

Attitudes Towards Teaching and Perceptions of School Climate Among Health Education Teachers in the United States, 2011-2012

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ABSTRACT

PURPOSE: In general, teachers who are highly satisfied are more motivated teachers and positively affect health and student learning to improve academic achievement. The purpose of this study was to provide national-level data with regard to teachers' attitudes, perceptions, and beliefs related to teaching, job satisfaction, and working environment. Findings were compared to health teachers due to their specific knowledge related to health and academics and their potential leadership roles when implementing the Whole School, Whole Community, Whole Child (WSCC) model. **METHODS:** Data reported for this study were extracted from the most recent Schools and Staffing Survey, a comprehensive nationally representative survey of school employees conducted by the National Center for Educational Statistics. Descriptive statistics were used to identify health education teachers' attitudes toward teaching, job satisfaction, and the working environment as compared to all other teachers. **RESULTS:** Health teachers reported more positive attitudes toward teaching, reported higher levels of satisfaction with teaching, and perceived their school environment as more supportive when compared to all other teachers. They often were less positive about their colleagues sharing a common mission or vision. **CONCLUSIONS:** Health teachers may serve as key leaders during the implementation phase of the WSCC model due to their knowledge of health and academics, high levels of job satisfaction, and positive attitudes towards teaching. **RECOMMENDATIONS:** Working together as a team with a shared goal of increasing student well-being is a cornerstone of the WSCC model and the perception that some health teachers feel isolated in part is an area of concern. Overall, teachers perceive administrative support, however there is a need for school leaders to establish collaborative and trusting relationships between teachers, parents, and community members during the implementation phase of the WSCC model in order to achieve desired student goals and objectives related to health and learning.

INTRODUCTION

Academic success among school-aged youth is dependent on numerous factors. Increased empirical evidence suggests a strong link between health and learning, such as poor health leading to poor academic performance (Basch, 2010; CDC, 2015b; Dunkle & Nash, 1991). Conversely, healthy students have higher levels of academic achievement (CDC, 2014; Basch, 2010). According to the Centers for Disease Control (CDC) (2015b), healthy students had better academic performance, education behavior, cognitive skills, and attitudes. Schools play an important role in community-wide efforts supporting this link between health, learning, and academic achievement among youth. Schools have a unique capacity through infrastructure and personnel to improve the health of all students and to improve the quality of the learning environment (Demissie et al., 2015). Education professionals, such as principals, serve as leaders in creating healthy schools and promoting factors that contribute to healthy youth (Lewallen, Hunt, Potts-Datema, Zaza, & Giles, 2015; Valois, Slade, & Ashford, 2011).

As summarized by Valois et al. (2011), in 2006, the CDC and the ASCD (formerly known as the Association for Supervision and Curriculum Development) partnered to evaluate the school and community factors that led to a school-community environment that improved children's cognitive, physical, social, and emotional development and well-being. ASCD conducted a structured pilot study of the Healthy School Communities Model (HSCM) in eight American and three Canadian districts, using the *Healthy Schools Report Card* to evaluate the effectiveness of the program in changing school culture relative to health and well-being. ASCD identified nine key factors critical for implementing the HSCM: The principal as leader; active and engaged leadership; distributive leadership; integration with the school improvement plan; effective use of data for continuous school improvement; ongoing and embedded professional development; authentic and mutually beneficial community collaborations; stakeholder support of the local efforts; and, the creation or modification of school policy related to the process.

As a result of this study, eight components of the Coordinated School Health (CSH) model

were expanded to ten components encompassing the Whole School, Whole Community, Whole Child (WSCC) model, which surrounds and ensures each child is healthy, safe, engaged, supported, and challenged (ASCD & CDC, 2014). Components of the CSH model that were revised and updated based on current research included: health education; nutrition environment and services; employee wellness; health services; counseling, psychological and social services; and, physical education and physical activity (ASCD & CDC, 2014). The expansion of two CSH components shifted the focus from a healthy and safe environment to the effect of the social and emotional climate and physical environment of the school on students' health and learning. Family and community involvement were expanded to family engagement and community involvement (i.e. role of community agencies, businesses, and organizations). These changes brought attention to the need for greater emphasis on both the psychosocial and physical environments of the school as well as the potential contributions of community agencies and families towards engaging students as active participants in their learning and health (ASCD & CDC, 2014). These expanded roles emphasize the importance of an integrated approach between each component of the WSCC model and individuals working together to implement policies, practice, and processes that contribute to students' learning and health (Lewallen et al., 2015).

Researchers (Lewallen et al., 2015; Valois et al., 2011) noted that coordination of policies, practice, and processes require administrator support in order to achieve the intended outcomes of the WSCC model; in particular, the researchers identified the principal as a key factor in the success of the integration of learning and health in schools. The researchers emphasized that principal leadership skills are needed at the school level to promote and coordinate district and school policies with regard to enhancing health and learning specific to local needs. Principals reinforced policies and desired behaviors of staff and students. In addition, they managed coordination, planning, use of data, and continuous improvement in order to integrate all components of the WSCC model. Furthermore, they must bring together all stakeholders such as school staff, educators, families, community agencies, and students to

achieve the common goal of improved health and learning (Lewallen et al., 2015).

Rasberry, Slade, Lohrmann, and Valois (2015) also noted that lessons learned from successful implementation of the CSH model concerning infrastructure within a school and district may be applied to WSCC model implementation. For example, researchers (Murray, Hurley, & Ahmed, 2015; Rasberry et al., 2015) recommend the presence of a school health coordinator or a leadership team (i.e. coordinating council, district-level health advisory team, etc.). The team usually includes a representative from each component of the model. Support for program initiatives from both inside and outside of schools is essential for overcoming barriers and challenges to achieving outcomes of improved health and learning. In summary, the WSCC model provides a framework in improving health and learning of students that leads to improved academic success, however an action plan is needed which is facilitated and supported by key district and school-level administrators.

In addition to monitoring policies, practice, and processes related to all ten tenets of the WSCC model at the local level, data are needed, as well, to monitor national health and learning objectives and drive policy development (CDC, 2015b). The School Health Policies and Practices Study (SHPPS) was developed by the CDC to meet the need for national-level data (CDC, 2015). This national survey is periodically conducted to assess school health policies and practices of the ten CSH components (CDC, 2015b). For example, data were collected with regard to policy and practices specific to health education, which was defined by the CDC (2015a) as: Formal, structured health education consists of any combination of planned learning experiences that provide the opportunity to acquire information and the skills students need to make quality health decisions. When provided by qualified, trained teachers, health education helps students acquire the knowledge, attitudes, and skills they need for making health-promoting decisions, achieving health literacy, adopting health-enhancing behaviors, and promoting the health of others. Comprehensive school health education includes curricula and instruction for students in pre-K through grade 12 that address a variety of topics such as alcohol and other drug use and abuse, healthy eating/nutrition, mental and emotional health, personal health

and wellness, physical activity, safety and injury prevention, sexual health, tobacco use, and violence prevention. Health education curricula and instruction should address the National Health Education Standards (NHES) and incorporate the characteristics of an effective health education curriculum. Health education, based on an assessment of student health needs and planned in collaboration with the community, ensures reinforcement of health messages that are relevant for students and meet community needs. Students might also acquire health information through education that occurs as part of a patient visit with a school nurse, through posters or public service announcements, or through conversations with family and peers.

SHPPS findings identified practices such as the extent to which highly qualified and trained teachers were teaching comprehensive school health education and to the degree to which health education topics were taught. Also, additional data regarding required health education courses and classes were collected and reported. As a result, SHPPS has provided an extensive longitudinal and descriptive lens regarding practices and policies of health education component of the CSH and WSCC models.

However, as Murray et al. (2015) noted, effective and consistent implementation of WSCC model requires more than establishing policy. The researchers cited a publication by the National Association of State Boards of Education, *Fit, Healthy, and Ready to Learn* (Bodgen, 2000), which emphasized that effective policy needed specific foundational elements such as effective management, adequate training, and good staff morale. Furthermore, Murray et al. (2015) stated that administrators (i.e. school health or team coordinators) must work with faculty leaders to facilitate communication that engages students, families, and community members to support policies designed to achieve the outcomes of improved health and learning. Rooney, Videto, and Birch (2015) noted that the WSCC model planning process should consider such factors as school climate and culture, administrative support, as well as the need for building trust and collaborative relationships between administrators, teachers, parents, students, and community members. They also suggested that in order to meet desired student goals and

objectives related to health and learning, faculty and staff with knowledge about the link between health and academics (CDC, 2014) may serve as key individuals to initiate the WSCC model implementation process. Health teachers, who would coordinate and implement the health education component, are examples of faculty with essential and unique knowledge about the link between health and academics and could function as leaders during the implementation process. Through collaboration they could share their health education knowledge and expertise with faculty and staff to coordinate and align health-promoting instruction and programs with goals and outcomes.

In general, for faculty to share a vision of supporting WSCC goals and outcomes within their school, they need to perceive that the school leadership and climate are supportive of their efforts. The faculty need to function in an environment with visionary leadership, administrative support, share mission and goals, and attention to student well-being as a central contributor to student success. Yet, there is little current research describing teachers' perceptions of their school as an environment that provides a professional and supportive working environment such as support from administrators, other faculty, and parents. There is also a need for expanding the knowledge related to teacher job satisfaction, which is a key determinate of workplace morale (Bodgen, 2000). Moreover, higher teacher satisfaction was found to be associated with specific workplace conditions, such as administrative support and leadership, good student behavior, and a positive school atmosphere (NCES, 1997).

PURPOSE

The purpose of this study was to provide national-level data with regard to teachers' attitudes, perceptions, attitudes, and beliefs related to teaching and job satisfaction. Also, teachers' perceptions, attitudes, and beliefs about a supportive working environment were described, for example, support from administrators, principal, colleagues, and parents. These findings were compared to health teachers, who due to their specific knowledge related to health and academics, may serve as leaders and health champions during the implementation phase of the WSCC

model. To this end, the purposes of this study were to:

1. Describe general characteristics of health teachers as compared to all other teachers;
2. Describe health teachers' job satisfaction as compared to all other teachers;
3. Describe health teachers' perceptions of their school as an environment that provides a professional and supportive working environment as compared to all other teachers; and,
4. Describe attitudes of health teachers towards the profession of teaching as compared to all other teachers.

METHODS

Data reported for this study were extracted from the 2011-2012 Schools and Staffing Survey (SASS), which is a comprehensive national survey of school employees conducted by the National Center for Educational Statistics (NCES). Beginning in the 1980's, the SASS has generally been administered every three years. It is a large, nationally representative survey of public, private and charter school teachers, administrators and library media specialists. The survey contains sections related to class organization, education and training, certification, professional development, working conditions, school climate, and teacher attitudes. For this study, questions about school climate and teacher attitudes were used.

Participants

Teachers for this study were defined as staff members in U.S. public schools who indicated they were full-time teachers in grades seven through twelve during the 2011-2012 school year. A total sample size of 24,152 teachers was obtained using this method. Among the sample, 318 subjects indicated health education as their primary area of teaching.

Instrumentation

Data for this study were from the *Teacher questionnaire: Schools and staffing survey 2011-2012* (U.S. Department of Education, 2011). Teachers indicated the grades they taught, their employment status (full-time or part-time) and their primary teaching assignment by academic subject (i.e. health). To assess their attitudes and perceptions, subjects responded to

survey questions using a 4-point anchored Likert scale that included strongly agree, somewhat agree, somewhat disagree, and strongly disagree.

Procedure

The following data collection procedures for the most recent SASS were described in a study conducted by Cardina (2014). The sample for SASS included a total of 11,000 public schools from 5798 districts, from which 37,497 teachers were surveyed. A stratified complex design was used to select sample elements and subsequently weight them to correct for sampling bias due to deliberate oversampling of certain elements of the population. The initial stage included schools as the frame. Using a complex cluster sampling methodology, teachers in schools selected for the study were subsampled to produce a nationally representative sample of public school teachers. NCES employed a multi stage stratified sampling design due to the great variations in district sizes across the country. To ensure that states, such as Maryland, Florida, Nevada and West Virginia, that have a small number of county-level districts with a large number of school buildings were appropriately represented in the frame, school units were aggregated at the state level for sampling purposes. Schools were selected from the universe of public schools included in the 2009-10 Common Core of Data school universe file. Schools from all 50 states were included in the frame, however Department of Defense and overseas schools were excluded. Furthermore, schools from alternative and juvenile justice system schools in California, Pennsylvania, and New York were added to include a total frame of 90,530 public schools. For this study, the separate charter school sample was not included for analysis. Selection is defined as follows:

To be eligible for SASS, a school was defined as an institution or part of an institution that provides classroom instruction to students, has one or more teachers to provide instruction, serves students in one or more of grades 1–12 or the ungraded equivalent, and is located in one or more buildings apart from a private home. It was possible for two or more schools to share the same building; in that case, they were treated as different schools if they had different administrators (i.e., principal or school head) (Goldring, Taie, Rizzo, & Fraser, 2013, p. 5)

Based on established criteria, schools were

systematically selected using an algorithm that selected sample units. The systematic selection included the following variables: state, urbanicity code, collapsed ZIP code, percent free or reduced-price lunch, highest grade in the school, percent minority enrollment, and total enrollment. Approximately 5,800 public school districts were included into the sample by being associated with sampled public schools.

Teachers were defined as staff members who teach regularly scheduled classes to students in any of grades K–12. Sample members were stratified into four strata: (1) Beginning teachers (2) early-career teachers (in their second or third years of teaching), (3) mid-career teachers (4 through 19 years of teaching), and (4) experienced teachers (20 or more years of teaching). Beginning and early-career teachers were systematically oversampled to provide a subsample that can be generalized to all national teachers in their first three years of teaching. Districts selected within the sample were asked to provide electronic teacher rosters for the selected schools. Survey data was collected via online, mail, telephone and in-person administration to minimize non-response bias. Data collection ended in June 2012.

Weights developed by NCES were applied to the SASS data set to approximate the population of public school teachers. As a result, the final weighted sample of the public school teachers was 3,385,171. This weighted sample was nationally representative of public school teachers and therefore generalizable to the national population of public school teachers. For this study, final sample weights were used in data analysis. As a result, the final weighted sample of teachers who reported teaching in any of grades seven through twelve and reported being employed full-time by a school district during the 2011-2012 school year was 1,513,629 teachers.

Data Analysis

The weighted sample population was separated into two groups, those who indicated health education as their primary teaching responsibility (n = 18,177) and those who indicated a primary teaching responsibility other than health education (n = 1,495,452). Descriptive statistics were used to identify and compare attitudes toward teaching and overall job satisfaction among the sample populations.

Tables and discussion in this article used these weighted data for the presentation of frequencies and calculation of percents.

Human Subjects Approval Statement

Buffalo State College, SUNY IRB Office provided human subject approval for this study effective December 16, 2015.

Limitations

NCES used a cluster sampling design to produce a sample that would support generalization to the entire population of K-12 public school teachers in the United States. The complex design of the sampling strategy and subsequent assignments of replicate weights allowed for generalization of subsamples down to the state level. The sample used in this study was a subsample of the larger national frame. As such, generalization was at the national level, but there was a higher possibility of design-related bias introduced into the results that one would face with the entire sample of all teachers.

RESULTS

Table 1 illustrates the characteristics of health education teachers compared to the larger school population of teachers. While health teachers were more likely to be female, the disparity between the percentage of male and female teachers was less than observed in the general teacher population. Nearly 90 percent of Health teachers were white, slightly higher than the general population of teachers (n = 88.5%). In addition, fewer health teachers self-identified as all other ethnic groups when compared to the general population of teachers, with the exception of Pacific Islander. Note, respondents were able to select multiple ethnicities as well as a separate "yes - no" item that asked if they were of Hispanic origin.

Using select school climate and teacher attitude SASS questions related to district, school, and classroom-level characteristics, health education teachers' responses were compared to all other teachers who reported positive attitudes toward teaching and job satisfaction. Table 2 presents the percentage of respondents who responded most favorably (i.e. strongly agree) to questions regarding teaching and job satisfaction. Likert-scale response options were strongly agree, somewhat agree, somewhat disagree, and strongly disagree. Results showed that health teachers were over

ten percentage points higher in their level of general satisfaction with teaching in their school as compared to the all other teachers. In addition, health teachers were far less likely to report that behavior issues or student absences were major detriments to their teaching in the classroom when compared to other teachers. Furthermore, health teachers were much less apt to feel that the routine paperwork and duties of the job interfered with their classroom teaching as compared to their teaching colleagues. As a group, teachers were not overly satisfied with their salaries, but health teachers were more positive than all other teachers. Also, as a group, few teachers (approximately 6 percent) reported strong agreement that district or state standards had a positive influence on their level of satisfaction with teaching. However, health education teachers were more worried about their job security as a result of the performance of their students on state and/or local tests as compared to teachers who did not report health education as their primary teaching assignment.

The third research question investigates whether or not teachers perceive their school as an environment that provides a professional and supportive working environment. Select school climate and teacher attitude SASS questions related to school and classroom-level characteristics were used to determine if the teachers felt supported in their work (see Table 3). Health teachers' responses were compared to all other teachers. In general, health teachers perceived their school environment as more supportive when compared to all other teachers. For example, nearly half of health teachers strongly agreed that the school administration's behavior toward staff was supportive and encouraging and that their principal enforced school rules and supported them in discipline matters. All other teachers were less likely to strongly agree with these statements. Furthermore, health teachers were somewhat more positive than the population of other teachers in their perceptions about the availability of materials needed by staff and one-quarter of health teachers felt that they had the support they needed to help special education students, which was over four percentage points higher than reported by other teachers. In addition, health teachers were a bit more apt to feel that staff members were recognized for a job well done, though less than one-third of all respondents shared this belief. Also, less than

one-third of all respondents strongly agreed that there was a great deal of cooperative effort among staff. Although health teachers were more positive than other teachers in their beliefs about support from parents for the work they do, only 12 percent strongly agreed with the statement. Similarly, teachers reported low levels of support from colleagues, with just 15 percent of all teachers strongly agreeing that their colleagues consistently enforced rules for student behavior. Interestingly, health teachers were less likely to report that most of their colleagues shared their beliefs and values about what should be the central mission of the school.

The final research question describes the attitudes of teachers toward the profession of teaching using select school climate and teacher attitude SASS questions (see Table 4). Respondents were asked questions related to factors that may influence a teacher to leave the profession. Health teachers' responses for each question were compared to all other teachers. Findings suggest that for each question, health teachers had more positive attitudes toward teaching when compared to other teachers. For example, nearly eleven percent of teachers who did not list health as their primary teaching responsibility expressed a desire to leave teaching for better pay; health teachers were half as likely to express this belief, matching their lowered interest in transferring to another school. Nearly one-third of health teachers expressed strong agreement that the teachers in their school were a satisfied group, more than two percentage points higher than responses from all other teachers. When asked if their enthusiasm for teaching had waned since they started the job, health teachers were less likely to strongly agree compared to responses from all other teachers. Relatively few teachers (less than five percent) expressed a strong affinity for the statement that the stress of teaching was more than the job was worth.

CONCLUSIONS

Health education teachers in public schools in the United States are different from the larger population of teachers in some important ways. For the whole population of public school teachers in grades 7-12, the job is still more attractive to females, but among health teachers the disparity was less, as females outnumbered males by about ten percent. Health teachers represent a largely white demographic. These

results were similar to demographic results describing U.S. public school teacher gender and race (Feistritzer, 2011; Ingersoll, Merrill, and Stuckey, 2014).

Grade 7-12 health teachers as a group were generally positive about their job and work environment. They were far more likely than their peers to report satisfaction with being a teacher at their school. Health teachers were far less likely to cite issues such as student misbehavior, tardiness, and class cutting as being factors that interfered with their teaching. These findings support previous research that suggested teacher perceptions of good student behavior and teacher autonomy were associated with higher teacher satisfaction (NCES, 1997).

Although health teachers reported more job satisfaction, overall, they were more worried than other teachers about their job security based on the performance of their students or school on state and/or local tests. State or district standards did little to enhance respondents' job satisfaction as only about five percent of all respondents felt that state or district standards have had a positive influence on their satisfaction with teaching. The whole population of teachers in the study evidenced lower satisfaction with their salary level. This is a concern because teachers are more likely to quit when their salaries are low relative to other professions (Darling-Hammond, 2003).

Health teachers, overall, had more positive attitudes about teaching than other respondents. Health teachers more often indicated they strongly agreed that they liked the way things were run at their school and half as likely than other teachers to strongly agree that they think about transferring to other schools or leave teaching as soon as possible if they could get a higher paying job. Health teachers were also less likely to strongly agree that they did not have as much enthusiasm now as they did when they began teaching. Health teachers, due to their knowledge of health and academics and their positive attitudes toward job satisfaction and administrative support, may serve as key individuals to initiate the WSCC model implementation process at the school-level.

Leadership and the level of perceived support from the building principal have been found to be associated with higher levels of teacher satisfaction (NCES, 1997). Health

teachers felt more supported by their building principal than other teachers. Close to half of the health teachers strongly agreed that school administration's behavior toward staff was supportive and encouraging and that their principal enforced school rules for student conduct and backed them when they needed it. They were more likely to believe that necessary materials were available, such as textbooks, supplies and copies, and that staff members were recognized for a job well done. Conversely, health teachers perceived less support from their colleagues in terms of the staff having shared beliefs and values about the central mission of the school and were slightly less likely to strongly agree that there was a great deal of cooperative effort among staff. Among health teachers, only approximately 15 percent of all respondents strongly agreed that teachers in their school consistently enforced student behavior rules, even for students who were not in their classes. To characterize these beliefs, there was a far stronger feeling of support from administration, coupled with much diminished feelings of support from school faculty colleagues as a whole. These differences in perception about support from administrators and colleagues and a shared vision for their school may serve as barriers to health teachers as leaders and health champions during school-wide efforts to implement the WSCC model.

Health teachers in general did not perceive a high degree of parental support for the work that they do. This lack of perceived support may serve as a barrier when implementing the WSCC model, which includes family engagement as one of the ten components. The linkage between the home and school is key to building a positive and collaborative relationship between stakeholders during the implementation phase of the WSCC model and improve health and learning.

RECOMMENDATIONS

The place of health education in the American public school system has seen significant change in the new millennium. What was once an isolated "special" subject area is being increasingly viewed as an essential support to student learning and well-being. Recently, federal education law, the *Every Student Succeeds Act* (2015), a reauthorization of the *Elementary and Secondary Education Act of 1965*, included health as a well-rounded

education subject. To function as part of a whole school community with a focus on healthy learners, the provision of health education has to exist beyond the four walls of the classroom and the traditional curriculum.

This study sought to measure the extent to which health teachers' attitudes, perceptions, and beliefs related to teaching, job satisfaction, and working environment in order to determine if they were engaged and positive members of their school communities. Based on findings from this study, it appears that they are. Health teachers felt supported by their building administrators, but showed less confidence in their colleagues in some regards. The relationship between teachers and parents and the expectations inherent in the perceptions of "support" are an important area for future inquiry. Overall, these findings suggest teachers perceive administrative support, however there is a need for school leaders to establish collaborative and trusting relationships between teachers, parents, and community members during the implementation phase of the WSCC model in order to achieve desired student goals and objectives related to health and learning. School-level leaders, such as health educators who have knowledge of health and academics and who have been found to have high job satisfaction and positive attitudes towards teaching, may provide key leadership during the implementation phase of the WSCC model.

Teacher job satisfaction is often cited in the popular press using anecdotal information. As the job of teaching changes significantly with increased emphasis on achievement testing, accountability, employee evaluation systems tied to test scores, and additional barriers to enter the profession, the questions of morale, mission, and general satisfaction with the profession are increasingly important. This study provided a nationally-representative survey of teacher attitudes toward their jobs and school communities. As current as these findings are, these beliefs and attitudes remain a moving target given the national and state level changes to the profession. Further, ongoing study of the impacts of the larger policy environment on teacher job satisfaction over time remains an important question for study. The following recommendations for further study are proposed:

- In many communities, the health education teacher may not be

representative of the population served by the building. Further inquiry into the relationship between teacher gender and ethnicity and the implications of a largely white teacher population serving and increasingly diverse student population would be timely.

- Many health teachers believed that parents were not overly supportive. Further inquiry into the nature of the parent-school relationship and the expectations of both sides of this relationship would help better define the meaning of "parent support" as a specific operational definition.
- Many health teachers believed their principals to be supportive in different ways. The degree to which this support extends to creating a WSCC model within the building is unclear and needs to be developed further.
- While health teachers felt confident in their building administrator, they often were less positive about their colleagues sharing a common vision or even enforcing rules consistently. Working together as a team with a shared goal of increasing student well-being is a cornerstone of the WSCC model and the perception that some health teachers feel isolated in part is an area of concern.
- In general, health teachers reported a fairly high level of job satisfaction. A question, therefore, is what variables would contribute to a model of teacher satisfaction and how effective would this model be in predicting to various subpopulations of teachers.

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Table 1: General Characteristics of Health Education Teachers Compared to Other Teachers as Percent of Sample (N=1,513,629)^a – SASS 2011-12

| General Characteristics | Health Education Teachers ^b (n = 18,177) | Other Teachers ^c (n = 1,513,628) |
|---|--|--|
| Gender | | |
| Male | 44.4 | 37.9 |
| Female | 55.6 | 62.1 |
| Total | 100.0 | 100.0 |
| Race/Ethnicity ^d (check all that apply) | | |
| Hispanic | 5.6 | 7.0 |
| Black, non-Hispanic | 7.0 | 7.9 |
| White | 89.7 | 88.5 |
| Native American | 1.0 | 1.5 |
| Asian | 1.7 | 2.3 |
| Pacific Islander | 2.6 | .4 |

^aThere is an insignificant variation of up to 3 cases in the denominator due to non-response. ^bFull-time public school teachers (Grades 7-12) who reported health education as their primary teaching assignment. ^cFull-time public school teachers (Grades 7-12) who did not report health education as their primary teaching assignment. ^dRespondents were able to select multiple ethnicities, therefore totals exceed 100 percent.

Table 2: Health Education Teachers Compared to Other Teachers Who Reported Positive Levels of Teaching Satisfaction by Selected District, School, and Classroom Characteristics as a Percent of Sample (N=1,513,629)^a – SASS 2011-12

| <i>Characteristics</i> | Health Education Teachers ^b (n = 18,177) | Other Teachers ^c (n = 1,513,628) |
|---|--|--|
| | Strongly Agree | Strongly Agree |
| Generally satisfied with being a teacher in this school. | 61.5 | 51.4 |
| I am satisfied with my teaching salary. | 14.8 | 12.6 |
| State or district standards have had a positive influence on my satisfaction with teaching. | 6.2 | 5.7 |
| I am worried about the security of my job because of the performance of my students or my school on state and/or local tests. | 34.5 | 28.3 |
| Routine duties and paperwork interfere with my job of teaching. | 15.3 | 24.9 |
| The level of student misbehavior in this school (such as noise, horseplay, etc.) interferes with my teaching. | 6.1 | 13.2 |
| The amount of student tardiness and class cutting in this school interferes with my teaching. | 6.6 | 15.0 |

^aThere is an insignificant variation of up to 3 cases in the denominator due to non-response. ^bFull-time public school teachers (Grades 7-12) who reported health education as their primary teaching assignment. ^cFull-time public school teachers (Grades 7-12) who did not report health education as their primary teaching assignment.

Table 3: Health Education Teachers Compared to Other Teachers Who Reported Positive Levels of Support by Selected School and Classroom Characteristics as a Percent of Sample (N=1,513,629)^a – SASS 2011-12

| Characteristic | Health Education Teachers ^b (n = 18,177) | Other Teachers ^c (n = 1,513,628) |
|---|--|--|
| | Strongly Agree | Strongly Agree |
| Most of my colleagues share my beliefs and values about what the central mission of the school should be. | 25.5 | 28.5 |
| The school administration's behavior toward staff is supportive and encouraging. | 48.6 | 45.6 |
| My principal enforces school rules for student conduct and backs me when I need it. | 49.7 | 44.5 |
| Necessary materials (i.e. textbooks, supplies, copies) are available as needed by staff. | 43.9 | 38.7 |
| There is a great deal of cooperative effort among staff. | 31.9 | 32.8 |
| In this school, staff members are recognized for a job well done. | 30.5 | 28.3 |
| I am given the support I need to teach students with special needs. | 24.1 | 20.2 |
| I receive a great deal of support from parents for the work I do. | 12.3 | 10.6 |
| Rules for student behavior are consistently enforced by teachers in this school, even for student who are not in their classes. | 14.9 | 15.0 |

^aThere is an insignificant variation of up to 3 cases in the denominator due to non-response. ^bFull-time public school teachers (Grades 7-12) who reported health education as their primary teaching assignment. ^c Full-time public school teachers (Grades 7-12) who did not report health education as their primary teaching assignment.

Table 4: Health Education Teachers Attitudes Toward Teaching Compared to Other Teachers by Selected School and Classroom Characteristics as a Percent of Sample (N=1,513,629)^a – SASS 2011-12

| Characteristic | Health Education Teachers ^b (n = 18,177) | Other Teachers ^c (n = 1,513,628) |
|--|--|--|
| | Strongly Agree | Strongly Agree |
| The stress and disappointments involved in teaching at this school aren't really worth it. | 4.1 | 4.4 |
| The teachers at this school like being here; I would describe us as a satisfied group. | 29.4 | 27.0 |
| I like the way things are run at this school. | 30.5 | 24.6 |
| If I could get a higher paying job I'd leave teaching as soon as possible. | 5.7 | 10.7 |
| I think about transferring to another school. | 5.4 | 9.2 |
| I don't seem to have as much enthusiasm now as I did when I began teaching. | 9.0 | 13.8 |

^aThere is an insignificant variation of up to 3 cases in the denominator due to non-response. ^bFull-time public school teachers (Grades 7-12) who reported health education as their primary teaching assignment. ^c Full-time public school teachers (Grades 7-12) who did not report health education as their primary teaching assignment.