

# Tailoring Health Programming to Clergy

*Findings from a Study of United Methodist Clergy in North Carolina*

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## Abstract

Research indicating high rates of chronic disease among some clergy groups highlights the need for health programming for clergy. Like any group united by similar beliefs and norms, clergy may find culturally tailored health programming more accessible and effective. There is an absence of research on what aspects clergy find important for clergy health programs. We conducted 11 focus groups with United Methodist Church pastors and district superintendents. Participants answered open-ended questions about clergy health program desires and ranked program priorities from a list of 13 possible programs. Pastors prioritized health club memberships, retreats, personal trainers, mental health counseling, and spiritual direction. District superintendents prioritized for pastors: physical exams, peer support groups, health coaching, retreats, health club memberships, and mental health counseling. District superintendents prioritized for themselves: physical exams, personal trainers, health coaching, retreats, and nutritionists. Additionally, through qualitative analysis, nine themes emerged concerning health and health programs: (1) clergy defined health holistically, and they expressed a desire for (2) schedule flexibility, (3) accessibility in rural areas, (4) low cost programs, (5) institutional support, (6) education on physical health, and (7) the opportunity to work on their health in connection with others. They also expressed concern about (8) mental health stigma and spoke about (9) the tension between prioritizing healthy behaviors and fulfilling vocational responsibilities. The design of future clergy health programming should consider these themes and the priorities clergy identified for health programming.

*Keywords:* Clergy, health programming, intervention, qualitative



## Introduction

Preventive interventionists posit that culture and environment influence health-related behavior, and that prevention interventions will be more effective if tailored to the cultures and environments of groups of people. Clergy, and in the case of this study, United Methodist clergy, are one such group. Their culture includes a devotion to Christianity and the belief that they have been divinely called to ministry. Their environments include their immediate family, the church or churches they serve, the larger United Methodist connectional ministry, and the community in which they live (Proeschold-Bell et al., 2009). The clergy work day is unique in a number of ways. Clergy engage in prayer, worship, and preaching; perform weddings and funerals; and visit sick congregants. Additionally, clergy conduct extensive administrative activities (Carroll, 2006), and also serve as mentors and spokespersons (Kuhne & Donaldson, 1995). Frequently, clergy attend to crises such as deaths, accidents, and mental health conditions, requiring them to be “on call.” The overall workday picture for clergy is busy, fragmented, and varied, with little predictability (Kuhne & Donaldson, 1995). Further, the highly visible role occupied by clergy grants them little privacy (Rowatt, 2001), although it simultaneously allows them to advance community goals. Given the unique set of responsibilities and beliefs held by clergy, tailoring health interventions to their beliefs and vocation is likely to be helpful.

Recent research has revealed higher rates of obesity, hypertension, diabetes, asthma, and arthritis for United Methodist clergy in North Carolina (NC), when compared to the rates of their non-clergy peers (Proeschold-Bell & LeGrand, 2010). Clergy obesity rates (41% compared to 30%) were particularly high, and some health conditions were alarmingly high among certain gender and age groups. For example, 18.3% of clergy females age 55-64 reported having ever been diagnosed with diabetes, compared to only 10.8% of non-clergy females the same age. High rates of clergy obesity have also been found among clergy in the Evangelical Lutheran Church in America (Halaas, 2002). Interestingly, clergy may not be fully aware of the toll that physical health problems exact on them, based on self-reports of better physical health functioning among clergy who simultaneously report high disease burdens (Proeschold-Bell & LeGrand, 2010). Thus, there is growing evidence not only that clergy need health interventions, but also that it may be difficult to convince them to participate in such interventions.

Our particular interest in health programs for clergy arose in 2007, when we received funding to design a health-promoting program for United Methodist clergy serving in the two annual conferences in NC. Because our population of interest was United Methodist Church (UMC) clergy, we learned from UMC officials about the UMC institution and how it may or may not be conducive for clergy health programming. The UMC is divided geographically into conferences. Each conference is divided further into districts, and each district is led by a district superintendent (DS). Between the two UMC conferences in NC, there are 27 DSs. DSs report directly to the bishop, with each conference being led by a single bishop. DSs are part of the decision-making cabinet, play a large role in determining new church assignments for pastors, and supervise pastors. Most DSs have served as pastors during their career, and often in the same conference where they now serve as DS, making some pastors leery of sharing their struggles with peer pastors who may someday become a DS.

The UMC operates under an itinerant system. The bishop, in consultation with a cabinet, appoints a pastor or pastors to each congregation, and has the power to move a pastor to a different church in a different town. Within this system, the bishop and cabinet exercise responsibility for the impact of work assignments on a pastor's family and social well-being. Itinerancy also requires the UMC to think carefully about the fit between pastor and congregation, an important issue for clergy health and effectiveness. The relationship between DSs and pastors, as well as between DSs and congregations, may also provide groundwork to improve pastor health and encourage pastor participation in clergy health programming.

In searching the literature, we were unable to find any studies reporting on the kind of health programming clergy desire. We sought to understand what programs pastors would and would not consider using. Because our population of interest is United Methodist clergy, we also sought to understand what programs UMC DSs would prioritize for themselves and for their pastor supervisees. Because health behavior is difficult to change, and because clergy are a unique population, data on what programs clergy value and find acceptable are critical to successful program design.

## Methods

### Data Collection

We conducted a total of eight pastor focus groups (n=59) and three DS focus groups (n=29) between January and May 2008. Recruitment for the pastor focus groups was divided evenly between the NC and Western NC UMC conferences and urban and rural areas. We drew pastor names from published conference rosters and invited a convenience sample of pastors who were diverse in age, gender, and race. Recruitment for the DS focus groups occurred during a day-long meeting in which DSs convened for other purposes, but allowed us to conduct focus groups. Pastor focus groups were separate from DS focus groups. Focus groups lasted 60-90 minutes and were audiotaped and transcribed.

Questions in the focus group guide ranged from unstructured to semi-structured. They focused on how participants conceptualize health; barriers to and facilitators of health promotion; and health programming desired by the participants. Participants were asked an open-ended question about the kind of health programming they wanted. Then they were given a list of 13 kinds of health services and asked to rank their top five choices and to indicate two services they would not use. DSs were asked to do this twice; once for themselves and once for the pastors they supervise.

### Data Analysis

We compiled a list of every program suggestion that arose during the 11 focus groups. We also noted whether the program was suggested more than once. In addition, to identify themes, we developed coding categories from the data rather than from pre-existing hypotheses (Charmaz, 2001). To promote confirmability (Miles & Huberman, 1994), two members of the team coded each transcript and discrepancies were resolved through discussion.

In terms of the ranking data, we assigned each item that ranked as first priority a score of 5, second priority a 4, and so forth, through the top five choices. We summed the scores for each item and then divided by the total number of participants to generate a mean score for that item. Higher mean scores indicate greater participant priority. We also generated a score that takes into account the number of pastors who said they would not utilize a program (they could indicate two such programs) versus the number of pastors who prioritized that program (they could indicate five priority programs). We created this score by dividing the number of pastors who prioritized a program by the sum of (1) the number of pastors who would not utilize the program and (2) the number who prioritized it. This score reflects a combination of strong negative and positive feelings toward a specific program. Lower scores indicate split opinions on programs. The study was approved by the Duke University Institutional Review Board.

## Results

In reporting the results, we use the terms “pastors” and “DSs” rather than “participants” to distinguish between the two kinds of clergy participants. When both pastors and DSs gave the same response, we use the more generic term “clergy.”

### **Results of Pastors Ranking 13 Suggested Programs**

Table 1 reports the rankings that pastors and DSs gave for each of the 13 specific program ideas. Pastors were most interested in paid health club memberships; this program option was the top priority for 11 pastors and the second priority for 8 pastors. In contrast with pastors, DSs ranked paid health club memberships sixth when ranking priorities for themselves. For pastors, there was close to a three-way tie in desiring retreats, personal exercise trainers, and mental health counseling. As indicated in the pastor proportion score, pastors had split opinions regarding mental health counseling, with 6 pastors indicating they would not consider it, and 26 pastors ranking it within their top five priority programs. The fifth most highly ranked program by pastors was spiritual direction. Programs of low interest to pastors were continuing education programs, financial advising, and mentoring.

Like pastors, DSs were not very interested in continuing education programs, financial advising, or mentoring. DSs were personally most interested in physical exams, followed by personal trainers, health coaching, and retreats. DSs ranked spiritual direction seventh, whereas pastors ranked it fifth. The fifth most highly ranked program by DSs was meeting with a nutritionist or dietician. Pastors rated paid health club memberships and mental health counseling more highly than DSs. In contrast, DSs rated physical exams more highly than pastors.

Overall, DS priorities for themselves versus their priorities for the pastors they supervise were similar. However, DSs were more interested in personal trainers for themselves than for pastors. DSs were also more interested in mental health counseling and peer group support for their pastor supervisees than for themselves.

### **Responses to the Open-Ended Question on Desired Health Programs**

We first asked the open-ended question of what kind of health programming clergy wanted. Clergy named a total of 47 distinct programming ideas. Some of the more frequently mentioned ideas were: health coaching; health club memberships that stay with pastors when they move; financial incentives for completing health behavior changes; marriage enrichment retreats; Sabbath-keeping; exercise equipment purchases; mental health counseling; a list of, and access to, retreat centers that offer spiritual renewal; and financial seminars. Clergy considered combining health goal-setting with a specific behavioral plan to be desirable.

In addition to specific program ideas, nine themes related to programming emerged.

**Holistic health.** In every focus group, clergy defined health holistically.

*I'd say a state of holistic synergy where mind, body, soul and spirit are operating at such a level that the individual is able to participate in life successfully.*

They linked this holistic definition to their desire for health programming that encompasses the whole person, including mental and spiritual aspects.

**Schedule flexibility.** Clergy reported that their unpredictable schedules pose challenges for self-care routines.

*It's almost [part of] clergy life not to develop a rhythm because life is made up of interruptions and change. That's what it's about. It's about being interrupted. It's about being on call. It's about not being able to plan and schedule because something else is going to come up. So, getting the rhythms of health care and self-care are very difficult in that context.*

Clergy indicated that they need health programming that is flexible enough to occur around unpredictable schedules. They also indicated that persons suggesting health behaviors for clergy need to recognize that interruptions are typical for clergy.

**Accessibility in rural areas.** Many pastors expressed geographic barriers to caring for their health. For example:

*I had [multiple heart] bypasses two years ago and they wanted me to get into [a heart health program at a hospital]. It's 65 miles away, one-way trip. I mean, I couldn't do it. I can't drive 65 miles there and 65 miles back plus whatever it costs ...that's geographic.*

Pastors indicated that they need health programming that can occur in rural as well as urban areas and is not contingent upon local resources.

**Low cost programs.** Many clergy indicated that they experience financial strain, resulting in negative effects on their health. They linked income to the foods they buy; they also

linked it to gym memberships (“I had a membership to the Y and then my financial situation became really strained and ... that was the thing to go.”), and to rest and rejuvenation.

*Often [those] who need the rest the most can't afford - not job-wise but just financially - to go to the retreat center or someplace even if it's just to sleep, which can be a very healing, restoring thing.*

Clergy urged us to keep program participation costs low for clergy.

**Institutional support.** Pastors indicated a desire for UMC institutional support for their health. For example, pastors suggested that DSs could ask churches to take care of their pastors by recognizing their need for personal time. One way to do this, pastors suggested, would be for DSs to educate Pastor Parish Relations Committees (a UMC's local equivalent of a personnel committee) to develop and instill appropriate expectations among congregants for their pastors.

Pastors suggested that the UMC mandate participation in health programs but allow health programming to occur during the work day.

*I was kind of teasing with [District Superintendent] - if he wants us to be healthy and mandate these things, get a discount membership for all of us at a gym somewhere. But then the problem is, when do I have time to do this? I already get up at 5:30 every morning and I don't go to bed until midnight.*

They suggested further that programming be made available for clergy spouses at retreats, and that clergy spouses take spiritual retreats together.

Clergy also discussed the impact that “dysfunctional” churches have on clergy and indicated the need for programs or UMC institutional changes that address these churches. Clergy considered dysfunctional churches to be those that resist even small changes proposed by pastors; those with family feuds; and those that directly antagonize pastors, for example, by heckling during preaching. They also called such churches “life-threatening,” to the point of blunting stating, “they will kill you.”

*For me that taps into a real critical piece in that healthy congregations will foster healthy clergy and if you happen to be one of those clergy who are appointed to an unhealthy congregation and a dysfunctional situation, it's very, very difficult not only to just practice good health habits, but also in dealing with the stress related to the patterns of behavior in a dysfunctional congregation. And in my experience that's been the most challenging obstacle to good health.*

Pastors suggested that DSs could give pastors who are moving to a new church, information on the dynamics of the church to help prepare them. They also asked for more support while serving a dysfunctional church.

**Education on physical health.** Clergy expressed a lack of knowledge regarding physical health issues and a desire for someone with expertise to lead them in this regard.

*Give us some guidance because we are not experts for the most part in the health area. We know what we need to do as far as the spirituality and even in some cases as for the emotional part, but most of us are not experts on, "Alright, this is how you need to get your blood pressure down without taking three pills a day."*

I'm always interested in nutrition because my biggest weakness is fast food and donuts and things like that. And they're always changing what's good for you and what isn't good for you, it seems like, all the time. So, up-to-date nutrition information that you could do through district meetings or things like that.

Thus, programming that includes physical health knowledge was regarded as important. However, it is interesting to note that in this quotation, the pastor already knows to stay away from fast food and donuts. Although he is overtly asking for information on health, what he may really desire is information on behavioral change techniques.

**Health in connection with others.** Clergy expressed interest in working on their health with others, rather than on their own. The term "accountability" arose often, conveying that the clergy perceived that they would be more likely to engage in health behaviors if they felt another person was noticing and cared.

*I miss the guy in Greenville I used to walk and run with ... and we met once a week for lunch. He would look at my lunch tray with a certain point of view in mind. So, it really was done out of love.*

Another participant gave an example of encouragement from a DS to take a regular Sabbath day.

*I'd get a note. She said, "Okay, what day is your Sabbath," and I said, "I don't have one." She says, "You do now. It's Friday." And she would write me on Friday, "You're taking Sabbath." Sometimes I'd answer right back and she'd say, "What are you doing on your computer?" And I'd say, "Oh, nothing." [laughter].*

Clergy expressed a desire to gain support through coaching. Some clergy were interested in working with personal trainers, and other clergy suggested that health coaches are a resource that could tie several aspects of health care together.

*So you can go to that [health coach] and say, "Look this is my goal. This is my interest. What are the options?" Someone that you can go to and then keep checking in. Someone who knows how to put them all together.*

**Mental health stigma.** Pastors reported reluctance to seek mental health care or to discuss

mental health issues with their peers and DSs due to the stigma associated with mental illness. One DS said:

*I think there's a number of clergy that are suffering from depression and other mental illness and I think it's silent. You're not allowed to talk about it. ... There's not a way to catch it at the beginning and all of a sudden it becomes a much more serious problem .... Because in society in general you don't speak about mental illness but especially when it may affect your next appointment, you're going to keep all of that to yourself.*

In one focus group, the concept of “preventive counseling” emerged as a possible solution to mental health stigma:

*I liked [focus group participant's] idea about having counseling as a preventative -- not necessarily as help once you're sick but as to prevent. ... Before I went to my previous pastoral appointment, because of some of the dynamics that I knew I was going to face, it was recommended to me by a district superintendent that I might want to go into some preventative counseling just so as things arose I knew how to handle them. ... And I found that to be helpful.*

Overall, pastors indicated interest in counseling and mental health supports, but only if participation would not be stigmatizing within the connectional, itinerant system.

**Tension between prioritizing healthy behaviors and fulfilling vocational responsibility.** Pastors discussed a deep tension between their many church responsibilities, for which they are called by God, and the time needed to care for their own health.

*I have to have a discussion with myself ... every time I take some time for myself. ... “Well, there's all these things I need to do at church. Okay. Then I need to do this to take care of myself. Now how can I justify spending some time on myself when all of these other people have needs?”*

This struggle was particularly evident in statements about maintaining one's spiritual well-being. Pastors were split in their feelings. Some felt like they had their spiritual well-being under control, but lacked time for other health behaviors or a well-rounded life.

*And the other thing is – I don't want to knock spirituality too much – but some of us are doing pretty good spiritually. I don't need help in spirituality and my wife doesn't need help in spirituality. God and the church have almost 100% of our time. We need something for us. ... If you're looking at making my family healthier, help us be well-rounded people and not just church people.*

Others felt like they lacked the time to maintain spiritual well-being.

*We think sometimes, "Okay, well, I'm right there with God because I'm preaching and I'm reading the Bible and I'm doing that stuff all the time." And I know from my own experience that whenever I'm thinking that, it generally means that I am about five or six steps away from where I need to be. Because it's so easy for us to get caught up in the busyness of being the pastor that we don't take time to feed ourselves spiritually.*

Pastors suggested that they need permission--from the UMC but also from themselves--to take the time to attend to their health.

*I have tried to put time in there, but I'm very unsuccessful with that because I keep saying, "But I've got this meeting. That's really something I've got to do because if I don't do that, this won't happen." And so it's a matter ...of giving ourselves permission to take care of ourselves, I think. And I am lousy at that.*

Clergy suggested instituting structures that enable healthy behaviors. One such structure is preaching on only the first four Sundays of the month, and not working on the fifth Sunday.

*Since the beginning of my ministry I've taken fifth Sundays off for a retreat, renewal, rest, rejuvenation. And that's been a great practice because then I know I have that time to focus on my spiritual life and carving it out for that and not thinking, "Oh, well, I'll get around to that."*

## Discussion

This study highlights the need to place prevention intervention programming for clergy in the context of their beliefs, congregations, and institutional structures. Further, in this study, it proved important to go beyond quantitative rankings to hear from clergy in their own words. Had we stopped with quantitative rankings for program ideas we would have believed that pastors primarily desire paid health club memberships, retreats, personal exercise trainers, mental health counseling, and spiritual direction. Instead, based on qualitative analysis, we are better able to understand that it is not so much these programs that pastors want, but the time and permission to engage in exercise, solitude, and the things that they already know enhance their well-being.

The programming ideas identified by clergy are notably individual in nature. This is consistent with the coping literature on clergy that indicates a preference for personal-level coping rather than interpersonal- or institutional-level coping (McMinn et al., 2005). However, a few institutional ideas emerged. We found that pastors would also like to see the barrier of stigma removed from their participation in mental health counseling. Despite indicating that a high degree of stigma is attached to counseling, 26 pastors ranked mental health counseling in their top five programs. On the other hand, six pastors indicated that they would definitely not consider mental health counseling. Future study is needed to understand how universal perceived stigma for mental health care is among clergy and the

means to address such stigma. Institutional support for counseling may be helpful, and indeed, in this study, DSs ranked counseling for their pastors highly (tied for fifth priority).

Pastors also indicated that they face financial barriers to caring for their health. The median salary in 2008 for the two NC UMC conferences was \$40,010. Eighty-seven percent of pastors in these conferences are married, which often brings spousal income but also children to support. With such financial strain, it makes sense that pastors found programs like paid health club memberships desirable.

However, even if financial and stigma barriers are removed, the barrier formed by the tension between prioritizing healthy behaviors and fulfilling vocational responsibility remain. We were unable to find any intervention studies that attempted to address this barrier among clergy. We tentatively hypothesize that three things are needed to address this ultimate barrier and improve clergy health: (1) institutional support for pastors to attend to their holistic health, even if doing so means neglect or delegation of some responsibilities; (2) skills to manage stress and competing responsibilities; and (3) reinvigoration of a theological basis for holistic health. For United Methodist clergy, it may not be difficult to provide them with this theological basis. In this study, clergy defined health as mind, body, and spirit, which is not surprising given the holistic nature of the United Methodist tradition, rooted in John Wesley's theology. John Wesley had strong views on health and the connections between faith, health, and community, and on the way the body and soul influence one another and are meant to work in harmony (Maddox, 2007).

It may be possible to draw UMC pastors back to their Wesleyan roots to give them the spiritual grounding to prioritize healthy behaviors. Also, it should be noted that one's theology of ministry may affect how much a clergyperson experiences the tension between ministry and health. Clergy who subscribe to a high theology of ministry, in which the pastor is very important for ministry and clergy experience high internal pressure to prioritize their call, likely experience more tension between call and health. In contrast, clergy who subscribe to a high baptismal theology, in which baptism is one's first vow and all baptized persons have a high calling, likely experience less tension in caring for their health while fulfilling their vocational responsibilities (Stewart-Sicking, Pereira, & Mouzon, 2010).

We find it interesting that DSs ranked physical exams with follow-up first in priority for themselves, whereas pastors ranked this service ninth. Most DSs served as pastors, so what accounts for this shift in perspective? Perhaps it is the result of DSs' sense of increased stress that comes with the demands of their expanded responsibilities. Perhaps it is the result of the critical distance they gain as supervisors of unhealthy pastors. It is noteworthy in this respect that they ranked physicals first not only for themselves, but also for the pastors they supervise.

Neither pastors nor DSs were interested in mentoring, education, or financial counseling. It may be that the clergy in our study already have substantial access to mentoring and education, for example, though funds from the Lilly Foundation for pastor mentoring in North Carolina, which would explain why they gave other program ideas higher rankings. In terms of financial counseling, when we asked clergy

an open-ended question about their desired programming, they listed financial counseling. However, when they were asked to rank programs, clergy ranked many other kinds of programs higher than financial counseling. We were surprised by this in light of the financial strain they discussed in the focus groups. Perhaps clergy are more interested in salary increases than financial counseling.

DSs ranked some programs – physical exams, health coaching, and retreats – highly for both themselves and their pastor supervisees. For themselves, they also ranked in their top five personal trainers and nutritionists, whereas for pastors they prioritized peer support groups and health club memberships. These findings suggest that DSs may be concerned about the stress (Lee & Iverson-Gilbert, 2003; Lewis, Turton, & Francis, 2007; Morris & Blanton, 1994) and isolation (Hall, 1997; Warner & Carter, 1984) pastors experience, and thus prioritize exercise and peer support for pastors. In their prioritization of personal trainers and nutritionists for themselves, DSs appear to be concerned about their physical health and possibly their weight, perhaps because of a critical distance they gain as supervisors that make them more aware of these issues than when they served as pastors. It appears that from an institutional perspective, DSs would prioritize regular physical exams and would be supportive of a range of physical and mental health programming. They also ranked retreats highly for pastors. In our qualitative data, most pastors assumed that retreats offered both spiritual and mental health renewal. In fact, retreats may be a spiritualization of mental health support.

This study is limited by its use of a convenience sample. In particular, caution must be used in generalizing the findings beyond NC United Methodist clergy or to clergy of other denominations and faiths. For example, because of the Wesleyan emphasis on holistic health, we do not know the extent to which clergy of other denominations would value holistic programming. However, the richness of focus group data allows for deeper understanding. In addition, our sample size was large for qualitative research.

## Conclusion

United Methodist pastors in NC are interested in health programming that attends to holistic health, includes information on physical health, and is conducted with the support of other people to help hold them accountable. On a practical level, they desire programs that can be woven into their unpredictable schedules, can occur in rural areas, and are low cost. Stigma around mental health services may prevent pastors from using them. Pastors are very interested in receiving denominational institutional level support in attending to their health, and such support may be critically important to address pastors' struggle to devote precious time to their own health while responding to the call to minister to many. This enhanced understanding of clergy programming desires, needs, and motivators is a first step in effective program design for clergy.

## Author's Note

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**Table 1: Pastor and District Superintendent Rankings of Thirteen Clergy Health Program Ideas**

Program idea	Pastor mean score (n=58)	Pastor ranking	Number of pastors ranking program in top 5	Number of pastors saying they would not consider program	Pastor proportion: # priority/# would not consider + # priority	DS mean score for DSs (n=29)	DS ranking for DSs	Number of DSs ranking program in top 5 for DSs	DS mean score for pastors (n=29)	Number of DSs ranking program in top 5 for pastors	DS ranking for pastors
<i>Paid health club membership</i>	1.95	1	31	3	.91	1.14	6	12	1.17	11	5
<i>Retreats, alone or with spouse</i>	1.40	2	25	1	.96	1.76	4	17	1.28	12	4
<i>Personal trainer</i>	1.38	3	24	1	.96	2.14	2	16	.45	5	12
<i>Counseling/mental health</i>	1.34	4	26	6	.81	0.79	9	8	1.17	14	5
<i>Spiritual direction</i>	1.26	5	23	3	.88	1.07	7	9	.83	9	8
<i>Dietician/nutritionist</i>	1.09	6	22	4	.85	1.41	5	13	1.14	12	7
<i>Health coaching</i>	0.77	7	17	9	.65	1.83	3	18	1.62	15	3
<i>Peer support groups</i>	0.71	8	19	7	.73	0.90	8	10	2.10	16	2
<i>Physical exam with follow-up</i>	0.59	9	13	8	.62	2.28	1	18	2.72	19	1
<i>Incentives for participation</i>	0.53	10	10	7	.59	0.69	10	9	.45	5	12

<i>Continuing education programs</i>	0.47	11	10	6	.63	0.41	12	6	.52	7	11
<i>Financial advising</i>	0.45	12	10	8	.56	0.45	11	6	.83	13	8
<i>Mentoring</i>	0.38	13	7	10	.96	0.21	13	3	.72	7	10

*Note: Higher mean scores indicate higher prioritization of a program. Lower proportion scores indicate split opinions on programs, such that some participants prioritized the program and others said they would not consider the program. Note: DS=District Superintendent*

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