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EVALUATION OF THE ILLINOIS STATE POLICE

PILOT DARE PROGRAM

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EVALUATION OF THE ILLINOIS STATE POLICE DARE PILOT PROGRAM

In January 1987 the Illinois State Police (ISP) contracted with A.H. Training and Development Systems, Inc. (AHTDS) of Springfield to help the ISP conduct an evaluation of its pilot Drug Abuse Resistance Education (DARE) program. The agreement reached was that the ISP would define the goals of the evaluation; AHTDS would collect the data and be responsible for the final report; and, Dr. Ralph B. Earle, Jr., a consultant to AHTDS, would design the evaluation, analyze the data and contribute to the final report.

The DARE program teaches resistance skills to fifth and sixth graders through a curriculum of 17 weekly one-hour lessons. The unique aspect of DARE which sets it apart from other school-based drug education programs is the fact that its curriculum is delivered by a uniformed (unarmed) police officer, and not by a classroom teacher or other school employee. The evaluation of the DARE pilot program, therefore, has three major areas of investigation:

1. Is the DARE officer accepted in the classroom by the students, teachers, and principal?

2. Is the DARE program accepted by the community?

3. Does DARE effectively teach resistance skills?

To address these three major areas of concern, the ISP identified nine specific questions which it wanted the evaluation to answer. After restating these nine questions in operational terms and obtaining the ISP's approval for the evaluation's design, AHTDS collected and analyzed survey data obtained from police officers who taught DARE, teachers, principals, alcohol and drug abuse service providers, community representatives, law enforcement officials and the DARE students themselves. AHTDS staff videotaped DARE students in role-plays designed to show whether the students could demonstrate refusal skills. Three judges from outside the State of Illinois rated the students' resistance skills. Here are the results of the surveys and analyses, in response to the nine specific questions about DARE's effectiveness posed by the ISP.

1. **How Has DARE Been Accepted by Principals, Teachers, Parents, Community Groups, Police Agencies, Students and Local Drug/Alcohol Service Providers?**

To answer this question AHTDS sent surveys to and received surveys from the following numbers of people in these groups:

Group Surveyed	Surveys Sent	Surveys Received	Percent Received
Service Providers	20	10	50%
Law Enforcement	45	14	31%
Community Reps.	30	26	87%
Principals	93	64	69%
Teachers	280	174	62%

The surveys showed that the DARE pilot program won broad acceptance from the law enforcement community, from community representatives, and from teachers and principals. More than 90% of each of these four groups felt it was either "very appropriate" or "somewhat appropriate" for a state police officer to teach the DARE curriculum. Alcohol and drug abuse service providers, however, generally did not find it appropriate. Only 40% of this group responded "very" or "somewhat" appropriate. This is significantly lower than the other four groups surveyed. Despite this high degree of support for the appropriateness of a state police officer coming into elementary classrooms to teach DARE, a majority of four of the groups surveyed felt that, in most communities, it was more appropriate for a local police officer to teach DARE. Teachers differed on this question; only 42% of that group felt that it was more appropriate for a local officer to teach DARE. Law enforcement officials and principals agreed with this statement significantly more often than the service providers, community representatives and teachers.

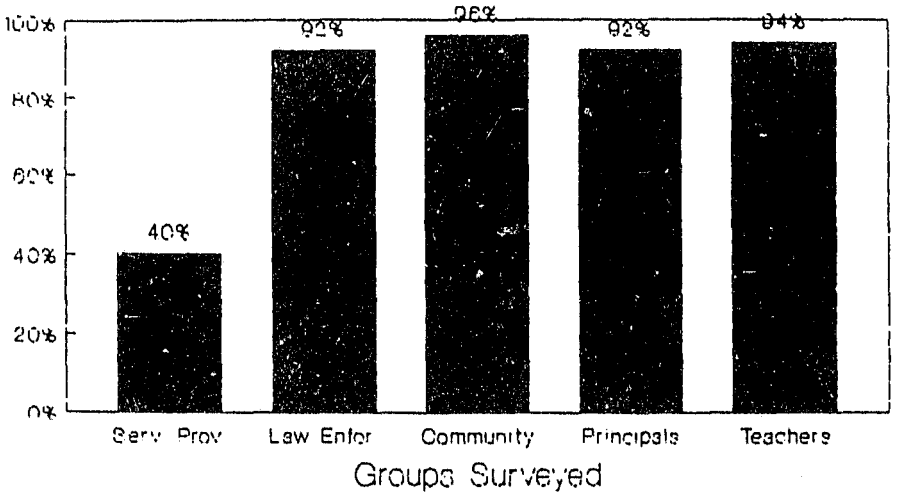
With the exception of the service providers, overwhelmingly those surveyed felt that classroom teachers would not have obtained the same results, if they had taught DARE. Only 8% of the teachers themselves thought they could have accomplished the same results. None of the law enforcement officers thought so, and only 5% of the community representatives and 5% of the principals thought so. But about half (55%) of the service providers did think that the teachers could have done as well.

While only one in three service providers would recommend DARE to their fellow professionals, all of the law enforcement officials, all of the community representatives, and all of the principals would recommend DARE without any qualifications. Of the teachers, 87% would recommend DARE without qualification.

The first four charts on the following pages summarize the general acceptance which DARE has received from these five groups. It should be clear from these charts that the service providers do not share the positive view of DARE which the other groups have.

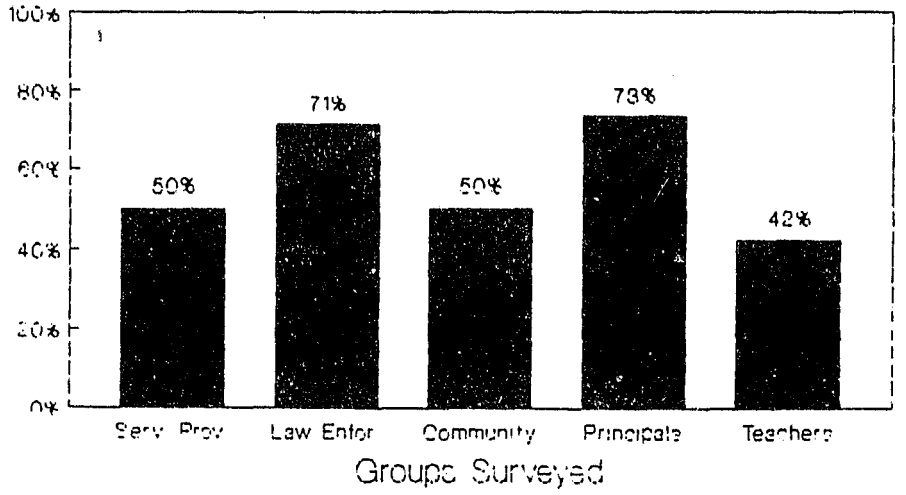
The ISP should also note the large and significant difference of opinion between the law enforcement officials and school principals on the one hand and the teachers, on the other, as to whether it is more appropriate for local officers to teach DARE. In

Percent Who Feel It Is Appropriate for State Police Officers to Teach DARE*



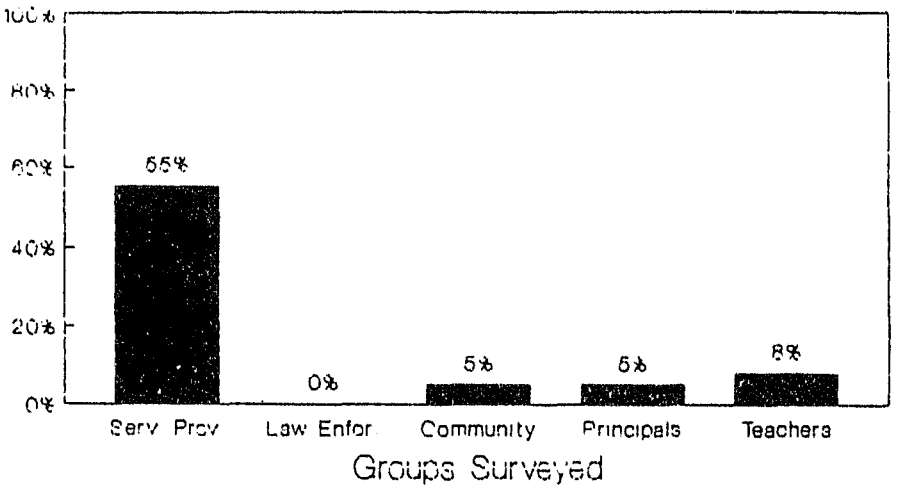
*Percent answering "Very" or "Somewhat" Appropriate

Percent Who Feel It Is More Appropriate for Local Police Officers to Teach DARE*



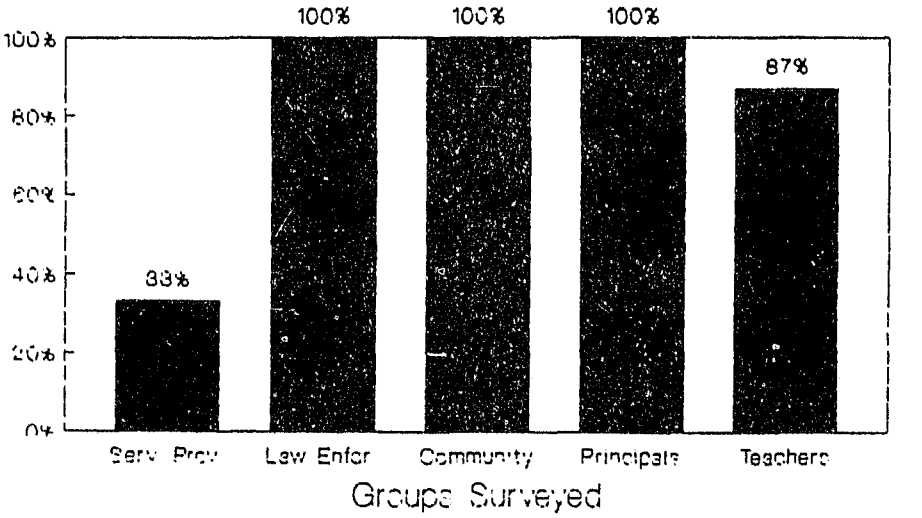
*Percent answering "Yes" or "In Most Communities"

*Percent Who Feel Classroom Teachers Would Have Obtained the Same Results**



*Percent answering "Definitely Yes" or "Probably Yes"

Percent Who Would Recommend DARE to Fellow Professionals*



*Percent "Yes" without qualification

view of the ISP's plans to expand DARE over the next two years, this difference of about 70% vs. 40% suggests that the DARE classroom teachers may foresee problems for local officers teaching DARE which others do not.

We are not sure of this: the teachers may simply feel that local officers are neither more nor less appropriate for teaching the DARE curriculum. It might reflect a feeling that ISP officers command a necessary level of respect that some local officers would not. No teacher made this comment explicitly, but some did indicate that the quality of the officer was the crucial factor, not which uniform he or she wore.

To estimate the degree to which the DARE students accepted the program and the officer in their classrooms, students in five schools were asked simply, "Do you like the DARE program?" Because some students may have been reluctant to answer "No" directly, we used a method of surveying called "randomized response," which gives students an extra level of confidentiality. We also administered this survey twice, in the middle and near the end of the term, to allow the students to become accustomed to the method and the extra protection it gives.

Even with this protection for students who wished to answer "No", the overall response was extremely positive, averaging over 90% "Yes" responses, and never lower than 80%. (These results are shown in the chart on the next page.)

Because of their critical roles in the success of the DARE program, we surveyed teachers and principals at some length. Table 1 on the following page summarizes the extent to which 151 teachers and 50 principals agreed with statements about DARE's possible positive impact on students.

In both groups over 96% agreed that DARE has made a positive impression on the children, that DARE is a valuable program, and that they would like to have their school participate in DARE in the future. The only statement to which a majority of either group did not agree is whether DARE has improved student behavior. Only about a third of the teachers thought this was true, compared to two-thirds of the principals.

This support for DARE was corroborated by a survey of the DARE officials themselves. Based upon their experience with DARE, officers of the Los Angeles Police Department (LAPD) provided us with a list of teachers' and principals' helping and hindering behaviors which they had noted in their DARE schools. We asked all 30 Illinois DARE officers whether the teachers and principals in the DARE schools had helped or hindered the DARE officer, and received responses from 17.

On the average, the teachers helped the officers 85% of the time and hindered the officers only 6% of the time. Principals helped 77% of the time and hindered only 7% of the time. Table 2 summarizes the results of the Helping/Hindering Behaviors survey. Two

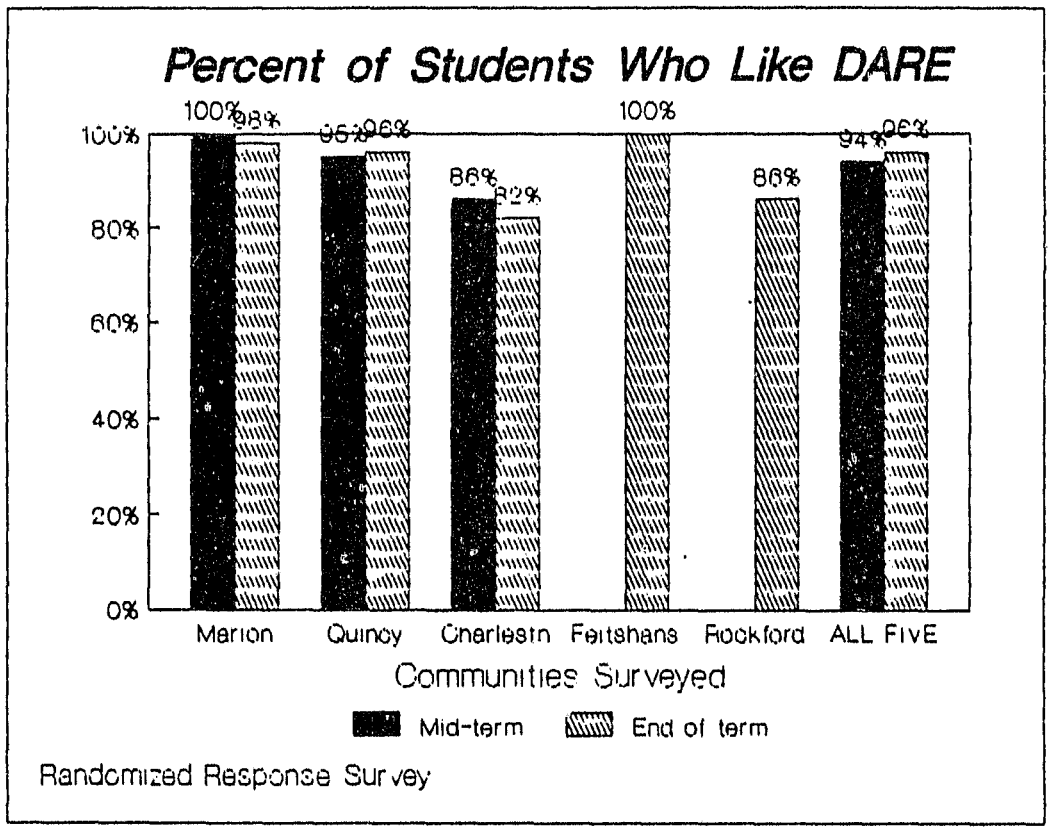

Percent of Students Who Like DARE
100%
80%
60%
40%
20%
0%
100%
98%
95%
96%
86%
82%
100%
86%
94%
96%
Marion
Quincy
Charlestn
Fairshans
Rockford
ALL FIVE
Communities Surveyed
Mid-term
End of term
Randomized Response Survey

TABLE 1

PERCENTAGE OF "STRONGLY AGREE" OR "AGREE" RESPONSES OF ELEMENTARY SCHOOL TEACHERS AND PRINCIPALS TO QUESTIONS CONCERNING THE DARE PROGRAM

	Illinois Teachers (n=151)	Illinois Principals (n=50)
1. To what extent do you think Project DARE has made a positive impression on the children in your classes/ school?	96%	98%
2. To what extent do you support the manner in which the program is being delivered? (i.e. Illinois officers providing instruction)	100%	98%
3. Do you think DARE is a valuable program?	97%	100%
4. Would you like to have your school participate in DARE in the future?	98%	100%
5. To what extent do you think the students have carried over the knowledge and skills they have learned in DARE to other classes?	64%	71%
6. Do you believe the aspects of DARE which were not a part of the regular curriculum were valuable? (i.e., parent involvemnt, presentations in other classes, interaction with students outside of the classroom)	75%	82%
7. To what extent do you think DARE has improved student behavior at your school?	36%	69%

areas where the DARE officers could use a bit more help are from teachers; in helping students who were absent catch up in their DARE workbook, and from principals; in holding a school assembly to introduce the officer and the program.

Parents of DARE students were also surveyed, at meetings held by 45 of the 86 schools. Their responses are discussed more fully in the next section. With regard to their acceptance of the DARE program, of those who expressed an opinion, fully 99% felt that the use of a uniformed officer to teach about drugs is a good idea, and 100% supported DARE's goals.

In summary, with the exception of local drug/alcohol service providers, DARE has been accepted by everyone involved to a remarkable degree, especially considering the fact that DARE is taught by "outsiders" who, until now, have not been considered part of the drug education community.

2. **Does the Parent Component Meet the Needs of the Community?**

Between the fifth and the thirteenth weeks of the DARE curriculum, 45 out of the 86 DARE pilot schools held parent information meetings. At 30 of these 45 meetings the DARE officer asked the parents to agree or disagree with five statements about the DARE program and to make additional comments. Table 3 summarizes the results. (Table 3 also includes the responses which the Los Angeles Police Department received from their DARE parent meetings in 1984-85 and 1985-86, for comparison.)

Among the parents who expressed an opinion, there was almost unanimous support for DARE. (The percentage of parents who did not express an opinion on a particular statement ranged from 9% to 1%.) In addition, 141 out of the 452 parents who responded added comments. Most (over 75%) just thanked the officer for the presentation and/or further endorsed the program. Twenty-eight parents made suggestions, the most frequent of which were:

1. DARE should be expanded to the junior and/or senior high schools (9 comments, or 32%); and,

2. DARE should expand the parent component (12 comments, or 43%), to include more meetings (3), and a Parents' Handbook (6). One parent suggested that the Handbook help parents reinforce their child's self-esteem and sense of responsibility. Another wrote that it should contain "20 ways to encourage your children to use drugs," to focus parents on the need to change their own habits.

Almost a third (31%) of the parents took the trouble to make comments, and the most frequent suggestion was for more parent involvement and education. The idea of a Parents' Handbook is a good one, since the ISP already have many of the materials. The Parents' Handbook should contain the children's DARE lesson materials, matched with what a parent should and should not do to reinforce each lesson.

TABLE 2

HELPING/HINDERING BEHAVIORS

Teachers' Helping Behaviors		Helped	Did Not Help
1.	Available seating charts or name cards.	82%	6%
2.	Help students that were absent get workbook current.	65%	12%
3.	Reinforce lesson concept throughout week	100%	0%
4.	Assist in classroom control when necessary.	94%	0%
Principals' Helping Behaviors			
1.	School assembly to introduce officer.	65%	18%
2.	Introduce officer to key employees, i.e. faculty, office managers, PTA President, Plant Manager, District personnel.	88%	0%
3.	Mailbox on each campus.	59%	29%
4.	Work area with desk and phone.	76%	12%
5.	Availability of reproduction materials.	94%	0%
6.	Display technique on bulletin board or wall of school building.	82%	0%

Teachers' Hindering Behaviors		Hindered	Did Not Hinder
1.	Core teachers doing classwork during lesson, i.e. bulletin boards, collecting papers, watching TV, calling student out of seat to discuss whatever.	18%	71%
2.	Teacher admitting drug use to the class.	6%	94%
3.	Ignoring classroom control when officer is having trouble.	0%	100%
4.	Making negative remarks about or to students: i.e. "shut up", "never amount to anything".	0%	100%

Principals' Hindering Behaviors	Hindered	Did Not Hinder
1. Special event that interrupt without warning.	12%	82%
2. Negative attitude of principal towards officer or program that limits contact with students and movement around school.	0%	88%
3. Not having support with audio/visual equipment.	0%	100%
4. Non-availability of auditorium.	6%	88%

Table 3

PERCENTAGE OF PARENTS AGREEING WITH THE FOLLOWING STATEMENTS AFTER DARE PARENT INFORMATION MEETINGS*

		Illinois Parents 1986-87 (n=452)	Los Angeles Parents 1984-85 (n=142)	Los Angeles Parents 1985-86 (n=478)
1.	I think I will be able to communicate better with my children about drug use as a result of this meeting.	99%	100%	89%
2.	I would like to attend other meetings like this.	99%	100%	93%
3.	I would recommend meetings like this to other parents.	99%	100%	96%
4.	I think it is a good idea to have uniformed police officers teaching about drugs.	99%	100%	93%
5.	I support the goals of the DARE program.	100%	100%	96%

* The percentages reflect the proportion of parents agreeing or strongly agreeing with each statement.

3. What Ways Is the DARE Program Having an Effect on the Community?

We had proposed to answer this question by asking the Los Angeles Police Department (LAPD) for a set of helping/hindering behaviors for significant community representatives, along the lines of the set of helping/hindering behaviors which they provided us for teachers and principals. The LAPD were unable to come up with any, apparently because DARE has been quite successful in Los Angeles without the extensive involvement of anyone beyond the school, the parents and the LAPD itself.

All we can present here, then, is the fact that all 23 of the community representatives we surveyed would recommend DARE without reservation to the fellow professionals, as we noted above in section 1. Certainly, the ISP need not worry that DARE has aroused any opposition in any of the communities we surveyed.

4. What Are the Strengths and Weaknesses of the Program?

The ISP wanted to know the strengths and weaknesses of both DARE's operation and content. We, in turn, proposed to evaluate DARE operationally in terms of the degree to which it has been accepted by the major actors in the community. And, we proposed to evaluate DARE's content by the percentage of DARE students who can demonstrate full refusal skills after lesson 5 and after lesson 15, compared to the percentage of non-DARE students who can demonstrate full refusal skills.

We have reported above the high degree of acceptance which DARE has received this year. To evaluate the content of the DARE program, sometime after the fifth week (by which time initial resistance skills training has been completed) and again at the end of the school year, we videotaped pairs of DARE students in two role-plays, both of which involved one student attempting to persuade the other to do something which the other did not want to do. Because the results from the videotaping are the central measure of the effectiveness of the DARE curriculum, we shall explain how they were obtained in some detail.

The first role-play was intended as a warm-up, to get the students used to the evaluators and to being videotaped. Before beginning, an AHTDS staffperson asked the students, "What things do kids try to get you to do that you don't want to do?" From the list generated by the students, the staffperson chose one and asked one of the pair (the Persuader) to try to get the other (the Resister) to do it.

This first role-play did not involve tobacco, alcohol or other drugs. (Examples: toilet-paper ("t.p") a house, copy homework, break into a house as part of an initiation.) The students improvised this role-play; at the first taping, thirteen of fourteen pairs had no trouble doing so.

After the pair had played out the first situation (which would end when the Persuader gave up or the Resister gave in), we gave them a second role-play situation which we had prepared, this time involving drug use, and asked them to think about it while we videotaped another pair.

We were careful to divide the students into equal numbers of same-sex pairs and opposite-sex pairs. From the first pair at each school we designated the taller student to be the Persuader in the first role-play and then the Resister in the second. From the second pair we designated the shorter student to be the Persuader in the first and the Resister in the second. Thereafter we alternated, taller, shorter, etc.

At the first school in which we videotaped, all the students agreed that the second, prepared role-plays represented situations which could actually happen to them or their friends. Four students felt that they could have acted out the drug-related role-play more easily if they had made it up, as they had the first role-play. The other 23 felt that having the situation prepared for them was better.

All fourteen pairs (the 27th student was paired with the 23rd) were able to act out these prepared situations. We were struck by their inventiveness, the number and variety of inducements to use drugs which the Persuaders were apt to offer, and the ability of the Resisters to reject each type of inducement.

When we noticed halfway through this first taping that the students were so skilled at improvising the first of each role-plays, we began asking students whether they felt that students who had not been in the DARE program would be able to improvise either their own or our role-play situations. All 12 we asked believed that non-DARE students would <u>not</u> be able to do so.

It turned out that the DARE officers had been using role-playing throughout the curriculum, and not just in the two weeks that the DARE curriculum itself seemed to indicate. When we found out that DARE students had about four hours' practice in role-playing, we confirmed with a principal of a nearby non-DARE school that non-DARE fifth and sixth graders would not have had any practice in role-playing any situation. We therefore had to abandon the plan to videotape non-DARE students in these same situations, because their failure to perform would not necessarily reflect positively on DARE's <u>content</u>, but might only reflect positively on DARE's <u>methods.</u>

We videotaped 50 pairs of students in drug-related situations after the fifth week of the DARE curriculum, and 41 pairs after the fourteenth week. The children attended six schools chosen from around the state to reflect a balance of rural and urban communities. The tapes were edited only to the extent that tapes from different schools were combined on a single cassette, for the convenience of the judges.

Three judges from outside Illinois scored the videotapes. All three judges have classroom teaching experience, all have at least ten years' experience in prevention, and all are well-known in the prevention community in the Midwest.

For each role-play the judges were asked first to assess whether the Resister had:

1. demonstrated a resistance skill response;

2. attempted, but did not complete, a resistance skill response; or,

3. did not attempt to demonstrate a resistance skill response.

Then each judge scored each role-play more intensively in terms of what both the Persuader and the Resister said and did.

The judges' scores were not in complete agreement, as Table 4 shows, in terms of the percentage of each type of behavior demonstrated by the Resister student. The clearest instance of this is the first type of behavior, in which the Resister just says "No." Judge A consistently noted this behavior more frequently than did Judge B, who noticed it more often than Judge C. But the instructions to the judges were to count every repetition of each type of behavior, and these differences may simply reflect how often a judge noted a shake of the head, or an "Unh-Unh," instead of a literal "No." The other differences is in the number of behaviors per role-play that each judge noticed: especially on the 14th-week videotape, Judge B scored more behaviors than did Judges A and C.

But overall, in terms of the relative frequency each judge noted each type of resisting behavior, their scores were highly correlated:

Rank-Order Correlations between Judges

	Judge B		Judge C	
	5th wk.	14th wk.	5th wk.	14th wk.
Judge A				
5th wk.	.95		.90	
14th wk.		.74		.83
Judge B				
5th wk.			.93	
14th wk.				.90

All of these correlations are statistically significant at the p=.05 level.

TABLE 4

JUDGES' SCORINGS OF RESISTING BEHAVIORS, 5TH AND 14TH WEEKS

Type of Resisting Behavior Observed	JUDGE A*		JUDGE B		JUDGE C	
	5th WK	14th WK	5th WK	14th WK	5th WK	14th WK
Says "No" but gives no reason	60%	58%	50%	46%	40%	41%
Says he or she will suffer direct, harmful physical or psychological effects (does not include punishment)	11%	20%	16%	16%	18%	17%
Says he or she doesn't want to	6%	1%	9%	13%	12%	9%
Expresses fear of getting caught by authorities (does not include caught by parents)	5%	8%	4%	5%	8%	10%
Says parents would disapprove or discipline	4%	6%	4%	4%	5%	4%
Walks away, breaking contact with persuader	1%	3%	3%	1%	7%	9%
All others combined	9%	4%	13%	15%	9%	10%
RESISTER GIVES IN	4%	0%	1%	0%	1%	0%
Average Number of Resisting Behaviors Observed	4.1	2.9	5.7	7.7	4.0	5.1

* The distribution of Judge A's 14th week ratings is significantly different from the 5th week ratings. This is due to the fact that, when rating the 5th week role-plays, Judge A put responses along the lines of "It's bad for you" into the general category "Other", instead of the second category "...suffer...harmful ...effects."

As to whether the DARE students can successfully resist peer pressure to use tobacco, alcohol or drugs, the evidence from the videotaped role-plays is very encouraging. We cannot tell whether the role-plays are truly comparable to the real-world situations in which students might be pressured to try drugs, away from the watchful eye of the camera and the evaluators.

But, as the next chart shows, in their general assessments the judges scored, on average, 87% of the students as demonstrated full refusal skills after the fifth week of the DARE curriculum. After the fourteenth week, 92% of the students demonstrated full refusal. (The increase from 87% to 92% is not statistically significant.) Also note from Table 4 that no judge observed any student giving in to the Persuader in any of the role-plays videotaped at the end of the semester.

These are impressive results. About the only observation we have is that the ISP may want to review the judges' scoring of the types of resisting behaviors which the students displayed, with an eye towards giving some more emphasis. Whether to do this, of course, does depend on the basic philosophy of DARE and perhaps that of the students and their parents, as well. If one believes a child should "Just Say No," and leave it at that, then it appears that about half the time the DARE students did just that. But if one believes that children would be better able to handle these kinds of situations if they had a variety of reponses available to them, then DARE might want to give more training in the harmful physical and psychological effects of drugs, which resisting students mentioned less than 20% of the time.

Another under-utilized resisting behavior was parental disapproval. Only about 5% of the Resister responses used this disapproval, lest they appear to their peers to be too much under their parents' control. But the apparent interest among parents for more ways to be involved with DARE could bolster parent-child communication and make the child more willing to cite parental disapproval as a positive reason for not using drugs.

Our final suggestion coming out of the judges' scoring is that the DARE curriculum emphasize non-verbal refusal. One of the judges commented on this specifically: "In general, the . . . resisters were weak on body language. I suggest that the DARE program give more attention to this important means of communication."

We collected one additional set of data on DARE's impact. From a survey used by the LAPD, ISP officials chose to ask teachers and principals about other possible, indirect, impacts. The items and the responses are summarized in Table 5.

In addition to teaching refusal skills, according to 70% or more of the teachers and the principals, DARE also had the following positive results:

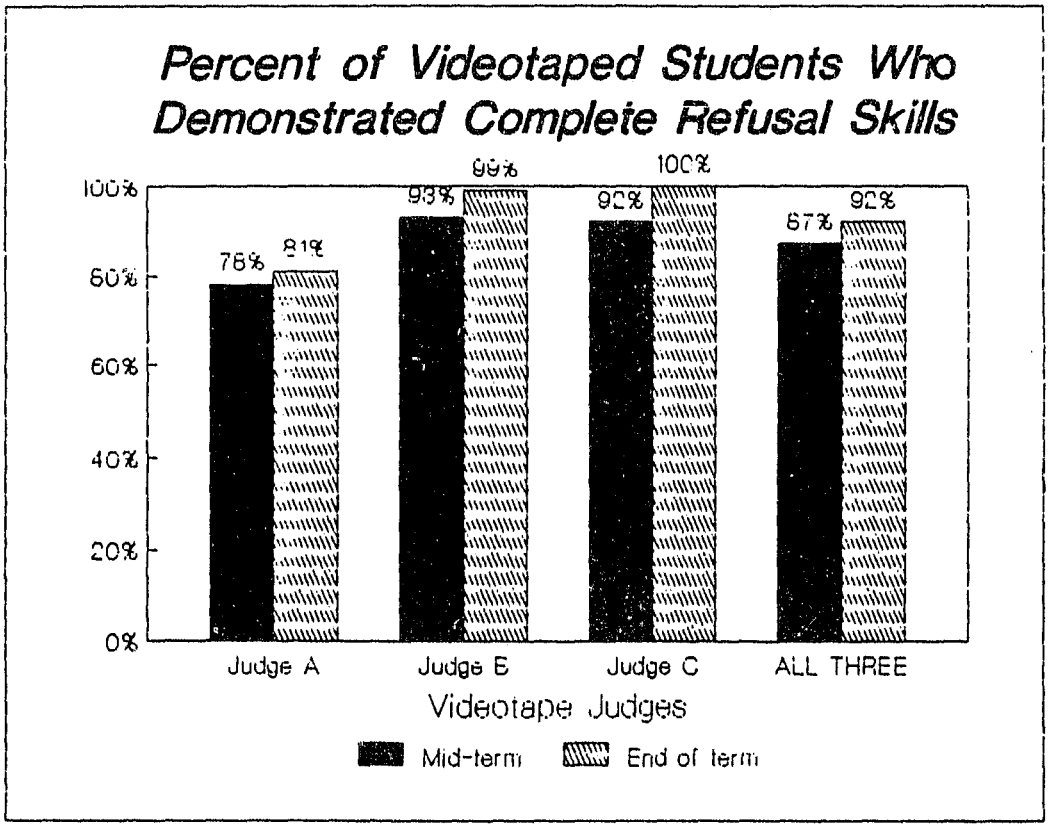

Percent of Videotaped Students Who Demonstrated Complete Refusal Skills
100%
80%
60%
40%
20%
0%
78%
81%
93%
99%
92%
100%
67%
92%
Judge A
Judge B
Judge C
ALL THREE
Videotape Judges
Mid-term
End of term

TABLE 5

PERCENTAGE OF "STRONGLY AGREE" OR "AGREE" RESPONSES OF ELEMENTARY SCHOOL TEACHERS AND PRINCIPALS TO STATEMENTS CONCERNING THE IMPACT OF THE DARE PROGRAM

	Illinois Teachers (n=170)	Illinois Principals (n=62)
1. Students are better equipped to deal with drug-oriented situations.	96%	66%
2. Students are more willing to talk about problems related to drugs.	88%	92%
3. Students are more likely to say "no" to negative behavior.	82%	86%
4. There are fewer disciplinary problems	27%	41%
5. Students are more aware of the consequences of their actions.	77%	87%
6. The classroom learning environment in general has been enhanced.	57%	80%
7. Students have more positive attitudes towards police officers.	90%	93%
8. There has been an increase in students' self-esteem.	61%	71%
9. Students are taking more responsibility for their actions.	50%	60%
10. Students are better able to resist peer pressure.	71%	78%
11. Students have more negative attitudes about drug use.	85%	89%
12. School staff awareness of drug abuse problems and ways to deal with them has been increased.	75%	95%

1. Students are more willing to talk about problems relating to drugs;

2. Students are more likely to say "no" to negative behavior;

3. Students are more aware of the consequences of their actions;

4. Students have more positive attitudes towards police officers;

5. Students are better able to resist peer pressure;

6. Students have more negative attitudes about drug use; and,

7. School staff awareness of drug abuse problems and ways to deal with them have been increased.

5. How Does the Illinois DARE Pilot Program Compare with the Los Angeles DARE Program?

In Table 3 we presented a summary of the percentage of parents who agreed or strongly agreed with five statements about the DARE program. That summary included corresponding figures from two surveys conducted by the Evaluation and training Institute for the LAPD. The Illinois results were virtually the same as the Los Angeles 1984-85 results (their first year). When the survey was repeated last year in Los Angeles, the percentage of agreement fell off slightly. **Clearly, Illinois parents are as supportive of DARE as Los Angeles parents.**

To evaluate DARE in Illinois the ISP chose two other surveys administered to Los Angeles DARE participants. The results have been presented above in Tables 1 and 5; here they are again, this time scored in the same manner as was used in the Los Angeles evaluation -- on a scale of 1 to 5.

Table 6 summarizes the responses to the seven questions concerning general impressions of the DARE program in both jurisdictions. The Illinois teachers and principals rate DARE slightly but consistently lower than the Los Angeles teachers and principals. Because of the large numbers of responses, all these Illinois vs. Los Angeles differences are statistically significant ($p=.05$), even though most of them are so small as to be fairly unimportant.

The one exception is question 7, which was not asked of Los Angeles teachers. More principals in Los Angeles than in Illinois feel that DARE has improved student behavior. This may be because many of the Los Angeles schools had behavior problems more serious than those in Illinois schools and, hence, more room

TABLE 6

AVERAGE OF RESPONSES OF ELEMENTARY SCHOOL PRINCIPALS

AND TEACHERS TO QUESTIONS CONCERNING THE DARE PROGRAM**

	Illinois Teachers (n=151)	Illinois Principals (n=50)	Los Angeles Teachers (n=271*)	Los Angeles Principals (n=50)
1. To what extent do you think Project DARE has made a positive impression on the children in your classes/ school?	4.5	4.6	4.7	4.8
2. To what extent do you support the manner in which the program is being delivered? (i.e. Illinois officers providing instruction)	4.7	4.8	5.0	5.0
3. Do you think DARE is a valuable program?	4.6	4.8	5.0	5.0
4. Would you like to have your school participate in DARE in the future?	4.6	4.9	5.0	5.0
5. To what extent do you think the students have carried over the knowledge and skills they have learned in DARE to other classes?	4.1	3.9	4.6	***
6. Do you believe the aspects of DARE which were not a part of the regular curriculum were valuable? (i.e., parent involvement, presentations in other classes, interaction with students outside of the classroom)	4.1	4.3	***	4.9
7. To what extent do you think DARE has improved student behavior at your school?	3.3	3.7	***	4.6

* Estimated

** These responses are based on a five-point scale, with "1" meaning "not at all" and "5" meaning "very much."

*** These questions were not asked of both groups in Los Angeles.

for improvement. But the ISP might want to confer with the LAPD about this, in case DARE in Los Angeles is addressing this problem more specifically than DARE in Illinois. (They might be doing this in exercises geared to each school's behavior problems and not included in general DARE materials.)

Table 7 shows that Illinois teachers and principals always agreed less strongly than their Los Angeles counterparts on whether DARE had any of a list of 12 impacts. Again, all the differences are statistically significant, but this could be simply the result of people in Illinois being generally less likely to say that they "strongly agree" with any statement than people in Los Angeles.

Although they differ in the strength of their agreement, those closest to the DARE students, the teachers in Illinois and Los Angeles, concur in the relative order of DARE's other impacts. The two sets of teacher ratings have a rank-order correlation of .95, which is statistically significant.

The Illinois and Los Angeles principals responses are also significantly correlated, but not so strongly (.66). The primary reason is that the Los Angeles principals' responses placed the first item -- "Students are better equipped to deal with drug-oriented situations," -- first, while the Illinois principals' responses placed this item in a tie for seventh. The other major discrepancies in how each group of principals saw these DARE impacts were that the Los Angeles principals ranked item 6 -- "The classroom learning environment in general has been enhanced" -- last, while the Illinois principals placed it in a tie for seventh. And the Los Angeles principals ranked item 4 -- "There are fewer disciplinary problems" -- last, while the Illinois principals ranked it in a tie for eighth.

The fact that the Illinois teachers showed uniformly lower levels of agreement than their Los Angeles counterparts could reflect a less confident delivery of the DARE curriculum. People who adapt innovations virtually always do so with somewhat less enthusiasm than the inventors.

We do not mean to disparage the ISP's commitment to DARE; we just mean to recognize that importing a new program into a notably different jurisdiction can mean that the original jurisdiction's results are not fully replicated. If this is what has happened, then the caution should be that when more local police officers start to teach DARE, there may be another drop in perceived impact.

Granted, next year, DARE should lose any aura of "Not-Invented-Here", if it exists. Nevertheless, our experience in watching the dissemination of drug prevention education curricula suggests that getting newly involved school systems to "own" the program requires special attention to the quality and enthusiasm of those delivering it. And it requires first-rate training, if the new providers are to have confidence in the materials and approach.

TABLE 7

AVERAGE RESPONSES OF ELEMENTARY SCHOOL TEACHERS AND PRINCIPALS

TO STATEMENTS CONCERNING THE IMPACT OF THE DARE PROGRAM

	Illinois Teachers (n=170)	Illinois Principals (n=62)	Los Angeles Teachers (n=271*)	Los Angeles Principals (n=50)
1. Students are better equipped to deal with drug-oriented situations.	4.3	4.0	4.7	4.8
2. Students are more willing to talk about problems related to drugs.	4.1	4.3	4.6	4.8
3. Students are more likely to say "no" to negative behavior.	4.0	4.1	4.2	4.5
4. There are fewer disciplinary problems.	3.1	3.3	3.4	4.5
5. Students are more aware of the consequences of their actions.	4.0	4.1	4.4	4.6
6. The classroom learning environment in general has been enhanced.	3.6	4.0	3.9	4.2
7. Students have more positive attitudes towards police officers.	4.2	4.5	4.8	4.8
8. There has been an increase in students' self-esteem.	3.7	3.8	4.1	4.4
9. Students are taking more responsibility for their actions.	3.4	3.7	3.8	4.4
10. Students are better able to resist peer pressure.	3.8	3.9	4.3	4.6
11. Students have more negative attitudes about drug use.	4.1	4.1	4.7	4.8
12. School staff awareness of drug abuse problems and ways to deal with them has been increased.	3.8	4.3	4.3	4.7

* Estimated

** These responses are based on a five-point scale, with "1" meaning "strongly disagree" and "5" meaning "strongly agree"

6. What Kind of Follow-Up Educational Needs Are Necessary?

Since 92% of the videotaped DARE students did demonstrate full refusal skills after the fourteenth week of the curriculum, and only 2% did not even attempt to refuse, the ISP need not be concerned about the basic ability of the DARE program to teach refusal skills.

Looking at how DARE is delivered, several teachers offered the same two suggestions, which we endorse. The first is that the curriculum may be too long; it possibly can be delivered in 12 weekly lessons, and be just as effective. We recommend that the ISP consider this, especially since a 12-week curriculum could be delivered three times in a year, instead of just twice. This manpower saving could be important, given the demand for DARE which we project later in this report.

The second recommendation from teachers is that DARE officers receive some training in classroom management. It seems that, occasionally, an officer did not know the rules, and students got away with breaking them during DARE lessons. (A recommendation at training that DARE officers find out the rules for the classroom before the first lesson might be sufficient.)

The only recommendations we have are those made above: that more emphasis be given to the bad effects of drugs and that parents be made more a part of the program.

7. What demand for DARE can we expect to see in the coming year and beyond?

We operationalized this question for the coming (1987-88) school year as the percentage of DARE communities in which the superintendent, the principal, all but one of the DARE teachers and the police chief indicated that they would recommend DARE. We did not interview superintendents, but based on the nearly unanimous results from the surveys of principals, teachers and law enforcement, we can say that, if asked, 98% of the pilot communities would recommend DARE to their non-DARE schools. (The missing 2% comes from the fact that 2% of the teachers would not recommend DARE.)

For the 1988-89 school year, we operationalized this question as the percentage of DARE communities in which all but two members of these groups either recommend DARE or recommend DARE with reservations, so long as the reservations do not include replacing the DARE officer with a classroom teacher. Since none of the teachers who had reservations indicated that they felt that a classroom teacher should teach DARE, we expect that 100% of the pilot communities will want to have DARE in all their schools in two years.

In addition, if we assume that the DARE program will be as well-received next year in the 56 new (non-pilot) school districts be-

ing trained this June, by the fall of 1988 about 100 school districts will want DARE at least in every elementary school.

According to the Research and Evaluation Division of the Illinois State Department of Education, not counting the Chicago school district, there are 870 school districts in Illinois, containing 2,216 elementary schools. On average, a school district contains about 2.5 elementary schools; therefore, for 1987-88 we project a demand for DARE in about 112 schools, and for 1988-89 a demand for DARE in an additional 142 schools, not including the Chicago school district. The Chicago school district contains 494 elementary schools. If, by June 1988 only one-third of the Chicago elementary schools want DARE, the projected demand for DARE in 1988-89 will be an additional 300 elementary schools.

Many of the parents, teachers and principals who wrote comments on their surveys expressed an interest in seeing DARE put into the junior and senior high schools. State-wide, there are 1,522 junior and senior high schools and 2,708 elementary schools, a ratio of about .56 to 1. If every school district which wants DARE in its elementary schools wanted DARE in its grades 7-12, there would be an additional potential demand for DARE in about 63 junior and senior high schools in 1987-88 and an additional 168 junior and senior high schools in 1988-89.

If only half the school districts who would welcome DARE for their elementary schools would also want DARE in their junior and senior high schools, the 1987-88 demand for DARE could be about 133 schools and the 1988-89 demand, about 384, including Chicago.

8. What needs to be in place for a Longitudinal Study?

The ultimate test of DARE's effectiveness has to be whether it delays the onset of drug use. We have seen good evidence that DARE students do acquire the skills to resist offers from same-age peers to use drugs. Being able to say "No" is not, however, the complete answer to preventing drug use -- what if the child wants to say "Yes?" Thus, no one should expect all DARE students to avoid drugs totally, even if they do have good resistance skills.

To estimate the impact of DARE on drug use, the ISP will need a way to measure drug use accurately, during a time in children's lives when they are subject to increasing pressures and/or reasons to try drugs. This is difficult to do, because it requires honest reporting by children as to their use, if any, and a way to tell whether their amount of use is any less than it would have been if they had gone through DARE.

The ideal procedure would be to assign children at random to DARE, letting some in the program, keeping others out, and periodically asking them how often they use drugs. This is impractical, for two major reasons.

First, once DARE has been invited into a school, it is almost impossible to deny some children the right to participate, just because an evaluator wants to carry out an ideal experiment. Also, it is difficult to obtain the cooperation of teachers, principals in schools who are not taking part in a program to gather drug-use data on control groups of students. It almost always requires a lot of money and time to be able to get researchers inside schools which are not participating in the program.

Second, if you ask them directly, many students who use drugs will not admit it, especially if they are in a school which is actively trying to discourage drug use. This is especially true to children who are starting to experiment with drug use. These are precisely the students DARE would be most interested in, and they are precisely the students who are least likely to admit their use.

To get around the first of these problems -- how much students would use drugs if they had not gone through DARE -- requires two basic approaches, depending upon whether a school district puts all of its elementary students through DARE or only some of its elementary students.

First, in school districts which want to put all of their elementary students through DARE, school districts which want DARE should be asked to conduct drug-use surveys before participating in DARE.

During the school year before DARE begins, all students would take the surveys; they would provide estimates of how much drug use was typical for seventh and eighth-graders in that school district.

The next year, students in the same grades would take the survey again. The seventh-graders would have had DARE; the eighth-graders would not have. Each grade's results for the current year would be compared with that grade's results for the previous year. Note that we are not comparing eighth-graders to seventh-graders. We would compare this year's eighth-graders to last year's eighth-graders, and this year's seventh-graders to last year's. This avoids the problem of the fact that drug use normally increases with age.

(This approach is essentially the same as you would take if you were trying to improve students' SAT or ACT scores. If you instituted a three-year program to raise their scores, you would not try to track down seniors after they graduated and test them again. Instead, you would compare current seniors' average grades with previous senior classes at your high school, to see if test scores had improved.)

The only flaw in this approach is that there might be something happening to increase or decrease drug use generally, apart from

the DARE program. The way to test this possibility is to compare the pre-DARE survey results from different school districts across Illinois. If year-to-year changes show up in surveys given the year before a school district participates in DARE, then these general changes can be incorporated into the analysis of DARE's impact on drug use.

In school districts which do not put all elementary students through DARE, then the seventh and eighth-grade drug use surveys just have to provide a place for students to indicate whether they had DARE in elementary school. We would still recommend, however, that these school districts also begin surveying during the year before they institute DARE.

The second major problem facing an evaluation of DARE's impact on drug use is that of the students' not being honest. The remedy is to use a method of surveying called "randomized response." We used this method in estimating the percentage of students who like DARE; the appendix contains the instrument and instructions for its use.

When surveying for drug use, we modify this survey to enable us to estimate the frequency of use, because we want to be able to pay particular attention to students who are starting to experiment with drugs. Instead of just asking, "Do you use [a particular substance]?" we would ask, "Since last Friday, how many days have you used [the substance]?"

This sensitive question about drug use is paired with a non-sensitive one about class attendance. Although there are two questions on the survey, there is only one set of possible answers. Which question a student answers is determined by where he or she happens to be sitting in the classroom when the survey is given. All the completed surveys are placed in the same box, so there is no way anyone can tell which question -- the one about drug use or the one about attendance -- a particular student answered. Here is what the survey, given on a Friday, would look like:

RANDOMIZED RESPONSE SURVEY ON ALCOHOL USE

****

This survey is different from most. There are two questions, but only one set of answers. Your teacher will ask some students to answer question 1. The rest of you will be asked to answer question 2.

Please think back to last Friday.

Question 1. Since last Friday, how many days did you drink beer, wine or liquor?

	0 days
	1 day
NO MATTER WHICH QUESTION YOU ANSWER, CIRCLE ONE OF THESE NUMBERS	2 days
	3 days
	4 days
	5 days or more

Question 2. Since last Friday, how many days were you absent from this class?

****

It might appear that there is no way to obtain reliable information on drug use, if no one knows which question a student answered, but there is. We know the proportion of students who were asked to answer the attendance question, and we obtain from the teacher the correct answers to how many students were absent the previous week. From this we can estimate how many students who answered the attendance question responded "0", how many responded "1", or "2", etc. The extra 0's, 1's, 2's, etc. come from the students who answered the drug questions.

This type of survey does have the drawback that it must be repeated for each substance of interest. But it takes only 15 minutes to administer the first time it is given, and only 10 minutes after teachers and students get used to it.

The basic plan for analyzing the data obtained from these surveys will depend on whether or not all the students had DARE in their elementary school. If they did, then the second-year, post-DARE results will be compared, grade-by-grade, with the first-year, pre-DARE results, to see if the new students (who had DARE in their elementary schools) are using less drugs than their counterparts used the previous year. The comparisons will be corrected for any general year-to-year trends in the population.

If only some had DARE in elementary school, then the students will be asked to indicate on their surveys whether they had DARE or not. The non-DARE students will be compared with the DARE students, using a computer program recently developed by N. J. Scheers of the F.B.I. Academy and C. M. Dayton of the University of Maryland.

In summary, for a longitudinal study of the impact of DARE on drug use during the seventh and eighth grade the ISP will need:

1. the willingness to require school districts to survey students the year before they receive DARE;

2. a commitment from the schools to continue surveying in the first and second years of DARE (making a total of three years' surveying); and,

3. a willingness to use a proven but novel form of drug-use survey, to get the honest reporting which will be essential to revealing the extent of student experimentation with drugs during the junior high years.

9. Does DARE Meet the State Board of Education's Goals for Health Curricula for Alcohol and Drugs?

The ISP wanted to know if DARE met the Illinois State Board of Education (ISBE) goals for alcohol and drug education. We proposed that ISBE be asked to review the DARE curriculum and inform us as to whether it did or did not meet their goals.

A copy of the curriculum along with a cover letter which provided background information on DARE, prevention in Illinois and the purpose of our request was sent to Superintendent Ted Sanders in late March. On May 1, 1987 A.H.T.D.S., Incorporated, received the following letter from ISBE.

While the letter does not specifically address our question, there are two significant points worth noting. First, ISBE has historically declined to endorse or recommend specific teaching aids on curricula. Second, this allows more flexibility for local districts in choosing their own curriculum or teaching aids.

There are two documents which may be of further assistance to the ISP in their effort to answer their original question. The "Critical Health Problems and Comprehensive Health Education Act" of 1973 states the following:

Health Education, Grades K-6

The health education program at the elementary level should place strong emphasis on the health guidance of elementary school children. Many of the health education experiences of primary-age children should be planned around the regular school program and activities of daily living in the school, home, and community. While some of the most effective learning experiences for elementary school children should result from their living in an environment which promotes good health and safety, the elementary school program should also provide a planned curriculum composed of specific units of instruction for particular grade levels.

Illinois
State Board of
Education

EXCELLENT SCHOOLS: THE ILLINOIS ADVANTAGE

100 North First Street
Springfield, Illinois 62777-0001
217/782-4321

Walter W Naumer Jr Chairman
Illinois State Board of Education

Ted Sanders
State Superintendent of Education

May 1, 1987

Ms. Jackie Garner
Director
AHTDS Prevention Resource Center
901 South 2nd Street
Springfield, IL 62704

Dear Ms. Garner:

I am responding to your letter of March 25, 1987 to Superintendent Sanders in which you ask if curriculum materials developed for the Illinois State Police program, Project D.A.R.E., meet Illinois State Board of Education goals for alcohol and drug education.

The Illinois State Board of Education does not have goals for "fifth, sixth or seventh grade health curricula concerning alcohol and drugs," as indicated in your letter. In response to the educational reform legislation of 1985, the Board has established State Goals for Learning in six fundamental areas of learning: language arts, mathematics, biological and physical sciences, social sciences, fine arts, and physical development and health. School districts will develop learning objectives for their students in grades 3, 6, 8, and 10 which meet or exceed these State Goals. Districts also have complete flexibility in choosing curriculum materials and instructional activities in relation to their objectives. Therefore, I cannot respond to your question.

If you have further questions, please contact me or Ms. Mary Jo Leeds of the Curriculum Improvement Section at 217/782-2826.

Sincerely,

Lyndon B. Wharton
Assistant Superintendent
School Improvement Services

KAG8566k

State of Illinois Center
Suite 14 300
100 West Randolph
Chicago, Illinois 60601 3405
312 917 2220

Telecommunications Device for the Deaf (TDD)
217/782-1900

Southern Illinois Regional Office
First Bank and Trust Building
Suite 214, 123 South 10th Street
Mt Vernon, Illinois 62864 4013
618 242-1676

(See chart, page 4.) These units of instruction should be clearly related to the comprehensive health education curriculum plan for the school district.

Health education should be a part of the regular formal instructional program offered in the elementary school. In addition, special attention should be given to opportunities for incidental instruction in health and safety education when appropriate situations arise during the school day.

Specific time requirements for the elementary health education program are purposely avoided. However, school districts are expected to have a well-developed plan which will insure that the curricular elements required by the legislation are being adequately taught.

This plan will also be of primary importance when the district is visited by the School Approval Section for recognition purposes.

Many authorities from the fields of education, medicine, and psychology feel strongly that the values and attitudes which will ultimately determine the pattern of health habits youth adopt are firmly established by the time they enter the middle or junior high school.

The elementary years, Grades 4, 5, and 6, are important. Health education programs should emphasize decision-making processes, problems solving, and values clarification techniques during this crucial period.

A quick assessment of DARE clearly shows that it does address those life skills defined in the last paragraph as decision-making, problem solving and values clarification.

The second document which we recommend the ISP become familiar with is "State Goals For Learning and Sample Learning Objectives-Physical Development and Health, Grades 3, 6, 8, 10, 12." Assistant Superintendent Wharton referred to the State Goals for Learning in his letter and noted that local districts will develop their own learning objectives to meet the goals. ISBE has also developed sample learning objectives which distrits may or may not choose to follow. The State Goals and specific learning objectives for goal 2 (the goal most strongly linked to substance abuse prevention) are included in the appendix.

The ISP should become familiar with both documents so that they are able to communicate with local districts as to exactly how DARE coincides with the State Goals For Learning. Obviously, the "Critical Health Problems and Comprehensive Health Education Act" strongly encourages instruction on alcohol and drug use and abuse. Both documents are essential to an effective marketing strategy.

APPENDIX

APPENDIX A

DARE EVALUATION QUESTIONNAIRE

AHTDS' Prevention Resource Center is assisting the Illinois State Police in an evaluation of the DARE Program. We are very much interested in your feelings regarding the DARE Program.

It would be of great help if you could please review the following five questions. You will be contacted by telephone during late April for a personal interview. Thank you for your time.

1. Do you think it is appropriate for a state police officer to teach the DARE curriculum in the classroom? For a local police officer? Why?

   Very appropriate _____
   Somewhat appropriate _____
   Not sure _____
   Somewhat inappropriate _____
   Inappropriate _____
   No opinion _____

2. Do you think it is more appropriate for a local police officer to teach DARE than a state police officer? Why?

   Yes _____
   In most communities _____
   Not sure _____
   Not in most communities _____
   No _____
   No opinion _____

3. Based on your knowledge of how DARE has operated in your community, do you think that classroom teachers would have gotten the same results with the DARE curriculum as police officers? Why?

   Definitely not _____
   Probably not _____
   Not sure _____
   Probably yes _____
   Definitely yes _____
   No opinion _____

4. Would you recommend DARE to your fellow (principals/ teachers/parents, etc.)?

   Yes _____
   Yes, with reservations _____
   Not sure _____
   Not unless changes were made _____
   No _____
   No opinion _____

5. (If interviewee expresses reservations or changes needed --) What changes would you want to see in DARE before you could recommend it?

Prevention Resource Center
901 South Second Street
Springfield, IL 62704

217/525-3456
800/252-8951

HELPING/HINDERING BEHAVIORS

	Disagree	Neutral	Agree
Teachers Helping Behaviors			
1. Available seating charts or name cards.			
Principal Helping Behaviors			
1. School assembly to introduce officer.			
2. Introduce officer to key employees, i.e. faculty, office managers, PTA President, Plant Manager, District personnel.			
3. Mailbox on each campus.			
4. Work area with desk and phone.			
5. Availability of reproduction materials.			
6. Display technique on bulletin board or wall of school building.			
Other Helping Behaviors			
Teachers Hindering Behaviors			
1. Core teachers doing classwork during lesson, i.e. bulletin boards, collecting papers, watching TV, calling student out of seat to discuss whatever.			
Principals Hindering Behaviors			
1. Special event that interrupt without warning.			
2. Negative attitude of principal towards officer or program that limits contact with students and movement around school.			
3. Not having support with audio/visual equipment.			
4. Non-availability of auditorium.			
Other Hindering Behaviors			

STUDENT PRE/POST TEST

1. Do you like having the DARE Program come to your classroom?

2. Were you in school every day last week?

   Yes_____ No_____

DARE TO SAY NO

PRINCIPALS/TEACHERS

AHTDS' Prevention Resource Center is assisting the Illinois State Police in an evaluation of the DARE Program. We are very much interested in your feelings regarding the DARE Program. Please review the following questionnaire. You will be contacted in April regarding your responses. Thank you for your help.

	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
1. To what extent do you think Project DARE has made a positive impression on the children in your classes/school?					
2. To what extent do you support the manner in which the program is being delivered? (i.e. Illinois officers providing instruction)					
3. Do you think DARE is a valuable program?					
4. Would you like to have your school participate in DARE in the future?					
5. To what extent do you think the students have carried over the knowledge and skills they have learned in DARE to other classes?					
6. Do you believe the aspects of DARE which were not a part of the regular curriculum were valuable? (i.e., parent involvement, presentations in other classes, interaction with students outside of the classroom)					
7. To what extent do you think DARE has improved student behavior at your school?					

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DARE TO SAY NO

PRINCIPALS/TEACHERS

AHTDS' Prevention Resource Center is assisting the Illinois State Police in an evaluation of the DARE Program. We are very much interested in your feelings regarding the DARE Program. Please review the following questionnaire. You will be contacted in April regarding your responses. Thank you for your help.

	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
1. Students are better equipped to deal with drug-oriented situations.					
2. Students are more willing to talk about problems related to drugs.					
3. Students are more likely to say "no" to negative behavior.					
4. There are fewer disciplinary problems.					
5. Students are more aware of the consequences of their actions.					
6. The classroom learning environment in general has been enhanced.					
7. Students have more positive attitudes towards police officers.					
8. There has been an increase in students' self-esteem.					
9. Students are taking more responsibility for their actions.					
10. Students are better able to resist peer pressure.					
11. Students have more negative attitudes about drug use.					
12. School staff awareness of drug abuse problems and ways to deal with them has been increased.					

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APPENDIX B

RESPONSIBILITIES OF THE PERSON (PAC) IN CHARGE OF THE SURVEY

1. On the Instructions for Administering the DARE Survey, write your name in the appropriate place.

2. On the Tally Sheet, write the teacher's name, classroom number, you name and the time of day you will come to that teacher's classroom to pick up the tally sheet.

3. Get one shoebox or large envelope for each classroom, in which the students will place their slips. If you are going to use a shoebox (better than an envelope), make a slot in the cover so it resembles a ballot box.

4. On either the shoebox or envelope, mark places for the classrrom teacher to put her or his name and classroom number. THIS IS VERY IMPORTANT.

5. If a student or teacher is confused by the randomized response method of surveying, and seems to believe that it cannot provide any worthwhile information (because we cannot tell which question a student has answered), respond along the following lines:

> "It is true that we cannot tell which question a student answered. We do it this way so that students will feel extra protection and, we hope, will answer the questions completely honestly.
>
> "But, overall, we can get valuable information from this survey, because we know that, generally speaking, about one student in five will circle NO to the absence question. That is, in a typical week like last week, four out of five students will have perfect attendance, and one out of five will be out at least one day.
>
> "If we know how many students answered the absence question (even though we don't know PSwhich onesPS answered the absence question), we can estimate that about one fifth of them would answer NO. If there are any more NO's, they must have come from the students who answered the other question.
>
> "We still don't know WHO said NO, but we do know about how many NO's came from the students who answered the other question. That's good enough for us to tell about how many people like the DARE program and how many don't. And that's all we really want to know."

GENERAL INFORMATION ON RANDOMIZED RESPONSE SURVEYS

We give the students a pair of questions, one about the DARE program and one about absence from class. For the two quetions there is only one set of responses Yes and No. Students circle just one answer, no matter whether they are answering the DARE question or the absence question. This way, if someone saw a student's answer, that someone could not tell which question the student had answered.

Here is the general outline of the procedure. The teacher (or Prevention Area Coordinator, if he or she will administer the survey) chooses alternate rows to answer the DARE question and the absence question. If there is an odd number of rows, the students in the extra row should answer the DARE question.

The teacher passes out slips of paper with the two questions and the one possible set of answers (Yes/No). The students circle the appropriate response, and put their slips into a box.

While the students are answering, the teacher counts and records the numbers of students answering each question.

When all the students have placed their slips in the box, the teacher picks a student trusted by the others in the class to take the box to the PAC in charge of the survey for the school.

Later, the teacher send the PAC the counts of how many answered each question, and how many of the students who took the survey were in that class every day during the previous week.

The PAC in charge of the survey tallies all the responses from the slips, the total number of students answering the DARE question and the total number answering the absence question. The PAC gets the attendance records for the previous week for the classrooms responding and tallies the number of students who were in class every day during the previous week and the number who missed at least one class during the previous week.

The PAC then gives Nancy Phillips these three pieces of information:

1) the tallies of Yes's and No's from the students' slips;
2) the total number of students who were asked to answer the DARE question and the total who were asked to answer the DARE question; and,
3) the attendance counts (present every class vs. absent at least once) for the previous week for the classrooms participating.

The PAC in charge keeps the slips, and copies of the counts of how many students answered each question and the attendance figures, in case any of these gets lost in the mail or elsewhere.

PAIRS OF QUESTIONS FOR THE RANDOMIZED RESPONSE SURVEY

For every 50 students to be surveyed, make ten copies of this page and use a paper cutter to create 50 answer slips.

Question 1: Do you like the DARE program?

YES NO (Circle one answer)

Question 2: Were you present for this class every day last week?

Question 1: Do you like the DARE program?

YES NO (Circle one answer)

Question 2: Were you present for this class every day last week?

Question 1: Do you like the DARE program?

YES NO (Circle one answer)

Question 2: Were you present for this class every day last week?

Question 1: Do you like the DARE program?

YES NO (Circle one answer)

Question 2: Were you present for this class every day last week?

Question 1: Do you like the DARE program?

YES NO (Circle one answer)

Question 2: Were you present for this class every day last week?

INSTRUCTIONS FOR ADMINISTERING THE DARE SURVEY

1. READ THE FOLLOWING TO THE STUDENTS:

   The teachers and administration of (your school's name) would like to know if you like the DARE program.

   Today we are asking you to answer one of these two questions.

2. PASS OUT THE SLIPS.

3. DIVIDE THE CLASS IN HALF BY ALTERNATE ROWS, LEFT TO RIGHT. ASSIGN QUESTION 1 (the DARE question) TO ROWS 1, 3, 5 (etc.) AND QUESTION 2 (the absence question) TO ROWS 2, 4, and 6. (Assign any extra row to Question 1.)

4. SAY TO THE STUDENTS:

   All the people in these rows (indicate 1, 3, 5) should answer Question 1 honestly.
   All the rest should answer Question 2 honestly.

   No matter which question you answer, just circle either "YES" or "NO". That is all there is to it.

   Do not put your name or which question you answered on the slip.

   When you have circled your answer, place your slip in this (box/envelope, depending on which you use). (Point to the shoebox or envelope.)

   All the slips for both Question 1 and Question 2 go into the same (box/envelope), so when the slips are mized together, there will be no way for anyone to know which question you answered.

5. WHILE THE STUDENTS ARE ANSWERING, COUNT THE NUMBER OF STUDENTS ANSWERING QUESTION 1 AND THE NUMBER ANSWERING QUESTION 2. PUT THESE NUMBERS ON THE TALLY SHEET.

6. WHEN ALL THE STUDENTS HAVE PLACED THEIR SLIPS IN THE BOX OR ENVELOPE, SEAL IT AND WRITE YOUR NAME AND CLASSROOM NUMBER ON THE OUTSIDE. SELECT A STUDENT RESPECTED BY THE REST OF THE CLASS TO TAKE THE BOX OR ENVELOPE TO THE PERSON IN CHARGE OF THE SURVEY (whose name is _____).

7. LATER, FILL IN ABSENCE INFORMATION ON THE TALLY SHEET. THE PERSON IN CHARGE WILL BE BY TO PICK IT UP.

DARE SURVEY TALLY SHEET

Teacher _____ Classroom _____

Number of Students on Roll _____ Number Taking Survey _____

Please use this form to report the absences for the students who were in class today to take the survey.

Number of students PRESENT TODAY who were present in my class EVERY DAY last week: _____

Number of students PRESENT TODAY who were absent from my class AT LEAST ONE DAY last week: _____

Please record the total number of students who were asked to answer each question today.

Total Number of students asked to answer Question 1 (those seated in rows 1, 3, 5, etc.): _____

Total Number of students asked to answer Question 2 (those seated in rows 2, 4, 6, etc.): _____

Please save this tally sheet for (name: _____), who is charge of the survey in this school, and who will come by to pick this sheet up today at _____.

THANK YOU FOR YOUR HELP AND COOPERATION!

APPENDIX C

INSTRUCTIONS FOR RATING RESISTANCE SKILLS

This videotape contains pairs of students, one of whom is attempting to demonstrate the ability to refuse to engage in a behavior suggested by the other of the pair.

Each pair is shown twice. In the first scenario, the behavior is one suggested by one or both of the students as something which another student might try to persuade them to do, but which is something that the pair member(s) would not want to do.

In the second scenario, the behavior involves either smoking cigarettes, drinking alcohol or smoking marijuana.

In each scenario, one student is a "persuader"; the other is the potential "resister." Each scenario lasts until either the "resister" agrees to engage in the behavior or the "persuader" gives up attempting to persuade.

We want you to record five dimensions of each scenario:

1) How many different reasons does the persuader offer?

   Be alert to sudden changes in the reasons, such as the persuader saying, "It'll be fun!" and, upon getting no response, following up quickly with the epithet "Chicken?" This sequence constitutes two separate reasons, one coded "Enjoy," the other coded "Cowardice."

2) How many times does the persuader offer each reason?

   Count as repetitions each individual follow-up exhortation, such as "C'mon" -- "Why not?" -- "Huh?" -- "Whaddya say?" -- "Chicken!", etc.

3) Does the scenario end with the resister agreeing to the behavior or with the persuader giving up?

4) What are the gender of the persuader and of the resister?

5) Who is "larger?"

   By "larger" we mean the (albeit subjective) combination of height and weight.

Note that the rating sheet provides for <u>two</u> scenarios from each pair of students, and that you are to indicate the behavior being sought/resisted in the first and the setting and substance offered in the second. The rating sheet also contains codes for the behaviors or reasons students are likely to demonstrate or give.

RATING CODES FOR RESISTING BEHAVIORS AND REASONS

Abbreviation	Content
(A)dvances -----	Moves toward the persuader
(B)ad ----------	Says will suffer direct, harmful physical or psychological effects (do not include punishment)
(CH)anges ------	Tries to change the subject
(D)isinterest --	Says doesn't want to
(F)ear ---------	Expresses fear of getting caught by authorities (not by parents; see below)
(M)oves away ---	Increases the distance to the persuader, but does not break contact; see (W)alk away, below
(N)o -----------	Says "No" but gives no reason
(OK) -----------	Agrees to behavior
(P)arents ------	Says parents would disapprove or discipline resister
W(R)ong ---------	Says behavior is wrong or not right
(S)anctions ----	Threatens to reveal something negative about persuader
(Th)reat -------	Threatens to hurt persuader
(Thr)eat -------	Threatens to rob persuader
(W)alks away ---	Breaks contact with persuader
(X) ------------	Repeats a reason
Wh(Y) -----------	Asks for or demands a reason for engaging in behavior
(Z) ------------	Other reason/behavior; please specify the content

RATING CODES FOR PERSUADING REASONS AND BEHAVIORS

Abbreviation	Content
(A)dvances -----	Physically moves towards resister
(C)owardice ----	Says resister is afraid, "chicken"
(E)njoy --------	Says resister will enjoy behavior
(F)riends ------	Appeals to friendship
(H)igh ---------	Says resister will get intoxicated
(J)oin ---------	Invites resister to become part of a seemingly desirable group
(L)ike ---------	Says persuader will like/not like resister, depending on response
(N)on-specific -	Either: Gestures with hands and/or body for resister to acquiesce; or, Utters a general urging, such as "C'mon!," "Huh?," "How about it?."
(O)we ----------	Claims from or offers an obligation
(S)anctions ----	Threatens to reveal something negative about resister
($) ------------	Offers to pay resister
(Th)reat -------	Threatens to hurt resister
(Thr)eat -------	Threatens to rob resister
(X) ------------	Repeats a reason; for example, this sequence "C'mon." (no response) "Huh?" (no response) "Whaddya say?" should be scored "N,X,X", to indicate a (N)on-specific reason with two repetitions.
Wh(Y) ----------	Asks for or demands a reason for resistance
(Z) ------------	Other reason/behavior; please specify the content

RATING SHEET FOR RESISTANCE SKILLS

Rater's Name _____ Telephone _____

GENERAL INSTRUCTIONS: A Resister's behavior and/or reasons should be coded on the same line as the Persuader's behavior or reason, until the Persuader's behavior or reason changes.

EYE CONTACT is an important element of resistance. Note whether the Resister makes eye contact with the Persuader when responding by drawing a CIRCLE around the code you put down for the Resister's behavior or reason.

First Scenario

Behavior Sought/Resisted _____

Gender of Persuader _____ of Resister _____; Taller (P/R) _____

Persuader's Reasons: (Letter code, plus "X"'s)	Resister's Responses: (Letter code or "N" or both)
1 _____	1 _____
2 _____	2 _____
3 _____	3 _____
4 _____	4 _____
5 _____	5 _____
6 _____	6 _____
7 _____	7 _____

Second Scenario

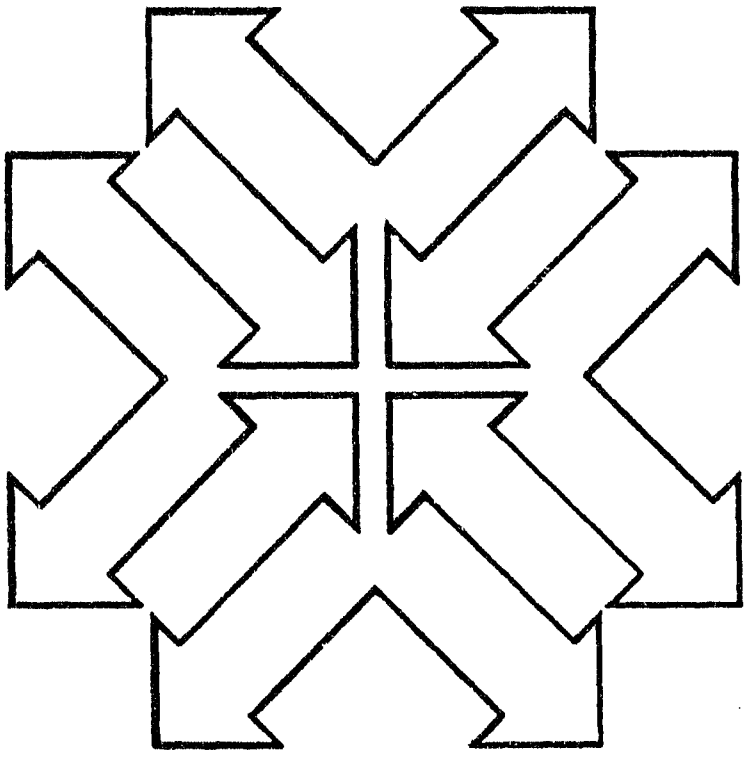
Setting _____ Substance Offered _____

Gender of Persuader _____ of Resister _____; Taller (P/R) _____

Persuader's Reasons: (Letter code, plus "X"'s)	Resister's Responses: (Letter code or "N" or both)
1 _____	1 _____
2 _____	2 _____
3 _____	3 _____
4 _____	4 _____
5 _____	5 _____
6 _____	6 _____
7 _____	7 _____

Implementing The "Critical Health Problems and Comprehensive Health Education Act"

GUIDELINES FOR



Updated and Reprinted February 1981

This document does *not* constitute a revision of the rules and regulations and guidelines originally distributed in 1973, filed with the Secretary of State, and entitled *Rules and Regulations to Govern the Administration and Operation of Comprehensive Health Education Programs* based on the *"Critical Health Problems and Comprehensive Health Education Act."*

GUIDELINES

INTRODUCTION

The *Guidelines for Implementing the "Critical Health Problems and Comprehensive Health Education Act"* were developed, printed, and distributed to all school districts in March 1973.

Because of Federal Legislation (Title IX) and other changes in regulations associated with teacher requirements, the guidelines have been updated; *however, no changes have been made in time requirements or scheduling procedures.*

Most school districts have made excellent progress in planning comprehensive health education programs which meet the intent of the legislation.

The three major persistent issues which remain unresolved in many districts are the need to: (1) appoint a coordinator/director to direct, supervise, and coordinate the health education program; (2) upgrade the competence of health education teachers to meet at least minimal standards for teaching health education; and (3) incorporate instructional techniques which will emphasize student involvement and the affective domain.

These guidelines were originally developed to assist school districts to develop comprehensive health education programs which would assist Illinois youth to make wise personal decisions in matters of health. That purpose is still the paramount consideration.

The "Critical Health Problems and Comprehensive Health Education Act" (copy appended) was signed into law on August 31, 1971. Authority and responsibility for implementing the legislation at the local district level rest with the local board of education and the school administration.

Because of the scope, nature, and magnitude of the legislation, each school district is encouraged to develop provisions whereby the health education program can be evaluated regularly to insure that it is meeting the requirements and intent of the legislation, as well as critical health problems which may arise at the local level.

It is the responsibility of the district administration and board of education to maintain a file which contains the program of studies and evidence that each student has received instruction in health education as required by the legislation.

POWERS OF THE STATE SUPERINTENDENT OF EDUCATION

Key provisions of the Act empower the State Superintendent of Education to:

(a) Establish the minimum amount of instruction time to be devoted to comprehensive health education at all elementary and secondary grade levels.

(b) Establish guidelines to aid local school districts in developing comprehensive health education programs at all grade levels.

Time and Scheduling Guidelines

1. Health education should be identified and developed as a distinct subject matter area in the school curriculum, even though it has inherent relationships to several other subject matter areas.

2. Health education programs should be developed around program objectives and behavioral goals for students; adequate instructional time should be allocated to accomplish these goals and objectives. Time allotments may vary depending on individual and community needs but shall not be less than the recommended minimum. School districts are encouraged to continue present scheduling patterns that provide elective courses in health education beyond the minimum requirements.

Health Education, Grades K-6

The health education program at the elementary level should place strong emphasis on the health guidance of elementary school children. Many of the health education experiences of primary-age children should be planned around the regular school program and activities of daily living in the school, home, and community. While some of the most effective learning experiences for elementary school children should result from their living in an environment which promotes good health and safety, the elementary school program should also provide a planned curriculum composed of specific units of instruction for particular grade levels. (See chart, page 4.) These units of instruction should be clearly related to the comprehensive health education curriculum plan for the school district.

Health education should be a part of the regular formal instructional program offered in the elementary school. In addition, special attention should be given to opportunities for incidental instruction in health and safety education when appropriate situations arise during the school day.

Specific time requirements for the elementary health education program are purposely avoided. However, school districts are expected to have a well-developed plan which will insure that the curricular elements required by the legislation are being adequately taught.

This plan will also be of primary importance when the district is visited by the School Approval Section for recognition purposes.

Many authorities from the fields of education, medicine, and psychology feel strongly that the values and attitudes which will ultimately determine the pattern of health habits youths adopt are firmly established by the time they enter the middle or junior high school.

The elementary years, Grades 4, 5, and 6, are important. Health education programs should emphasize decision-making processes, problem solving, and values clarification techniques during this crucial period.

Health Education, Grades 7-12

The minimal time allocation shall not be less than one semester or equivalent during the middle school or junior high school experience and one semester during the senior high school experience.

Several options are available to schools for scheduling health education. The following procedures have been found to be effective:

1. A one-semester course, meeting daily and including all students at a particular grade level, is recommended. Depending upon school organization, a course may be scheduled at one of the Grades 6, 7, or 8 (middle school), 7, 8, or 9 (junior high school), and another more advanced course at one of the Grades 10, 11, or 12 (senior high school). In high schools organized on a 9-12 basis, the course may be offered at any of the grade levels. In schools organized on a K-8 basis, health education in Grades 7 and 8 may be scheduled as a separate course or on a block-of-time basis.

2. Health education may be offered in conjunction with another course on a block-of-time basis. When the block-of-time method is used, the total time devoted to health education must equal a minimum of one semester or equivalent of work during Grades 7, 8, or 9 and another semester or equivalent of work during Grades 10, 11, or 12.

3. School districts are encouraged to develop alternative scheduling procedures for health education, taking into account practices, such as modular scheduling and individualization of instruction. In these situations, the board of education must certify that the recommended minimum time allocation for health education is being met.

4. Such practices as scheduling health education on a one-day-per-week basis, utilizing massive assembly programs and/or through the use of resource persons alone are discouraged, as the educational value accruing from such procedures is questionable.

5. Integrating health education with other related disciplines usually produces an ineffective program. Such programs tend to be fraught with repetition and gaps in instruction. It is also difficult to develop programs which will make instruction available to all students. Correlated and integrated health instruction should be supplementary to, not a substitute for, direct health teaching in specific health education courses.

Basic Components of a Comprehensive Health Education Program

1. Health education should be a planned, sequential program, K-12. Crash programs, emphasizing special health topics only, should be avoided.

2. Individualized instruction is particularly relevant to health education. Class size should be maintained at a level which will provide adequate opportunities for interaction among students and between students and teachers.

3. Typical classrooms should be provided which facilitate the use of modern teaching and learning resources. The environmental setting should provide adequate heat, light, ventilation, and appropriate furniture to enhance learning.

4. Students should receive a grade for a health education course and one-half Carnegie unit of credit or equivalent for successfully completing the program at the high school level. Health education must be required for high school graduation.

5. Title IX[1] requires that health education classes be coeducational. The following is excerpted from a summary of Title IX Regulations:

> "Classes in health educaton...may not be conducted separately on the basis of sex, but the final regulation allows separate sessions for boys and girls at the elementary and secondary level during times when the materials and discussion deal exclusively with human sexuality."[2]

6. School districts must employ teachers with specific academic preparation in health education. Teachers qualify to teach either through certification in health education or by meeting minimal standards.[3]

7. Sufficient funds should be allocated to provide up-to-date and adequate instructional resources for teachers and students.

8. Each school district should appoint a qualified person to assume responsibility for the development, coordination, and implementation of the health education program. A qualified person could be any person with academic preparation and interest in health education. Ideally, the person should have a graduate degree in health education.

Curriculum

1. Instructional programs should include the curricular areas defined in the "Critical Health Problems and Comprehensive Health Education Act."

2. Curriculum development should focus on student achievement of desired behavioral objectives.

3. Relevant health concepts should be included at the most appropriate developmental levels of children and youth.

4. Health education should be responsive both to the needs of students and the demands of society. It should present current, accurate, scientific knowledge related to current health issues and problems.

5. Health instruction should focus on the positive aspects of optimal health. Health teaching should inculcate in youth the knowledge that they can exert significant influence and have some control over their future health. Desirable practices and attitudes formed early in life can prevent some serious complications in later life.

6. Students and citizens should be involved in curriculum development in order to assure the inclusion of instructional topics related to local health needs, interests, problems, and goals.

7. Teachers should be encouraged to explore innovative and creative instructional techniques which actively involve students in the achievement of established behavioral objectives. Such techniques as small discussion groups, independent study, team teaching, and values clarification activities based on teacher-student dialogue have been used successfully in many districts.

Curricular Emphasis

The "emphasis chart" which follows offers suggested grade level placement of the various curricular topics at Grades K-6. Local districts will be responsible for making final decisions concerning curricular emphasis based on the needs and interests of students. At all levels, incidental instruction is encouraged when appropriate.

At the middle, junior, and senior high school levels, the method of scheduling health education will determine, to a large extent, the manner in which curricular topics are incorporated into the program.

[1] *Federal Register,* Volume 40, Number 108, Part II. Department of Health, Education and Welfare, Office of the Secretary. "Nondiscrimination on the Basis of Sex," Education Programs and Activities Receiving or Benefiting from Federal Financial Assistance.

[2] U.S. Department of Health, Education, and Welfare. *HEW News,* Statement by Casper W. Weinberger, Secretary of Health, Education, and Welfare. June 3, 1975.

[3] Certification standards for teacher of health education are described in *Minimal Requirements for State Certification.* Illinois State Board of Education, August 1, 1980.

Minimal standards are described in *The Illinois Program for Evaluation, Supervision, and Recognition of Schools.* Illinois State Board of Education, Document Number 1.

If the block-of-time method of scheduling is employed, the placement of topics with the various grade level units will have to be determined at the local level. As an example, a program developed for two, nine-week blocks-of-time at Grades 10 and 12 might cover consumer health, dental health, drug use and abuse, smoking and disease, mental health, and nutrition during the Grade 10 experience. At grade 12, human ecology and health, human growth and development, personal health, public and environmental health, safety education, disaster survival, and prevention and control of disease could be taught.

When programs are organized on a block-of-time basis which includes shorter periods of time over three or four years, the curricular topics must be divided so that all will be included during the program.

In those situations where health education is offered as a one-semester course, all areas specified in the legislation must be included in the course.

Curriculum Emphasis for Curricular Areas (K-6)
(Areas Specified in the Legislation)

	Level I				Level II		
Major Curricular Topics*	K	1	2	3	4	5	6
Consumer Health Education[1]	X		X			X	
Dental Health Education	X	X	X			X	
Drug Use and Abuse, Alcohol	X	X	X			X	X
Human Ecology and Health		X		X		X	
Human Growth and Development	X			X		X	X
Mental Health and Illness	X	X		X			X
Nutrition	X		X		X		X
Personal Health	X	X	X			X	X
Prevention and Control of Disease	X	X				X	
Public and Environmental Health[2]			X		X		X
Safety Education and Disaster Survival[3]	L	L	L	L	L	L	L
Smoking and Disease				X	X	X	X

X — Indicates levels at which major emphasis should be placed.
L — Indicates legislation contained in *The School Code of Illinois*.

*Curricular topics specified in the legislation are arranged alphabetically.
[1]Section 27-12.1, *The School Code of Illinois*, specifies that consumer education be taught.
[2]Section 27-13.1, *The School Code of Illinois*, specifies that conservation be taught. Time requirements not specified.
[3]Section 27-23, *The School Code of Illinois*, requires that instruction shall be given in safety education in each Grade 1 through 8 equivalent to one class period each week, and in at least one of the years in grades 10 through 12.

Evaluation

The primary goal of evaluation is to assess behavioral change, health knowledge gained, and interests and attitudes developed as a result of instruction. Evaluation should be a continuous process.

Districts should plan for: (1) Preevaluation to determine student knowledge, attitudes, and practices relating to curriculum topics, (2) Self-evaluation to give the student an opportunity to assess his own performance, and (3) Post evaluation to determine the extent to which the instructional objectives have been attained.

Students, teachers, parents, and others should be involved in the evaluative process.

CRITICAL HEALTH PROBLEMS AND COMPREHENSIVE HEALTH EDUCATION ACT

P.A. 77-1405, eff. August 31, 1971

Sec.

AN ACT to create a critical health problems and comprehensive health education program in the schools of this State, and to define the powers and duties of the Office of the Superintendent of Public Instruction.

P.A. 77-1405.1, eff. August 31, 1971.

Be it enacted by the People of the State of Illinois, represented in the General Assembly.

861.1 **Short title.**

This Act shall be known and may be cited as the "Critical Health Problems and Comprehensive Health Education Act."

862.2 **Definition.**

The following terms shall have the following meanings respectively prescribed for them, except as the context otherwise requires:

(a) "Comprehensive Health Education Program:" a systematic and extensive educational program designed to provide a variety of learning experiences based upon scientific knowledge of the human organism as it functions within its environment which will favorably influence the knowledge, attitudes, values and practices of Illinois school youth; and which will aid them in making wise personal decisions in matters of health.

863.3 **Comprehensive health education program.**

The program established hereunder shall include, but not be limited to, the following major educational areas as a basis for curricula in all elementary and secondary schools in this State: human ecology and health, human growth and development, prevention and control of disease, public and environmental health, consumer health, safety education and disaster survival, mental health and illness, personal health habits, alcohol, drug use and abuse, tobacco, nutrition and dental health.

864.4 **Powers of the Superintendent of Public Instruction.**

In order to carry out the purposes of this Act, the Superintendent of Public Instruction is empowered to:

(a) Establish the minimum amount of instruction time to be devoted to comprehensive health education at all elementary and secondary grade levels.

(b) Establish guidelines to aid local school districts in developing comprehensive health education programs at all grade levels.

(c) Establish special in-service programs to provide professional preparation in the field of health education for teachers and administrators throughout the schools of the State.

(d) Develop cooperative health training programs between school districts and institutions of higher education whereby qualified health education personnel of such institutions will be available to guide the continuing professional preparation of teachers in health education.

(e) Encourage institutions of higher education to develop and extend curricula in health education for professional preparation in both inservice and pre-service programs.

[(f) Blank]

(g) Assist in the development of evaluative techniques which will insure that a comprehensive program in health education is being conducted throughout the State which meets the needs of Illinois youth.

(h) Make such additions to the staff of the Office of the Superintendent of Public Instruction to insure a sufficient number of health education personnel to effectuate the purposes of this Act.

No subdivision (f) appeared in the 1971 enactment of this section.

865.5 **Advisory committee.**

An advisory committee consisting of 11 members is hereby established as follows: the Chairman of the Illinois Commission on Children, the Director of the Illinois Department of Public Health, the Director of the Illinois Department of Mental Health, the Director of the Illinois Department of Children and Family Services, the Chairman of the Illinois Joint Committee on School Health and 6 members to be appointed by the Superintendent of Public Instruction to be chosen, insofar as is possible, from the following groups: colleges and universities, voluntary health agencies, medicine, dentistry, professional health associations, teachers, administrators, members of local boards of education, and lay citizens. The public members to be appointed by the Superintendent of Public Instruction shall, upon their appointment, serve until July 1, 1973, and, thereafter, new appointments of public members shall be made in like manner and such members shall serve for 4-year terms commencing on July 1, 1973, and until their successors are appointed and qualified. Vacancies in the terms of public members shall be filled in like manner as original appointments for the balance of the unexpired terms. The members of the advisory committee shall receive no compensation but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties. Such committee shall select a chairman and establish rules and procedures for its proceedings not inconsistent with the provisions of this Act. Such committee shall advise the Office of the Superintendent of Public Instruction on all matters relating to the implementation of the provisions of this Act. They shall assist in presenting advice and interpretation concerning a comprehensive health education program to the Illinois public, especially as related to critical health problems. They shall also assist in establishing a sound understanding and sympathetic relationship between such comprehensive heath education program and the public health, welfare and educational programs of other agencies in the community.

866.6 **Rules and Regulations.**

In carrying out the powers and duties of the Superintendent of Public Instruction and the advisory committee established by this Act, the Superintendent and such committee are authorized to promulgate rules and regulations in order to implement the provisions of this Act.

APPENDIX E

STATE GOALS FOR LEARNING

AND SAMPLE LEARNING OBJECTIVES

PHYSICAL DEVELOPMENT AND HEALTH

GRADES 3, 6, 8, 10, 12

Illinois State Board of Education
Department of School Improvement Services

PHYSICAL DEVELOPMENT AND HEALTH

Effective human functioning depends upon optimum physical development and health. Education for physical development and health provides students with the knowledge and attitudes to achieve healthful living throughout their lives and to acquire physical fitness, coordination and leisure skills.

State Goals for Learning

As a result of their schooling, students will be able to:

- understand the physical development, structure and functions of the human body;
- understand principles of nutrition, exercise, efficient management of emotional stress, positive self-concept development, drug use and abuse, and the prevention and treatment of illness;
- understand consumer health and safety, including environmental health;
- demonstrate basic skills and physical fitness necessary to participate in a variety of conditioning exercises or leisure activities such as sports and dance;
- plan a personal physical fitness and health program;
- perform a variety of complex motor activities;
- demonstrate a variety of basic life-saving activities.

PHYSICAL DEVELOPMENT AND HEALTH
GRADE 3

STATE GOAL FOR LEARNING 2

As a result of their schooling, students will be able to understand principles of nutrition, exercise, efficient management of emotional stress, positive self-concept development, drug use and abuse, and the prevention and treatment of illness.

SAMPLE LEARNING OBJECTIVES FOR GOAL 2

By the end of GRADE 3, students should be able to:

Physical Development

A1. Perform a variety of activities that require cooperation, direct physical assistance and partner relationships.

C1. Know activities which contribute to endurance, flexibility and strength.

M1. Know that winning, improving and enjoying are measures of success in physical activities.

Health

F1. Identify foods associated with the four basic food groups.

F2. Understand the importance of eating nutritious meals.

F3. Identify food combinations that provide a balanced diet.

K1. Know the factors that influence a positive self-esteem.

K2. Understand one's importance as an individual.

K3. Recognize that all people are unique.

K4. Know how to enhance self-concept.

O1. Identify common hazardous substances used in daily life.

O2. Understand why adults should keep drugs out of the reach of children.

O3. Understand problems created by the use of tobacco, alcohol, and other misused substances.

R1. Recognize the difference between illness and health.

R2. Know common signs of illness.

T1. Identify the differences between communicable and noncommunicable diseases.

T2. Understand ways to prevent the spread of communicable diseases.

T3. Know proper dental care.

PHYSICAL DEVELOPMENT AND HEALTH
GRADE 6

STATE GOAL FOR LEARNING 2

As a result of their schooling, students will be able to understand principles of nutrition, exercise, efficient management of emotional stress, positive self-concept development, drug use and abuse, and the prevention and treatment of illness.

SAMPLE LEARNING OBJECTIVES FOR GOAL 2

By the end of GRADE 6, students should be able to:

Physical Development

B1. Know the difference between static and dynamic stretching.

B2. Explain how stretching improves flexibility.

B3. Know the difference between muscular strength and muscular endurance.

C1. Demonstrate skills and activities which improve and maintain cardiorespiratory fitness, muscular strength, flexibility and body composition.

Health

F1. Recognize the basic nutrients for good health.

F2. Know how to choose a properly balanced meal.

F3. Know the major parts of the digestive system.

G1. Recognize how the quality of nutrition depends on eating habits.

G2. Understand how overeating foods with limited nutritional value is related to problems with growth and development.

G3. Know how the improper intake of certain vitamins may cause disease.

H1. Understand the relationship of physical, mental and emotional health to healthy body functions.

H2. Understand how exercise affects emotions.

K1. Know basic human needs and relate them to self-esteem.

K2. Understand the importance of having a positive self-concept.

K3. Understand the factors contributing to self-concept.

L1. Know several community agencies that deal with drug-related problems.

M1. Understand the difference between positive and negative social behaviors.

N1. Know various types of child abuse.

N2. Know community agencies that provide professional help to child-abuse victims.

O1. Know effects of tobacco and alcohol use on the body.

O2. Know various types of treatment of alcoholism.

O3. Understand how alcoholism and other chemical dependency can affect the family unit.

P1. Understand how drug abuse may affect the members of our society.

Q1. Recognize the effects of diet on an individual's well-being.

Q2. Understand factors that contribute to a positive lifestyle.

R1. Know symptoms of infection in the body.

R2. Recognize when a person should seek medical advice.

T1. Know several communicable and noncommunicable diseases.

T2. Identify factors that may cause the spread of disease.

T3. Know ways to prevent the spread of diseases.

PHYSICAL DEVELOPMENT AND HEALTH
GRADE 8

STATE GOAL FOR LEARNING 2

As a result of their schooling, students will be able to understand principles of nutrition, exercise, efficient management of emotional stress, positive self-concept development, drug use and abuse, and the prevention and treatment of illness.

SAMPLE LEARNING OBJECTIVES FOR GOAL 2

By the end of GRADE 8, students should be able to:

Physical Development

B1. Know the effects of overload, specificity, frequency, duration, intensity on aerobic and anaerobic training.

B2. Know how muscle energy is developed.

B3. Know the structures in the body which control flexibility.

B4. Know the changes in heart, lung, muscle, bone and connective tissue resulting from physical exercise.

C1. Know the contribution of appropriate skills and activities which promote cardiorespiratory fitness, muscular strength, flexibility and body composition.

Health

F1. Recognize the relationship between caloric intake and growth.

F2. Identify the function and source of each nutrient.

F3. Understand the function of each part of the digestive system.

F4. Understand the importance of a balanced diet to the adolescent's development.

G1. Understand common eating disorders among adolescents.

G2. Recognize potential outcomes of obesity.

G3. Understand the potential hazards of an excessive use of nutrients as they relate to disease.

H1. Understand the effects of being physically fit on mental and social health.

H2. Know the relationships among exercise, cardiovascular disease, and weight control.

I1. Identify sources of stress for the adolescent.

J1. Understand healthy and unhealthy responses to stress.

J2. Understand stress as it relates to suicide and physical and mental illness.

K1. Understand the basic human needs and their relationship to self-esteem.

K2. Understand how use of defense mechanisms relate to self-esteem.

K3. Recognize situations which require decisions that may affect well-being.

K4. Know and analyze alternative solutions to problems.

L1. Know community agencies specializing in the treatment of mental and emotional problems.

L2. Know services provided by substance-abuse agencies.

M1. Understand how gender-role stereotypes can influence behavior.

M2. Understand how physical characteristics play a role in the development of self-concept.

M3. Understand the relationships between self-concept and environmental influences.

N1. Know the causes of child abuse.

N2. Understand why the child is not responsible for child abuse.

N3. Know local sources of help for abused children.

O1. Recognize factors that influence decisions about the use of chemical substances.

O2. Identify alternatives to chemical use in meeting basic needs.

P1. Know the major classes of drugs and their physical effects on the body.

P2. Understand the social and emotional consequences of drug abuse.

P3. Understand the hazardous effects of social drugs.

P4. Recognize symptoms of physical and psychological addiction.

Q1. Identify factors that constitute a healthy lifestyle.

Q2. Know the effects of inadequate exercise on lifestyle.

R1. Know symptoms of an infection in the body.

R2. Recognize symptoms of disease as it relates to body systems.

R3. Know the warning signs of cancer.

R4. Know symptoms of diabetes.

S1. Identify local health agencies that treat disease.

S2. Recognize medical personnel and the types of service they provide.

S3. Recognize health agencies that deal primarily in the prevention of disease.

T1. Understand how pathogens cause and spread communicable diseases.

T2. Know the causes and the risk factors associated with major noncommunicable diseases.

T3. Recognize preventive measures that reduce the risk of developing communicable and noncommunicable diseases.

T4. Know the causes of dental disease and describe preventive health practices.

U1. Know diseases that have had major effects on mankind.

U2. Identify the major causes of death ten years ago versus those of today.

V1. Know characteristics of mental illness.

V2. Know factors that influence mental illness.

PHYSICAL DEVELOPMENT AND HEALTH
GRADE 10

STATE GOAL FOR LEARNING 2

As a result of their schooling, students will be able to understand principles of nutrition, exercise, efficient management of emotional stress, positive self-concept development, drug use and abuse, and the prevention and treatment of illness.

SAMPLE LEARNING OBJECTIVES FOR GOAL 2

By the end of GRADE 10, students should be able to:

Physical Development

D1. Understand principles of a training program for development and maintenance of cardiorespiratory endurance, muscular strength and endurance and flexibility.

D2. Know the comparative energy expenditure of selected physical activities.

D3. Identify a training program for improving body composition.

E1. Understand the competitive process and its effects on emotions.

E2. Understand the influences of physical activity on stress control.

E3. Contrast aggressive behavior with aggressiveness.

E4. Identify coping mechanisms for controlling stress.

E5. Understand the influences of stress on performance of selected sports and activities.

Health

F1. Understand nutritional concepts used in selecting balanced meals.

F2. Understand the relationships between caloric intake and growth.

F3. Recognize the changing nutritional needs from adolescence through adulthood.

G1. Understand the relationships between diet and cardiovascular disease.

H1. Know the importance of warm-up, cool down, and target heart rate.

H2. Understand the difference between health-related and skill-related fitness.

I1. Know the types of stress.

J1. Understand the relationships between adolescent stress and suicide.

J2. Know possible causes and symptoms of adolescent suicide.

J3. Know constructive ways of coping with stress.

K1. Recognize the relationships between self-esteem and personality development.

K2. Understand behaviors associated with defense mechanisms.

K3. Know characteristics of a mentally healthy person.

K4. Know basic steps in problem solving related to health issues.

K5. Know how to seek information relevant to making decisions regarding health practices.

K6. Understand how individual responsibility relates to decision making.

L1. Understand the function of community agencies which specialize in the treatment of mental and emotional problems.

L2. Know the steps one must take to enter a local drug treatment program.

M1. Understand how self-concept influences interpersonal relationships.

M2. Know parenting skills that contribute to positive self-concepts in children.

M3. Understand the importance of verbal and nonverbal communication.

N1. Distinguish among the types of child abuse.

N2. Evaluate factors that are associated with child abuse.

N3. Know characteristics of an abused child and of an abusive adult.

N4. Identify community agencies that can provide counseling for child abuse.

O1. Know common reasons people give for choosing to use chemical substances.

O2. Understand how the decision-making process relative to substance use can be influenced by peers.

O3. Know positive alternatives to substance use in meeting human needs.

P1. Know the basic effects of different chemical substances on the body.

P2. Know the effects of smoking and chewing tobacco on the body and know diseases related to tobacco use.

P3. Understand the effects of alcohol on mental functioning as blood alcohol levels rise.

P4. Know symptoms of alcoholism.

P5. Recognize behaviors commonly seen in chemically dependent people.

P6. Know physiological dangers of methods of illicit drug administration.

Q1. Know the relationships between a stressful lifestyle and disease.

Q2. Know lifestyles that contribute to the spread of communicable disease.

Q3. Recognize how choices in male and female relationships can affect future well-being.

Q4. Relate the importance of an adequate amount of sleep to a healthy lifestyle.

R1. Know symptoms of disease associated with the body systems.

S1. Identify local hospitals and clinics where treatment for disease can be obtained.

T1. Know the stages of a communicable disease.

T2. Know pathogens causing communicable disease and explain how they are spread.

T3. Know ways to reduce the spread of communicable disease.

T4. Know the body's lines of defense against disease.

T5. Identify the vaccines that adolescents and adults should have been given.

T6. Recognize possible complications of selected communicable diseases.

T7. Know reproductive diseases, their symptoms, and methods of prevention.

T8. Know risk factors for cardiovascular disease.

T9. Recognize methods of detecting cancer.

U1. Know the effects of today's communicable disease epidemics on society.

U2. Understand the effects of major epidemics throughout history.

V1. Know major characteristics of mental health.

V2. Analyze factors contributing to mental illness.

PHYSICAL DEVELOPMENT AND HEALTH
GRADE 12

STATE GOAL FOR LEARNING 2

As a result of their schooling, students will be able to understand principles of nutrition, exercise, efficient management of emotional stress, positive self-concept development, drug use and abuse, and the prevention and treatment of illness.

SAMPLE LEARNING OBJECTIVES FOR GOAL 2

By the end of GRADE 12, students should be able to:

Physical Development

A1. Understand how cooperation and emotional control affect physical performance.

B1. Understand how basic principles of exercise physiology are related to cardiorespiratory efficiency, flexibility and muscular strength and endurance.

C1. Know selected skills and activities which make a contribution to physical fitness.

D1. Understand the principles of exercise physiology and training in relationship to the development of personal physical fitness.

E1. Know the relationships of emotional control and stress to physical performance.

E2. Compare objective and subjective competitive situations.

E3. Perform techniques to relax and to control excitement related to participation in competitive sports.

Health

F1. Understand proper diet and changing balances in special conditions.

F2. Know ways to gain and lose weight safely.

G1. Understand the health problems of development and disease resulting from faulty nutrition.

H1. Understand the effects of regular exercise on emotional, physiological and social well-being.

I1. Distinguish between stress and distress.

J1. Understand healthy and unhealthy responses to stress and their relationships to physical and mental illness.

K1. Recognize behaviors which promote self-esteem without being destructive to self or others.

K2. Understand behaviors which positively affect the self-concept of others.

L1. Understand how several community agencies provide personal and family assistance for mental and emotional problems and chemical use and abuse.

M1. Understand how positive self-concept is developed and how it relates to physical and emotional variations and interpersonal relationships.

N1. Understand the causes of child abuse and the methods of prevention.

O1. Know the motives for use and nonuse of chemical substances and recognize alternatives.

P1. Understand how drug-related behaviors affect physical, mental, and social well-being.

P2. Understand how the misuse of chemicals can produce immediate and situational or slow-developing chronic problems.

Q1. Know how various lifestyles affect well-being.

R1. Recognize signs and symptoms indicating the need for professional medical attention.

S1. Know several health agencies and the type of medical personnel providing services for prevention and treatment of disease.

S2. Analyze valid criteria in the selection of health information, products, and services.

T1. Recognize the causes and methods of preventing common communicable and noncommunicable diseases, including dental disease.

U1. Understand the effects of certain diseases on society.

V1. Recognize the characteristics of mental health and mental illness.