same time.

### Step III Distribution and Processing

Each item of the instrument utilized a 1-to-6 rating scale with weighted values as follows:

The activities and resources listed below are essential if a school district is to provide a comprehensive school health instruction program:

<u>Scale Step</u>	<u>Values Assigned</u>
Strongly agree (SA)	1
Agree (A)	2
Agree with reservation (AR)	3
Disagree with reservation (DR)	4
Disagree (D)	5
Strongly disagree (SD)	6

A 1-6 scale was used because there is no middle number. Even though a respondent may feel somewhat neutral about an item, he must choose between either the agree or disagree side of the scale. A zero (0) was recorded if no response was indicated for a particular item. All zeros were treated as missing data and were not included in the statistical calculations. A space was provided after each item for comments supporting a position taken. (See Appendix C.) Questionnaire #1 was mailed to members of the expert committee during the first week in May 1974. A cover letter accompanied the questionnaire explaining the purpose of the study and the process to be used. (See Appendix C.) Each member was assured that comments and answers would be kept confidential. In this respect, only a summary of the comments would be included in the report of data. Each questionnaire was identified to allow for analysis and for follow-up; however, no individual was referred to as

having made a particular statement or having expressed a particular opinion. The committee was instructed to complete and return the questionnaire within one week.

Three days after the mailing of the questionnaire each participant was called by phone. The respondents were asked if the questionnaire had been received, if they had considered whether or not they had any questions that might be answered. If necessary, alternate members would have been selected for the expert committee following this initial phone call. A follow-up phone call was made at the beginning of the second week to those respondents who had not returned the questionnaire. A total of three calls was made at this time.

Step IV Analysis of Questionnaire #1 and the Preparation and Processing of Questionnaire #2

a. Analysis of Questionnaire #1

- 1) The mean, standard deviation, and consensus were calculated for each item. The consensus was defined as the interval containing the middle 50 percent of the responses (12, 43).
- 2) Reasons for taking a position of agreement or disagreement were summarized for each item.

b. Preparation and Processing of Questionnaire #2

1) Preparation

The second questionnaire indicated the individual's responses to Questionnaire #1. Each response was circled. A square around the appropriate number indicated the mean on that item.

Response

Agree						Disagree								Activities/Resources	
1	2	3	4	5	6	1	2	3	4	5	6				
															1. Written guidelines are available for the selection of school health instruction personnel. . . based on guidelines furnished by the state
															2. The health education coordinator has a communication link with the state for the purpose of updating criteria for selecting school health instruction personnel

A summary of the reasons given for choosing positions on the initial questionnaire were summarized for each item and included as a separate document. Respondents were asked to review each item in light of this additional information. If a respondent did

agree with the mean, he was asked to state his reason(s) in the space following each item. If no reason was stated, it would be assumed that the respondent agreed with the mean score.

2) Processing

Questionnaire #2 was mailed to the members of the committee with instructions to return the completed form within one week. Two weeks after the questionnaire had been distributed, a follow-up telephone call was made to the one respondent who had not returned the second questionnaire as requested.

3) Analysis of Questionnaire #2

- a) The mean, standard deviation, and consensus were calculated for each item.
- b) Reasons for agreeing or disagreeing were summarized for each item.

Treatment of Data

1. The measures of central tendency obtained from questionnaire #2 were listed for each respondent.
2. Statistical analysis was based on the following formulas:

Mean

$$\bar{X} = \frac{\sum x_j}{N}$$

Where:

X = statements of activities and resources

N = number of respondents

x<sub>j</sub> = responses (1 through 6; according to weighted values)

Standard deviation

$$S = \sqrt{\frac{N \left( \sum x_j^2 \right) - \left( \sum x_j \right)^2}{N^2}}$$

Standard Error of the Mean

$$\frac{S}{\sqrt{N}}$$

$$\underline{t} \text{ score} = \frac{\bar{X} - Mo}{\frac{S}{\sqrt{N}}} \quad \begin{array}{l} \bar{X} = \text{sample mean} \\ Mo = 3.5 \end{array}$$

3. Those statements of activities or resources which had a "t" score outside the acceptance range, s = Standard Deviation, N = Sample size, were considered to have obtained consensus.
4. Since the second questionnaire was the end product of this study, the statements of questionnaire #2 which obtained a "t" score which was significantly different than Mo were utilized to identify the activities and resources believed to be important for comprehensive school health instruction in the State of

Washington.

5. The data of questionnaire #2 was also utilized to perform a two-tailed t-test comparison of the activity and resource statement means of respondents from large metropolitan areas and respondents from districts in smaller city areas:

$$\underline{t} = \frac{(\bar{x}_1 - \bar{x}_2) - (u_1 - u_2)}{S\bar{x}_1 - \bar{x}_2}$$

Where:

$\bar{x}_1$  = Sample mean of first sample

$\bar{x}_2$  = Sample mean of second sample

$u_1$  = Population mean of first sample

$u_2$  = Population mean of second sample

$S\bar{x}_1 - \bar{x}_2$  = Standard error of difference between means

$$= \sqrt{\left( \frac{\sum x_1^2 + \sum x_2^2}{n_1 + n_2 - 2} \right) \left( \frac{1}{n_1} + \frac{1}{n_2} \right)}$$

The null hypothesis used was that there was no significant difference existing between the means, and the alternate hypothesis was that there was a significant difference between the means.

6. The data from questionnaire #2 were also used to perform a two-tailed t-test comparison of the activity and resource

statement means of respondents who had supervisory responsibility for health instruction and respondents whose main responsibility in health instruction was in a classroom setting. The null hypothesis was that there was no significant difference existing between the means, and the alternate hypothesis was that there was a significant difference between the means.

7. A two-tailed t-test comparison, using the data obtained from questionnaire #2, was performed on the activity and resource statement means of respondents who had direct health education responsibility and respondents whose responsibility included all areas of education. The null hypothesis was that there was no significant difference existing between the means, and the alternate hypothesis was that there was a significant difference between the means.

#### IV. ANALYSIS AND RESULTS

The analysis and results of this study are based on the five major sections of the questionnaire used in this research: (1) personnel, (2) in-service, (3) community involvement, (4) written guidelines, (5) evaluation.

As indicated in Chapter III, all items on the questionnaire were assigned a six-point scale ranging from "strongly agree" to "strongly disagree." Each response alternative--strongly agree, agree, agree with reservation, disagree with reservation, disagree, strongly disagree--was respectively weighted 1, 2, 3, 4, 5, and 6 to facilitate the necessary computations to be made on the data. Only the responses that actually indicated one of the six scaled-response alternatives were used to compute individual item statistics.

The initial section of the analysis and results describes the data from all members of the expert committee. Each of the five major sections of the questionnaire is treated separately. For purposes of determining which activity/resource statements were believed to be important in leading to and supporting comprehensive school health instruction programs in the State of Washington, a t-test was conducted, indicating the significance of the difference between the obtained sample mean value of the expert committee on

each item and the population mean of 3.5. The population mean of 3.5 on the six-point response scale indicates a position in which there is neither agreement nor disagreement. Some members of the expert committee provided comments supporting their position in favor of the activity/resource statement or in opposition to that statement. These comments are found in Appendix E.

The second part of the analysis and results looks at sub-groups within the expert committee. The null hypotheses of no significant difference between the means of these sub-groups have been tested at the .001, .01, and .05 levels of significance. The data used in testing each hypothesis are presented along with an analysis of the results for each section of the questionnaire.

### Identification of Program Activities and Resources

#### Personnel

The first section of the questionnaire contained 18 activity/resource statements related to the personnel necessary to administer and to carry out a comprehensive school health instruction program. Table 1 indicates that all 18 items in this section had mean values on the positive side of the six-point response scale. Mean values which fell within the "agree" range on the scale were obtained for 13 of the 16 items, while five of the items had mean values in the "agree with

Table 1. Responses to Activity/Resource Statements Dealing with Personnel Showing Areas of Consensus

Item Number	Questionnaire Items*	Mean Response	Standard Deviation	Obtained t value	Level of Significance **
1.	Written guidelines are available for the selection of school health instruction personnel . . . based on guidelines furnished by the state	2. 25	. 968	6. 313	. 001
2.	The health education coordinator has a communication link with the state for the purpose of updating criteria for selecting school health instruction personnel	1. 97	. 493	15. 149	. 001
3.	A qualified health education coordinator has been assigned responsibility for districtwide coordination	1. 96	. 539	14. 000	. 001
4.	Time has been provided to carry out coordination activities which is equal to coordination time provided for other programs	2. 00	. 408	18. 072	. 001
5.	A yearly budget for school health instruction has been established and is at least equal to the budget for other major disciplines	2. 42	1. 115	4. 737	. 001
6.	Each elementary school has a staff member assigned to coordinate all health instruction experiences and curricula in that school	1. 88	. 439	18. 000	. 001
7.	At least one hour of released time has been provided the staff member assigned responsibility for coordinating the elementary school health instruction program	2. 83	. 986	3. 303	. 01
8.	Every elementary school budget has designated money to support the school health instruction program	2. 08	. 571	12. 137	. 001
9.	Each secondary school has a staff member assigned to coordinate the school health instruction program	1. 96	. 359	20. 533	. 001

Table 1. (Continued)

Item Number	Questionnaire Item*	Mean Response	Standard Deviation	Obtained <u>t</u> value	Level of Significance**
10.	Secondary school building health education specialists have at least one class period free to carry out the responsibility of coordinating the school health instruction program	3.09	1.100	1.790	NS
11.	Each secondary school has designated a budget for health instruction as determined by an interdisciplinary faculty-administration committee	2.13	.679	9.648	.001
12.	Specific criteria for competency in health education has been applied in selecting prospective elementary teachers	2.75	1.090	3.378	.01
13.	An in-service program has been established to raise the competency of elementary teachers	2.00	.577	12.712	.001
14.	Cooperation has been established between the district health education coordinator, the intermediate school district, and the state in determining in-service for elementary teachers	1.76	.406	20.964	.001
15.	Sufficient health education specialists have been hired to establish a 1:20 ratio in each health education class	3.13	.971	1.869	NS
16.	Secondary health instruction personnel have been hired from a list provided by the district health education coordinator	2.57	1.378	3.240	.01
17.	The school district health education coordinator has established an in-service program to raise the competency of secondary personnel	1.96	.464	15.876	.001
18.	A policy has been developed to relieve secondary school health instruction personnel of their teaching assignments if competency is not attained within a two-year period	3.09	.830	2.370	.05

\*The complete wording of the questionnaire items appears in Appendix C.

\*\*The critical value of t at the following levels of significance with one degree of freedom: .001 = 3.767; .01 = 2.807; .05 = 2.069.

reservation" range. Statistical significance at the .001 level was obtained on activity/resource statements which indicated that a school district:

Item  
Number

1. Has available written guidelines for selecting school health instruction personnel based on state guidelines.
2. Has established communication with the Supervisor of Health Education, State Office of Public Instruction, which is used in updating criteria for selecting school health instruction personnel.
3. Has a qualified health education coordinator who has been assigned the responsibility for districtwide coordination of the school health instruction program.
4. Has a district health education coordinator who has time assigned to carry out coordination activities which is at least equal to the average time given for coordination of other major disciplines.
5. Has a yearly budget for school health instruction established in an amount at least equal to the budget of other major disciplines.
6. Has at each elementary school in the district at least one staff member who is assigned the responsibility for coordination of all health instruction experiences and curricula in that school.

Item  
Number

8. Has at each elementary school a budget for school health instruction as determined by a faculty-administrating committee which includes the building health education specialist.
9. Has at each secondary school a faculty member with state-approved health education preparation assigned the responsibility of coordinating that school's health instruction program.
11. Has a budget for health instruction in each secondary school which is determined by an interdisciplinary faculty-administration committee.
13. Has an in-service program in order to raise, within a two-year period after first employment, the health education competency level of those elementary teachers who have not met minimum standards.
14. Has in-service programs to raise the competency level of elementary teachers determined by communication with both the intermediate school district and the Superintendent of Public Instruction.
17. Has an in-service program to raise the competency level of secondary school health instruction personnel who do not meet at least minimum standards.

Statistical significance of the .01 level was obtained on three items in this section of the questionnaire dealing with school health

instruction personnel. The three items indicated that a school district:

Item  
Number

7. Provide at least one hour of released time for the staff member(s) assigned responsibility for coordination of the school health instruction program at the elementary level.
12. Apply criteria for competency in health education, as determined by the Superintendent of Public Instruction, in selecting prospective elementary teachers.
16. Hire secondary school health instruction personnel only from a list approved by the district health education coordinator.

One of the 18 items in this section of the questionnaire attained statistical significance at the .05 level. This activity/resource statement indicated that a school district:

Item  
Number

18. Has established a policy to relieve secondary school health instruction personnel of their teaching assignments in the health program if competency has not been attained within a two-year period.

Failure to obtain statistical significance was noted in the case of the activity/resource statement that suggested:

Secondary school building health education specialists have been provided at least one class period, in addition to any regular planning period provided for all faculty members, to carry out the responsibility of coordinating the school health instruction program.

Two members of the expert committee indicated that they felt the statement makes it sound as if all secondary schools are large enough to have a staff of several health teachers. Since this is not the case in most school districts in the State of Washington, the statement could not be supported. A third respondent felt that this activity/resource statement was difficult to support because the provision of an extra period, free from teaching responsibility would be too dependent on individual factors such as school size or finances. One respondent supported the statement emphasizing the need for coordination. This member of the expert committee also emphasized the need for coordination activities to be strictly health-oriented and not combined with coordination activities related to physical education or science.

A statistical finding of no significant difference was also obtained for the activity/resource statement:

The school district has hired health education specialists in sufficient numbers to establish a teacher-student ratio not greater than 1:20 for each health education class offered.

Six members of the expert committee took the opportunity to comment about this statement. One respondent felt that sufficient

research had not been completed on optimum class size for effective health education to make this kind of statement at this time. This respondent felt that the ratio of 1:20 was an arbitrary figure. Other members of the expert committee felt that this low ratio was completely out of the question from a practical viewpoint. One response, which supported the statement, indicated that this was an "ideal" goal which would be good for every class.

There seems to be evidence indicating that the expert committee felt that most of the activity/resource statements dealing with school health instruction personnel are important. Only two of the 18 items in this section of the questionnaire failed to obtain statistical significance on the agree side of the six-point response scale. The remaining 16 items were accepted as being important in leading to and supporting a districtwide, comprehensive school health instruction program.

### In-service

Activity/resource statements in the second section of the questionnaire dealt with providing continuous opportunities for in-service programs to increase the knowledge and skills, and to improve the attitudes of those individuals responsible for conducting the school health instruction program. A total of 16 items were included in this section.

As indicated in Table 2, all mean values obtained fell on the positive side of the six-point response scale. Mean values which fell within the "strongly agree" range were obtained on two of the items. On the remaining 14 items all mean values fell within the "agree" range.

Statistical significance at the .001 level was attained on each of the 16 items in this section as indicated in Table 2. The activity/resource statements indicated that in each school district:

Item  
Number

1. The district health education coordinator has established written criteria for developing in-service programs by using input from ancillary personnel and interdepartmental personnel.
2. A process has been established for continuous updating and revision of the criteria.
3. Representative ancillary health personnel have been identified.
4. Representative health in-service consumers have been identified.
5. A planning committee has been established, composed of representatives from the above, which meets at least monthly.
6. Provisions are made for the mechanical arrangements for each in-service program.
7. Current list of human resources is maintained from which

Table 2. Responses to Activity/Resource Statements Dealing with In-Service Programs Showing Areas of Consensus

Item Number	Questionnaire Items*	Mean Response	Standard Deviation	Obtained t value	Level of Significance**
1.	Written criteria are available for developing in-service programs	1.92	.400	19.268	.001
2.	A process has been established for continuous updating and revision of the criteria	1.04	.200	60.000	.001
3.	Representative ancillary health personnel have been identified	1.92	.400	19.268	.001
4.	Representative health in-service consumers have been identified	2.00	.408	18.072	.001
5.	A planning committee has been established and meets at least monthly	1.96	.611	12.320	.001
6.	Provisions exist for the mechanical arrangements for each in-service program	1.92	.276	28.214	.001
7.	A current list of human resources is maintained from which instructors for in-service programs may be selected	1.92	.493	15.644	.001
8.	Both the software and hardware necessary to conduct each in-service program are available	2.04	.539	13.273	.001
9.	Opportunities are provided for program incentives	1.04	.200	60.000	.001
10.	A written plan for publicity has been established	1.92	.276	28.214	.001
11.	Packages of implementation resources have been developed and are available to each in-service participant	1.83	.373	21.974	.001
12.	The district provides an evaluation instrument, or process, to be used with each in-service offering	1.83	.373	21.974	.001
13.	The district provides a process for continual feedback from in-service participants	1.88	.439	18.000	.001
14.	Each in-service participant is personally contacted within a two-month period following each in-service program	2.29	.735	8.067	.001

Table 2. (Continued)

Item Number	Questionnaire Items*	Mean Response	Standard Deviation	Obtained <u>t</u> value	Level of Significance**
15.	Information from immediate and long-range evaluation processes is utilized in future planning	2.00	.577	12.712	.001
16.	The district publicizes new health programs, program improvements and specialized training received by staff	1.92	.400	19.268	.001

\*The complete wording of questionnaire items appears in Appendix C.

\*\*The critical value of t at the following levels of significance with one degree of freedom is: .001 = 3.767; .01 = 2.807; .05 = 2.069.

- instructors for the in-service programs may be selected.
8. The software and hardware needed for the most effective presentation and implementation of each course are available for each in-service program.
  9. Opportunities are provided for program incentives, including college credits, district credits or salary adjustments.
  10. A written plan for publicity has been established which encourages each target group's interest and participation.
  11. Packages of implementation resources are developed and are available to each in-service participant.
  12. Provides an evaluation instrument, or process, to be used with each in-service offering to determine the extent to which program objectives have been met, and to identify emerging needs.
  13. Provides a process for continual feedback from the in-service participants to identify how ideas are working and to identify additional needs and resources.
  14. Each in-service participant is personally contacted within a two-month period following each in-service program by personal visitation, small group meeting, or by telephone.
  15. Information from both immediate and long-range evaluation processes is utilized by the planning committee in future planning of in-service programs.
  16. There is publicity emphasizing new health programs, program

improvements and specialized training received by health instruction staff.

All 16 items in this section were accepted as being important in leading to and supporting a districtwide, comprehensive school health instruction program.

### Community Involvement

The third section of the questionnaire contained ten activity/resource statements which were believed to be important in leading to and supporting districtwide, comprehensive school health instruction programs. Each activity/resource statement suggested ways in which a school district could encourage cooperative involvement between the community and school health personnel.

Table 3 indicates that the mean values obtained from the responses of the expert committee fell within the "agree" range of the six-point scale for nine of the ten items. The mean value obtained from the remaining activity/resource statement fell within the "agree with reservation" range on the scale.

Statistical significance was attained at the .001 level in all ten items of this section. Activity/resource statements suggested that in a school district:

Table 3. Responses to Activity/Resource Statements Dealing with Community Involvement Showing Areas of Consensus

Item Number	Questionnaire Items*	Mean Response	Standard Deviation	Obtained <u>t</u> value	Level of Significance**
1.	Representatives from community groups have been identified	1.83	.373	21.974	.001
2.	Written guidelines have been established for the school and community health education committee's operation	2.08	.493	14.059	.001
3.	Basic purposes of the committee have been identified and are available in writing	1.92	.276	28.214	.001
4.	Local forms of communication have been identified	2.00	.289	25.424	.001
5.	Community news outlets have been incorporated into the in-service training program	2.13	.439	15.222	.001
6.	The district health education coordinator has supplied information concerning the health education program on a monthly basis to all segments of the media	2.79	.644	5.420	.001
7.	Media and members of the community have access to the program through a process which is available in writing	2.00	.408	18.072	.001
8.	A written plan has been made available for disseminating information to the community	1.96	.200	37.561	.001
9.	A written, updated list of people and groups available as resources has been distributed to all school health instruction personnel	1.83	.373	21.974	.001
10.	The district health education coordinator has a process for maintaining and updating a list of community resources	1.92	.400	19.268	.001

\*The complete wording of the questionnaire items appears in Appendix C.

\*\*The critical value of t at the following levels of significance with one degree of freedom: .001 = 3.767; .01 = 2.807; .05 = 2.069.

Item  
Number

1. Representatives from community groups have been identified.
2. Written guidelines for the school and community health education committee's operation have been established.
3. Basic purposes of the committee have been identified and are available in writing.
4. Local forms of communication have been identified.
5. Community news outlets are incorporated into the in-service training program.
6. The district health education coordinator supplies information concerning the health education program on a monthly basis to all segments of the media.
7. Media and members of the community have access to the program through a process which is available in writing.
8. A written plan is available for disseminating information to the community.
9. A written, updated list of people and groups available as resources is distributed to all school health instruction personnel.
10. The district health education coordinator has a process for maintaining and updating a list of community resources.

Each of the ten items in this section met the criteria for

acceptance as an activity/resource statement believed to be important in leading to and supporting districtwide comprehensive school health instruction programs.

### Written Guidelines

Activity/resource statements which were believed to be important if a school district is to have written guidelines which provide direction for the school health instruction program were included in this fourth section of the questionnaire. There was a total of 24 items in this section.

Table 4 indicates that mean values obtained on 21 of the 24 items fell within the "agree" range on the six-point response scale. The remaining items in this section had mean values which fell within the "agree with reservation" range. As was the case in the other sections of this instrument, all responses in this section obtained mean values on the positive side of the six-point scale.

On the 24 items in Table 4 the level of statistical significance attained was .001. The activity/resource statements in this section suggest that a school district:

#### Item Number

1. Has appointed a health education coordinator who is responsible for planning written curriculum guidelines.

Table 4. Responses to Activity/Resource Statements Dealing with Written Guidelines Showing Areas of Consensus

Item Number	Questionnaire Items*	Mean Responses	Standard Deviation	Obtained <u>t</u> value	Level of Significance**
1.	The school district has appointed a health education coordinator responsible for planning written curriculum guidelines	1.88	.331	23.824	.001
2.	The school district has established a curriculum planning committee	1.88	.331	23.824	.001
3.	The school district has developed a conceptually based health scope and sequence chart	1.88	.331	23.824	.001
4.	The school district has designed a set of written objectives	1.88	.331	23.824	.001
5.	The school district has described examples of learning experiences	1.92	.276	28.214	.001
6.	The school district has established a procedure for selection and use of materials	1.92	.400	19.268	.001
7.	The school district has developed written guidelines for teaching strategies at all levels	2.04	.935	7.644	.001
8.	The school district has developed a plan for in-service opportunities to implement health instruction	1.92	.400	19.268	.001
9.	Appropriate staff have been assigned to establish the proposed health education curriculum experimentally	2.00	.289	25.424	.001
10.	Resource materials appropriate to the learner have been obtained and made available to support the program	1.92	.400	19.268	.001
11.	After the experimental phase, the proposed health education program has been revised	1.17	.222	51.778	.001
12.	Appropriate staff positions and resource materials have been obtained	1.13	.439	26.333	.001
13.	A procedure for distributing the teaching resources has been established	1.13	.439	26.333	.001
14.	A management tool has been constructed for use by principals	1.92	.400	19.268	.001
15.	Teaching models have been developed at all levels	2.04	.889	8.066	.001

Table 4. (Continued)

Item Number	Questionnaire Items*	Mean Responses	Standard Deviation	Obtained <u>t</u> value	Level of Significance**
16.	Teaching strategies at all levels have been developed	1.88	.331	23.824	.001
17.	Time allotment has been determined at the building level	1.96	.200	37.561	.001
18.	A plan has been formulated and implemented which provides for teacher sharing and interaction at least three times a year	1.79	.406	20.602	.001
19.	Continuing consultant services have been insured	1.88	.331	23.824	.001
20.	Written evaluation instruments have been constructed	1.88	.331	23.824	.001
21.	A written procedure has been established for selection and operation of a community-school health committee	1.83	.373	21.974	.001
22.	The school district has written policies and guidelines that include: (a) role of personnel; (b) time allotment; (c) selection of materials; (d) teaching environment; and (e) controversial issues	1.83	.373	21.974	.001
23.	A plan has been provided for dissemination of district policies and guidelines	1.92	.276	28.214	.001
24.	A management tool has been developed which indicates steps from implementation to full use of policies and guidelines	2.00	.289	25.424	.001

\*The complete wording of questionnaire items appears in Appendix C.

\*\*The critical value of t at the following levels of significance with one degree of freedom: .001 = 3.767; .01 = 2.807; .05 = 2.069.

2. Has established a curriculum planning committee.
3. Has developed a conceptually based health scope and sequence chart.
4. Has designed a set of written objectives.
5. Has described examples of learning experiences.
6. Has established a procedure for selection and use of materials.
7. Has developed written guidelines for teaching strategies at all levels.
8. Has developed a plan for in-service opportunities to implement health instruction.
9. Has assigned appropriate staff to establish the proposed health education curriculum experimentally.
10. Has obtained and made available resource materials appropriate to the learner.
11. Has revised the proposed health education program following the experimental phase.
12. Has secured appropriate staff positions and resource materials.
13. Has established a procedure for distributing the teaching resources.
14. Has constructed a management tool for use by principals.
15. Has developed teaching models at all levels.
16. Has developed teaching strategies at all levels.
17. Has determined the time allotment for school health instruction

in each building.

18. Has formulated and implemented a plan which provides for teacher sharing and interaction at least three times a year.
19. Has insured that continuing consultant services are available.
20. Has constructed written evaluation instruments.
21. Has established a written procedure for the selection and operation of a community-school health committee.
22. Has written policies and guidelines that include: (a) role of personnel, (b) time allotment, (c) selection of materials, (d) teaching environment, and (e) controversial issues.
23. Has provided a plan for the dissemination of district policies and guidelines.
24. Has developed a management tool which indicates the steps from implementation to full use of policies and guidelines.

Since a statistically significant difference was attained for each activity/resource statement in this section, all 24 statements were accepted as being important in leading to and supporting a districtwide, comprehensive school health instruction program.

### Evaluation

The final section of the questionnaire dealt with activity/resource statements which were believed to be important for the continuing evaluation of all phases of the school health instruction

program, including an assessment of planning, implementation, program outcomes, and feedback processes. This section contained a total of 12 activity/resource statements.

Mean values obtained on each item in this section of the questionnaire were all found to be on the positive side of the six-point response scale, as indicated in Table 5. All mean values fell within the "agree" range on the scale.

Table 5 also indicates that the differences found among all 12 items was statistically significant. A statistical significance level of .001 was attained on all 12 items. These items included:

Item  
Number

1. The school district has assigned specific responsibility for evaluation of the school health instruction program.
2. Time has been assigned for school health instruction program evaluation.
3. A specific budget has been established which supports evaluation activities.
4. A specific instrument has been developed to determine the steps taken to implement the districtwide program.
5. A procedure has been established to provide information about the extent of implementation to program planners.
6. A file of the above information has been forwarded to the local intermediate school district.

Table 5. Responses to Activity/Resource Statements Dealing with Evaluation Showing Areas of Consensus

Item Number	Questionnaire Items*	Mean Responses	Standard Deviation	Obtained t value	Level of Significance **
1.	The school district has assigned specific responsibility for evaluation of the school health instruction program	2.00	.289	25.428	.001
2.	Time has been assigned for school health instruction program evaluation	2.00	.408	18.072	.001
3.	A specific budget has been established which supports evaluation activities	2.00	.408	18.072	.001
4.	A specific instrument has been developed to determine the steps taken to implement the districtwide program	1.92	.276	28.214	.001
5.	A procedure has been established to provide information about the extent of implementation to program planners	2.21	.815	7.771	.001
6.	A file of the above information has been forwarded to the local ISD	2.13	.525	12.804	.001
7.	Instruments, or procedures, for measuring attainment of knowledge, attitudes and behaviours have been identified and are available for use	1.88	.331	23.824	.001
8.	Procedures have been developed and explored to determine teaching models	1.92	.276	28.214	.001
9.	Procedures have been developed and employed to determine teaching strategies	1.92	.276	28.214	.001
10.	An assessment has been made of the resources which are used to support program activities	1.88	.331	23.824	.001
11.	Classroom teachers and other personnel have been trained in the development and administration of evaluation techniques	1.88	.331	23.824	.001

Table 5. (Continued)

Item	Questionnaire Items*	Mean Responses	Standard Deviation	Obtained <u>t</u> value	Level of Significance **
12.	A communication network has been established involving all personnel active in the implementation of the school health instruction program	1.79	.406	20.602	.001

\*The complete wording of questionnaire items appears in Appendix C.

\*\*The critical value of t at the following levels of significance with one degree of freedom: .001 = 3.767; .01 = 2.807; .05 = 2.069.

7. Instruments, or procedures, for measuring attainment of knowledge, attitudes and behaviors have been identified and are available for use.
8. Procedures have been developed and explored to determine teaching models.
9. Procedures have been developed and employed to determine teaching strategies.
10. An assessment is made of the resources which are used to support program activities.
11. Classroom teachers and other personnel have been trained in the development and administration of evaluation techniques.
12. A communication network has been established involving all personnel active in the implementation of the school health instruction program.

All 12 activity/resource statements met the criteria for acceptance. Therefore, all statements in this section of the questionnaire were considered to be important in leading to and supporting a districtwide comprehensive school health instruction program.

A total of 78 of the 80 items included in the questionnaire were found to be statistically significant toward the "agree" side of the six-point response scale. On 74 of the activity/resource statements a statistical significance was attained at the .001 level, while a statistical significance at the .01 level was found on three

activity/resource statements. A statistical significance at the .05 level was attained for one activity resource statement.

In considering the total number of activity/resource statements, mean values which fell within the "strongly agree" range on the six-point response scale were obtained for five items. Mean values which fell within the "agree" range on the six-point response scale were identified with 69 activity/resource statements. A total of six activity/resource statements had mean values which fell within the "agree with reservation" range on the scale.

#### Comparisons Between Various Sub-groups Found within the Expert Committee

The expert committee selected to participate in this study was described in Chapter III. In further analyzing the data obtained from the second questionnaire, the committee members were divided into three types of sub-groups. The first grouping was based upon the size of the district in which committee members carried out their responsibilities. The mean responses of committee members from districts located in large metropolitan areas were compared with the mean responses of expert committee members from districts located in smaller cities. A second grouping provided a comparison of the mean responses of those respondents who had supervisory responsibility with respondents whose main area of responsibility for school

health instruction was in a classroom setting. Mean responses from members of the expert committee whose main responsibility was health education were compared with mean responses obtained from members of the expert committee whose responsibility in a school district was general education.

The null hypothesis of no significant difference between mean values was used to test each sub-group comparison. A two-tailed t test for testing independent means was used to test the null hypothesis.

Differences of Opinion on Activity/Resource  
Statements Dealing with Personnel

On 13 of the 18 activity/resource statements found in Table 6, respondents from districts in metropolitan areas obtained mean responses which fell within the "agree" range on the six-point scale. Members of the expert committee whose districts were in smaller cities had mean responses on 11 of the activity/resource statements in this section of the second questionnaire. Mean responses for all other items in this section fell within the "agree with reservation" range for both groups.

There appeared to be a difference of opinion between respondents from metropolitan areas and respondents from smaller city areas on items dealing with providing a staff member to coordinate

Table 6. t Test of the Differences Between Mean Values of Sub-groups within the Expert Committee on Activity/Resource Statements Dealing with Personnel

Item Number	Questionnaire Item**	Metropolitan Area Mean Response	Smaller City/Rural Areas Mean Response	Obtained <u>t</u> value	Supervisory Responsibility Mean Response	Classroom Responsibility Mean Response	Obtained <u>t</u> value	Health Educators' Mean Response	Non-health Educators' Mean Response	Obtained <u>t</u> value
1.	Written guidelines are available for selecting personnel	2.09	2.38	.707	2.33	2.17	.405	2.30	2.21	.206
2.	A communication link has been established with the state office to update criteria	1.82	2.00	.870	2.08	1.75	1.682	1.80	2.00	.957
3.	A qualified health education coordinator has been assigned districtwide responsibility for coordination	1.82	2.08	1.161	2.08	1.83	1.121	1.70	2.14	2.090*
4.	Time is provided for districtwide coordination on the same basis as for other major disciplines	2.00	2.00	0.000	2.17	1.83	2.101*	1.90	2.07	.994
5.	Budget is at least equal to the average amounts given other major disciplines	2.27	2.54	.570	2.83	2.00	1.893	2.40	2.43	.060
6.	Each elementary school has a staff member responsible for coordination	1.73	2.00	1.508	1.92	1.83	.452	1.80	1.93	.921
7.	One hour released time is provided the elementary building coordinator	3.00	2.69	.743	3.17	2.50	1.651	2.40	3.14	1.881
8.	The budget is determined by a faculty-administrative committee which includes the elementary building coordinator	2.09	2.08	.041	2.17	2.00	.693	2.10	2.07	.117

Table 6. (Continued)

Item Number	Questionnaire Item**	Metropolitan Area Mean Response	Smaller City/Rural Areas Mean Response	Obtained t value	Supervisory Responsibility Mean Response	Classroom Responsibility Mean Response	Obtained t value	Health Educators' Mean Response	Non-health Educators' Mean Response	Obtained t value
9.	Each secondary building has a building coordinator who has state approved health education preparation	2.00	1.92	.510	2.00	1.92	.532	1.90	2.00	.641
10.	The secondary school building health education specialist has at least one period specifically for coordination	3.20	3.00	.415	3.27	2.92	.751	3.00	3.15	.319
11.	The secondary school building budget is determined by a committee which includes the school health education specialist	2.40	1.92	1.714	2.09	2.17	.257	2.20	2.08	.413
12.	Criteria for competency in health education are applied when selecting elementary teachers	2.73	2.78	.090	2.83	2.67	.359	2.40	3.00	1.325
13.	An in-service program has been established to raise the competency of elementary teachers	1.91	2.08	.686	2.17	1.83	1.421	1.90	2.07	.692
14.	The district health education coordinator works with regional and state agencies when determining in-service programs for elementary teachers	1.73	1.85	.692	1.83	1.75	.483	1.80	1.79	.080
15.	Sufficient numbers of health educators are employed to establish a ratio of 1:20 for each health education class offered	3.09	3.15	.152	3.25	3.00	.611	3.20	3.07	.309

Table 6. (Continued)

Item Number	Questionnaire Item**	Metropolitan Area Mean Response	Smaller City/Rural Areas Mean Response	Obtained $t$ value	Supervisory Responsibility Mean Response	Classroom Responsibility Mean Response	Obtained $t$ value	Health Educators' Mean Response	Non-health Educators' Mean Response	Obtained $t$ value
16.	Secondary personnel are hired only from a list supplied by the district coordinator	2.50	2.62	.190	2.64	2.50	2.66	2.60	2.54	.101
17.	In-service programs have been established to raise the competency of secondary personnel	1.90	2.00	.493	2.00	1.92	.411	1.90	2.00	.493
18.	A policy has been established to relieve secondary personnel of teaching responsibility if competency has not been reached within a two-year period	3.10	3.08	.063	3.09	3.08	.022	3.20	3.00	.551

\*The critical value of  $t$  at the .05 level of significance within two degrees of freedom = 2.074.

\*\*The complete wording of questionnaire items appears in Appendix C.

school health instruction in each elementary school and with determining the secondary school health instruction budget. This difference was not found to be statistically significant. No significant differences were found among any of the 18 items in this section. The null hypothesis was not rejected.

When the expert committee was divided into those who, primarily, had supervisory responsibility for school health instruction and those who had classroom responsibility, it was found that mean responses of the supervisory group fell in the "agree" range for 11 of the 18 items. Table 6 also indicates that the mean responses of the supervisory group fell in the "agree" range for 11 of the 18 items. Table 6 also indicates that the mean responses of the classroom group fell within the "agree" range on 14 of the 18 items. All remaining responses fell within the "agree with reservation" range on the six-point response scale for both the supervisory sub-group and the classroom sub-group.

On the activity/resource statement which dealt with establishing a communication link between a district and the State Office of Public Instruction as a means of updating criteria to be used in selecting school health instruction personnel, there appeared to be some difference of opinion between those respondents with supervisory responsibility and those respondents with classroom responsibility. This difference was not statistically significant. A similar finding was

noted in relation to activity/resource statements which suggested that a district provide a budget for school health instruction, provide one hour of release time for coordinators at the elementary building level, and establish an in-service program to raise the health instruction competency level of elementary teachers. On one of the activity/resource statements the difference in the opinions of supervisory personnel and classroom personnel was statistically significant at the .05 level. This statement related to a district's providing time for districtwide coordination on the same basis as for other major disciplines.

A third method of grouping the responses of the expert committee involved separating those members whose primary responsibility was related to health education from those members of the committee whose primary responsibility was in areas other than as health educators. Table 6 indicates that mean responses grouped in this manner fell within the "agree" range on 14 of the 18 items for health educators and on 12 of 18 items for non-health educators. Mean responses within the "agree with reservation" range on the remaining activity/resource statements in this section on personnel were obtained for both health educators and non-health educators.

Statistical significance at the .05 level was attained for the activity/resource statement which suggested that it was important for a district to assign a qualified health education coordinator to

responsibility for districtwide coordination. Some differences were noted in items involving release time for elementary building coordinators and criteria for selecting elementary teachers. The differences noted were not statistically significant.

Differences of Opinion on Activity/Resource  
Statements Dealing with In-service

Members of the expert committee from metropolitan areas and members of the committee from smaller cities appeared to differ slightly in their opinions about the activities and resources believed to be important in leading to and supporting a comprehensive school health instruction program. Mean values of both groups fell within the "strongly agree" range of the six-point response scale on two of the 16 statements. Responses of both groups on the remaining 14 statements in this section fell within the "agree" range on the six-point response scale.

There were apparently some differences in the opinions of respondents from metropolitan areas and respondents from smaller cities about items which suggested that a district should provide for the mechanical arrangements for each in-service program and should make available the needed software and hardware for each in-service program. These differences were not found to be statistically significant. A significant difference at the .05 level was attained on items

dealing with:

Item  
Number

3. Identifying ancillary health personnel
4. Identifying health in-service consumers
11. Developing and making available packages of implementation resources
13. Providing a process for continual feedback from in-service participants.

The null hypothesis was rejected on these four items although the observed difference of opinion seemed to be related to the intensity of agreement and not to a disagreement about the items being important.

Expert committee members who had supervisory responsibility did not appear to differ in their opinions about activity/resource statements related to in-service programs from opinions about the same statements held by members of the expert committee who had classroom responsibility. Table 7 indicates that both groups obtained mean values that fell within the "strongly agree range" for two of the 16 activity/resource statements and within the "agree" range for the remaining 14 statements. Differences were not statistically significant for any of the 16 items.

Grouping the expert committee into health educators and non-health educators seemed to produce some differences of opinion.

Table 7. t Test of the Differences Between Mean Values of Sub-groups within the Expert Committee on Activity/ Resource Statements Dealing with In-service Programs

Item Number	Questionnaire Item**	Metropolitan Area Mean Response	Small City/ Rural Area Mean Response	Obtained t value	Supervisory Responsibility Mean Response	Classroom Responsibility Mean Response	Obtained t value	Health Educators' Mean Response	Non-health Educators' Mean Response	Obtained t value
1.	Written criteria for developing in-service programs	1.91	1.92	.082	1.92	1.92	0.000	2.00	1.86	.841
2.	A process has been established for updating and revision of criteria	1.00	1.08	.917	1.00	1.08	1.000	1.10	1.00	1.190
3.	Representative ancillary health personnel have been identified	1.73	2.08	2.273*	1.92	1.92	0.000	2.00	1.86	.841
4.	Representative health in-service consumers have been identified	1.82	2.15	2.113*	1.92	2.08	.976	2.20	1.86	2.130*
5.	A planning committee has been established which meets at least monthly	1.82	2.08	1.012	2.00	1.92	.320	2.00	1.93	.270
6.	Provisions are made for mechanical arrangements for each in-service program	1.82	2.00	1.640	1.92	1.92	0.000	1.90	1.93	.244
7.	A current list of human resources is maintained	1.82	2.00	.879	1.92	1.92	0.000	2.10	1.79	1.554
8.	The software and hardware needed are available for each in-service program	1.82	2.23	1.939	2.08	2.00	.364	2.10	2.00	.431
9.	Opportunities are provided for program incentives	1.09	1.00	1.096	1.08	1.00	1.000	1.00	1.07	.835
10.	A written plan for publicity has been established	1.91	1.92	.119	1.92	1.92	0.000	1.90	1.93	.244

Table 7. (Continued)

Item Number	Questionnaire Item**	Metropolitan Area Mean Response	Small City/Rural Area Mean Response	Obtained $t$ value	Supervisory Responsibility Mean Response	Classroom Responsibility Mean Response	Obtained $t$ value	Health Educators' Mean Response	Non-health Educators' Mean Response	Obtained $t$ value
11.	Packages of implementation resources are developed and are available	1.64	2.00	2.600*	1.83	1.83	0.000	1.90	1.79	.717
12.	The district provides an evaluation instrument, or process, to be used with each in-service offering	1.73	1.92	1.273	1.83	1.83	0.000	1.90	1.79	.717
13.	The district provides a process for continual feedback from in-service participants	1.64	2.08	2.706*	1.83	1.92	.452	2.00	1.79	1.163
14.	Each in-service participant is personally contacted with two-months of each in-service program	2.36	2.23	.425	2.17	2.42	.812	2.50	2.14	1.159
15.	Evaluation information is used by the planning committee for future planning	1.91	2.08	.686	2.00	2.00	0.000	2.20	1.86	1.441
16.	The district publicizes new health programs, program improvements and specialized training received by staff	1.91	1.92	.082	1.92	1.92	0.000	1.90	1.93	.169

\*The critical value of  $t$  at the .05 level of significance with two degrees of freedom = 2.074.

\*\*The complete wording of questionnaire items appears in Appendix C.

Mean values obtained indicated that two of the 14 items were within the "strongly agree" range and all others were within the "agree" range on the six-point response scale.

Some differences were noted for activity/resource statements dealing with keeping a current list of human resources and using evaluation information for future planning of in-service programs. The differences were not statistically significant. A difference of opinion between health educators and non-health educators about the activity/resource statement dealing with identifying health in-service consumers was statistically significant at the .05 level.

Differences of Opinion on Activity/Resource Statements  
Dealing with Community Involvement

As indicated in Table 8, mean values obtained for activity/resource statements believed to be important in leading to and supporting community involvement in the school health instruction program remained the same for each of the three methods of grouping respondents from the expert committee. Mean values which fell within the "agree" range on the six-point response scale was obtained for nine of the ten items in this section. One mean value fell within the "agree with reservation" range.

When responses were grouped according to the size of the district there appeared to be some differences between the opinions

Table 8. t Test of the Differences Between Mean Values of Sub-groups within the Expert Committee on Activity/Resource Statements Dealing with Community Involvement

Item Number	Questionnaire Items**	Metropolitan Area Mean Response	Small City/Rural Area Mean Response	Obtained t value	Supervisory Responsibility Mean Response	Classroom Responsibility Mean Response	Obtained t value	Health Educators' Mean Response	Non-health Educators' Mean Response	Obtained t value
1.	Representatives from community groups have been identified	1.73	1.92	1.260	1.92	1.75	1.077	1.70	1.93	1.487
2.	Written guidelines have been established for the committee's operation	2.09	2.08	.066	2.08	2.08	0.000	1.90	2.21	1.554
3.	Basic purposes of the committee have been identified and are available in writing	1.91	1.92	.119	2.00	1.83	1.491	1.90	1.93	.244
4.	Local forms of communication have been identified	1.91	2.08	1.424	2.00	2.00	0.000	2.10	1.93	1.437
5.	Community news outlets are incorporated into the in-service training programs	2.18	2.08	.565	2.00	2.25	1.397	2.30	2.00	1.685
6.	Information concerning the health education program is supplied to all segments of the media on a monthly basis	2.73	2.85	.433	2.67	2.92	.929	2.80	2.79	.050
7.	Media representatives and members of the community have access to the health program through a process available in writing	2.00	2.00	0.000	1.92	2.08	.976	2.00	2.00	0.000
8.	A written plan exists for disseminating information about the health instruction program to the community	1.11	2.00	1.096	1.92	2.00	1.000	2.00	1.93	.835

Table 8. (Continued)

Item Number	Questionnaire Item**	Metropolitan Area Mean Response	Small City/Rural Area Mean Response	Obtained $t$ value	Supervisory Responsibility Mean Response	Classroom Responsibility Mean Response	Obtained $t$ value	Health Educators' Mean Response	Non-health Educators' Mean Response	Obtained $t$ value
9.	A written, updated list of people and groups available as resources is distributed to all school health instruction personnel	1.64	2.00	2.600	1.75	1.92	1.077	1.80	1.86	.354
10.	A process exists for maintaining and updating a list of community resources	1.73	2.08	2.273	1.83	2.00	1.006	1.90	1.93	.169

\* The critical value of  $t$  at the .05 level of significance with two degrees of freedom = 2.074.

\*\* The complete wording of questionnaire items appears in Appendix C.

of respondents from metropolitan areas and respondents from smaller cities on the item related to identifying local forms of communication. These differences were not statistically significant. Differences of opinion about items dealing with the distribution of a list of people and groups available as resources, and the provision for maintaining and updating a list of community resources were statistically significant at the .05 level.

Differences of opinion between supervisory personnel and classroom personnel was not statistically significant for any of the ten items in this section on community involvement. Some differences of opinion seemed to be evident about items related to the basic purposes of a school and community school health instruction committee, and to incorporating community news outlets into the in-service training programs.

Health education personnel and non-health education personnel did not differ at a statistically significant level in their opinions about the activity/resource statements related to community involvement. There appeared to be some differences in opinions about statements related to:

Item  
Number

1. Identifying representatives from community groups
2. Establishing written guidelines for the operation of a

Item  
Number

school-community committee

4. Identifying local forms of communication
5. Incorporating community news outlets into the in-service training programs.

Differences of Opinion about Activity/Resource Statements  
Dealing with Written Guidelines

Responses of expert committee members from metropolitan areas and members from smaller cities resulted in mean values for 21 of the 24 items dealing with written guidelines that fell within the "agree" range. Mean values which fell within the "strongly agree" range were obtained for three of the 24 items. These data are presented in Table 9.

Some differences of opinion between metropolitan area respondents and small city respondents seemed to be present in items dealing with:

Item  
Number

5. Describing examples of learning experiences
7. Developing written guidelines for teaching strategies
9. Assigning appropriate staff to establish the curriculum on an experimental basis

**Table 9.  $t$  Test of the Differences Between Mean Values of Sub-groups within the Expert Committee on Activity/ Resource Statements Dealing with Written Guidelines**

Item Number	Questionnaire Item**	Metropolitan Area Mean Response	Small City/ Rural Area Mean Response	Obtained $t$ value	Supervisory Responsibility Mean Response	Classroom Responsibility Mean Response	Obtained $t$ value	Health Educators' Mean Response	Non-health Educators' Mean Response	Obtained $t$ value
1.	The district has appointed a health education coordinator responsible for planning written curriculum guidelines	1.82	1.92	.750	1.83	1.92	.604	1.80	1.93	.921
2.	The district has established a curriculum planning committee	1.82	1.92	.750	1.83	1.92	.604	1.80	1.93	.921
3.	The district has developed a conceptually based scope and sequence chart	1.82	1.92	.750	1.92	1.83	.604	1.90	1.86	.301
4.	The district has designed a set of written objectives	1.82	1.92	.750	1.92	1.83	.604	1.90	1.86	.301
5.	The district has described examples of learning experiences	1.82	2.00	1.640	1.83	2.00	1.491	1.90	1.93	.244
6.	The district has established a procedure for selection and use of materials	1.73	2.08	2.273*	1.83	2.00	1.006	2.10	1.79	1.975
7.	The district has developed written guidelines for teaching strategies	1.73	2.31	1.529	1.92	2.17	.635	1.90	2.14	.608
8.	The district has developed a plan for in-service opportunities	1.73	2.08	2.273†	1.83	2.00	1.006	2.00	1.86	.841

Table 9. (Continued)

Item Number	Questionnaire Item**	Metropolitan Area Mean Response	Small City/Rural Area Mean Response	Obtained t value	Supervisory Responsibility Mean Response	Classroom Responsibility Mean Response	Obtained t value	Health Educators' Mean Response	Non-health Educators' Mean Response	Obtained t value
9.	Appropriate staff have been assigned to establish the curriculum experimentally	1.91	2.08	1.424	1.92	2.08	1.419	2.10	1.93	1.437
10.	Resource material appropriate to the learner has been obtained and made available to support the program	1.73	2.08	2.273*	1.75	2.08	2.148*	1.90	1.93	.169
11.	After the experimental phase, the proposed health education program will be revised	1.09	1.23	.700	1.17	1.07	0.000	1.20	1.14	.281
12.	Appropriate staff positions and resource materials have been obtained	1.09	1.15	.337	1.25	1.00	1.397	1.00	1.21	1.163
13.	A procedure for distributing the teaching resources has been established	1.09	1.15	.337	1.25	1.00	1.397	1.00	1.14	.228
14.	A management tool has been constructed for use by principals	1.91	1.92	.082	1.92	1.92	0.000	2.00	1.86	.841
15.	Teaching models have been developed at all levels	1.82	2.23	1.116	1.92	2.17	.667	1.80	2.21	1.107
16.	Teaching strategies at all levels have been developed	1.82	1.92	.750	1.92	1.83	.604	1.80	1.93	.921
17.	Time allotment has been determined at the building level	2.00	1.92	.917	2.00	1.92	1.000	1.90	2.00	1.190

Table 9. (Continued)

Item Number	Questionnaire Item**	Metropolitan Area Mean Response	Small City/Rural Area Mean Response	Obtained $\bar{t}$ value	Supervisory Responsibility Mean Response	Classroom Responsibility Mean Response	Obtained $\bar{t}$ value	Health Educators' Mean Response	Non-health Educators' Mean Response	Obtained $\bar{t}$ value
18.	A plan has been formulated and implemented which provides for teacher sharing and interaction at least three times a year	2.00	1.92	.917	2.00	1.92	1.000	1.90	2.00	1.190
19.	Continuing consultant services have been insured	1.82	1.92	.75	1.83	1.92	.604	1.90	1.86	.301
20.	Evaluation instruments have been constructed	1.82	1.92	.75	1.92	1.83	.604	1.90	1.86	.301
21.	A written procedure has been established for selection and operation of a community-school health committee	1.73	1.92	1.273	1.83	1.83	0.000	1.80	1.86	.354
22.	The district has written policies and guidelines which include: (a) role of personnel; (b) time allotment; (c) selection of materials	1.73	1.92	1.273	1.75	1.92	1.077	1.80	1.86	.354
23.	A plan has been provided for dissemination of district policies and guidelines	1.91	1.92	.119	1.92	1.92	0.000	1.90	1.93	.244
24.	A management tool has been developed which indicates steps from implementation to full use of policies and guidelines	1.91	2.08	1.424	2.00	2.00	0.000	2.00	2.00	0.000

\*The critical value of  $\bar{t}$  at the .05 level of significance with two degrees of freedom = 2.074.

\*\*The complete wording of the questionnaire items appears in Appendix C.

Item  
Number

18. Formulating and implementing a plan which provides for teacher sharing
24. Developing a management tool which indicates the steps from implementation to full use of written policies and guidelines

A statistically significant difference was not obtained for these items. Activity/resource statements which did attain a statistically significant difference at the .05 level included items related to:

Item  
Number

6. Establishing a procedure for the selection and use of materials
8. Developing a plan for in-service opportunities
10. Obtaining and making available resource material appropriate to the learner

Grouping the respondents according to supervisory or classroom responsibility produced some apparent differences of opinion. Mean values obtained for each item, as presented in Table 9, did not reflect this difference. Responses from both groups produced mean values within the "strongly agree" range on the six-point response scale on three of 24 items, while the mean values on two items fell within the "agree" range.

Differences in opinions between respondents with supervisory responsibility seemed to be indicated on items dealing with:

Item  
Number

5. Describing examples of learning experiences
9. Establishing the curriculum experimentally
12. Securing appropriate staff positions and resource materials
13. Developing a procedure for distributing teaching resources

Both groups seemed to feel that these statements were important but there was some apparent disagreement between groups as to how strongly the statement should be supported. Differences were not found to be statistically significant about these items. Differences in the opinions of supervisory and classroom personnel was found to be statistically significant at the .05 level on only one item. This statement suggested that school districts should have obtained and made available resource material appropriate to the learner.

No significant differences were found among any of the 24 items when comparing the opinions of health educators and non-health educators. Mean values obtained for each item reflected the same breakdown as for the other sub-group analyses conducted on this section of the questionnaire. Although not statistically significant, there did appear to be some difference of opinion between health educators and non-health educators about items dealing with establishing a procedure for the selection and use of materials, and with assigning appropriate staff to establish the curriculum on an experimental basis.

Differences of Opinion about Activity/Resource Statements  
Dealing with Evaluation

Table 10 indicates that the mean values obtained from the 12 items in this section of the questionnaire did not fall outside of the "agree" range on the six-point response scale. This agreement was true regardless of the way the expert committee was divided into sub-groups.

When the expert committee was divided into respondents from metropolitan areas and respondents from smaller city areas there appeared to be some differences of opinion about items dealing with:

Item  
Number

3. Establishing a specific budget
4. Developing a specific instrument to determine the steps to be taken to implement the districtwide program
5. Establishing a procedure to provide information about the extent of implementation for planners
12. Establishing a communication network involving all personnel involved in the program

None of the differences was found to be statistically significant. There was a statistically significant difference between the opinions of respondents from metropolitan areas and respondents from small city areas in the statement identifying and making available for use,

Table 10. t Test of the Differences Between Mean Values of Sub-groups within the Expert Committee on Activity/Resource Statements Dealing with Evaluation

Item Number	Questionnaire Item**	Metropolitan Area Mean Response	Small City/Rural Area Mean Response	Obtained t value	Supervisory Responsibility Mean Response	Classroom Responsibility Mean Response	Obtained t value	Health Educators' Mean Response	Non-health Educators' Mean Response	Obtained t value
1.	The district has assigned specific responsibility for evaluation of the school health instruction program	2.00	2.00	0.000	2.08	1.92	1.419	2.00	2.00	0.000
2.	Time has been assigned for school health instruction program evaluation	2.00	2.00	0.000	2.08	1.92	0.976	2.00	1.93	0.470
3.	A specific budget has been established which supports evaluation activities	1.82	2.08	1.850	1.92	2.08	0.976	2.20	1.86	2.130*
4.	A specific instrument has been developed to determine the steps taken to implement the districtwide program	1.82	2.00	1.640	1.92	1.92	0.000	2.00	1.86	1.243
5.	A procedure has been established to provide information about the extent of implementation to planners	1.91	2.46	1.681	2.08	2.33	0.729	2.30	2.07	0.629
6.	A file of the above information has been forwarded to the local ISD	2.18	2.08	0.469	2.33	1.92	2.029	2.00	2.21	0.964
7.	Instruments, or procedures, for measuring attainment of knowledge, attitudes and behaviors have been identified and are available for use	1.73	2.00	2.116*	1.83	1.92	0.604	2.00	1.79	1.585
8.	Procedures have been developed and explored to determine teaching models	1.91	1.92	0.119	1.92	1.92	0.000	1.90	1.93	0.244

Table 10. (Continued)

Item Number	Questionnaire Items**	Metropolitan Area	Small City/ Rural Area	Obtained <u>t</u> value	Supervisory	Classroom	Obtained <u>t</u> value	Health Educators'	Non-health	Obtained <u>t</u> value
		Mean Response	Mean Response		Responsibility Mean Response	Responsibility Mean Response		Mean Response	Educators' Mean Response	
9.	Procedures have been developed and employed to determine teaching strategies	1.91	1.92	.119	1.92	1.92	0.000	1.90	1.93	.244
10.	An assessment has been made of the resources which are used to support program activities	1.91	1.85	.099	1.92	1.83	.604	1.90	1.86	.301
11.	Classroom teachers and other personnel have been trained in the development and administration of evaluation techniques	1.82	1.92	.750	2.00	1.75	1.923	1.80	1.93	.921
12.	A communication network has been established involving all personnel active in the implementation of the school health instruction program	1.64	1.92	1.761	1.75	1.83	.483	1.90	1.79	.717

\*The critical value of t at the .05 level of significance with two degrees of freedom = 2.074.

\*\*The complete wording of the questionnaire items appears in Appendix C.

instruments, or procedures, for measuring attainment of knowledge, attitudes and behaviors.

Differences of opinion between members of the expert committee who held supervisory roles in health education and members of the expert committee whose role was mainly in the classroom were not found to be statistically significant as indicated in Table 10.

There did seem to be some differences in items which dealt with:

Item  
Number

1. Assigning specific responsibility for evaluation
6. Forwarding a file of evaluation information to the intermediate school district
11. Training classroom teachers and other personnel in the development and administration of evaluation techniques

Opinions of health educators and non-health educators on the expert committee differed only slightly. The activity/resource statement dealing with establishing a specific budget which supports evaluation activities attained a statistically significant difference at the .05 level. There apparently were some differences of opinion about the activity/resource statement which suggested that a school district should identify and make available instruments, or procedures for measuring attainment of knowledge, attitudes and behaviors. These differences were not statistically significant.

While there did seem to be other differences of opinion between the sub-groups within the expert committee, these differences were not found to be statistically significant.

Mean values obtained for each of the items in the questionnaire fell with the "agree" side of the six-point response scale regardless of the grouping done within the expert committee. Differences of opinion seemed to be related, in each case, to the degree of agreement and not to a disagreement about whether the statement was important to a districtwide, comprehensive school health instruction program.

## V. SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Chapter V presents (1) a summary of this study; (2) the conclusions drawn from the data; and (3) implications.

### Summary

The purpose of this study was to identify program activities and resources believed to be important in leading to and supporting districtwide school health instruction programs in the State of Washington, according to an expert committee drawn from those who have worked in health instruction in the State. Reactions to activity/resource statements about school health instruction were obtained from members of the expert committee, using a modified Delphi technique.

A review of related literature and research revealed a lack of direction for those educators responsible for planning and administering school health instruction programs. This review also indicated that most school districts do not now have a comprehensive school health instruction program.

This study has been designed to identify the areas of agreement and disagreement among members of an expert committee of educators working in school health instruction programs about activities and resources necessary for districtwide, comprehensive school

health instruction programs. An identification of these areas of agreement and disagreement was seen as adding data to existing information to the standards that could be used in evaluating the organization and administration of school health instruction.

The five research questions posed for this investigation were:

1. What are the program activities and resources necessary to insure adequate health instruction personnel to administer and carry out a districtwide, comprehensive school health instruction program?
2. What are the program activities and resources necessary to be provided by a school district to meet the in-service needs of school health instruction personnel?
3. What are the program activities and resources needed to insure positive interrelationships between school health instruction personnel and the community?
4. What are the program activities and resources involved in providing written guidelines for the operation of a districtwide school health instruction program?
5. What are the program activities and resources needed to develop an evaluation process which involves assessment of planning, implementation, program outcomes, and feedback?

The opinions about the program activities and resources believed to be important in leading to and supporting districtwide,

comprehensive school health instruction programs in the State of Washington were obtained from the responses of the expert committee to 80 scaled-response items contained in the modified Delphi questionnaire. The questionnaire was mailed to the respondents on two separate occasions. The second mailing was accompanied by a summary of the comments made on the first questionnaire and included information about the mean response on each item. All members of the expert committee returned both questionnaires. Respondents also included comments supporting or rejecting activity/resource statements on the second questionnaire when they felt strongly about their position.

A t test comparison between the sample mean and the population mean of 3.5 on the six-point response scale was made for each of the activity/resource statements in the second questionnaire. The 80 activity/resource statements were divided into five clusters: 18 items formed the cluster related to personnel; 16 items related to in-service; ten items dealt with community involvement; 24 items related to written guidelines; and 12 items pertained to evaluation. In addition, the expert committee was divided into sub-groups in three different ways as follows:

1. Committee members from metropolitan areas were contrasted with committee members from smaller city areas.
2. Committee members whose primary responsibility in school

health instruction was in a supervisory capacity were contrasted with committee members whose primary responsibility was in the classroom.

3. Committee members who were primarily health educators were contrasted with committee members who were primarily involved in general education.

A two-tailed  $t$  test for testing independent means was used to test the significance of mean differences within each sub-group pairing concerning the 80 items included in the second questionnaire.

Eighty null-hypotheses were tested to answer the five research questions and 240 null-hypotheses were tested to compare sub-groups within the expert committee.

The first question considered the program activities and resources believed to be important in insuring adequate health instruction personnel. A total of 16 items were identified as having met the criteria for being important. Of the 16 items, 12 were statistically significant at the .001 level, three were statistically significant at the .01 level, and one was statistically significant at the .05 level. The differences obtained on the remaining two items were not significant.

The two items from the questionnaire section on personnel which did not show a difference which was statistically significant included:

Item  
Number

10. Secondary school building health education specialists have at least one class period free to carry out the responsibility of coordinating the school health instruction program.

The mean response on this item was 3.09 for the final questionnaire. Mean response on the first questionnaire had been 3.04. The standard deviation computed for this item was 1.71 on the first questionnaire and 1.10 on the second questionnaire.

15. Sufficient health education specialists have been hired to establish a 1:20 ratio in each health education class.

The mean response on this questionnaire item was 3.13, while on the first questionnaire it had been 3.29. A standard deviation of 0.97 on the final questionnaire compares with a standard deviation of 1.54 on the first questionnaire.

Although there was less variation in the responses from the expert committee on the second questionnaire for both of these questionnaire items, it seems obvious that the amount of variation in responses remained high.

The second question considered the program activities and resources believed to be important in meeting the in-service program needs of school health instruction personnel. All of the 16 items in

this section met the criteria for being considered important. Differences among all 16 items were found to be statistically significant at the .001 level.

The third question considered the program activities and resources believed to be important in insuring positive interrelationships between school health instruction personnel and the community. The differences for each item in this section was statistically significant at the .001 level.

The fourth question considered the program activities and resources believed to be important in providing written guidelines for the operation of a districtwide school health instruction program. A statistically significant difference at the .001 level was attained for each of the 24 items in this section. All items met the criteria for being important to establishing and supporting a districtwide, comprehensive school health instruction program.

The fifth question considered the program activities and resources believed to be important in developing an evaluation process to assess all phases of the school health instruction program. Differences attained on all 12 items were statistically significant at the .001 level. All items in this section met the criteria for being considered important to a districtwide comprehensive school health instruction program.

Of the 80 items included in the second questionnaire only two

failed to meet the necessary criteria for being important statements of activities and resources believed to be important in leading to and supporting a districtwide comprehensive school health instruction program. Mean values obtained for each item indicated that five of the 80 items fell within the "strongly agree" range on the six-point response scale, 69 items fell within the "agree" range, and six items fell within the "agree with reservation" range.

For further analysis of the data, the expert committee was divided into three types of sub-groups. Opinions of expert committee members from metropolitan areas differed, at a statistically significant level, from the opinions of expert committee members from smaller cities on a total of ten questionnaire items. Table 11 summarizes these questionnaire items and presents data obtained from statistical analysis of the first and second questionnaires.

Four questionnaire items were from the section on in-service programs. These items were:

Item  
Number

3. Representative ancillary health personnel have been identified.
4. Representative health in-service consumers have been identified.
11. Packages of implementation resources are developed and are available.

Table 11. Means and Standard Deviations of Items of Questionnaire #1 and Questionnaire #2 which Attained Statistically Significant Differences During Analysis of Metropolitan and Small City/Rural Sub-groups

Section and Item Number	Questionnaire Item*	Mean Responses				Standard Deviations			
		Metropolitan Area Questionnaire #1	Small City/Rural Area Questionnaire #1	Metropolitan Area Questionnaire #2	Small City/Rural Area Questionnaire #2	Metropolitan Area Questionnaire #1	Small City/Rural Area Questionnaire #1	Metropolitan Area Questionnaire #2	Small City/Rural Area Questionnaire #2
<b>In-service</b>									
3.	Representative ancillary health personnel have been identified	1.64	1.85	1.73	2.08	0.98	0.95	0.45	0.27
4.	Representative health in-service consumers have been identified	1.73	1.92	1.82	2.15	1.14	0.95	0.39	0.36
11.	Packages of implementation resources are developed and are available	1.36	1.75	1.64	2.00	0.48	0.83	0.48	0.00
13.	The district provides a process for continual feedback from in-service participants	1.82	2.31	1.64	2.08	0.72	1.44	0.48	0.27
	Total	6.55	7.83	6.83	8.31	3.32	4.17	1.80	.90
	Average	1.64	1.96	1.66	2.08	.83	1.04	.45	.23
<b>Community Involvement</b>									
9.	A written, updated list of people and groups available as resources is distributed to all school health instruction personnel	1.64	1.92	1.64	2.00	0.98	1.38	0.48	0.00
10.	A process exists for maintaining and updating a list of community resources	1.55	1.83	1.73	2.08	0.78	1.40	0.45	0.27
	Total	3.19	3.75	3.37	4.08	1.76	2.78	.93	.27
	Average	1.60	1.88	1.69	2.04	.88	1.39	.47	.14

Table 11. (Continued)

Section and Item Number	Questionnaire Item*	Mean Responses				Standard Deviations			
		Metropolitan Area Questionnaire #1	Small City/Rural Area Questionnaire #1	Metropolitan Area Questionnaire #2	Small City/Rural Area Questionnaire #2	Metropolitan Area Questionnaire #1	Small City/Rural Area Questionnaire #1	Metropolitan Area Questionnaire #2	Small City/Rural Area Questionnaire #2
<b>Written Guidelines</b>									
6.	The district has established a procedure for selection and use of materials	1.82	1.77	1.73	2.08	0.83	0.80	0.45	0.27
8.	The district has developed a plan for in-service opportunities	1.64	2.08	1.73	2.08	0.77	1.49	0.45	0.27
10.	Resource material appropriate to the learner has been obtained and made available to support the program	1.36	1.45	1.73	2.08	0.64	0.66	0.45	0.27
	Total	4.82	5.30	5.19	6.24	2.24	2.95	1.35	.81
	Average	1.61	1.77	1.73	2.08	.75	.98	.45	.27
<b>Evaluation</b>									
7.	Instruments or procedures, for measuring attainment of knowledge, attitudes and behaviors have been identified and are available for use	2.18	2.15	1.73	2.00	1.64	1.29	0.45	0.00

\*The complete wording of the questionnaire items appears in Appendix C.

Item  
Number

13. The district provides a process for continual feedback from in-service participants.

Within the questionnaire section on community involvement two items obtained a difference which was statistically significant. These items were:

Item  
Number

9. A written, updated list of people and groups available as resources is distributed to all school health instruction personnel.
10. A process exists for maintaining and updating a list of community resources.

Three questionnaire items in the section on written guidelines had a difference which was found to be statistically significant. These items were:

Item  
Number

6. The district has established a procedure for selection and use of materials.
8. The district has developed a plan for in-service opportunities.
10. Resource materials appropriate to the learner have been obtained and made available to support the program.

One questionnaire item from the section on evaluation had a difference between the metropolitan sub-group and the small city/rural sub-group which was statistically significant. This item was:

Item  
Number

7. Instruments, or procedures for measuring attainment of knowledge, attitudes and behaviors have been identified and are available for use.

On the second questionnaire all mean values obtained on the ten questionnaire items for the metropolitan sub-group were lower than mean values obtained for the small city/rural sub-group on these items. The average mean value for the metropolitan sub-group was near the "strongly agree" range on the six-point response scale, while the average mean value for the small city/rural sub-group was near the center of the "agree" range on the six-point response scale. This consistency of position was not noted on the first questionnaire where the mean value obtained on two of the ten questionnaire items included in this summary was higher for the metropolitan sub-group than for the small city/rural sub-group.

More variation within a sub-group was noted for the metropolitan area members of the expert committee on all ten of the questionnaire items in this summary analysis. The average standard deviation on the second questionnaire for the metropolitan sub-group

was 0.45 and for the small city/rural sub-group the average was 0.20. On three of the questionnaire items in this summary there was no variation in the responses within the small city/rural sub-group. The average change in standard deviations between the first and second questionnaires was 0.44 for the metropolitan sub-group, while the small city/rural sub-group had an average change in standard deviations of 0.92 on the ten questionnaire items under analysis in this summary.

It is possible that respondents from metropolitan areas respond to activity/resource statements about health education more favorably than respondents from small city/rural areas because resources related to health are more readily available in or near metropolitan centers. This could make ideal programs seem more attainable to health educators working in this environment. With limited resources and personnel available to small city/rural school districts it would seem difficult to envision the ability to attain ideal program goals. Small city/rural respondents exhibited little variation in response on the second questionnaire. This might result from similar situations in the school districts represented by the respondents.

Opinions of expert committee members who had supervisory responsibility for school health instruction were compared with opinions of expert committee members whose main responsibility in school health instruction was in the classroom. This second

Table 12. Means and Standard Deviations of Items of Questionnaire #1 and Questionnaire #2 which Attained Statistically Significant Differences During Analysis of Supervisory and Classroom Sub-groups

Section and Item Number	Questionnaire Item*	Mean Responses				Standard Deviations			
		Supervisors Questionnaire #1	Classroom Personnel Questionnaire #1	Supervisors Questionnaire #2	Classroom Personnel Questionnaire #2	Supervisors Questionnaire #1	Classroom Personnel Questionnaire #1	Supervisors Questionnaire #2	Classroom Personnel Questionnaire #2
Personnel 4	Time is provided for districtwide coordination on the same basis as for other disciplines	2.67	1.25	2.17	1.83	1.75	0.60	0.37	0.37
Written Guidelines 10.	Resource material appropriate to the learner has been obtained and made available to support the program	1.50	1.30	1.75	2.08	0.76	0.46	0.43	0.28
	Total	4.17	2.55	3.92	3.91	2.51	1.06	.80	.65
	Average	2.09	1.28	1.96	1.96	1.26	.53	.40	.33

\*A complete wording of the questionnaire items appears in Appendix C.

method of categorizing the expert committee into sub-groups resulted in two questionnaire items in which the difference was statistically significant. The first item occurred in the section on personnel:

Item  
Number

4. Time is provided for districtwide coordination on the same basis as for other disciplines.

The second item occurred in the questionnaire section on written guidelines:

Item  
Number

10. Resource material appropriate to the learner has been obtained and made available to support the program.

The average mean values obtained on the first questionnaire for the two items attaining a difference which was statistically significant indicated a position of "strongly agree" for the classroom personnel sub-group, while the supervisory sub-group position was within the "agree" range. On the second questionnaire the average means values was similar for both sub-groups.

On the two items under consideration in this summary the supervisory sub-group standard deviation was the same as the classroom sub-group on the item from the personnel section of the questionnaire. On the second item the standard deviation was larger for the supervisory sub-group. Standard deviations of the supervisory

sub-group were larger on both of these questionnaire items on the first questionnaire. The average change in standard deviations between the first and second questionnaires for the supervisory sub-group was 0.86, while the average change in standard deviations for the classroom sub-group on the two questionnaire items was 0.26.

There seemed to be little difference between the supervisory sub-group and the classroom sub-group. Only two questionnaire items were found to have a difference which was statistically significant. It is possible that the mixing of expert committee members from districts of varying size in each of the subgroups resulted in two groups that were similar in their thinking. Another possibility is that supervisory personnel and classroom personnel involved in school health are not as opposed in their viewpoints as might be true of similar personnel in other areas of education.

A third classification of the expert committee into sub-groups compared the responses of health educators with the responses of those who were classified as 'non-health' educators. Three questionnaire items had mean responses which were different at a statistically significant level. The one item from the personnel section was:

Item  
Number

3. A qualified health education coordinator has been assigned districtwide responsibility for coordination

Table 13. Means and Standard Deviations of Items of Questionnaire #1 and Questionnaire #2 which Attained Statistically Significant Differences During Analysis of Health Educator and Non-health Educator Sub-groups

Section and Item Number	Questionnaire Items*	Mean Responses				Standard Deviations			
		Health Educators' Questionnaire #1	Non-health Educators' Questionnaire #1	Health Educators' Questionnaire #2	Non-health Educators' Questionnaire #2	Health Educators' Questionnaire #1	Non-health Educators' Questionnaire #1	Health Educators' Questionnaire #2	Non-health Educators' Questionnaire #2
Personnel 3.	A qualified health education coordinator has been assigned districtwide responsibility for coordination	1.30	1.86	1.70	2.14	0.64	1.13	0.46	0.52
In-service 4.	Representative health in-service consumers have been identified	2.11	1.64	2.20	1.86	1.29	0.81	0.40	0.35
Evaluation 3.	A specific budget has been established which supports evaluation activities	2.44	1.93	2.20	1.86	1.77	1.28	0.40	0.35
	Total	5.85	5.43	6.10	5.86	3.70	3.22	1.26	1.22
	Average	1.95	1.81	2.03	1.95	1.23	1.07	.42	.41

\*The complete wording of questionnaire items appears in Appendix C.

One questionnaire item was from the section on in-service:

Item  
Number

4. Representative health in-service consumers have been identified

The final questionnaire item considered in this summary analysis of the health educator and non-health educator sub-groups was from the questionnaire section on evaluation:

Item  
Number

3. A specific budget has been established which supports evaluation activities

The change in mean values between questionnaires for the three items attaining a statistically significant difference when comparing health educator and non-health educator sub-groups did not seem to alter the relationship of these mean values. The mean values obtained for the health educator sub-group was slightly higher than the mean values obtained for the non-health educator sub-group.

A comparison of standard deviations for the health educator and non-health educator sub-groups on the three questionnaire items under consideration in this summary revealed that the standard deviation for the non-health educator sub-group was larger on the one questionnaire item from the section on personnel than the standard deviation on the same item for the health educator sub-group. On

the remaining two questionnaire items the health educator sub-group had the larger standard deviation. On the first questionnaire the standard deviations obtained for the health educator sub-group were larger on all three questionnaire items considered in this summary. The average change in standard deviations between the first and second questionnaires was 0.81 for the health educator sub-group and 0.67 for the non-health educator sub-group.

Dividing the expert committee into two groups identified as health educators and non-health educators failed to produce many differences of opinion. This could be explained by the fact that the non-health educators selected for the expert committee had been involved in a variety of school health instruction activities. Although formal training and current responsibility in education might be different for the two sub-groups, practical experience in school health instruction could make the two groups very similar.

### Conclusions

The following general conclusions are supported by the findings in this study:

1. Providing one free class period to carry out the responsibility of coordinating the school health instruction program at the secondary level is not important according to opinions of the expert committee. The difference between the mean value of

the committee response and a position of neutrality on the six-point scale is not significant.

2. A ratio of 1:20 in each health education class is not considered important according to the opinions of the expert committee. The difference between the mean value of the committee's responses and a position of neutrality on the six-point response scale was not significant.
3. A majority of the activities and resources identified in the statements included in the second Delphi questionnaire were considered to be important in leading to and supporting a districtwide comprehensive school health instruction program according to the opinions of the expert committee. A significant difference was observed in 78 of the 80 items.
4. The opinions of respondents from metropolitan areas were generally related to opinions of respondents from small city areas. Significant differences occurred in only ten of the 80 items.
5. The opinions of respondents holding supervisory responsibility were generally related to opinions of respondents holding classroom responsibility. Significant differences in mean values occurred in only two of the 80 items.
6. The opinions of respondents who were primarily health educators were generally related to opinions of respondents who

were primarily in general education. The difference in mean values was significant in only three of the 80 items.

The study revealed a significant consensus among members of the expert committee for activities and resources important to school health instruction programming. All 80 items used in the study received mean values which fell within the "agree" side of the six-point "agree-disagree" response scale. When there was a difference of opinion between sub-groups within the expert committee, the disagreement seemed to be in terms of intensity rather than direction.

### Implications

Developing a set of program activities and resources which are believed to be important in leading to and supporting districtwide, comprehensive school health instruction will be helpful in providing educational leaders standards against which they can assess their respective school health instruction programs. Baseline data provided from this type of assessment will be useful in school district planning for comprehensive programming.

In this study, five major areas involved in organizing and administering comprehensive school health instruction programs were identified. Each area will provide information to program planners about the steps involved in establishing and supporting a

comprehensive program. Programs identified in the past have been fragmented and poorly organized (35). This step-by-step program should be useful to all personnel involved in school health instruction.

A total of 24 individuals with a variety of responsibilities toward school health instruction programs participated in this study. It would seem advisable to involve other groups and individuals in responding to the findings of this study. There may be some benefits in obtaining reactions to the identified activity/resource statements from community health educators, as well as from other school health educators in other states. Parents and students should also have an opportunity to react to any proposed changes in existing educational programs.

Written documents have a tendency to be placed aside by those not directly involved in developing the document. It would seem advisable to plan implementation strategies that would involve those who might be directly affected by the activity/resource statements identified as being important in leading to and supporting districtwide, comprehensive school health instruction programs. The methodology employed in utilizing these statements in the State of Washington could influence the extent of success of this study. Actual field testing of the statements, as a variety of school districts work toward improving the comprehensive nature of their school health instruction programs, could provide important feedback for revising this current

research.

School health education is not limited to health instruction. School health services and the healthful school environment might also benefit from this process.

The modified Delphi process used in this study has some limitations. When participants are not used to develop the main questionnaire there is the possibility that some new and innovative areas of concern may be omitted. It is also more difficult to develop the questionnaire using language which is acceptable and understandable to those who will participate as respondents.

Further analysis of the sub-groups within the expert committee should be of some value. It may be that the sub-groups identified for this study are not mutually exclusive. The possibility exists that a member of the expert committee who was identified as a health educator respondent might actually be responding to the activity/resource statements based on the influence of district size. Additional exploration of factors which influence responses to activity/resource statements about school health instruction programs may make a significant contribution to understanding the difficulties involved in implementing these programs.

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## APPENDICES

APPENDIX A

PARTICIPANTS IN SUMMER TASK FORCE

## PARTICIPANTS IN SUMMER TASK FORCE

James Adamson, Director, Physical  
Education Department  
Moses Lake Public Schools  
1318 West Ivey Avenue  
Moses Lake, Washington 98837

Mary Begley, Health Education Teacher  
Clyde Hill Elementary  
9601 N. E. 24th  
Bellevue, Washington 98004

Toni Boss, Elementary Teacher  
Edison Elementary School  
3114 So. 58th  
Tacoma, Washington 98409

David Brogan, Health Educator, Board  
of Cooperative Education  
61 Parrott Road  
W. Nyack, New York 10994

William Burby, Health Education Teacher  
Vashon High School  
Rt. 2, Box 211  
Burton, Washington 98031

Paul Cohen, Coordinator, Drug and  
Health Education  
Suite 234, 4055 So. Spencer  
Las Vegas, Nevada 89109

Keith Coon, High School Teacher  
Mead High School  
W. 302 Hastings Road  
Spokane, Washington 99208

John Cooper, Executive Secretary  
School Health Section, AAHPER  
1201 16th Street N. W.  
Washington, D. C. 20036

Jerry Craig, Health Education Teacher  
White Swan High School  
Mt. Adams SD  
White Swan, Washington 98952

Michael Hosokawa, Dr., Professor  
University of Oregon  
Eugene, Oregon 97403

Lawrence U. Merlino, Coordinator for Health and P. E.  
Federal Way SD - 31455 28th Ave. So.  
Federal Way, Washington 98002

Louis Morelli, Coordinator, State  
Health and Drug Education  
State Department of Education  
412 Knott Building  
Tallahassee, Florida 32304

Steven R. Oliver, Health Education Teacher  
Baker Jr. High  
8320 So. I  
Tacoma, Washington 98408

Lorraine Owen, Health Education Teacher  
Covington-Cascade Jr. High  
Evergreen SD - Rt. 7, 7000 N. E. 117 Ave.  
Vancouver, Washington 98662

Margaret (Peg) Rockness, Health Education Teacher  
Interlake High School  
16245 N. E. 24th  
Bellevue, Washington 98008

Len Tritsch, State Supervisor, Health Education  
State Office of Education  
Salem, Oregon

Jean Workman, Supervisor Health Services - Spokane SD  
W. 825 Trent Ave.  
Spokane, Washington 99201

APPENDIX B

EXPERT COMMITTEE

## EXPERT COMMITTEE

- I. Coordinators of Health Education
  - A. Health and Physical Education Responsibility
    - 1. Paul Smith - Shoreline, Coordinator  
Physical Education and Health  
N. E. 158th and 20th Ave. N. E.  
Seattle, Washington 98155  
Phone: 362-7900
    - 2. Al Tweit - Director, Health and  
Physical Education  
1113 E. Legion Way  
Olympia, Washington 98501  
Phone: 753-8800
  - B. Health Education Specialists
    - 1. Bob Collins - Bellevue Coordinator,  
Health Education  
310 102nd Ave. N. E.  
Bellevue, Washington 98004  
Phone: 455-6112
    - 2. Clay Roberts, Coordinator, Health Education  
Intermediate School District #110  
100 Crockett Street  
Seattle, Washington 98109  
Phone: 284-3660
- II. Principals
  - A. Elementary
    - 1. John Moffitt, Seattle  
West Queen Anne Elementary  
515 W. Galer  
Seattle, Washington 98119  
Phone: 587-4250
    - 2. Conrad Lautenslager  
Vale Elementary School  
Cashmere, Washington 98815  
Phone: 509-782-2211

- B. High School or Jr. High
1. Marvin B. Lam  
Castle Rock High School  
Box 738  
Castle Rock, Washington 98611  
Phone: 274-6634
  2. John G. Nash  
Columbia High School  
930 Long  
Richland, Washington 99351  
Phone: 509-946-5121

III. Curriculum Directors

- A. Mrs. Neldalyn Simmons, Director,  
Instruction, Sp. Ed.  
Fife School District  
5602 20th Street E.  
Tacoma, Washington 98424  
Phone: 922-6697
- B. Elmo Little  
Seattle Public Schools  
815 4th Avenue N.  
Seattle, Washington 98109
- C. Ken Schamberger, Administrative Assistant,  
Curriculum  
Wenatchee School District  
235 Sunset Avenue  
Wenatchee, Washington 98801  
Phone: 509-663-8161
- D. Mona Stacy, Curriculum Consultant  
Yakima School District  
104 N. Fourth Avenue  
Yakima, Washington 98902  
Phone: 509-248-3030

IV. Health Educators

- A. Joan Roush, West Seattle  
4075 S. W. Stevens  
Seattle, Washington 98116  
Phone: 587-6391

- B. Virginia Brannon  
Shoreline High School  
18560 First Avenue N. E.  
Seattle, Washington 98155
- C. Bruce McQueen, Olympia  
Will Winlock Miller High School  
302 North Street  
Olympia, Washington 98501  
Phone: 753-8935
- D. Jerry Miller, Burlington  
Elementary Schools - Administrative Offices  
504 N. Garl  
Burlington, Washington 98232  
Phone: 757-3421
- E. Wanda Cross, Castle Rock  
Jr. High, Castle Rock Upper Elementary  
Box 458  
Castle Rock, Washington 98611  
Phone: 274-8231
- F. Ken Pleasant, Yakima  
Washington Jr. High  
501 S. Seventh Street  
Yakima, Washington 98901  
Phone: 509-248-3030 Ext. 253
- G. Mary Davidson  
Soos Creek Elementary  
12651 S. E. 218th Place  
Kent, Washington 98031
- H. Iva Harruda, Ellensburg  
High School  
1300 E. Third Ave.  
Ellensburg, Washington 98926  
Phone: 1-509-925-5386
- I. Pam McGee, Tacoma  
Henry Foss Senior High  
2112 S. Mason  
Tacoma, Washington 98405  
Phone: 752-9200

J. Roberta Thompson, Bellevue  
Newport High School  
4333 128th S. E.  
Bellevue, Washington 98006  
Phone: 455-6137

V. Nurses

A. Barbara Sandstrom, Seattle  
Greenwood Elementary  
144 N. W. 80th Street  
Seattle, Washington 98107  
Phone: 587-4310

B. Maxine Cross, Ephrata  
School Nurse, Ephrata High School  
Box 668  
Ephrata, Washington 98823  
Phone: 509-754-2043

APPENDIX C

INTRODUCTORY LETTER AND QUESTIONNAIRE #1

Dear

There is growing concern about improving the quality of school health instruction programs in the state of Washington. Good programs do exist in some classrooms, and there are some total school building programs, but there is little evidence to indicate the growth of districtwide school health instruction programs that serve all students. A comprehensive school health instruction program would provide each student (K-12) in a school district with opportunities to learn about himself physically, mentally, and socially.

Dr. Carl Nickerson, Health Education Supervisor, State Office of Public Instruction, and I are interested in identifying program activities and resources which would lead to and support a districtwide, comprehensive school health instruction program. This is a very important first step to improving school health instruction in our state.

A very small, select group is being asked to participate in a two part survey. The survey instrument has been developed after an extensive review of existing literature. The process that will be used is as follows:

1. The enclosed questionnaire asks you to place a priority on a set of activity and resource statements believed to be important in establishing a districtwide, comprehensive school health instruction program. There is also a space provided for any comments you wish to make supporting your position on each item.
2. You will receive a phone call within three days of receiving the first questionnaire. Any questions you have can be answered at that time.
3. A second questionnaire will be mailed to you in June. This questionnaire will show the average response on each item as indicated by the ratings on the first questionnaire. It will also provide you with a summary of the comments made supporting positions outside of the indicated average. You will be asked to consider revising your response in light of this additional information.

The consensus forming procedure has been used quite successfully by SPI to establish goals for Washington schools. This technique seems to hold a good deal of promise for identifying future program direction.

You are being asked to assist in this effort because of your recognized expertise and interest in school health instruction. Because you are a member of a relatively small group, your response is critical. Please take time to fill out and return the questionnaire by May 24, 1974.

I appreciate your willingness to help improve school health instruction. Your responses will become part of a pool of information and not identified individually. No tabulations will be made on an individual basis.

A self-addressed, stamped envelope has been provided for your convenience.

Sincerely,

Paul Templin, Health Educator  
Seattle Public Schools

### Definition of Terms Used in this Instrument

Activity/resource statements--Specific tasks that the district must accomplish to meet an objective.

Ancillary health personnel--Members of the professional community who work in medical or allied health fields (i. e. , doctors, dentists, nurses, medical technicians, nutritionists, home economists, etc. ).

Ancillary responsibility--The person or group of people identified to support the completion of district tasks.

Building Health Education Specialist--That person assigned responsibility for coordination of the school health instruction program in a specific school building.

Component--A specified part or subsection of the self-evaluation instrument.

Comprehensive school health instruction program--A planned, sequential K-12 health instruction program involving all schools within a district.

In-service--Updating of knowledge, attitudes, and skills of those persons directly involved in the school health instruction program.

In-service consumers--Those persons participating in in-service programs who are directly involved in school health instruction (i. e. , building health education specialists, health instruction teachers, elementary teachers, nurses, and counselors).

ISD--Intermediate School District serving your school district.

School health instruction--The process of providing a sequence of planned and spontaneously-originated learning activities comprising the organized aspects of health education in the school.

SPI--Supervisor of health education, State Office of Public Instruction.

The activities/resources listed below are essential if a school district is to provide a comprehensive school health instruction program: (Please circle your response. )

I. THE SCHOOL DISTRICT EMPLOYS AND SUPPORTS COMPETENT HEALTH INSTRUCTION PERSONNEL IN SUFFICIENT NUMBERS TO ADMINISTER AND TO CARRY OUT A COMPREHENSIVE HEALTH INSTRUCTION PROGRAM.

Response		Activities/Resources	Comments
Agree	Disagree		
1 2 3 4 5 6		1. Written guidelines are available for the selection of school health instruction personnel which are based on guidelines furnished by SPI, and which include: 1) A check on certification as a health teacher, 2) assessment of personal characteristics, and 3) consideration of the needs of special groups.	(Use back if necessary)
1 2 3 4 5 6		2. The health education coordinator has established a communication link with the supervisor of health education, SPI, for the purpose of updating criteria for selecting school health instruction personnel.	
1 2 3 4 5 6		3. A qualified health education coordinator as determined by criteria furnished by SPI has been assigned by the school board to assume responsibility for districtwide coordination of the school health instruction program.	
1 2 3 4 5 6		4. Each school year the school board provides the district health education coordinator with time to carry out coordination activities which is at least equal to the average time given for coordination of the math, language arts, social studies and science programs.	
1 2 3 4 5 6		5. Each school year those responsible for the school district budget have designated an amount of money to administer the school health instruction programs which is at least equal to the average amounts designated for the administration of the math, language arts, social studies and science programs.	

(Continued)

Response		Activities/Resources	Comments
Agree 1 2 3 4 5 6	Disagree 1 2 3 4 5 6	6. Each elementary school in the district has at least one staff member selected by the building principal and the district health education coordinator who is assigned responsibility for coordination of all health instruction experiences and curricula in that school.	
1 2 3 4 5 6		7. The staff member(s) assigned responsibility for the coordination of the health instruction program in the elementary school has at least one hour of released time during the school day to carry out that responsibility.	
1 2 3 4 5 6		8. Each school year every elementary school budget designates money to support the school health instruction program at a level determined by a faculty-administrative committee which includes the elementary building health education specialist.	
1 2 3 4 5 6		9. In each secondary school in the district a faculty member with state approved health education preparation has been assigned by the building principal and the district health education coordinator to the responsibility of coordinating that school's health instruction program.	
1 2 3 4 5 6		10. Secondary school building health education specialists have been provided at least one class period, in addition to any regular planning period provided for all faculty members, to carry out the responsibility of coordinating the school health education program.	

(Continued)

Response						Activities/Resources	Comments
Agree			Disagree				
1	2	3	4	5	6		
						11.	Each secondary school designates a yearly budget for health instruction in an amount determined by an interdisciplinary faculty-administrative committee which includes the school health education specialist.
						12.	The school district, with the help of the district health education coordinator, apply criteria for competency in health education, as determined by SPI, in selecting prospective elementary teachers.
						13.	The district health education coordinator has established an in-service program to raise, within a two-year period after first employment, the health education competency level of elementary teachers who do not meet this standard.
						14.	The district health education coordinator works with the ISD health education coordinator and the supervisor of health education, SPI, in determining in-service programs to raise the competency level of elementary teachers.
						15.	The school district has hired health education specialists in sufficient numbers to establish a teacher-student ratio not greater than 1-20 for each health education class offered.
						16.	Hiring of secondary school health instruction personnel is accomplished only from a list approved by the district health education coordinator.

(Continued)

Response		Activities/Resources	Comments					
Agree	Disagree							
1	2	3	4	5	6	17.	The school district health education coordinator has established an in-service program to raise the competency level of secondary school health instruction personnel who do not meet at least minimum standards as established by the Supervisor for Health Education, SPL.	
1	2	3	4	5	6	18.	A school district policy has been established to relieve secondary school health instruction personnel of their teaching assignments in the health program if competency is not attained within a two-year period.	

II. THE SCHOOL DISTRICT PROVIDES PLANNED, CONTINUOUS OPPORTUNITIES FOR IN-SERVICE TO INCREASE THE KNOWLEDGE AND SKILLS, AND TO IMPROVE THE ATTITUDES OF THOSE INDIVIDUALS RESPONSIBLE FOR CONDUCTING THE HEALTH INSTRUCTION PROGRAM.

Response						Activities/Resources	Comments
Agree			Disagree				
1	2	3	4	5	6		
						1. The district health education coordinator has established written criteria for developing in-service programs by using input from ancillary personnel and interdepartmental personnel.	
1	2	3	4	5	6	2. A process has been established for continuous updating and revision of the criteria.	
1	2	3	4	5	6	3. Representative ancillary health personnel have been identified and include such sectors as: a) Medical, b) allied health specialists, c) school nurses and d) other health personnel.	
1	2	3	4	5	6	4. Representative health in-service consumers have been identified and include such sectors as: a) Health teachers, b) elementary teachers, c) nurses, d) counselors, and e) administrators.	
1	2	3	4	5	4	5. A planning committee has been established, composed of representatives from the above, which meets at least monthly to accomplish the following tasks:	
						a. Identify the needs for health education in-service through a written ongoing process of needs assessment.	
						b. Formulate written criteria to prioritize the needs according to the district goals and objectives, such as impact on students, present and future needs and availability of resources.	
						c. Establish and maintain a list of prioritized health in-service programs.	

(Continued)

Response						Activities/Resources	Comments	
Agree			Disagree					
1	2	3	4	5	6			
						5.	d. Prepare a written plan to implement specific health education in-service opportunities according to district administrative procedures.	
1	2	3	4	5	6	6.	Provisions are made for the mechanical arrangements for each in-service program, including: a) Calendar, b) time-blocks, c) choice of sites and rooms, d) budgetary allocation, e) other.	
1	2	3	4	5	6	7.	A current list of human resources is maintained from which instructor(s) for the in-service programs may be selected.	
1	2	3	4	5	6	8.	The soft and hardware needed for the most effective presentation and implementation of each course are available for each in-service program.	
1	2	3	4	5	6	9.	Opportunities are provided for program incentives, including college credits or district credits, salary adjustments, etc.	
1	2	3	4	5	6	10.	A written plan for publicity has been established which encourages each target group's interest and participation.	
1	2	3	4	5	6	11.	Packages of implementation resources are developed and are available to each in-service participant.	
1	2	3	4	5	6	12.	The district provides an evaluation instrument, or process, to be used with each in-service offering to determine the extent to which program objectives were met, and to identify emerging needs.	

(Continued)

Response		Activities/ Resources	Comments					
Agree	Disagree							
1	2	3	4	5	6	13.	The district provides a process for continual feedback from in-service participants to identify how ideas are working and to identify additional needs and resources.	
1	2	3	4	5	6	14.	Each in-service participant is personally contacted within a two-month period following each in-service program by personal visitation, small group meeting, or telephone.	
1	2	3	4	5	6	15.	Information from immediate and long-range evaluation processes is utilized by the planning committee in future planning of in-service programs.	
1	2	3	4	5	6	16.	The district publicizes new health programs, program improvements and specialized training received by health instruction staff: 1) Intradistrict, 2) community.	

III. THE SCHOOL DISTRICT ENCOURAGES COOPERATIVE INVOLVEMENT BETWEEN THE COMMUNITY AND SCHOOL HEALTH PERSONNEL.

Response						Activities/Resources	Comments
Agree			Disagree				
1	2	3	4	5	6		
						1. Representatives from community groups have been identified and include individuals such as: a) Medical and health specialists, b) lawyers, c) counselors, d) clergy, e) parent associations, f) public health, g) school administrators, h) health service, i) voluntary health agencies, and j) young people.	
1	2	3	4	5	6	2. Written guidelines have been established for the committee's operation: a) Select a chairman, b) establish role of health education coordinator who acts as consultant liaison, c) publish a calendar of scheduled meeting dates, d) conduct orientation program for committee members, e) other.	
1	2	3	4	5	6	3. Basic purposes of the committee have been identified and are available in writing: a) Make recommendations to the health education staff about policies and procedures related to health education, b) serve as a liaison between school board and community, act as sounding board from committees, and interpret the health education policies and programs to the community, c) act as a voice for specific community-school needs.	
1	2	3	4	5	6	4. Local forms of communication have been identified: a) Newspaper, b) radio, c) television, d) school publications, e) civic organizations, f) parent groups.	
1	2	3	4	5	6	5. The district health education coordinator has incorporated the use of community news outlets into the in-service training program of health education personnel.	

(Continued)

Response						Activities/ Resources	Comments	
Agree	Disagree							
1	2	3	4	5	6	6.	The district health education coordinator supplies information concerning the health education program on a monthly basis to all segments of the media: a) New or innovative programs, b) community involvement, c) updating information about current program.	
1	2	3	4	5	6	7.	Media and members of the community are provided access to health instruction personnel, program, and resources through a process which is available in writing.	
1	2	3	4	5	6	8.	The district health education coordinator has a written plan for disseminating information about the health instruction program to the community.	
1	2	3	4	5	6	9.	The district health education coordinator has compiled and distributed a written, updated list of people and groups available as resources to all school health instruction personnel.	
1	2	3	4	5	6	10.	The district health education coordinator has a process for maintaining and updating a list of community resources.	

IV. THE SCHOOL DISTRICT HAS WRITTEN GUIDELINES WHICH PROVIDE DIRECTION FOR THE SCHOOL HEALTH INSTRUCTION PROGRAM.

Response		Activities/Resources	Comments
Agree	Disagree	1. The school district has appointed a health education coordinator responsible for planning written curriculum guidelines.	
1	2 3 4 5 6	2. The school district has established a curriculum planning committee made up of representative teachers, students, administrators, and ancillary personnel.	
1	2 3 4 5 6	3. The school district has developed a conceptually based health scope and sequence chart.	
1	2 3 4 5 6	4. The school district has designed a set of written objectives which are appropriate to the identified health education concepts, clearly defined in terms of knowledge, attitudes, and skills.	
1	2 3 4 5 6	5. The school district has described examples of learning experiences designed to assist the students in achieving the stated health education objectives.	
1	2 3 4 5 6	6. The school district has established a procedure for selection and use of materials appropriate to the learners.	
1	2 3 4 5 6	7. The school district has developed written guidelines for teaching strategies at all levels of health education instruction (i. e., direct health instruction, integration and/or correlation with other subject areas and incidental).	
1	2 3 4 5 6	8. The school district has developed a plan for in-service opportunities to implement health instruction as established by the curriculum guidelines.	

(Continued)

Response						Activities/ Resources	Comments	
Agree	Disagree							
1	2	3	4	5	6	9.	Appropriate staff has been assigned to establish the proposed health education curriculum on an experimental basis (refer to personnel guidelines).	
1	2	3	4	5	6	10.	Resource materials appropriate to the learner have been obtained and made available to support the experimental health education program.	
1	2	3	4	5	6	11.	After the experimental phase, the proposed health education program is revised.	
1	2	3	4	5	6	12.	Appropriate staff positions and resource materials are secured to implement the established health instruction curriculum.	
1	2	3	4	5	6	13.	A procedure for distributing the teaching resources has been established to insure accessibility for health education teachers and their students when needed.	
1	2	3	4	5	6	14.	A management tool has been constructed for principals' use which is designed to insure implementation of the health education program within his jurisdiction.	
1	2	3	4	5	6	15.	Teaching models have been developed at all levels of health instruction to insure effective health education instruction: a. Direct health instruction b. Integration and coordination c. Correlation d. Incidental	

(Continued)

Response						Activities/Resources	Comments	
Agree	Disagree							
1	2	3	4	5	6	16.	Teaching strategies at all levels of health instruction have been developed to insure effective health education instruction: a. Problem solving b. Inquiry c. Individual learning opportunities d. Learning centers e. Value clarification f. Others	
1	2	3	4	5	6	17.	Each building has provided for participatory planning by building staff to determine a health instruction time allotment which is consistent with district and state guidelines.	
1	2	3	4	5	6	18.	A plan has been formulated and implemented which provides for teacher sharing and interaction at least three times a year.	
1	2	3	4	5	6	19.	Continuing consultant services are insured both upon request and on a regularly scheduled basis.	
1	2	3	4	5	6	20.	Written evaluation instruments have been constructed which will insure the revitalization of the health curriculum, health resources, and health teaching strategies at least once every three years.	
1	2	3	4	5	6	21.	A written procedure has been established for selection and operation of a community-school health committee to encourage cooperative planning and to assist in the formation and continuous reviewing of policies and procedures for health instruction.	

(Continued)

Response		Activities/ Resources	Comments					
Agree	Disagree							
1	2	3	4	5	6	22.	The school district has written policies and guidelines to encompass the following aspects of the health instruction program:	
						a.	The role of the following personnel: School board, superintendent, curriculum coordinator, staff consultants, principal, health education teachers, elementary classroom teachers, counselors, school nurses, ancillary health related personnel, resource specialists, parents, students, paraprofessionals.	
						b.	Time allotments for health education instruction at all levels of instruction, commensurate with other academic subjects.	
						c.	Selection and procurement of health education instructional materials.	
						d.	Teaching environment.	
						e.	Controversial health education topics.	
1	2	3	4	5	6	23.	A plan has been provided for the dissemination of the district's policies and guidelines related to health instruction.	
1	2	3	4	5	6	24.	A management tool has been developed which indicates steps from implementation to full use of the written policies and guidelines.	

V. THE SCHOOL DISTRICT, WORKING WITH THE DISTRICT HEALTH EDUCATION COORDINATOR, HAS DEVELOPED AND PUBLISHED A PLAN FOR THE CONTINUING EVALUATION OF ALL PHASES OF THE SCHOOL HEALTH INSTRUCTION PROGRAM, INCLUDING AN ASSESSMENT OF PLANNING, IMPLEMENTATION, PROGRAM OUTCOMES, AND FEEDBACK PROCESSES.

Response						Activities/ Resources	Comments
Agree			Disagree				
1	2	3	4	5	6		
						1. The school district has assigned specific responsibility for evaluation of the school health instruction program, using the same criteria used to select evaluators for other school district programs.	
						2. Time has been assigned for school health instruction program evaluation on the same basis as time has been assigned for evaluation of other school programs.	
						3. A specific budget has been established which supports evaluation activities.	
						4. A specific instrument has been developed to help the person or persons responsible for evaluation to determine the steps taken to implement the school health instruction program on a districtwide basis.	
						5. A procedure has been established to provide information about the extent of program implementation to those responsible for program planning.	
						6. A file of the above information has been forwarded to the health education office of the local ISD, and this information is used by district program planners in making decisions about program changes and about additional steps in program implementation.	
						7. Instruments or procedures for measuring attainment of knowledge, attitudes and behaviors have been identified and are available for use.	

(Continued)

Response						Activities/ Resources	Comments	
Agree	Disagree							
1	2	3	4	5	6	8.	Procedures have been developed and explored to determine the teaching models used in health education programs.	
1	2	3	4	5	6	9.	Procedures have been developed and employed to determine the teaching strategies in health instruction programs.	
1	2	3	4	5	6	10.	An assessment is made of the resources which are used to support program activities.	
1	2	3	4	5	6	11.	Classroom teachers and other personnel have been trained in the development and administration of evaluation techniques.	
1	2	3	4	5	6	12.	A communication network has been established involving all personnel active in the implementation of the school health instruction program, so that at least once each year:	
						a.	Information is provided about the conclusions drawn from evaluation studies.	
						b.	Information is provided about how data collected helped determine program changes.	
						c.	Reaction to proposed program direction decisions are obtained from program planners.	

APPENDIX D

SUMMARY COMMENTS FROM QUESTIONNAIRE #1

## SUMMARY OF COMMENTS

## I. PERSONNEL

1. Written guidelines are available for the selection of school health instruction personnel . . . based on guidelines furnished by the state
  - a. The teacher is the most important key to a successful program.
  - b. SPI should establish broad general guidelines which give local school districts considerable autonomy to do creative and innovative teaching.
  - c. This is one way to keep unqualified personnel out of an area usually staffed based on extracurricular needs.
  - d. Not a special certification route for these people - please.
  - e. Difficult to define "personal characteristics". How are guidelines going to be set up? How enforced?
  - f. Crucial to insure that health teaching positions not to be filled as a convenience measure from available but unqualified staff.
2. The health education coordinator has a communication link with the state for the purpose of updating criteria for selecting school health instruction personnel  
(None)
3. A qualified health education coordinator has been assigned responsibility for districtwide coordination
  - a. I agree and strongly encourage that a health education coordinator be hired for our district.
  - b. Will not happen in small districts, and these are a majority. A good idea in large districts.
  - c. Can serve to review resources which teachers don't have time to do. Vital if a teacher is to do an effective job.
  - d. Local conditions may warrant additional criteria for selecting health educators.
4. Time has been provided to carry out coordination activities which is equal to coordination time provided for other programs.

- a. This "equal time" in our small district would be no time at all.
  - b. Do we want to be tied to a comparison with other disciplines when there is a tendency to eliminate curriculum specialists in favor of generalists?
  - c. If the health coordinator and program are worth their salt, they should have equal status.
  - d. "Equal time" may not be appropriate if total district staff is involved because of the need to emphasize basic skills.
5. A yearly budget for school health instruction has been established and is at least equal to the budget for other major disciplines.
- a. Budgets may need to be different because of consumable and non-consumable supplies used.
  - b. The budget should be based upon needs of the program and not upon equality with other programs.
  - c. Is school size an influencing factor?
  - d. Mostly reasonable, but at the secondary level health staffing and other needs may not be equal with other disciplines.
6. Each elementary school has a staff member assigned to coordinate all health instruction experiences and curricula in that school
- a. Need to involve parents and school principal.
  - b. Will probably be the principal.
  - c. As a team leader - in a multi-disciplinary instruction team to insure health concepts are included and effectively presented.
  - d. If the school is large, it may be advisable to have one at the primary level and another at the intermediate level.
  - e. The faculty should have a say in the selection process.
  - f. Not only to coordinate, but also should be a resource.
7. At least one hour of released time has been provided the staff member assigned responsibility for coordinating the elementary school health instruction program
- a. Released time and/or extra compensation.
  - b. Only if this same hour is the PCP time now allocated.

- c. Needs more than one hour.
  - d. Not practical in an era of budget cutting. Might be done if same applied to all subjects. (Idealistic)
  - e. If an hour each day is provided and the schools are small, this person could coordinate for more than one school which might have some advantages in coordinating resources.
8. Every elementary school budget has designated money to support the school health instruction program
- a. Separate health from physical education.
  - b. Consultation with district health education coordinator.
  - c. Not all district budgets are designated or determined at building level.
  - d. Nothing extraordinary except--if included in funding formula.
  - e. If all other department budgets are designated this way, yes.
9. Each secondary school has a staff member assigned to coordinate the school health instruction program.
- a. A health education department head?
  - b. This seems dependent on the size of the district and individual school. The district coordinator can influence the effectiveness of the building coordinator and the size of the school may determine the likelihood of the department heads.
  - c. This is a building principal's responsibility.
  - d. No more "stepchild" hanging on the coattails of the P. E., Science, etc. department budgets.
10. Secondary school building health education specialists have at least one class period free to carry out the responsibility of coordinating the school health instruction program
- a. And/or extra compensation.
  - b. Only if there is more than one health education specialist in the building.
  - c. Ideally, each day - also depends on whether health is an elective or is required at that level.
  - d. If there is a district coordinator, no time should be provided for coordination at the building level.
  - e. Too costly, and could not effectively use this amount of time.

11. Each secondary school has designated a budget for health instruction as determined by an interdisciplinary faculty-administration committee
  - a. No need for this type committee for health when we don't use them in making out the budgets for other departments.
  - b. The district coordinator should serve as a consultant.
  - c. Size and make-up of school (i. e. , deprived schools, etc. ) should be determining factors.
  - d. If all other department budgets are designated this way, yes.
  
12. Specific criteria for competency in health education has been applied in selecting prospective elementary teachers
  - a. The most critical factor in programs is well-trained teachers.
  - b. It is difficult to get teacher-training institutions to develop programs.
  - c. Only if the school district agrees with the criteria set up by SPI.
  - d. Develop criteria cooperatively with local and regional (ISD) health education coordinators.
  - e. Should this be done by the personnel department or at the school?
  
13. An in-service program has been established to raise the competency of elementary teachers
  - a. The most critical factor in a program is well-trained teachers.
  - b. There is a need for more in-service and university courses.
  - c. Impractical for small districts that hire few teachers each year.
  - d. Is it mandatory? Is this a condition of contract?
  
14. Cooperation has been established between the district health education coordinator, the intermediate school district, and the state in determining in-service for elementary teachers.
  - a. If the elementary teacher is not competent, who determines this?  
building principal should be involved.

15. Sufficient health education specialist have been hired to establish a 1:20 ratio in each health education class
  - a. Ideally #1 - In reality, probably 1-25 a closer ratio.
  - b. This is not true in any area of instruction.
  - c. This is established by negotiations.
  - d. Not a realistic ratio.
  - e. Probably a very long-range goal.
  
16. Secondary school health instruction personnel have been hired from a list provided by the district health education coordinator
  - a. Others should be consulted.
  - b. This would give full authority for hiring policies and practices in the hands of curriculum specialists. A district needs a much broader base for hiring than mere subject area competency and personal characteristics.
  - c. How would a person get on the list? What criteria will determine?
  
17. The school district health education coordinator has established an in-service program to raise the competency of secondary personnel
  - a. This will be difficult - sometimes it's not subject matter background that makes a health education teacher incompetent.
  - b. Not practical in small district.
  - c. Some might be encouraged to do their fifth year in the area of health education.
  
18. A policy has been developed to relieve secondary school health instruction personnel of their teaching assignments if competency is not attained within a two-year period
  - a. The law is pretty touchy about this sort of thing.
  - b. Local conditions may warrant more than two years in some cases.
  - c. Need to check legal: negotiated contractual rights of teachers.
  - d. What is competency and who determines it? What provisions does the district make to help a person become competent?

- e. We will then be able to find someone who is competent to take this person's place???

## II. IN-SERVICE

1. Written criteria are available for developing in-service programs
  - a. Add teachers and students' input
2. A process has been established for continuous updating and revision of the criteria
  - a. By who? SPI? or ISD? or combination?
3. Representative ancillary health personnel have been identified
  - a. Add students - they are excellent resources for what they need or needed and when they should have received it.
  - b. Are counselors included?
4. Representative health in-service consumers have been identified  
(None)
5. A planning committee has been established and meets at least monthly
  - a. A health coordinator needs flexibility and has to operate fast. Committee should be advisory with decisions made by coordinator.
  - b. Qualifications of the committee members? Need to have total needs of the child in mind rather than self-interests.
  - c. Too many meetings and written tasks. Actual needs of the district might get lost in a maze of meetings.
  - d. Add students.
  - e. Expensive on released time basis. Hard to get help on a voluntary basis.
6. Provisions exist for the mechanical arrangements for each in-service program  
(None)

7. A current list of human resources is maintained from which instructors for in-service programs may be selected.
  - a. This should be an ISD service.
8. Both the software and hardware necessary to conduct each in-service program are available
  - a. Some of this can come from ISD's.
9. Opportunities are provided for program incentives
  - a. Great!
  - b. Released time (Most important if you want to get people most in need of it.)
10. A written plan for publicity has been established
  - a. Need not be written.
11. Packages of implementation resources have been developed and are available to each in-service participant (None)
12. The district provides an evaluation instrument, or process, to be used with each in-service offering (None)
13. The district provides a process for continual feedback from in-service participants
  - a. Most inservice follow-up is dropped. Good idea if time and personnel permit.
  - b. A real need.
  - c. A must!!
14. Each in-service participant is personally contacted within a two-month period following each in-service program
  - a. "Two month period" is too restrictive.
  - b. The energy expended here may be necessary for other parts of the program, particularly during early developmental stages.
  - c. Exclude telephone - prefer small group meeting for more input.

15. Information from immediate and long-range evaluation processes is utilized in future planning  
(None)
16. The district publicizes new health programs, program improvements and specialized training received by staff  
(None)

### III. COOPERATIVE INVOLVEMENT: School and Community

1. Representatives from community groups have been identified
  - a. What happens once they are identified?
  - b. Not from all areas identified.
  - c. The community should be involved in the health education program no more or no less than it is in another education program.
  - d. Publicizing some areas of the health program to the general public could possibly cause harm to the program.
2. Written guidelines have been established for the school and community health education committee's operation
  - a. Would a group with such wide backgrounds be effective?
  - b. The health coordinator's role should be 70% determined by the school district, and he should be instrumental in picking committee.
3. Basic purposes of the committee have been identified and are available in writing
  - a. Committee could be concerned with health services also, especially in small districts.
4. Local forms of communication have been identified
  - a. Designate someone on the committee to take care of publicity.
5. Community news outlets have been incorporated into the in-service training program  
(None)

6. The district health education coordinator has supplied information concerning the health education program on a monthly basis to all segments of the media
  - a. Sometimes the more publicity you get, the more problems you encounter.
  - b. There may not be newsworthy information on a monthly basis.
  
7. Media and members of the community have access to the program through a process which is available in writing
  - a. Does this have to be written?
  - b. To what extent should instruction personnel be available?
  - c. Better avenue of communication than preceding statement.
  
8. A written plan has been made available for disseminating information to the community
  - a. Does this have to be in writing?
  - b. Will vary in each school.
  - c. Still keep it low visibility.
  - d. Only through established communications channels approved by district.
  
9. Written, updated list of people and groups available as resources has been distributed to all school health instruction personnel  
(None)
  
10. The district health education coordinator has a process for maintaining and updating a list of community resources
  - a. Other agencies perform this function.

#### IV. WRITTEN POLICIES AND GUIDELINES

1. The school district has appointed a health education coordinator responsible for planning written curriculum guidelines
  - a. Statement is confusing. A health education coordinator is a high priority, but written curriculum guidelines is not a high priority.

- b. Important also for special education programs.
2. The school district has established a curriculum planning committee  
(None)
  3. The school district has developed a conceptually based health scope and sequence chart
    - a. Why conceptually based?
    - b. Through hell and fire - through tick and thin.
  4. The school district has designed a set of written objectives.
    - a. A must.
    - b. Change "concepts" to "needs" of youth and the community.
  5. The school district has described examples of learning experiences
    - a. More than examples are needed. Specific activities should be identified.
  6. The school district has established a procedure for selection and use of materials
    - a. Only for basics.
  7. The school district has developed written guidelines for teaching strategies at all levels
    - a. With several alternatives.
    - b. Integrations, correlation and incidental methods of health teaching are cop-outs and are usually done to cut costs.
  8. The school district has developed a plan for in-service opportunities to implement health instruction.  
(None)
  9. Appropriate staff have been assigned to establish the proposed health education curriculum experimentally?
    - a. Why experimental basis?

- b. Staff and resource people.
10. Resource materials appropriate to the learner have been obtained and made available to support the program
    - a. Budget problems !
    - b. Why experimental?
  11. After the experimental phase, the proposed health education program has been revised
    - a. Build in flexibility at the start.
  12. Appropriate staff positions and resource materials have been obtained
    - a. If a district were financially able to provide these things, we'd be half-way home.
  13. A procedure for distributing the teaching resources has been established  
(None)
  14. A management tool has been constructed for use by principals
    - a. What does "management tool" entail?
    - b. Needs to be refined and provided in an in-service format showing integration at the elementary level.
  15. Teaching models have been developed at all levels
    - a. Sounds great!
  16. Teaching strategies at all levels have been developed
    - a. Effective as well as "affective".
    - b. Through in-service classes.
  17. Time allotment has been determined at the building level
    - a. If this becomes a "duty", teachers may reject it.
    - b. If health education is integrated with other subjects, it would be hard to determine time allotment.
    - c. Integration into other subject areas will solve this.

18. A plan has been formulated and implemented which provides for teacher sharing and interaction at least three times a year
  - a. Should do more of this in other areas.
  - b. At what levels - school, regional, district?
  - c. A good idea.
  - d. If not more.
  - e. Within and between grade levels.
  
19. Continuing consultant services have been insured
  - a. If positive!
  
20. Written evaluation instruments have been constructed
  - a. If it doesn't take too long, and all the time is spent in revitalization.
  - b. Instruments would grow old, like the curriculum.  
Perhaps common sense by the coordinator would be better.
  
21. A written procedure has been established for selection and operation of a community-school health committee  
(None)
  
22. The school district has written policies and guidelines that include (a) role of personnel; (b) time allotment; (c) selection of materials; (d) teaching environment; and (e) controversial issues
  - a. Time allotment determined on the basis of student needs and not "other academic subjects".
  - b. Need for more input from each building level when considering controversial topics.
  - c. Has not happened, but I would like to see it.
  
23. A plan has been provided for dissemination of district policies and guidelines
  - a. Hopefully these will be positive.
  - b. Very important.

24. A management tool has been developed which indicates steps from implementation to full use of policies and guidelines

a. What does the term "management tool" mean?

## V. EVALUATION

1. The school district has assigned specific responsibility for evaluation of the school health instruction program  
(None)

2. Time has been assigned for school health instruction program evaluation

a. Should we tie ourselves to other subjects as a yardstick for determining activities and resources?

b. Does this imply "equal time"? May not be best basis.

3. A specific budget has been established which supports evaluation activities.

a. Shouldn't be a special budget. Provide for in regular budget.

4. A specific instrument has been developed to determine the steps taken to implement the districtwide program  
(None)

5. A procedure has been established to provide information about the extent of implementation to program planners  
(None)

6. A file of the above information has been forwarded to the local ISD

a. For the most part, ISD's have had the function of encouraging and supporting, not on managing and controlling

7. Instruments, or procedures, for measuring attainment of knowledge, attitudes and behaviours have been identified and are available for use

a. If this ever happens, let me know! (Refers to measuring attitudes and behaviors)

8. Procedures have been developed and explored to determine teaching models
  - a. How do models differ from strategies?
9. Procedures have been developed and employed to determine teaching strategies
  - a. Sometimes these may be difficult to follow in a classroom.
10. An assessment has been made of the resources which are used to support program activities  
(None)
11. Classroom teachers and other personnel have been trained in the development and administration of evaluation techniques
  - a. What about parents and students?
  - b. On-going program to keep resource lists updated.
12. A communication network has been established involving all personnel active in the implementation of the school health instruction program
  - a. Good.
  - b. Time, money and instruments will be a big problem.

#### SOME GENERAL COMMENTS

Excellent survey - It would be nice to fill and be able to do all this in our district.

Where does all the money come from?

These guidelines are highly idealistic and necessary if an effective health education program is to be designed and implemented.

It would also demand tremendous fiscal support - probably unrealistic in today's rising educational costs.

Undertaking and one not to be quickly achieved unless earmarked funds are legislated.

Alot of desirable things are included in this questionnaire, but until we get more state support for education there is no way alot of smaller districts will be able to offer a comprehensive health program.

APPENDIX E

INTRODUCTORY LETTER TO QUESTIONNAIRE #2

June 3, 1974

Dear

Thank you for your rapid and meaningful response to our initial effort to identify the program activities and resources believed to lead to and support comprehensive school health instruction programs.

Enclosed you will find the second, and final, questionnaire in our two-part survey. This questionnaire is identical to the first one except that the area of consensus has been indicated by a black square. Your initial response has been indicated by a red circle. A separate summary of comments has also been provided for your information.

Remember that this questionnaire is being used to survey what should be and not what your school or district is now doing.

The purpose of this second survey is to increase consensus and to find out minority positions where they still exist. Please take the following steps in responding this time:

1. Study the questionnaire and the summary of contents.
2. If you do not agree with the consensus, as indicated by the black square, please indicate your present position on the item in black (or blue) and briefly state your reason in the space provided.
3. If you do not mark a response, it will be assumed that you support the consensus.

Your past cooperation in this study is most appreciated. I want to thank you in advance for this final effort. Each of you will receive a copy of the final report as soon as it is available.

A self-addressed stamped envelope is again enclosed for your convenience. Please return your completed questionnaire by June 20, 1974.

Sincerely,

Paul Templin  
Seattle Public Schools

APPENDIX F

SUMMARY OF COMMENTS FROM QUESTIONNAIRE #2

## SUMMARY OF COMMENTS FROM QUESTIONNAIRE #2

## I. PERSONNEL

1. Written guidelines are available for selecting personnel
  - a. Uniform guidelines should be set by SPI, but there should not be special certification. Personnel should have training and/or experience in the field.
  - b. Guidelines might be okay for specialized personnel, but they could be a problem at the elementary level.
  - c. Although these are guidelines, they are essential to the foundation of a program.
  
2. A communication link has been established with the state office to update criteria
  - a. Communication link with SPI is essential.
  - b. I feel that it is very important to have this communication.
  - c. It is crucial that the coordinator be involved.
  
3. A qualified health education coordinator has been assigned districtwide responsibility for coordination
  - a. Though this is unrealistic in small districts the ISD can provide a similar position on a county basis.
  
4. Time is provided for districtwide coordination on the same basis as for other major disciplines
  - a. Still not sure I buy the tie to and equating with other disciplines in the curriculum.
  - b. If not too idealistic in small districts this is essential.
  
5. Budget is at least equal to the average amounts given other major disciplines
  - a. Budget amounts should relate only to the program it is budgeted for and should not in any way relate to any other discipline unless there is interdisciplinary instruction where one is dependent upon another. I think this is a very negative approach to budgeting.

- b. (Equal) could be limiting.
  - c. Based on needs of program.
  - d. Other variables involved before I can buy this as stated.
  - e. Health is a total program and is as important to receive at least equal the average amounts of all other programs.
  - f. Equal money for equal programs!
6. Each elementary school has a staff member responsible for coordination
- a. It will need administrative support. Staff member unlikely to have that much influence.
7. One hour released time is provided the elementary building coordinator
- a. This does not seem practical to me:
    - 1. First, it depends on question 6 having a positive answer (a dependent question).
    - 2. If this were done for one subject area, it should be done for all. This would take a minimum of one extra teacher per building.
    - 3. I'm for extra pay rather than release time--less scheduling problems.
  - b. Time is essential.
  - c. Compensation better. One hour causes scheduling difficulties at the elementary level.
8. The budget is determined by a faculty-administrative committee which includes the elementary building coordinator
- a. This assumes there is a district health coordinator which is not the fact in most districts. Ideally, yes, but in any event, it is the building principal's responsibility to determine who in his building is best qualified.
  - b. Continuity in a specific school situation is critical.
  - c. May eliminate misassignments in many instances.
9. Each secondary building has a building coordinator who has state approved health education preparation
- a. If all other budgets are designated this way.
  - b. If only department budgets are determined this way, okay. Ours are not, so I couldn't see uputting the health budget through this type of hearing.
  - c. This may be done better at a higher administrative level.

10. The secondary school building health education specialist has at least one period specifically for coordination
  - a. Only if there is a large health education department.
  - b. This sounds like all secondary schools are large enough for multi-staff health teachers. Elementary-secondary differences are not that clear.
  - c. Depends on school size, finances, etc.
  
11. The secondary school building budget is determined by a committee which includes the school health education specialist  
(None)
  
12. Criteria for competency in health education are applied when selecting elementary teachers
  - a. Opens a can of worms. Elementary teachers are generalists and not specialists. If one teacher is responsible for health education for the whole school I agree to #12.
  - b. This is completely impractical. Would each subject specialist have the same option? Consider the time and number of people this would involve in dozens of interviews.
  - c. Better educate the school district what health education is first, starting with the superintendent down.
  - d. Criteria won't include much because many schools (colleges) don't offer much for elementary teachers.
  - e. I still feel that more emphasis should be put here in hiring elementary teachers.
  
13. An in-service program has been established to raise the competency of elementary teachers
  - a. More problems - negotiated agreements, mandatory competencies. This can be worked out with 5th year program.
  - b. Perhaps being mandatory would be too idealistic or impractical.
  
14. The district health education coordinator works with regional and state agencies when determining in-service programs for elementary teachers
  - a. Great if ISD's are given staff who work only on health.

- b. Input should come from teachers and principals or health specialists.
  - c. Not only will this increase quality and variety of in-service courses, but it will be one more step in insuring communication between various health personnel.
15. Sufficient numbers of health educators are employed to establish a ratio of 1-20 for each health education class offered
- a. This doesn't seem possible at this time--agree with the person who said it's a good long range goal.
  - b. Unrealistic.
  - c. 1-20 ratio completely out of the question from a practical viewpoint.
  - d. Ideally 1-20 for every class.
  - e. I don't feel that enough research has been done on optimum class size for effective health education. I think 1-20 is an arbitrary figure.
16. Secondary personnel are hired only from a list supplied by the district coordinator.
- a. I disagree - I would go along with the list, but the building principal and department head must have a say in hiring.
  - b. This list would not necessarily be developed by the health education coordinator. It states "approved" - leaves a bit of flexibility.
  - c. Many times a teacher is chosen by the athletic director-- this should not be!
  - d. People make "the program" happen. Need say as to who is assigned health teaching responsibilities.
  - e. Otherwise teachers will be placed for convenience.
  - f. I feel this is important - most of the time they are not even consulted.
17. In-service programs have been established to raise the competency of secondary personnel
- a. This will be difficult. Sometimes it's not subject matter background that makes a health teacher incompetent.
  - b. Critical that teacher have the opportunity to gather skills that will increase their degree of comfort in the classroom.

18. A policy has been established to relieve secondary personnel of teaching responsibility if competency has not been reached within a two-year period
  - a. May be a problem legally.
  - b. Would this be consistent with other subject areas?
  - c. Need to be flexible on the two-year requirement.
  - d. Ideal, but probably teacher organizations would really fight it.
  - e. Qualified teachers most important to program. Better no program than unqualified teachers.

## II. IN-SERVICE

1. Written criteria for developing in-service programs
  - a. Includes teachers and principals.
  - b. Agree with statement - "add teachers' and students' input."
2. A process has been established for updating and revision of criteria  
(None)
3. Representative ancillary health personnel have been identified
  - a. This is supportive and helpful - but basic program (of which this should be a part) must rely on its own merit.
  - b. A broad base for input should be insured.
  - c. Add students - they are excellent resources for what they need, or needed, and when they should have received it.
4. Representative health in-service consumers have been identified
  - a. Hasn't this been done over and over - now is the time to implement.
  - b. Health, being an interdisciplinary area, all of these people should be involved.
  - c. Add students.
5. A planning committee has been established which meets at least monthly

- a. This could be restrictive for the coordinator.
  - b. Very important as a communication throughout all areas, particularly health.
6. Provisions are made for mechanical arrangements for each in-service program
    - a. Having provisions for these items in existence can greatly simplify the task at hand.
  7. A current list of human resources is maintained
    - a. Agree with the statement - "This should be an ISD service".
    - b. Resources should be known to all teachers and in-service could be a great benefit.
  8. The software and hardware needed are available for each in-service program
    - a. During in-service participants should be shown how to use it and to do activities to involve personnel to take back to classrooms.
  9. Opportunities are provided for program incentives
    - a. Released time.
  10. A written plan for publicity has been established
    - a. In-service is more important than publicity for the growth of program.
  11. Packages of implementation resources are developed and are available
    - a. Developed by who?
    - b. This pays off when a few teachers benefit immediately from material.
    - c. The only way to have complete follow-up and use of the in-service presentations in the classroom.
    - d. Important!

12. The district provides an evaluation instrument, or process, to be used with each in-service offering
  - a. Could SPI provide evaluation statewide as well as district in-service?
  - b. We need to develop an instrument as a means of meeting objections.
  
13. The district provides a process for continual feedback from in-service participants
  - a. Possibly college credit system which would be part of the requirements to insure follow-up.
  - b. If emphasized and continued this can provide valuable guidelines.
  - c. There is never enough feedback. Need all we can get and share.
  - d. Very important!
  
14. Each in-service participant is personally contacted within two-months of each in-service program
  - a. Good idea, but impractical.
  - b. Assuming there is a health coordinator to do this.
  - c. Group meeting for input and exchange of ideas.
  - d. Small group would be preferred. Lots of contact.
  - e. It is my experience that follow-up is the key to successful change and if in-service is designed to change and improve, then the initial shot will be ineffective in a large per cent of the time. A follow-up could reveal some simple roadblock that could make the difference between success or "it was a stimulating experience but impractical."
  
15. Evaluation information is used by the planning committee for future planning
  - a. If not utilized, the gathering of information soon becomes cumbersome and may be eliminated.
  - b. I still think this is reasonable. It does not say to limit planning to these evaluations, just to "utilize them."
  - c. If this is not a top priority why collect the information?

16. The district publicizes new health programs, program improvements, and specialized training received by staff
  - a. Who's responsibility? Health coordinator?
  - b. We really need to keep communication open with all.

### III. COMMUNITY INVOLVEMENT

1. Representatives from community groups have been identified
  - a. How are they chosen? Volunteers often are vocal and do not carry community concerns.
  - b. Constant communication is so important with all agencies.
2. Written guidelines have been established for the committee's operation
  - a. Selection and hiring of a coordinator should precede the committee and guidelines for its operation.
  - b. Who determines guidelines?
3. Basic purposes of the committee have been identified and are not available in writing.
  - a. It is ideal, I guess, but it can really be a handicap.
  - b. Committee members selected - are they competent to deal with the topic of health education?
4. Local forms of communication have been identified
  - a. Include a committee member with background in media.
  - b. Important. Needs someone to take care of this who is on the committee.
5. Community news outlets are incorporated into the in-service training programs
  - a. Maybe quarterly meetings instead of monthly.
6. Information concerning the health education program is supplied to all segments of the media on a monthly basis

- a. Agree with the comments, "Sometimes the more publicity you get, the more problems you encounter."
  - b. Monthly information may not be available or even of interest. I agree though that the media should be used.
  - c. A good health education program will sell itself.
  - d. Easy for large district.
7. Media representatives and members of the community have access to the health program through a process available in writing
- a. Does this include community health education to the community by school health instruction personnel?
  - b. If this is the same for all school programs - but let's not make ours an area to watch dog because of its "individual differences."
8. A written plan exists for disseminating information about the health instruction program to the community
- a. Should be written to insure continual, uniform dissemination of information so no one gets left out.
9. A written, updated list of people and groups available as resources is distributed to all school health instruction personnel
- a. How often should this be updated? May already be available through a community agency or district resource center.
  - b. Teachers can help coordinator identify and evaluate resources.
  - c. This list would need to be current to be effective.
  - d. Most important!
10. A process exists for maintaining and updating a list of community resources
- a. Agree with comment - "Other agencies perform this function."

## IV. WRITTEN GUIDELINES

1. The district has appointed a health education coordinator responsible for planning written curriculum guidelines
  - a. Important for interdistrict coordination.
  - b. Needs to be separate from physical education.
2. The district has established a curriculum planning committee
  - a. Needs input from others.
3. The district has developed a conceptually based scope and sequence chart
  - a. It is important that we have a scope and sequence, otherwise some teachers get hung up when they don't have a specific time to teach something.
4. The district has designed a set of written objectives
  - a. We need activities for the teachers to see.
5. The district has described examples of learning experiences (None)
6. The district has established a procedure for selection and use of materials
  - a. Already in use in most districts.
  - b. Helps prevent problems on sensitive issues.
7. The district has developed written guidelines for teaching strategies
  - a. The teachers generally don't have the background for this unless they have special training.
  - b. Maybe some, but I don't think we should plan it that way. Integration is letting someone else do our work and incidental is hoping an area will be covered.
  - c. Especially correlation with other subjects.
8. The district has developed a plan for in-service opportunities.

- a. Health coordinator's responsibility?
  - b. Good to try to develop interschool coordination of available materials for maximum utilization by all.
  - c. If this isn't done, nothing else will happen.
9. Appropriate staff have been assigned to establish the curriculum experimentally
- a. Is an experimental phase needed?
  - b. Experimental at first, but branch out to be incorporated as part of the curriculum.
10. Resource material appropriate to the learner has been obtained and made available to support the program  
(None)
11. After the experimental phase, the proposed health education program will be revised
- a. Evaluated first, then revised according to need.
  - b. Should continually undergo revision as needed.
12. Appropriate staff positions and resource materials have been obtained
- a. Budgets may create a year-to-year implementation with total participation at the end of a selected time limit. There is a need for in-service too at this point.
13. A procedure for distributing the teaching resources has been established  
(None)
14. A management tool has been constructed for use by principals.
- a. Without implementation what good is there to doing everything else?
15. Teaching models have been developed at all levels
- a. I still don't like the idea of correlation - integration or incidental methods of teaching health.
16. Teaching strategies at all levels have been developed  
(None)

17. Time allotment has been determined at the building level
  - a. This would have to be negotiated as a time slot for elementary.
18. A plan has been formulated and implemented which provides for teacher sharing and interaction at least three times a year
  - a. If there is no such plan it probably won't happen.
  - b. Provide release time and conduct in a building or in a high school area.
19. Continuing consultant services have been insured  
(None)
20. Evaluation instruments have been constructed
  - a. Along with implementation and in-service this is extremely important.
21. A written procedure has been established for selection and operation of a community-school health committee
  - a. This will save us lots of headaches !
22. The district has written policies and guidelines which include: (a) role of personnel; (b) time allotment; (c) selection of materials
  - a. A necessity. Some parts may require negotiation with personnel.
23. A plan has been provided for dissemination of district policies and guidelines  
(None)
24. A management tool has been developed which indicates steps from implementation to full use of policies and guidelines  
(None)

## V. EVALUATION

1. The district has assigned specific responsibility for evaluation of the school health instruction program

- a. Evaluation is top priority.
2. Time has been assigned for school health instruction program evaluation
  - a. Based on need, not equal to. Should be at least equal to other subjects for a start.
3. A specific budget has been established which supports evaluation activities
  - a. Agree with the comment - "Shouldn't be a special budget. Provide for this need in the regular budget."
4. A specific instrument has been developed to determine the steps taken to implement the districtwide program (None)
5. A procedure has been established to provide information about the extent of implementation to planners
  - a. Communication is vital to all aspects of the curriculum.
  - b. Goals and the extent of progress need to be known by the involved.
  - c. If this is not done how can there be a high correlation between planning and implementation?
  - d. If they don't know what's happening now how can they realistically plan?
6. A file of the above information has been forwarded to the local ISD
  - a. Health education office or at the ISD level?
  - b. This is okay if ISD's will be funded and able to do something with it.
7. Instruments, or procedures, for measuring attainment of knowledge, attitudes and behaviors have been identified and are now available for use
  - a. We had better have these.
  - b. Knowledge may be important, but final outcome determined by attitude and behavior.

8. Procedures have been developed and explored to determine teaching models  
(None)
9. Procedures have been developed and employed to determine teaching strategies
  - a. This needs continual updating and revision to avoid repetition and boredom in "health classes."
10. An assessment has been made of the resources which are used to support program activities  
(None)
11. Classroom teachers and other personnel have been trained to the development and administration of evaluation techniques
  - a. What good are evaluations if this isn't done?
12. A communication network has been established involving all personnel active in the implementation of the school health instruction program
  - a. A must. Revitalizing weaknesses and continuing with strengths. This should create a program where money and time are well spent.
  - b. Absolutely essential.

#### GENERAL COMMENTS

I'll leave my answers the way they are - some may be idealistic, but many of the questions promote idealism.

I seem to have followed along the lines of general consensus. This is a good way to gain information.