Montana's health enhancement: An old question revisited - combining health and physical education

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The University of Montana

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MONTANA'S HEALTH ENHANCEMENT:
An Old Question Revisited - Combining Health and Physical Education

by

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Presented in partial fulfillment of the requirement
for the Degree of
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## CONTENTS

### LIST OF TABLES

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>iv</td>
</tr>
</tbody>
</table>

### CHAPTER I. INTRODUCTION

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

- Purpose of Project
- Research Questions
- Significance
- Related Definitions

### CHAPTER II. LITERATURE REVIEW

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
</tr>
</tbody>
</table>

- Youth at Risk
- The School’s Role in Health Promotion
- Role of Health Education in the Comprehensive School Health Program
- Quality Health Education
- Montana Health Education Policies
- The Role of Physical Education in Comprehensive School Health Program
- Quality Physical Education Programs
- Montana’s Physical Education Policies
- Health Enhancement: Montana’s Approach to Health and Physical Education
- Summary of Related Literature

### CHAPTER III. METHODOLOGY

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
</tr>
</tbody>
</table>

- Population
- Instrumentation
- Procedures

### CHAPTER IV. RESULTS

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
</tr>
</tbody>
</table>

- Changes Made to Health and Physical Education Curriculums Due to the Health Enhancement Initiative
- Professional Preparation and Continuing Education
- Preferred Format for Teaching Health and Physical Education
- Importance of Health and Physical Education
- Interest in Teaching Health and Physical Education
- Comfort Level in Teaching Health and Physical Education

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List of Tables

Table                                      Page

1. REPORTED CHANGE IN THE AMOUNT OF TIME SPENT
   IN THE CLASSROOM FOR HEALTH INSTRUCTION AS A
   RESULT OF THE HEALTH ENHANCEMENT MANDATE ..........35

2. REPORTED PERCENTAGE OF TIME SPENT IN THE
   CLASSROOM FOR HEALTH INSTRUCTION RATHER THAN
   ENGAGED IN PHYSICAL ACTIVITY.........................35

3. HEALTH-RELATED COURSES TAKEN AS AN
   UNDERGRADUATE............................................38

4. INTEREST LEVELS IN TEACHING HEALTH AND
   PHYSICAL EDUCATION.......................................40

5. COMFORT LEVELS IN TEACHING HEALTH AND
   PHYSICAL EDUCATION......................................41
Introduction

Programs designed to improve and maintain the health of school children have been in existence for many years. National education groups began placing students' health as a major objective of education immediately following World War I (Mayshark & Irwin, 1968). The adverse physical, mental and emotional conditions of most of the draftees then, in part, caused educators to evaluate the need for better school health programs. Though there was a strong interest in student health, the development of what is now considered acceptable school health programs evolved very slowly. However, physical education classes implemented to assist in a similar effort to improve the physical health of students, gained widespread popularity. "Unfortunately, a rather general impression grew that physical education was the same as health education and that physical education was entirely adequate" (Mayshark & Irwin, 1968, p. 9).

Eventually, health education in the schools became more than fitness and exercise. National health statistics prompted the need to teach about other health issues. Physical educators became the logical persons to assume the responsibilities because of their background and the opportunities to teach about health in the physical education program (Jenny, 1968).
The pattern of physical educators doubling as health educators continued. However, as the nation, communities, and health educators placed more emphasis on tackling the multitude of health related issues affecting students, it became clear that physical educators had neither the time in their own program nor the expertise to conduct satisfactory health instruction. The need for separation of these two content areas and a need for separate professional preparation existed (Jenny, 1991; Mayshark, 1968; Pollock and Hamburg, 1985). Health and physical education have shared mistaken identities for decades. Although both curricular areas are concerned with the promotion of student health, in actuality, "health and physical education are separate and distinct, though closely allied, fields" (Voltmer & Esslinger, 1968, p.176).

Montana’s educational community, attempting to manage the health problems of its youth, acted on the fact that health and physical education are, indeed, closely allied fields. Instead of separating the fields, the health and physical education committee, created by Project Excellence, designed a comprehensive program and again brought together the disciplines of health and physical education under a new umbrella term, Health Enhancement. Learner outcomes from both health and physical education were combined under this encompassing term to establish a curriculum that addressed the "intellectual, social, emotional, and physical dimensions of
self in addition to games and sport" (Office of Public Instruction [OPI], 1989). The Health Enhancement curriculum is founded on the concept that health and physical education are designed to assist students in becoming healthy, productive and responsible adults and therefore, should be combined into one curriculum to enhance the efforts of each. The Montana health and physical education committee suggests that combining health and physical education as Health Enhancement is a unique approach grounded in the theory of integration (OPI, 1989). Integration theory suggests that students are more likely to retain concepts and better understand ideas and solutions to problems when they are repeatedly exposed to subject matter in several disciplines (Hilgard and Bower, 1975).

Integrating health and physical education into a single curriculum may have potential, but it remains confusing whether this approach will best serve the health needs of our youth. Past practices of combining physical education and health often resulted in health being taught as a rainy day activity within the traditional physical education program (Pollock and Hamburg, 1985). As a result of the Health Enhancement mandate however, this is no longer accepted practice. The Health Enhancement curriculum necessitates teachers to possess the expertise to teach effectively in both curricular areas. Therefore, questions arise as to how well prepared or how interested health and physical education
teachers are to teach in the other’s field. This study, then, seeks to explore whether Health Enhancement is a change in the approach to teaching health and physical education or simply the same traditional program with a new name.
Purpose of the Project

The purpose of this study is to explore issues related to the secondary Health Enhancement program in Montana. Specifically, this study was designed to determine the extent of curricular change resulting from the Health Enhancement mandate. Further, the study begins to answer the question whether secondary Health Enhancement teachers are interested in and/or academically prepared to teach both health education and physical education. Though the Health Enhancement curriculum is kindergarten-12 in scope, it is the secondary level of the Health Enhancement program that was the focus of this study.

Research Questions

The following research questions were addressed in this study:

1. Have any changes been made to the state's secondary traditional health and physical education curriculums due to the Health Enhancement initiative?

2. What is the degree of health related professional preparation and continuing education of individuals teaching Health Enhancement?

3. According to current Health Enhancement teachers, what format would be most effective for teaching both health and physical education content?
4. How important are the curricular areas of health and physical education to current Health Enhancement teachers?

5. How interested are current Health Enhancement teachers in teaching health and how interested are current Health Enhancement teachers in teaching physical education?

6. Of those individuals currently teaching Health Enhancement, is there a significant difference between their interest level in teaching health education and their interest level in teaching physical education?

7. Is there a relationship between the interest level of teaching health and the number of health education courses taken as an undergraduate?

8. How comfortable are current Health Enhancement teachers in teaching health and how comfortable are Health Enhancement teachers in teaching physical education?

9. Of those individuals currently teaching Health Enhancement, is there a significant difference between their comfort level in teaching health education and their comfort level in teaching physical education?
10. Is there a relationship between the comfort level of teaching health and the number of health education courses taken as an undergraduate?

11. Is there a difference in the number of professional preparation courses taken by Health Enhancement teachers and their response to adequate time spent teaching health?

**Significance**

The quality of school health education and physical education is dependent, for the most part, on the quality of the teachers in those disciplines. Appropriate undergraduate preparation and continued education contributes to teacher quality (Butler, 1993). Therefore, sharing the results of this project with Health Enhancement teachers, the university educational community and interested state administrators at the Montana Association for Health, Physical Education, Recreation, and Dance (MAHPERD) convention may be useful in: (a) giving direction in the development of programs and workshops to help current teachers of Health Enhancement, and, (b) revising curricula of professional preparation and continuing education programs in the area of Health Enhancement.
Related Definitions

**School Health Education:**

School health education is one component of the comprehensive school health program that includes the development, delivery, and evaluation of a planned instructional program and other activities for students preschool through grade 12, for parents and for school staff. School health education is designed to positively influence the health knowledge, attitudes, and skills of individuals (Joint Committee on Health Education Terminology, 1991).

**Physical Education:**

Physical education is the study of how and why people move. Through a variety of planned instructional experiences ranging from cooperative to competitive, physical education promotes physical growth and development. Areas of activity include creative and expressive movement, rhythms and dance, gymnastics, games and sport, aquatics and outdoor recreation (MAHPERD, 1984).
**Health Enhancement Curriculum:**

Health Enhancement is a required curricular area through the Montana Accreditation Standards. It brings together the disciplines of health education and physical education into a combined, holistic, health-oriented program. The curriculum seeks to educate children regarding the importance of self-responsibility by focusing on the total self (OPI, 1989).

**Comprehensive School Health Program:**

A comprehensive school health program is an organized set of policies, procedures, and activities designed to protect the health and well-being of students and staff that has traditionally included health services, healthful school environment, and health education. It should also include, but not be limited to, guidance and counseling, physical education, food service, social work, psychological services, and employee health education (Joint Committee on Health Education Terminology, 1991).

**Health Promotion:**

Health promotion seeks to develop community and individual values that can help maintain and enhance the state of well-being. The report of the Department of Health, Education, and Welfare Task Force on Prevention (USDHEW, 1978) defines health promotion in terms of wellness and lifestyle programs.
Related Literature Review

Youth at Risk

Americas' youth are at risk. Many of today's young adults face the risk of substance abuse, poor nutrition, sexually transmitted diseases, unwanted pregnancies, stress-related illnesses, violence and suicide (Holcomb & Denk, 1993). In addition, the youth of today are threatened by their inactivity, laying the ground work for heart disease, hypertension, obesity and other health problems to plague them later in life (Loper, Scheer, Ansorge, Bahls, & Wanderzilak, 1989).

Montana's youth reflect a similar image of the nation's youth, often revealing a more dismal picture. Just as their counterparts throughout the land, Montana's children are choosing lifestyles incongruent with healthy behavior and are vulnerable to a host of negative lifelong effects. The Montana Youth Risk Survey (OPI, 1993) was conducted with the cooperation of 38 Montana schools. Eighty-six percent or 2518 students participated in the 1993 study. Consider a few facts taken from that survey:

1. Accidents remain the leading cause of death for Montana school-aged children.

2. An estimated 37,000 Montana school-aged children may have weight-related problems from obesity.
3. Suicide is the second leading cause of death in Montana youth, ranking Montana forth in the nation.

4. Montana ranks above the National average for youth using smokeless tobacco.

5. About 70% of Montana's 12th graders have had sexual intercourse. Twenty-five percent of sexually active 12th graders report rare use of a birth control method.

6. Twenty-six percent of 12th grade female students reported they had been sexually abused.

In an era where over 50% of death and disability is due to lifestyle choices, effective education is the key to changing these statistics (OPI, 1989). Schools must take the initiative and implement effective school programs that will help children and youth modify negative behavior and promote adherence to healthy lifestyles.

The School's Role in Health Promotion

It has been recognized that today's contemporary health promotion programs in the United States were greatly influenced by the release of two similar documents: Promoting Health/Preventing Disease: Objectives for the Nation (U.S. Department of Health and Human Services [USDHHS], 1980) and Healthy People 2000, National Health Promotion and Disease Prevention (USDHHS, 1990). Both publications, released 10 years apart, featured lists of national objectives designed
to guide health promotion through the 1990s and beyond, on the federal, state and local levels.

Very clear in both documents is the importance schools and school health can play in realizing these national health goals. More than one third of the objectives in both publications can be directly attained in schools or influenced by schools (McGinnis & Degraw, 1991).

Goals directly related to both school-based health education and physical education are included in Healthy People 2000. The document specifically addresses school health education by stating the following objective: "Increase to at least 75%, the proportion of the Nation's elementary and secondary schools that provide planned, sequential, kindergarten through 12th grade quality school health education" (p. 102). Ten other objectives focus on school health.

School-based physical education is specifically addressed in the following objective: "Increase to at least 50% the proportion of children and adolescents in first through twelfth grade who participate in daily school physical education" (p. 92). Nine other objectives in the area of physical activity and fitness are included in Healthy People 2000.
Role of Health Education in the Comprehensive School Health Program

An article written by health education experts, D. Lohrman, R. Gold, and W. Jubb, (1987) titled "School Health Education: A Foundation for School Health Programs" describes the status of health education. As one of the original components of the comprehensive school health program, health education is the formal curriculum delivery to students addressing the physical, mental, emotional, and social dimensions of health. Health education strives to accomplish three goals: (a) promote health as a value, (b) provide students with the knowledge, skills and the empowerment to choose and maintain healthy behaviors, and (c) promote the ability to collect, evaluate and use new information to make appropriate future health-related decisions. The National Professional School Health Education Organization (1984) defines school health instruction as:

- Instruction intended to motivate health maintenance and promote wellness and not merely prevent disease;
- Activities to develop decision making competencies related to health and health-behavior;
- A planned sequenced prekindergarten-12 curriculum based on students needs and current and emerging health concepts and societal issues;
• Opportunities for students to develop and demonstrate health-related knowledge, attitudes, and practices;
• Integration of the physical, mental, emotional, and social dimensions of health as the basis for study [in 10 content areas]; and
• Specific program goals and objectives, formative and summative evaluation procedures, an effective management system, and sufficient resources [including] budgeted instructional material, time, management staff, and teachers.

The 10 health content areas include community health, consumer health, environmental health, family life, growth and development, nutritional health, personal health, prevention and control of disease and disorders, safety and accident prevention and substance use and abuse (Lohrman, et. al 1987).

Furthermore, Lohrman et. al (1987) explain the importance of integrating and reinforcing health education in the entire curriculum in areas such as science, home economics, psychology, social studies and physical education. It is believed that integration will allow the learner to demonstrate higher level health-related thinking skills and practices.
Quality Health Education

The fact that health education is effective is proven. (Green, Cook, Doster, Fors, Hambleton, Smith, & Walhberg, 1985) The landmark School Health Education Evaluation (SHEE) study showed unequivocally that health education can be successful in helping children improve their health knowledge and develop healthy attitudes (Mason & McGinnis 1985). School Health in America (American School Health Association [ASHA], 1990), a document that chronicles and compares school health policies established by all states, reported that over 75% of the states are mandated by law to provide health education. However, just because health education is taught doesn't guarantee its effectiveness. The success of health education according to the SHEE study (1985) is dependent on several factors. Those factors include:

- teacher adherence to the curriculum;
- the amount of time exposed to the curriculum and year by year accumulation of the curriculum;

In turn those factors are dependent on two additional factors:

- adequately trained and motivated teachers;
- administrative support (Christenson, Gold, Kratz & Kreuter, 1985).

It is recognized that certification or endorsement as a health educator typically requires specific training at the undergraduate level and requires continued education. The
SHEE study (1985) found when teacher in-service and preparation were better, teachers were more likely to teach what was expected (teacher adherence to the curriculum). This combination of factors resulted in better health education (Fors & Doster 1985). Simply stated, health education taught by certified teachers is critical to the effectiveness of the school health curricula (Allensworth 1993).

Most health experts recommend that health be a separate subject at both the 11th and 12th grades (Council of Chief State School Officers, 1990). Parcel (1985) in written comment reviewing the landmark SHEE study says evidence exists in the study to preferably teach health education as an independent subject. However, health materials can be integrated into other courses. Rationale for integration exists and is based on learning theory. Students understand ideas and solutions to problems better that are covered in several disciplines (Carnegie Council, 1989). It is believed therefore, that the effort of integrating materials from complimentary, yet distinct health-related curriculums will provide the foundation for a team approach to effectively deal with the health and well-being of our youth (Council of Chief State School Officers, 1990). Parcels (1985) suggests however, that schools move with caution when integrating health into other courses. The integration must be done in
such a way as to not destroy or reduce the emphasis that should be placed on health education.

The SHEE study also concluded that 40 to 50 classroom hours of health instruction are necessary to affect behavior change (Allensworth, 1993). An even more stringent recommendation comes from the American School Health Association which suggests secondary students receive 150 hours of health education (Allensworth, 1993).

Montana's Health Education Policies

According to School Health in America, (ASHA, 1990) Montana requires health education, but it is combined with a requirement for physical education. Even though health education is required at the secondary level, Montana is one of eight states that does not identify any specific health topics to be taught. The National Professional School Health Education Organization has identified 10 essential topics of comprehensive health instruction, none of which are required to be taught in the state of Montana. Further, the average number of health education hours required in Montana is 36. Montana is above the National average of 29 health education hours, however, it must be noted that Montana's health education hours are shared with hours in physical education.

Thirty-nine states require teachers to be certified in health education in order to teach secondary health education. The health education certification can, however,
be combined with a certificate in physical education. The health certificate can come from as a few as six college credit hours to as many as 50 college credit hours. (Allensworth, 1993). Montana's higher education systems offer a program leading to dual certification in health and physical education.

The Role of Physical Education in the Comprehensive School Health Program

Nationally renowned authors in the field of physical education, Pate, Corbin, Simon-Morton, and Ross, in an article titled "Physical Education and its role in School Health Promotion" addressed the relationship physical education shares with the comprehensive school health program. The authors envision school-based physical education as playing a central role in a school health promotion program. In summary, the authors say "School-based physical education can and should serve as a primary intervention tool to enhance the health of children and youth" (Pate et. al, 1985, p. 445).

The following statements recap their reasoning:

- Exercise is accepted as an important part of a "healthy lifestyle";
- Exercise behavior initiated in youngsters often carries into adulthood;
School-based physical education parallels and is associated with the wellness “prevention” philosophy. Pate et. al (1985) admittedly recognize the difference in quality and types of physical education programs but emphasize the need for school-based physical education to focus on the health-related aspect. Many believe that an ideal physical education program teaches children how to become fit and that maintaining a level of fitness is important in long-term health (Goldfine & Nahas, 1993). Effective physical education programs will be the result of programs directed away from a focus on skill development and re-directed toward health promotion. This type of physical education program could be successfully integrated into the school health promotion program (Pate et. al 1985).

**Quality Physical Education Programs**

The release of the documents, *Promoting Health/Preventing Disease: Objectives for the Nation* (USDHHP, 1980) and *Healthy People 2000* (USDHHS, 1990), influenced current health promotion programs. Both publications listed specific health objectives in several priority areas. Physical fitness and exercise was a priority area in both publications. The earlier released document, *Promoting Health/Preventing Disease*, stated that, “Appropriate physical activity may be a valuable tool in therapeutic regimens for control and rehabilitation of obesity, coronary heart disease,
hypertension, diabetes, stress and depression/anxiety" (p.79). "Appropriate physical activity" was defined as the minimum frequency, duration, and intensity with which a person needs to be physically active in order to maintain an effectively functioning cardiorespiratory system (Ross, Dotson, & Gilbert, 1985).

In an effort to monitor the goals set forth in Promoting Health/Preventing Disease (USDHHP, 1980) in the priority area of physical fitness and exercise, the United States Public Health Service Office of Disease Prevention and Health Promotion took steps to measure the prevalence of appropriate physical activity and the carry over potential it has among school-age children, ages 10-17 years old. Thus the impetus behind the National Children Youth Fitness Study (NCYFS, 1984).

The NCYFS found that approximately one-half of American children in grades 5-12 did not perform the minimum weekly requirement of vigorous physical activity needed to maintain a minimum level of aerobic fitness. Further, the study found that the youth of our nation, because of seasonal exercise patterns, were deprived the health benefits of year-round exercise habits, setting a pattern to continue throughout their lifetime (Ross et. al, 1985).

It was the NCYFS that established the important role physical education could play in the comprehensive school health program. However, in order to become a vital player in
the health promotion of its students, school-based physical education must move toward emphasizing health-related physical fitness and lifelong physical activity (Pate et al., 1987).

The National Association for Sport and Physical Education (NASPE) recognized that physical education could and should indeed play an important role in the health status of the nation's youth. This position, coupled with the push nationwide to improve the quality of our schools by improving all subject areas, including physical education, propelled NASPE to define characteristics of quality physical education programs. NASPE launched "The Outcomes Project" and from this project came the definition of the physically-educated student. According to NASPE, the physically-educated person demonstrates the following characteristics:

- Has learned skills necessary to perform a variety of physical activities:
  1. Moves using concepts of body awareness, space awareness, effort and relationships;
  2. Demonstrates competence in a variety of manipulative, locomotor and nonlocomotor skills;
  3. Demonstrates competence in combinations of manipulative, locomotor and nonlocomotor skills performed individually and with others;
4. Demonstrates competence in many different forms of physical activity;
5. Demonstrates proficiency in a few forms of physical activity;
6. Has learned how to learn new skills.

- Is physically fit:
  7. Assesses, achieves, and maintains physical fitness;
  8. Designs safe, personal fitness programs in accordance with principles of training and conditioning.

- Does participate regularly in physical activity:
  9. Participates in health enhancing physical activity at least three times a week;
  10. Selects and regularly participates in lifetime physical activities.

- Knows the implications of and the benefits from involvement in physical activities:
  11. Identifies the benefits, costs and obligations associated with regular participation in physical activity;
  12. Recognizes the risk and safety factors associated with regular participation in physical activity;
  13. Applies concepts and principles to the development of motor skills;
  14. Understands that wellness involves more than being physically fit;
15. Knows the rules, strategies and appropriate behaviors for selected physical activities;
16. Recognizes that participation in physical activity can lead to multicultural and international understanding;
17. Understands that physical activity provides the opportunity for enjoyment, self-expression, and communication.

Values physical activity and its contributions to a healthful lifestyle:

18. Appreciates the relationship with others that result from participation in physical activity;
19. Respects the role that regular physical activity plays in the pursuit of lifelong health and well-being;
20. Cherishes the feelings that result from regular participation in physical activity. (NASPE, 1992)

NASPE clearly identified the need for daily physical education if, indeed, students are to become physically educated as they outlined. In addition to defining a physically educated person, NASPE established other recommendations concerned with providing and maintaining quality physical education programs. Selected recommendations include:
Quality physical education programs should be designed and taught by certified physical education specialists. Objectives should be clearly identified by grade level for appropriate physical activity. Learning activities should be sequenced by objectives. Daily participation should be a minimum of 50 minutes in length in grades 6-12, 50% of which time the student should be physically active (NASPE, 1990).

Until this time, no agency had attempted to set guidelines to encourage the development, improvement and maintenance of quality physical education programs within our schools. It is significant that NASPE developed such guidelines. It is a quality physical education program that will serve as a health promotion modality in the comprehensive school health program (Goldfine & Nahas, 1993).

Montana’s Physical Education Policies

According to School Health in America (ASHA 1989), Montana is one of 40 states that requires accredited schools to provide physical education programs in grades kindergarten-12. The state recommends fitness testing but does not require that it take place. It is reported that the average number of physical education hours in the state is 37.5. In comparison, the national average of physical education hours at the secondary level is 54. Montana’s required hours are much lower. It also must be noted that
the average number of hours in Montana are combined and shared with health instruction.

The personnel to teach physical education, according to the document, should ideally be specifically prepared and certified in physical education to teach at either the elementary or secondary level. Montana provides only a combined physical education/health education kindergarten-12 certification for it's professional preparation of physical educators.

**Health Enhancement: Montana's Approach to Health and Physical Education**

In the late 1980s, Montana embarked on a lengthy process, known as Project Excellence, to revise Montana's Accreditation Standards. The aim of the process was to fit accreditation standards to the needs of students of the coming century. The health and physical education committee of Project Excellence, designed a unique plan by combining the learner outcomes from the two curricular areas under the encompassing term Health Enhancement. The traditional programs of health and physical education were combined to better meet the health-related needs of students (OPI 1989).

The Health Enhancement curriculum operates on the concept that health and physical education are designed to assist students in becoming healthy, productive and responsible adults and, therefore, should be combined into
one curriculum to enhance the efforts of each. Health Enhancement emphasizes health as a value in life and enhances critical thinking, decision making, and problem solving skills. It helps students protect, maintain and improve their health and sensitizes them to society's critical health issues. The major goals of the Health Enhancement curriculum are:

a. Integrate lifestyle management throughout the curriculum;

b. Focus on the total self and the development of self-responsibility, values, attitudes and behaviors;

c. Give students decision making tools for personal health; and

d. Address intellectual, social, emotional, and physical dimensions of healthy lifestyles (OPI, 1989).

Health Enhancement learner goals have been identified in the Montana School Accreditation Standards and Procedures Manual. The following are the learner goals to be reached upon graduation:

(1) Upon graduation the student shall have the opportunity to:

(a) Demonstrate a variety of physical skills used in physical activity, including but not limited to dance, individual, dual or team sports, and lifetime leisure recreational activities.
(b) Demonstrate an appropriate level of physical fitness in cardiorespiratory function, body composition and musculoskeletal function.

(c) Understand the importance of a positive self-concept and interpersonal relationships for total health.

(d) Understand the role of lifelong physical activity and the principles of safe and effective exercise, be able to plan a personal fitness program.

(e) Understand the roles, responsibilities, contributions, and life cycles in family structures.

(f) Understand the risks of using drugs, alcohol, and tobacco.

(g) Understand attitudes and behaviors for preventing and controlling disease and accidents.

(h) Understand human reproduction and the emotional and ethical components of human sexuality.

(i) Be able to evaluate and select health services, practices, and products.

(j) Understand the relationship of sound nutrition to total health

(k) understand the consequences of personal and community decisions that affect the economy and the cost, availability, and quality of health care.

(l) Understand the relationship of sound mental health practices to total health.
(m) Identify careers in health and physical activity and their roles and responsibilities. (OPI, 1989)

Summary of Related Literature

In reviewing the related literature, the following topics were discussed: the nation’s youth at risk, the school’s role in health promotion, the relationship of health education and physical education to a comprehensive school health program, quality school health education and physical education, Montana’s current health education and physical education practices and policies, and Montana’s Health Enhancement program.

While health education forms the cornerstone of a comprehensive school health program, physical education also serves a vital component of the expanded concept of a comprehensive school health program. However, the effectiveness with which the programs serve the school health program is certainly dependent on the quality and success of the individual programs.
Methodology

Population

The population for this study was secondary Health Enhancement teachers in the state of Montana. Due to the relatively small number of high schools in this state, all 176 public high schools were asked to participate in this study. Montana secondary schools were identified with the use of the 1993-94 Montana High School Association Directory.

Instrumentation

After reviewing a health education survey used to assess health education in the middle schools in the state of Illinois (Sondag and Goldsmith, 1992), a similar instrument was constructed to assess health instruction specific to Montana's Health Enhancement curriculum. The Illinois survey, in addition to the Health Enhancement secondary level learner outcomes served as guidelines in the development of the Montana survey. A first draft was pilot tested by three qualified Health Enhancement teachers and revisions and editing of the instrument followed. (see Appendix A.)

Approximately one-third of the questions on the survey addressed changes made to existing curricula as a result of the 1989 Health Enhancement initiative. Several questions focused on teacher background, undergraduate preparation, and continuing education. In addition, teachers were asked
questions regarding their attitudes/beliefs about Health Enhancement. A combination of forced choice, likert scale and open ended questions were used to gather the data.

**Procedures**

Surveys were mailed to Health Enhancement teachers in all 176 secondary schools. A cover letter explaining the nature of the study accompanied the survey (see Appendix A). A self-addressed postage paid envelope was included for easy return of the completed survey. The larger (AA) schools in the state were mailed three individual letters, surveys and return envelopes, to be distributed among Health Enhancement teachers within that school. Any school that was initially sent a survey and failed to return it in a two-week period of time was sent an additional survey, return envelope and a follow-up letter asking them to reconsider their participation. (see Appendix A)
Results

The purpose of this study was to begin exploring whether Montana's attempt to manage its youth's health problems through Health Enhancement is a unique plan or simply a new name for an old approach. Specifically, this study was designed to determine the extent of curricular change resulting from the Health Enhancement mandate. Further, the study begins to answer the question whether secondary Health Enhancement teachers are interested in and/or academically prepared for teaching both health education and physical education.

Research Questions
The following research questions were addressed in this study:

1. Have any changes been made to the state's secondary traditional health and physical education curriculums due to the Health Enhancement initiative?

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3. According to current Health Enhancement teachers, what format would be most effective for teaching both health and physical education content?
4. How important are the curricular areas of health and physical education to current Health Enhancement teachers?

5. How interested are current Health Enhancement teachers in teaching health and how interested are current Health Enhancement teachers in teaching physical education?

6. Of those individuals currently teaching Health Enhancement, is there a significant difference between their interest level in teaching health education and their interest level in teaching physical education?

7. Is there a relationship between the interest level of teaching health and the number of health education courses taken as an undergraduate?

8. How comfortable are current Health Enhancement teachers in teaching health and how comfortable are Health Enhancement teachers in teaching physical education?

9. Of those individuals currently teaching Health Enhancement, is there a significant difference between their comfort level in teaching health education and their comfort level in teaching physical education?
10. Is there a relationship between the comfort level of teaching health and the number of health education courses taken as an undergraduate?

11. Is there a difference in the number of professional preparation courses taken by Health Enhancement teachers and their response to adequate time spent teaching health?

The data collected represents the information obtained from 133 returned surveys, out of 176 surveys sent. The return rate was calculated to be 76%. Data was analyzed using descriptive statistics to establish profiles related to changes made to the curriculum, the time spent teaching health, teacher preparation, levels of comfort and interest in teaching health and physical education, and attitude toward teaching health and physical education and health enhancement. Associations among variables such as the comfort level teaching health and the comfort level teaching physical education were investigated using correlational analysis. The association between the number of professional preparation classes and comfort level was also investigated. Mean difference tests (p<.05) were used to determine differences in interest and comfort levels between teaching health and teaching physical education.
Changes made to Health and Physical Education Curriculums Due to the Health Enhancement Mandate

Sixty-two percent of the schools returning surveys reported that they continue to refer to their programs as health and physical education rather than Health Enhancement. Thirty-five percent of the schools who returned surveys adopted the new title, Health Enhancement. The remaining six percent reported titling their program Health.

Only 25% of the schools had new curriculums, as a result of the Health Enhancement mandate and 50% of the schools reported making some revisions to their existing curriculums. Further, 25% said that there were no revisions or were not sure of any revisions made to their curriculums due to the mandate.

Schools were asked to report any change in the amount of time spent teaching health due to the Health Enhancement initiative. It was reported that 47% of the schools had increased the time spent in the classroom teaching health, however, 44% reported there was no change. See Table 1.

In the study, 40% of the respondents reported that 10 to 25% of the time devoted to Health Enhancement was spent in the classroom for health instruction rather that engaged in physical activity. Another 40% reported that 26 to 50% of the time devoted to Health Enhancement was spent in the health classroom rather than in physical education. See Table 2.
Table 1.

<table>
<thead>
<tr>
<th>Reported change in the amount of time spent in the classroom for health instruction as a result of the Health Enhancement mandate</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Change</td>
<td>59</td>
<td>44.4%</td>
</tr>
<tr>
<td>Decrease in Time</td>
<td>3</td>
<td>2.3%</td>
</tr>
<tr>
<td>Increase in Time</td>
<td>63</td>
<td>47.4%</td>
</tr>
<tr>
<td>Missing cases</td>
<td>7</td>
<td>6%</td>
</tr>
</tbody>
</table>

Respondents were asked whether the time allotted for health instruction and physical education within the Health Enhancement curriculum was adequate. Sixty-one percent responded yes to adequate time spent in the health, while, 71% responded yes to adequate time spent in physical education.

Table 2

<table>
<thead>
<tr>
<th>Reported percentage of time spent in the classroom for health instruction rather than engaged in physical activity.</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Time</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>10% - 25%</td>
<td>53</td>
<td>39.8%</td>
</tr>
<tr>
<td>26% - 50%</td>
<td>51</td>
<td>38.3%</td>
</tr>
<tr>
<td>51% - 74%</td>
<td>7</td>
<td>5.3%</td>
</tr>
<tr>
<td>More than 75%</td>
<td>17</td>
<td>12.8%</td>
</tr>
<tr>
<td>Missing cases</td>
<td>1</td>
<td>.8%</td>
</tr>
</tbody>
</table>

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The survey attempted to gain an understanding as to how the health instruction took place within the Health Enhancement curriculum. Twenty-four percent of the responding schools reported that health was taught two to three days per week per year; 21% reported teaching health daily for a semester; 16% reported teaching health two to three days per week for a semester. Thirty percent of the responding schools reported following a different format from those mentioned above. (see Appendix B)

The study found that in 90% of the schools health instruction was required at the ninth and tenth grade levels. Two percent of the respondents said that health instruction was required beyond a student’s sophomore year in high school.

**Professional Preparation and Continuing Education**

Respondents reported that they took an average of six health courses at the undergraduate level. Sixty percent or more of the respondents had taken courses in substance use and abuse, nutrition, secondary health education teaching methods, personal health, and safety and accident prevention. Less than 50% of those surveyed had taken courses in family life (sexuality education), consumer health, environmental health, mental and emotional health, prevention and control of disease, community health or courses concerned with the school health program. See Table 3.
The study found that 54% of the respondents were not aware of any Health Enhancement workshops or had not attended any Health Enhancement workshops. Thirty-six percent of the respondents, however, did report going to one or two workshops that dealt with Health Enhancement. The respondents did report that if given the opportunity to participate in workshops, 76% said that a workshop in Health Enhancement classroom methods would be most beneficial to them, while another 53% would benefit from a workshop on integrating health and physical education into one course.

**Preferred Format for Teaching Health and Physical Education**

Approximately 50% of the respondents believed that health education and physical education would be most effectively taught as two separate courses. Forty percent of the respondents indicated a belief that combining the two courses as Health Enhancement was the best method of teaching the two curricular areas. Ten percent of the respondents were undecided.
Table 3.

<table>
<thead>
<tr>
<th>Health-related courses taken as an undergraduate</th>
<th>Percent of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental and Emotional Health</td>
<td>44.4 %</td>
</tr>
<tr>
<td>Nutrition</td>
<td>68.4 %</td>
</tr>
<tr>
<td>Environmental Health</td>
<td>15.8 %</td>
</tr>
<tr>
<td>Prevention and control of Disease</td>
<td>48.1 %</td>
</tr>
<tr>
<td>Consumer Health</td>
<td>27.1 %</td>
</tr>
<tr>
<td>Substance Use and Abuse</td>
<td>78.2 %</td>
</tr>
<tr>
<td>Family Life (Sexuality ) Education</td>
<td>48.1 %</td>
</tr>
<tr>
<td>Accident Prevention And Safety</td>
<td>63.9 %</td>
</tr>
<tr>
<td>Community Health</td>
<td>29.3 %</td>
</tr>
<tr>
<td>Personal Health</td>
<td>66.9 %</td>
</tr>
<tr>
<td>Teaching Methods for Secondary Health Education</td>
<td>69.9 %</td>
</tr>
<tr>
<td>School Health Program</td>
<td>32.3 %</td>
</tr>
</tbody>
</table>

Importance of Health and Physical Education

Eighty-five percent of the respondents in the study rated both health and physical education in the curriculum as very important. There was a significant positive relationship (p<.05) between the number of health courses taken as an undergraduate and the level of importance placed on health.
Interest in Teaching Health and Physical Education

The participants of the study were asked to rate their level of interest in teaching health education and physical education. The study found that 59% were very interested in teaching health, while 74% of the same respondents reported they were very interested in teaching physical education. Results indicated that respondents were significantly (p<.05) more interested in teaching physical education than they were teaching health education. There was no significant relationship between the number of college preparatory courses taken in health education and the interest level in teaching health. See Table 4.

Comfort Level in Teaching Health and Physical Education

Participants rated their level of comfort in teaching health and physical education. Fifty percent of the respondents reported being very comfortable teaching health, while 77% of the same respondents reported being very comfortable teaching physical education. The study showed that respondents were significantly more comfortable teaching physical education than they were teaching health education (p<.05). There was no relationship in the number of undergraduate college health courses taken and the respondents comfort level in teaching health education.
Table 4.

<table>
<thead>
<tr>
<th>Interest levels in teaching health and physical education</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Health</th>
<th>Physical Education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Uninterested</td>
<td>2</td>
<td>1.5%</td>
</tr>
<tr>
<td>Somewhat Uninterested</td>
<td>6</td>
<td>4.5%</td>
</tr>
<tr>
<td>Neutral</td>
<td>10</td>
<td>7.5%</td>
</tr>
<tr>
<td>Somewhat Interested</td>
<td>37</td>
<td>27.8%</td>
</tr>
<tr>
<td>Very Interested</td>
<td>78</td>
<td>58.6%</td>
</tr>
<tr>
<td>Missing</td>
<td>3</td>
<td>2.3%</td>
</tr>
</tbody>
</table>
Table 5.

<table>
<thead>
<tr>
<th>Comfort levels in teaching health and physical education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health</strong></td>
</tr>
<tr>
<td>Frequency</td>
</tr>
<tr>
<td>Uncomfortable</td>
</tr>
<tr>
<td>Somewhat Uncomfortable</td>
</tr>
<tr>
<td>Neutral</td>
</tr>
<tr>
<td>Somewhat Comfortable</td>
</tr>
<tr>
<td>Very Comfortable</td>
</tr>
<tr>
<td>Missing cases</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
</tr>
<tr>
<td>Uncomfortable</td>
</tr>
<tr>
<td>Somewhat Uncomfortable</td>
</tr>
<tr>
<td>Neutral</td>
</tr>
<tr>
<td>Somewhat Comfortable</td>
</tr>
<tr>
<td>Very Comfortable</td>
</tr>
</tbody>
</table>
Discussion

Five years ago, Montana mandated that all schools begin a plan of curriculum development for Health Enhancement that was to start no later than 1991. Results of a survey of current secondary Health Enhancement teachers indicate that some schools have not begun that process. One quarter of the respondents said that they have not made any revisions to their curriculum to combine both health instruction and physical education into an integrated curriculum. Although, approximately half of the respondents reported making some changes to their curriculum, it is interesting that over half of the respondents refer to their program as health and physical education and not Health Enhancement. Based on this information, Health Enhancement curriculums, in the context in which the state intended, are not widespread.

Evidence exists, in the results of this study, that the Health Enhancement concept itself is unclear to some respondents. Some respondents answering the open-ended questions were admittedly confused as to what Health Enhancement is and requested more information about the state mandate and the curriculum model. (see Appendix C.) It is apparent that teachers and other school personnel need to better understand the concept in order to revise existing traditional health and physical education curricula. Increased efforts to communicate, in a
timely manner, with all practicing teachers, may have facilitated a change to the new curriculum. According to Rogers (1983) diffusion of an innovation is usually more successful when those who will be most affected by the change are involved from the beginning in a grassroots approach.

The question whether health and physical education would be most effectively taught separately or integrated into one course remains unanswered, as participant opinion was divided. Rationale for integration of subject matter does exist and is based on learning theory. Students better understand ideas and solutions to problems that span several disciplines (Carnegie Council, 1989). Health and physical education do lend themselves to integration in many ways. While integrating topics such as nutrition and safety with physical education have merit, it is not reasonable to integrate topics such as sexuality. Therefore, the practicality of integrating all health topics with physical education is questionable.

Health and physical education programs if integrated, however, must be taught effectively in order to change student health behaviors. Even though respondents in the study overwhelmingly believe health and physical education are important curricular areas, it was found that teachers were significantly more interested and more comfortable teaching physical education than health. Therefore, the
effectiveness of the health enhancement program may be diluted when teachers respond in such a manner.

Health Enhancement program effectiveness is also debatable in the 40% of the responding schools who report devoting only 18 to 35 hours to health instruction. The remaining time was spent engaged in physical activity. The division of time between the two content areas has been left to the discretion of individual schools and varies considerably throughout the state. Allensworth (1993) has determined that 40-50 hours of health instruction are necessary to affect change in behavior of students. NASPE has recommended that students experience daily physical activity. Therefore it seems reasonable to conclude that the quality of both programs may be diminished when time allowed for Health Enhancement is divided. Unfortunately, in some of the existing Health Enhancement programs, health instruction is once again taking on a less significant role, compared to the physical education portion of the curriculum.

Perhaps one reason for the seemingly weak emphasis placed on health instruction in some schools, is lack of adequate teacher preparation and continuing education. The survey indicated that respondents took an average of six health classes at the undergraduate level. Interestingly, over half of the respondents had not attended any workshops specifically related to the implementation of Health Enhancement. It is the lack of teacher training in health
education that remains a major barrier to the implementation and effectiveness of school health instruction (Lavin, 1993).

Conclusions and Recommendations

Montana schools, like all schools in the nation, are struggling to meet the health needs of their youth. What seems to be an insurmountable task, still must be met with aggression. Now more than ever, today's youth need effective school-based programs that will assist them in developing lifelong, healthy behaviors.

Montana's attempt to manage its youth's health, through Health Enhancement, has some problems and inconsistencies that need to be addressed if the concept is to be carried out effectively in the classroom. Based on the results of this study, recommendations to improve the existing Health Enhancement programs throughout the state include:

(a) Organize and provide current Health Enhancement teachers with appropriate and applicable workshops in a variety of locations throughout the state, and at different times of the year.

(b) Revise curricula at the state's colleges and universities to better prepare future Health Enhancement teachers.

RATIONALE: Undergraduate preparation and continued education influences the success of health instruction programs (Christenson et. all, 1985). Health no longer can be the
weak link of an integrated health and physical education program.

(c) Establish Health Enhancement coordinators in key geographical locations throughout the state. These individuals would be trained to help assist current Health Enhancement teachers.

(d) Develop and establish a communication network that is available to all current health enhancement teachers. 
RATIONALE: Improved communication will assist in the diffusion of the concept and the implementation of effective programs.

The recommendations listed above are intended to address some of the superficial problems associated with the current Health Enhancement program in Montana. The following recommendations, however, address what this researcher views as the root problems of providing all Montana students quality health and physical education programs.

(a) Lobby state officials to develop separate standards and adequate time requirements for both curriculum areas. 
RATIONALE: Separate standards would eliminate any question on the part of the schools and their personnel as to what exactly must be taught and how much time must be devoted to the curriculum area.

(b) Provide separate certification in health and physical education at Montana’s colleges and universities.
RATIONALE: It is debatable whether prospective teachers entering a college that offers only dual certification in health and physical education have equal interests in both areas. Offering separate certification would alleviate the problem of interest and allow individuals to pursue, in depth, the subject that they want to teach. Further, the feasibility of colleges to adequately prepare prospective teachers in two such exacting disciplines is debatable when only dual certification is offered.
References


American School Health Association (1989). *School Health In America.* Kent OH.: ASHA


APPENDIX A.

LETTERS AND INSTRUMENT
April 20, 1994

Dear Colleague:

Wait! Before you file this survey in the garbage, please take just a moment to hear us out. We are interested in what you are doing as a Health Enhancement teacher, and interested in what you, as a Health Enhancement teacher, think about the idea of integrating health and physical education. We understand that you may have recently filled out an OPI Health Education Survey, and realize you are probably not crazy about answering more questions on the same subject. However, with your help we hope to get information on issues specifically related to Montana’s Health Enhancement Program.

We are asking all of Montana’s public high school Health Enhancement teachers to take part in this survey. Information from the survey will be anonymous and results will be reported only in terms of the group as a whole. We in no way intend to evaluate your program or your school.

We know that your time is valuable and we sincerely appreciate your effort in completing this survey. If you are interested in the results, please feel free to contact us at the numbers below, or attend the 1994 Montana Association for Health, Physical Education, Recreation and Dance (MAHPERD)Convention, where we hope to share the data with interested individuals throughout the state.

Sincerely,

Maureen Thomas, Health Enhancement Teacher
Big Sky High School, Missoula, Montana
728-2401

Annie Sondag, Associate Professor
Certified Health Education Specialist
University Of Montana
243-5215

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May 23, 1994

Dear Colleague,

Hello again! Not too long ago we sent you a survey about Health Enhancement. We didn’t get a reply from you and we are still interested in what you have to say. Surely, the survey has unexplainably fallen into the deepest, darkest crevice of your desk, never to be found again! Be assured, however, you will no longer need to search in vain for that original survey because we have sent you another one.

To refresh your memory, we are interested in what you are doing as a Health Enhancement teacher, and interested in what you, as a Health Enhancement teacher, think about the idea of integrating health and physical education.

We are asking all of Montana’s public high school Health Enhancement teachers to take part in this survey. Information from the survey will be anonymous and results will be reported only in terms of the group as a whole. We in no way intend to evaluate your program or your school.

Your opinion is very important to us so please take the time to fill out the enclosed survey and return it to us before it, too, cannot be found! We understand how busy you are this time of year and appreciate the time you have taken to reply.

Maureen Thomas, Health Enhancement Teacher
Big Sky High School, Missoula, Montana
728-2401

Annie Sondag, Associate Professor
Certified Health Education Specialist
University of Montana
243-5215
WHAT'S UP WITH HEALTH ENHANCEMENT?

1. What title does your school district use to refer to your Health Enhancement curriculum?
   [ ] Health and Physical Education
   [ ] Health Enhancement
   [ ] Other ________________

2. What subjects do you teach? (Check all that apply)
   [ ] Health
   [ ] Physical Education
   [ ] Other ________________

3. To what extent has your school district revised it’s health and physical education curriculum as a result of the 1989 Health Enhancement initiative?
   [ ] Not sure
   [ ] No revisions
   [ ] Some revisions
   [ ] New curriculum

4. Which of the following best describes the format for your health instruction class?
   [ ] Taught everyday for one quarter
   [ ] Taught everyday for one semester
   [ ] Taught two or three days per week for one semester
   [ ] Taught two or three days per week for an entire year
   [ ] Other ________________

5. In your Health Enhancement program what percentage of the time is spent in the classroom for health instruction rather than engaged in physical activity?
   [ ] No time spent in classroom instruction
   [ ] 10 - 25% classroom instruction
   [ ] 26 - 50% classroom instruction
   [ ] 51 - 74% classroom instruction
   [ ] More than 75% of course time is spent in the classroom.

6. How has the percentage of the time spent in the classroom for health instruction changed with the implementation of the Health Enhancement program in 1989?
   [ ] No change
   [ ] Decrease in time spent in health instruction
   [ ] Increased in time spent in health instruction

7. Do you believe that adequate time is allotted for:
   • Health Education  • Physical Education
     [ ] yes          [ ] yes
     [ ] no           [ ] no
8. How would you rate your comfort level teaching:

- **Health Education**
  - [ ] Uncomfortable
  - [ ] Somewhat Uncomfortable
  - [ ] Neutral
  - [ ] Somewhat Comfortable
  - [ ] Very Comfortable

- **Physical Education**
  - [ ] Uncomfortable
  - [ ] Somewhat Uncomfortable
  - [ ] Neutral
  - [ ] Somewhat Comfortable
  - [ ] Very Comfortable

9. How would you rate the importance of

- **Health Education**
  - [ ] Unimportant
  - [ ] Somewhat Unimportant
  - [ ] Neutral
  - [ ] Somewhat Important
  - [ ] Very Important

- **Physical Education**
  - [ ] Unimportant
  - [ ] Somewhat Unimportant
  - [ ] Neutral
  - [ ] Somewhat Important
  - [ ] Very Important

10. How interested are you in teaching:

- **Health Education**
  - [ ] Uninterested
  - [ ] Somewhat Uninterested
  - [ ] Neutral
  - [ ] Somewhat Interested
  - [ ] Very Interested

- **Physical Education**
  - [ ] Uninterested
  - [ ] Somewhat Uninterested
  - [ ] Neutral
  - [ ] Somewhat Interested
  - [ ] Very Interested

11. Which of the following health topics have you integrated into the physical education curriculum?

  - [ ] None
  - [ ] Positive self-concept and interpersonal relationships
  - [ ] Human reproduction and the emotional and ethical components of human sexuality
  - [ ] Risks of using alcohol, and tobacco, and other drugs
  - [ ] Role of lifelong physical activity and the principles of safe effective exercise
  - [ ] Environmental Health
  - [ ] Careers in health and physical activity
  - [ ] Relationship of sound nutrition to total health
  - [ ] Roles, responsibilities, contributions, and life cycles in family structure
  - [ ] Consequences of personal and community decisions
  - [ ] Preventing and controlling disease and accidents
  - [ ] Evaluate health services, practices, and products
  - [ ] Life skills (decision making, refusal skills)
  - [ ] Sexually transmitted diseases, HIV / AIDS
  - [ ] Anatomy and physiology
  - [ ] Relationship of sound mental health practices to total health
  - [ ] Other ____________________
12. How often have you had the opportunity to attend a workshop specifically related to Health Enhancement and its implementation?

[ ] Not aware of any workshop opportunities
[ ] 0
[ ] 1 - 2
[ ] 3 - 4
[ ] 5 or more

13. What type of workshop would be most beneficial to you as a teacher of Health Enhancement? (check all that apply)

[ ] Rationale and philosophy of Health Enhancement
[ ] Health Enhancement classroom methods
[ ] Integrating Health and Physical Education into one course
[ ] Integrating Health into other parts of the curriculum
[ ] Other________________________

14. How would you rate the support for Health Enhancement from your:

- Administration

[ ] Poor
[ ] Below average
[ ] Average
[ ] Above average
[ ] Excellent

- Board of Trustees

[ ] Poor
[ ] Below Average
[ ] Average
[ ] Above Average
[ ] Excellent

15. Which of the following formats do you believe would be the most effective way to teach health and physical education?

[ ] Two separate required courses
[ ] Combined as one requirement (Health Enhancement)
[ ] Not sure
[ ] Other________________________

16. Please place a check mark in front of those health related courses which you took as an undergraduate student that helped prepare you to teach health.

[ ] Mental and Emotional Health
[ ] Nutrition
[ ] Environmental Health
[ ] Prevention and Control of Disease
[ ] Consumer Health
[ ] Substance use and abuse
[ ] Family Life (Sexuality) Education
[ ] Accident Prevention and Safety
[ ] Community Health
[ ] Personal Health
[ ] Teaching Methods for Secondary Health Education
[ ] The School Health Program
[ ] Other Health Education Classes (please specify)________________________
17. At what grade level(s) does required health instruction take place in your school? (check all that apply)

[ ] 9th  [ ] 11th
[ ] 10th  [ ] 12th

18. Which grade levels are included at your high school?

[ ] 9th - 12th grade
[ ] 10th - 12th grade

19. What is the approximate enrollment of your school?

[ ] Less than 300 students
[ ] 300 - 500 students
[ ] 500 - 750 students
[ ] 750 - 1000 students
[ ] Over 1000 students

PLEASE TAKE THIS OPPORTUNITY TO LET US KNOW WHAT YOU THINK ABOUT THE CONCEPT OF HEALTH ENHANCEMENT. COMMENTS?

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS SURVEY!

PLEASE RETURN BY_________
APPENDIX B.

RESPONSES TO OPEN-ENDED QUESTION

#4
RESPONSES TO OPEN-ENDED SURVEY QUESTION

4. Which of the following best describes the format for your health instruction class?
   [ ] Taught everyday for one quarter
   [ ] Taught everyday for one semester
   [ ] Taught two or three days per week for one semester
   [ ] Taught two or three days per week for an entire year
   [x] Other _________________________

   • Taught every day for 6 weeks.
   • One day per week; all year long
   • One or 2 days per week; all year long
   • Once a week, per semester
   • One day per week, some weeks more
   • One week blocks—freshman 6 weeks, sophomores 8 weeks.
   • One day per week for one quarter
   • Two weeks per quarter
   • Two weeks for 1 semester.
   • Two days, per week, per quarter
   • Two week blocks
   • Two, 4-1/2 week blocks, per year
   • Two weeks each quarter
   • Three weeks per quarter
   • Four to 5 week blocks for one semester
   • Four days in 3 weeks, for entire year
   • Five days, every other week; all year long
   • Total 18 weeks, 3 weeks on, 3 weeks off
   • Taught every Friday
   • Every other 3 week period, for one semester
   • On and off for 2 weeks at a time
   • Every Friday, except when teaching CPR, then taught until it is finished
   • Taught everyday for 1/3 of the year plus 10 days in Physical education
   • Blocks of 2 or 3 weeks, 5 to 6 times per year
   • About every other day for a quarter
APPENDIX C.

RESPONSES TO FINAL OPEN-ENDED QUESTION
The final survey question, stated above, elicited the following responses (Printed as written):

- Personally speaking, I have taught PE for 18 years. The last couple of years we have worked on our health curriculum. I would like to see health offered as a separate class with a more certified health teacher. I guess I'm more orientated toward PE and find my 7th-9th-10th health classes take alot of special talents I'm not great at or comfortable teaching.

- Whatever we can do to help students become active-moving etc. is what we need to do. Information is only good if it becomes a part of their life. I'm not concerned about health information compared to my concern for their lack of physical fitness

- I don't believe it is clearly understood among the professionals teaching it. I believe the state of Montana is over-looking one of the most important subjects to our youth today. I also believe to do our subjects justice they should be two separate requirements.

- I'd like more updated training.

- It's a great concept, long overdue in implementation.

- Great idea- We are in favor of it here. Would like in-service to implement the program.
I like the concept but would like to know how other schools implement their program. Although we are called Health Enhancement instructors, we still teach either all health or all PE. I would like to know how other instructors around the state have their assignments designed so they teach both.

I feel rushed to get through all the material. I believe PE/Health need to be split into two classes.

I think the concept is great and is needed. We have a curriculum for 9th and 10th graders but have yet to implement it fully. We also are in need of training to integrate more into the physical education aspect.

I would like more resource material and some updated curriculum information from OPI.

The concept of integrating health and physical education has merit. I feel we were doing it pretty well. The name change seems to dress up the program, at least by name, to make it more acceptable. I think it is confusing and unnecessary. I would like to see in-service and set curriculum for all to follow in our district.

I would appreciate any and all information and/or materials available concerning health enhancement.

I would like it to remain physical education and health, two separate, required courses.

An excellent idea but, we do need workshops.
I believe more needs to be done in the area of health. We cannot afford to wait.

I believe that health education is very important, however, when combined with PE I believe these classes suffer. The students resent the health curriculum because it cuts down their gym time, I would like to see the two separated.

The concept is very good, however, we have felt to do it right we need more time to plan and more in-service to help us.

What exactly is health enhancement anyway?

Regional workshops, should be required for credit with statewide information on implementation and understanding the program might be very beneficial.

What I would really like from you is any health topics that I could give to our students. I'm always looking for more information.

I think this is a vitally important area, but I would like more preparation (workshops, classes)

Separate required classes are essential for good classes

I am unsure of the content and the scope of the health enhancement program of 1989. I would appreciate any and all information and/or materials available.

The Montana public school system is 10-20 years behind other states in the area of health education.
I believe physical education and health are very related topics, but when the two classes are combined, I find it difficult to give the students a grade that accurately reflects both areas. This is my first year teaching health enhancement in Montana so I'm not exactly sure what health enhancement is suppose to cover. Any information you could give me on health enhancement would be greatly appreciated.

I am amazed at how first year teachers know so little about teaching health or up-to-date health issues.