California State University, Northridge

THE ROLE OF THE CONSULTANT IN THE DEVELOPMENT, IMPLEMENTATION AND EVALUATION OF A SCHOOL AND COMMUNITY HEALTH PROJECT, WITHIN A VOLUNTARY HEALTH AGENCY

A graduate project submitted for partial fulfillment of the requirements for his degree of Masters in Public Health

by

Barry R. Humphrey

June 1974
The project of Barry R. Humphrey is approved:

Committee Chairman

California State University, Northridge
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ABSTRACT

THE ROLE OF THE CONSULTANT IN THE DEVELOPMENT, IMPLEMENTATION AND EVALUATION OF A SCHOOL AND COMMUNITY HEALTH PROJECT, WITHIN A VOLUNTARY HEALTH AGENCY

by

Barry R. Humphrey

Master of Public Health in Community Health

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Health education delivery systems in major metropolitan areas have become very complex. As health agencies, both voluntary and public, expand and the number of health educators on staff grows, there evolves a need for systematic development of a management level for continuity of services. This need, for continuity and coordination, is usually filled through the hiring of a health education consultant, either internally or externally. In general, the area of consultation services has been limited to areas dealing with major businesses and industries, and educational systems in other countries. The field of health education consultation has not been explored for similarities and differences between health education
consultation and the type found in business and industry. One of these major differences is that business usually consults on topics dealing with the profit-making systems and/or process development. Health education consultation deals primarily with changing health-related behavior.

In this paper, the author reviews agencies that presently hire health education consultants. Most of these agencies are based in California, and the focus of this paper is on those with major offices in the Los Angeles area. The structure of the American Cancer Society (ACS) is explained and levels of consultation are described. This Agency's structure (ACS) is used as a model for further discussion of other agencies and structures. The author of this paper is an employee of the ACS with four years tenure, and has worked as a health education consultant for the past two years.

This paper further expands the field of consultation by reviewing the literature relevant to the other types of consultation, and ties these consultative characteristics to those of the health education consultant.

The types of consultation discussed range from the internal systems consultant for large industrial organizations to the consultation used by our education consultants in other countries. Process consultation is discussed as well as professionalism in the consultation tact. One author even suggests a Code of Ethics for the "Professional consultant."
The second half of this text deals with a case study. This case study is developed from inception through the eventual end, and further through recognition and replication of other projects similar to the case study.

The case study deals with a one-week special project on a high school campus in the area of cancer education for youth. The project subjected two-thirds of the student body to four different types of health education programs. A representative sample of that group was tested for two factors. The first factor was an increase in cancer knowledge, and the second was the acceptance level of the youth to the four different types of health education approaches. This project involved community people, on-campus health education staff, high school students, students from the local State University, the local ACS staff, and the area consultant for public education. The author of this text was the consultant to the entire project. He relates both the current literature and his personal observations to the consultative process, and develops through the case study an appropriate consultative design for a Health Education Consultant.
CHAPTER 1

INTRODUCTION

The main topic of this paper will be to explore the role of the health education consultant by reviewing the literature on consultation and following a consultant (the author) through a case study. Health educators are employed primarily in four major fields: County Health Departments, Federal and State Agencies, and colleges and universities. County Health Departments lead the field in the number of health educators employed. Those employed by State and Federal Agencies run a close second; below these two groups the number of health education positions drop rapidly. Ranking third in the number of health education staff are the national voluntary health agencies such as the American Cancer Society, the Lung Association, and the American Heart Association. Last, but probably most important, are the health educators hired by colleges and universities through the country. These health educators have chosen to share their skills and knowledge to teach others to become leaders in the field of health education.¹

¹Results of a survey of the three major health agencies in Los Angeles County by telephone, plus correspondence with the State Department of Public Health, Berkeley, California, and a personal interview with Mr. Frank Stafford, M.P.H., Director of the Bureau of Health Education, Los Angeles County Department of Public Health.
Within two of these fields, County Health Departments and educators at the colleges and universities, the health educator's position and function is somewhat well defined by their job descriptions. Health educators who work for the Health Department plan and implement programs of health education within the guidelines of the administration and clinical services available through other departments of that agency. This brief description is a vast generalization. Even though the position of health educator is well defined, the activities are usually generated by innovative and creative professionals and often assume the profile of the health educator's personality and training. University and college professor's roles are better defined. These health educators prepare, with all of their skills and basic tools at hand, qualified health educators to fill the many active roles in the other three areas. Once again, their position is well defined, but their activities and creativeness vary from person to person.

The two remaining areas of discussion are the positions of the health educator in the voluntary health agency and the health educator hired by the State and Federal Government. These two positions have purposely been combined because of their basic similarities. There are subtle differences between the two roles which will be discussed later. The major similarities revolve around the role of the health educator as a consultant. This project
will explore only one role, that of the health education consultant within the voluntary health agency. The role of the State and Federal consultant involves working relationships between the Local, State and Federal Departments of Public Health. These top level consultants (State and Federal) act as resource persons for all other Governmental and Public Health Agencies. They develop special projects within program areas and then serve wherever necessary throughout a State as consultants to further attain the goals of their projects.

Voluntary health agencies differ a great deal from the other three groups in that the real work of a voluntary health agency is performed by volunteers. The climate of authority is very different than in a Public Agency. Working with volunteers to provide health education programs is at times more difficult than performing the function alone. Volunteers have many varied reasons for donating their time. Directing the activities of volunteers and coordinating efforts of both volunteers and the staff requires a great deal of tact and understanding of interpersonal relationships. This working relationship is far afield from the employee-employer concept practiced by Public and other health agencies. The spirit of volunteerism is serving because a person wants to serve and not because that individual is hired to perform a specific task. This spirit maintains itself in the management of the staff. The consultant in this field works not only
with the volunteers and staff, but often with other health agencies.

Chapter 2 will explore consultation in health education, which will attempt to justify the position of the health education consultant and spotlight agencies that use health education consultants, as well as discuss consultation protocol and basic types of consultation. Its closing discussion revolves around types of consultation and contrasting theories of developing the climate that will initiate a request for consultation.

Chapter 3 is the case study which will describe the consultant's role through the development, implementation and evaluation stages of a school and community health project.

Because of the nature of the case study, the concluding chapter will summarize the contents of previous chapters and contain the author's recommendations for strengthening consultation as an effective tool for promotion of health education for the Public.
CHAPTER 2

CONSULTATION IN HEALTH EDUCATION

A. THE AGENCY STRUCTURE: AMERICAN CANCER SOCIETY

To identify the health educator as a consultant, a description of the agency that employs that health education consultant is in order. Because the American Cancer Society is the largest voluntary health agency in the world,¹ and hires the greatest number of professional health education staff, and because the author has worked at many different levels within that agency, a health education consultant position from that organization has been picked for the purpose of contributing to this paper. The consultant position to be discussed will be that of the Director of Public Education, American Cancer Society, California Division Area III.

At the time this paper was written, the author had been with the agency four years. He has worked through three levels of health education positions. This author has both been a consultant and the receiver of consultation. It is from his experience in the field and his study of this area that this paper is written.

The American Cancer Society (ACS) hires staff at many different levels. The top level staff is in the

¹The Gentle Legions, Richard Carter, Page 170.
National Office in New York (see Figure 1). Basically that staff consists of the Executive Vice President, which is the top administrative position; Vice President for Fund Raising; Vice Presidents both for Professional, and Public Education and Service (Figure 2); and a large group of specialists in varying fields under education and service. Under the National Office are the four National Area Offices. The United States is divided into four geographic areas. Within each of these areas, there is a National Area Office (see Figure 3). The staffing pattern in the area offices are similar to that of the National less the specialists and assistants. These directors serve as consultants to the next lower level, the Division. The position of interest in this paper is the National Area Director of Public Education. This position is the first and top level of consultation (Figure 4).

The duties of the national area director of public education are primarily field implementation of national policy, procedures, goals and priorities. These four national area staff members are the consultative team that covers the entire United States. A major difference in the responsibility between the national vice president and the national area education directors is that the national director is responsible to, and for, national volunteer committees. The national director does little or no consultation. His duties are directed through his area directors. The national area directors do not have
committee responsibilities. They work primarily with the division level staff who are the top staff in each state.

The California division is the corporate body for the State of California. The California division offices house, much like the national office, an executive vice president, the top administrative officer and a complement of department directors and assistants (Figure 5). The position of the division public education director is similar to that of the national vice president for public education. The division director is responsible to, and for, volunteer committees at the State level. This division director works through his four area directors. These four area directors for public education are located, along with a small group of other area staff, in Oakland, Modesto, Los Angeles and Upland (Figures 6 and 7). The California division area directors' function is similar to that of the national area directors. One of the major differences is that the California area directors are responsible for some staffing of State-wide committees.

The next level is the implementation level — the Unit. In general, each County within California has a unit office (Figure 8). There are two exceptions to this generality. In the Northern Counties, there is not enough population to support a unit office, therefore, the usual pattern is to combine several Counties to form a unit. The pattern for unit development is in Los Angeles County. It is because of its size and population, it has been
divided into five unit offices. The staffing patterns vary from unit to unit. The option to hire education staff depends on the population of the unit. The formula for hiring directors and assistants has been established by the national headquarters. Units having 500,000 population or more hire a Program Director. This director is responsible for education, both public and professional, and service. When the unit population reaches one million, the unit is required to hire a Director of Public and Professional Education, and other specialists accordingly. In units the size of those in Los Angeles, (over one million population) there is not only an education director, but an assistant.

In summary, the staffing pattern for public education has two administrative levels: the national vice president for public education and the division director of public education. Further, there are two consultative levels: the national area directors and the division area directors. The implementation level then follows with directors of public education and in large units, assistants, and in smaller units, program directors with shared responsibilities (Figure 9).

B. THE POSITION OF THE HEALTH EDUCATION CONSULTANT

Each County in the entire State has a designated unit office of the ACS. The basic philosophy of the ACS is that local control of the agency and its budget and
staff provides for commitment to the agency by the community people that volunteer to direct the activities of the ACS in their community. It is generally believed that the strength of the community support determines the quality of the professional staff. Each County budgets for its own office. According to national policy, in order to become a fully chartered unit, forty percent of the collected funds must be sent to the State office to be used to support research programs. This means that the local office must be self-sufficient on the remaining sixty percent. The majority of these units do not raise enough money to support an office and the full complement of staff. The staff ratio in California is one staff person per 100,000 population. Consequently, there is a great need for persons other than staff to become involved in the agency. The ratio of volunteers to staff is nearly 100 to one. Each unit also has to meet certain minimum standards in program areas in order to keep their charter from year to year.

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3 This philosophy was expressed in an interview with Mr. Robert F. Murphy, Executive Vice President for the California Division, at a meeting with this author in San Francisco, September 6, 1974.

4 American Cancer Society, California Division, Standards for the Chartering of County Units, as approved by the Division Executive Committee, August 18, 1972 (3-page doc.).

5 This figure arrived at by taking the number of professional staff hired within the State of California and dividing it into the total State population.

6 Same as Footnote 4.
In areas where the population is low and crusade income is low, local budget does not allow sufficient funds to hire an academically qualified staff. Usually in these areas, the staff is hired and then trained on the job. On-the-job training within the specialty of the consultant is one of his major functions. The consultant is a person with the academic background, training and agency experience that provides the link to the State office and bridges the gap between the unskilled staff and the volunteers that the staff member will work with. Many health professionals volunteer for the ACS. Working with professionals requires a special skill and understanding. The consultant develops these skills in the unskilled new staff member. In larger units, the role of the consultant changes somewhat. The larger units hire more qualified and trained staff. On-the-job training in these areas is related to tasks rather than working relationships. The staff in these larger units also requires more expertise from their consultant. They require professional services such as training in areas of community organization, health care systems, research - both medical and educational. In both areas the consultant becomes an evaluator of the program and a resource person for staff evaluation as well.

The California State office, located in San Francisco, is the headquarters for the California operations. Because of the distance from San Francisco to all of the Counties in the State, it would be difficult to
directly supervise the program and the executive staff. This is why direct supervision of the program staff lies with the executive director of the unit. In order to assess the performance of the program staff, the evaluation of a unit staff person by a trained professional, and close working relationships between the consultant and that staff person is important. This supervision of unit staff by function or specialty is another role of the consultant.

Because of the nature of the program that the ACS offers, unit executives must be good administrators. The difficulty arises when these executives feel that they can supervise the many different types of professionals under their direct supervision. The executive may have a professional fund raiser, a Masters in Social Worker, a Masters in Public Health Educator. The professional skills of these fields vary by individual. Assisting in the selection, development, and termination of program staff, for hiring and firing, lies with the executive and is another role of the consultant. In general, the State level staff is available as specialists in every area that a unit needs staff, which covers areas such as education, service and crusade.  

The use of the consultant is provided at no cost to the unit. This "no-cost" policy helps maintain the 60%/40% spending ratio without losing the professional quality of the program.

The question arises as to why is there a need for four such consultants in the State? After a thorough study of the needs of California by a national study team, the State was divided into four areas. These four areas share geographic and demographic characteristics. Central California from Kern County to the Oregon border is one area. Even though these units (Counties) differ somewhat in population, they are very similar in community structure and population density. Modesto was chosen for the area office because of easy access to the existing Freeway systems and the closeness to the State office in San Francisco. This area office maintains one consultant in public education. All of the units that make up this area have no professional staff in the area of education. The usual staffing pattern is an executive director in addition to one, or possibly two, generalists to cover the program areas. The consultant's role here is to provide the expertise to these generalists and to the unit's volunteers directly, and to assist in the development, implementation and evaluation of the entire health education program. He is also responsible for keeping records on activities, and reporting these activities to the State office. This consultant is to see to it that the unit reaches the minimum standards for charter requirements within the

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Interview with Mr. George M. Saunders, Area Director of Public Education, American Cancer Society, California Division, Area II, September 9, 1974, in the Area Office, Modesto, California.
program. This consultant also must be sensitive to the types of population that live in the area. He should be able to adjust programs to suit the community and still be effective in changing health-related behavior. The areas were purposely designed to combine similar units and to employ a staff that works best with the type of population that is more prevalent within that area. Area II, Central California, is primarily agricultural, with the majority of the population being quite conservative. Most of the smaller communities are closely associated, both socially and economically. A consultant learns to work with all of these factors while furthering the goals of the American Cancer Society.

In sharp contrast to the rural agricultural area, Area II, there are the two large metropolitan areas, Areas I and III. Area I covers the greater San Francisco area Counties, and Area III encompasses all of Los Angeles County plus three coastal Counties to the North. Area IV is different from the others in that it houses several metropolitan units and several rural and desert regions. Area IV stretches from Los Angeles County to the Mexican border and from Los Angeles County West to Nevada.

Metropolitan areas differ sharply from those in rural areas. The level of professionalism is much higher. There are far more medical professionals and many cancer specialists. Colleges and universities are among the leading institutions in the State, and the Health
Departments are the largest and best staffed anywhere; the consultant's role here becomes much more academic. Every unit in Area III has a Master's level health educator and a Bachelor's level assistant. The consultant works primarily with the staff. The major stress on the consultant in these metropolitan areas is innovation. The consultant is called in to assist existing high level programs and to develop from the available resources innovative and new programs. Motivation of lower level staff is also a major area of interest. Systems development for routine office procedures to save time and to allow for more professional time for program development and implementation is very important. The consultant also deals with information sharing from successful new programs to informing units of new programs or to write new programs. In large units the number of programs may be impressive, but quality, in terms of effecting behavior change, may not be present. The consultant's role extends into evaluation of not only an effective program, but the effect that quality staff plays on developing behavior changing programs. In order to evaluate these programs and staff, the consultant must directly observe both program and staff in action. Consultation is usually done on an invitation basis. In order to be invited into a unit, the consultant must first have a "product to sell." This product is usually based on his "track record" for developing
innovative programs and assisting in the overall operation of the unit's education program. 9

The education director is directly responsible to the unit executive. The consultant has only a functional authority over the education director. Therefore, it is necessary for the consultant to develop a close working relationship between himself and that unit executive. Working with the unit executive is usually the most frustrating part of the consultant's position. Professional jealousy, separatism, competition, and basic ego problems all enter into this working relationship. The first duty of the consultant is to mold his working relationships with both the education director and the executive director into one of honesty and mutual trust.

Each consultant in each program area must individually develop a rapport with each executive and education director because without this closeness, the unit will be cut off from the State office and the unit charter may be in jeopardy. The consultants are a must in transferring information to the State office for in-depth evaluation of the unit program. This evaluation is not a qualitative nor quantitative one, but based on direct observation of behavior changing activities.

In summary, the consultant's role in Areas II and IV, where the units rarely hire specialists, are the

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9 Interview with Mr. Glenn I. Hildebrand, Director of Public Education, American Cancer Society, California Division, September 6, 1973.
following. The consultant: 1) trains the generalist staff and volunteers in the duties and policies of the ACS, 2) serves as a link between the units and the State office, 3) bridges the gap between the professional volunteer and the non-professional staff, 4) gives professional evaluation of program staff and executives, 5) keeps records on continuing activities, and 6) assists the unit executives in the recruitment, development and evaluation of staff and key volunteers. In Areas I and III, made up of large metropolitan units, the consultant's role primarily is: 1) evaluation of the professional staff and the unit's education program, 2) linking the unit with the State office for support of programs, 3) developing new and innovative programs, 4) the spread of information and guidelines to further the development and implementation of key programs, and 5) training of professional staff and volunteers in the areas of special projects and task forces.

Justification for four such consultants revolves around the character of the four areas of the California Division, each with their own special profiles and needs. Two areas are metropolitan and separated by more than 400 miles, and the other two areas are each individual from each other. Therefore, the justification for four different individuals to serve these different needs is well founded.
C. AGENCIES THAT USE HEALTH EDUCATION CONSULTANTS

This sampling of agencies is by no means all inclusive; however, the primary intent is to distinguish between the different areas of interest in the consultant's position and to further justify the overall use and acceptance of the consultant's role. This section is divided into four parts: 1) National Voluntary Health Agencies, 2) Official Public Health Departments, 3) Business and Industry Health Educators, and 4) Legislative Health Education Consultants.

1. National Voluntary Health Agencies

At the top of the list of Health Agencies that hire consultants is the American Cancer Society. As previously discussed in this paper, the ACS employs four area consultants in the State of California and four national area consultants in the United States. The ACS also hires consultants for special projects. The California Division hires one consultant as the Smoking Control Program Coordinator. This consultant is used wherever necessary to develop smoking control programs.

The Los Angeles Heart Association's structure is quite different than that of the ACS (Figure 10). The Los Angeles County Heart Association relates directly to their national office. They are completely separate from their State office. This eliminates one level of administration. There is another significant difference in the number of
consultants — there are no consultants between the Los Angeles operation and the State Office. The consultant levels are directed from their national office and from their County office down to their Division offices. The Heart Association calls their local offices Divisions, whereas the ACS calls them units. The Heart Association has ten Division offices in Los Angeles County.

The Heart Association believes in centralizing their expertise and decentralizing their offices. 10 This pattern of operation allows for much more consultation and with much more power than the ACS allows. Their Division offices staffing pattern is that of a Division Director and a Program Generalist (Figure 11). The Association then depends on volunteers, mostly professionals, to carry out their programs with the support from the headquarters office. In the headquarters office, the Heart Association employs what they term, Program Associates. These program associates act as consultants to the Division Coordinators and their council volunteers. The second area under which there are program personnel is under the Program Director. This Director oversees the activities of four Program Associates and one Health Educator. These program personnel deal entirely with the County-wide committees in the different areas of the

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10 Interview with Mrs. Ilene Lowder, Training Administrator, Los Angeles County Heart Association, October 1, 1973.
program. The primary difference between these consultants (the program associates and the ACS consultants) is that they have the direct authority to intervene into the Division function as it relates to their program. They are not "invited" in as consultants, but function more as local staff. The program associates under the program director actually direct their projects. These projects include heart sound screening, professional education, recognition and response. In summary, the Heart Association hires two levels of consultants: national consultants and program associates, and local consultants.

As the health agencies decrease in staff and income levels, their staff become much more directly involved in program activities; the number of consultant positions drop at the County level of organization and increase at the next level, usually the State level.

2. Official Public Health Departments

At the present time, there are two official Public Health Agencies which are going through major reorganization. The State Department of Public Health recently relocated from Berkeley, California to Sacramento (Appendix A). The Los Angeles Health Department has now become integrated into the Department of Health Services. This new local structure is still in a transition stage and has not been in operation long enough to provide organizational charts or clear operational procedures. Another change in
the Health Department at the local level is that Los Angeles County will be divided into five regions. Each of these regions will function as an autonomous entity and will not be under the direct control of the former County Headquarters (Figure 12).

Under the previous system, the top health education position was that of Director of the Bureau of Health Education, directly under this position there were two assistants. Both of these assistants were staffed by senior health educators. The next level of health educator was that of the district health educator and from there to the health education assistant, a Bachelors level position. The consultation positions were held by the senior health educators. Because of the entities within the Department of Health Services, the organizational charts will only be those of the Health Education Bureau (Figures 13a and 13b).

The consultative positions within the Health Department differ from those within the ACS. The two assistants function not only as consultants but as supervisors and trainers. The hiring of health educators is done by the headquarters office and does not necessarily have to be done with the approval of the district health officers. However, the release of a health educator is also quite different. The health educator must be outside of certain rules mandated by the civil service codes.
These consultants can bring the situation to the attention of the necessary officials and then must build a case against the employee for release. The District Health Officer has less authority over the health educators than does the unit executive over the unit education director within the ACS. This changes the consultative patterns as well.

It is not necessary for the District Health Officer to open the doors to consultation; the Department of Health Education can begin the consultation and evaluation on their own. Under the new system, the District Health Officer will have much more authority over the health educators. It is still unclear what the central office's role will be in the consultation patterns with these new regions.

This author feels that keeping a small core of coordinators and consultants at the central office is vital to the overall operation of the health education program. This author also feels that further study into the delivery of health education services before and after the reorganization would be an excellent study for another thesis.

At present, the State Department of Public Health is in the process of moving their offices from Berkeley to Sacramento. This author corresponded with the State office on several occasions asking for flow charts and descriptions of consultative positions, but received
inadequate information in return. The structure as described by one of the state level consultants follows. Within the Health Education Departments, there were sub-categories for specific state-wide projects. One of these projects was that of migrant health. Other Departments ranged from general disease control to suicide prevention. Organization charts on these Departments have not been included in this paper. The role of the health education staff at this State level usually involves a degree of consultation. Usually these health educators develop health education programs of State-wide interest by reviewing the State statistics on mortality and morbidity. Once these projects are developed from specific needs, the health educator publishes the project proposals and distributes them throughout the State system. From this point, the State level health educator becomes a consultant to the local Health Departments as a resource person to implement their programs at that level.  

3. Businesses and Industries

Very little formal, planned health education is done in the business and industry setting; however, this is not an indication that there is little need for such programs. Cancer alone kills three times as many people

\[\text{Discussion with Ms. Nancy Allen, M.P.H., Health Education Consultant, State Department of Public Health, following her presentation of project write-up on suicide.}\]
than are killed in all accidents combined. When the automobile accident death statistic is removed from the accidental death rate, the rate for all other accidental deaths including business and industry is 3.2 per 100,000. For the same year, the cancer death rate was 16.8 and the heart death rate was 38.4 per 100,000. The third ranking killer, stroke, rates 10.8. When these three are combined the overall rate becomes 66.0 in comparison to 3.2 for all other accidents not including motor vehicle.\(^\text{12}\) What this all means is that over 20 times as many people die from the three leading killers: heart disease, cancer, and stroke, than from the total of all accidents (excluding automobile), not just those in the business and industrial setting. The American Cancer Society states that "Of every six persons who get cancer (excluding skin and cervical), two will be saved and four will die. Numbers one and two will be saved, number 3 will die but might have been saved if proper treatment has been received in time. Numbers 4, 5 and 6 will die of cancers which cannot yet be controlled.\(^\text{13}\) Educating the Public to take action to seek early treatment is the task of health education. If indeed just one out of six can be saved by health education for cancer alone, imagine the life-saving potential for the three leading killers.

\(^{12}\)Cancer Facts and Figures, 1974, Chart, p. 13.
\(^{13}\)Ibid, p. 4.
At the present time only a few businesses and industries hire health educators. Usually these industries have an interest in health as part of their function. The Metropolitan Life Insurance Company hires a health education staff, Union Oil Company also hires a few personnel in this field. These health educators are usually placed far from the work setting, but placed in national headquarters developing materials or disseminating information, but rarely initiating programs. From the author's view and in view of the statistics given previously, there appears to be a great need for industrial health education positions. All too often business and industry programs revolve around safety. Once again, according to the statistics, the life-saving potential for a good health education program could save many, many more lives. Death from an industrial accident is no better than one from an illness that could have been prevented or not allowed to become fatal.

Governmental pressures through the Department of Occupational Health and Safety have brought about many industrial nurse positions.\textsuperscript{14} Many of these industrial nurses see the need for health education and have come to

\textsuperscript{14}Taken from the minutes of the Los Angeles County American Cancer Society minutes of the Business and Industry Subcommittee, Dr. Robert E. Funke, Chairman, as stated by Ms. Connie Sparks, Chairwoman-Elect of the Industrial Nurses Association, at their meeting, August 27, 1973.
the voluntary health agencies for assistance. The Los Angeles County ACS has developed programs of health education for major industries in the Los Angeles area. Much more study is needed in this area, and it is the author's suggestion that the professional organizations of health educators develop job descriptions and justification for such a position.

4. Legislative Bodies

Far afield from the usual activities of a health educator is the role of the legislative consultant. This consultant is usually a person that has had many years of health education experience and has obtained a level of expertise in many areas of health. The Executive Director of the Los Angeles Council of National Voluntary Health Agencies is such a person. In a discussion of her role of a legislative health education consultant during a class in consultation and supervision at California State University at Northridge, an executive described her many functions and contacts with the State and national

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15 A review of the American Cancer Society files shows that they have developed programs for many major businesses and industries. Several of these include First Western Bank, P.G.& E., Kal Kan Foods, Robinsons Department Stores, and many others.

16 Ms. Helene Brown is the Executive Director of the Los Angeles Council of National Voluntary Health Agencies. Ms. Brown is also the Chairwoman of the Board of the American Cancer Society, California Division, and a delegate to the National Board of Directors.
legislative processes. Because of the tax laws, all non-profit health agencies that are broadly supported by the Public are forbidden to effect legislation through the process of lobbying. Any contact with the legislator must be on an invitation basis and when information is given, it is given in an advisory manner not as a directed political stand. Because of her position, Executive Director of the Council of National Voluntary Health Agencies, this person is not an employee of any specific agency and, therefore, becomes the spokesman for all. Because of this person's position and activities within the health field, she was asked to be instrumental in the setup of the President's Committee on Health Education.\textsuperscript{17} Her role here was to seek out the most representative sample of major health problems in this area and have representatives from those agencies present documentation to a panel of expert health resource persons in the area of health education so that they could condense these needs into a proposal to the national level for consideration. This role is a very high level position and demands a great deal of knowledge and personal commitment and tact. Also, this position allows for massive changes in the health education delivery systems. The potential for State-wide and nation-wide effects of this one person's activities are immense.

\footnotesize{\textsuperscript{17}Report on President's Committee on Health Education.}
Other top level health educators from colleges and universities are asked to become health education consultants to the legislator. Recently the National Institute of Health and the National Cancer Institute were asked to formulate the national plan for the allocation of Federal funds in the Fight Against Cancer. Realizing that the approach not only involves research, clinical and other medical considerations, but health education as well, the National Cancer Institute brought together top leaders in the fields of Public Health and Cancer Education to design criteria for health education programs to augment the total cancer drive. Among others invited in this capacity were the Professor of Health Education from the School of Public Health in Berkeley, California, and the Education Director of the California Division of the American Cancer Society.18

The role of these legislative consultants are quite different than the ones mentioned earlier. These consultants are "after the fact" consultants. The consultants that deal with legislators are in two categories. The first group effects legislation and the second designs programs after legislation. The consultants brought together by the National Cancer Institute were

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post-legislation consultants. Their role was to design programs and priorities for health education programs in order to justify spending of NCI funds within that discipline.

On the local level (Los Angeles County) there is one legislative consultant known involved in City Government. One of the City Councilmen that represents the San Gabriel Valley hires a Master level health educator as an advisor to health problems. This advisor is the Councilman's resource person for health activities throughout his area and is a resource person to the total council on health problems as they relate to City function. As far as is known, this is a unique position and is also well worth some exploration by the professional organizations.

In summary, there are four agencies that hire health education consultants: Voluntary Health Agencies (usually at the State and National level), official Public Health Agencies (also the State and Local level), Business and Industry (usually at the State or National level, with a need for Local involvement), and the Legislative Consultant hired by a grouping of health agencies and/or commissioned by national legislative bodies for post-legislation development and review.

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19 Interview with Mr. Tomas Hibbard, M.P.H. Mr. Hibbard is a full-time staff person for City Councilman Pete Schabarum. This interview was held following a district council meeting of the American Cancer Society which Mr. Hibbard attended as Mr. Schabarum's official representative.
D. CONSULTATION PROTOCOL

Consultation protocol differs from agency to agency, the power structure and degree of decentralization are major factors in determining protocol for consultation. Again we will use the American Cancer Society as a model for comparison. A brief review of Section A on the agency structure may be of help to the reader.

Each local unit of the ACS is administrated by the Executive Director. Under his direction is the education program staff. The Area Directors are primarily resource staff ready to consult when their schedules allow. Because the Executive Director is the chief administrator, it is advisable to confer with him first, before consultation is initiated with the education staff, and with a brief follow-up on the basic topics of consultation at the conclusion of the session. The usual pattern for consultation is that the executive and the area public education director meet early in the program year to come to common ground on issues of strengths and weaknesses of both his staff and the consultant. This is an important session; if the executive is not impressed with the skills of the consultant, he has the ultimate decision to close or open the doors to any further consultation.

The initial request for assistance is from the unit education director through the executive and from the executive directly to the consultant. The executive then follows up on the consultant by sitting in on the first
few sessions of consultation until an overall trust has been developed. In the case where the executive is reluctant to invite the consultant and the invitation is indeed warranted, the consultant then can initiate the request through the area executive director. The area executive is the direct line supervisor of the unit executive. If there is sufficient evidence of poor quality or quantity in the professional program development, the consultant then initiates the request for consultation through this alternate channel. When the area education director goes to his area executive in order to gain entrance into the unit, there is usually a severe problem. In this case, there is a much higher level of tension when the consultant meets with the education director. Prior to the meeting of the consultant and the education director, the unit executive, the area executive and the consultant meet. This meeting is to determine the extent of the problem and to propose possible solutions. Following that meeting, the consultant and the unit education director meet. As in the first case, the unit executive usually sits in to directly observe the session. If at this time the unit executive does not agree with the process developed with the education director, the consultant can elect once again to bring the area executive in. These meetings are well documented. Usually a plan to solve the particular problem is developed.
in these sessions and if the person (education director) does not comply in a stated amount of time, that position is usually terminated.

Protocol is very important when staff evaluation is concerned. When the staff's effectiveness is high and the program is running smooth, protocol is usually loosely structured. It is only when there are serious problems that the rigid, time-consuming protocol is necessary.

Once again the effectiveness of the consultant depends on his past activities in program effectiveness. The qualifications of the consultant can open the doors to loosely structured protocol if the consultant is highly regarded as a constructive member of the local staff team. Conversely, if the consultant has a history of protocol tie-ups and ineffectiveness, rigid protocol may be imposed and the system put to the test. In any agency, time is always a factor. If a consultant has these protocol tie-ups and time problems, it is usually a sign of his weakness and time for a review of his effectiveness.

If consultation protocol is loosely structured, the amount of time the consultant and program staff can spend together is greatly increased. This working relationship also frees the time of the executive level staff to perform additional administrative tasks. The follow-up contacts with the executive directors are of ultimate importance. If the consultant does not use this follow-up
procedure, the executive directors may question the effectiveness of the consultant.

The local executives need to know the basic topics of discussion of the consultation meetings so that he can place into proper perspective the activities of the education director into the total activities of the unit. The consultant must keep in touch with the executive directors whenever possible, even if it be for public relations value alone.

Consultation protocol varies from agency to agency. Some agencies prefer routine consultation and some prefer consultation on a regular schedule. Others prefer consultation on an "as needed" basis. The routine consultation is usually implemented when the staff is new and a time table of training and development is set. The "as needed" consultation pattern is usually of more value when the staff have been on the job for a long time and the consultant is used for upper level planning rather than orientation and training. The consultant is vital to the new staff and the development of good working relationships as soon as possible is important.

In any agency when a health educator is hired, his first immediate need is to be oriented to the specifics of his position. These orientation meetings can be the first step in setting up good consultative protocol. The
consultant and his effectiveness depend on good working relationships that tend to eliminate the time consuming and rigid protocol procedures.

E. BASIC TYPES OF CONSULTATION

Most of the varying fields of consultation relate to big business and industry. Another major field of consultation is that of international education — consulting to underdeveloped countries to assist in the development of educational systems. The business and industry fields are primarily developments of inter-organizational systems to increase productivity and profit, which is not too different from the educational efforts of saving time and increasing the educational level and/or level of health within a certain area. The literature is conspicuously lacking on the role of the consultant within voluntary health agencies and in the field of health in general. In this section the author reviews types of consultation in different settings than the case study, and will relate areas of similarity to the processes of consultation described within a voluntary health agency. Descriptions of consultation types presented here can then be related to the similarities and differences to the consultative process developed by the case study.

1. The Internal Consultant

The first materials review by the author was taken from The American Management Association's research study
Even though it relates to the business and industry setting, this first review dealing with consultation is very close to the relationship of the consultant hired by an agency and used internally, much as the ACS has done in the case presented. The research report review here deals with the full time internal consultant hired by major industry, as opposed to the hiring of part-time consultants.

Anton K. Dekom's definition of the internal consultant is excellent and is worth repeating here in its entirety.

Internal consulting is a natural evolution of the staff function. It recognizes and incorporates into a wide variety of organizations much of the expert knowledge and many of the specialized services previously obtained from independent professional firms. Additionally, it provides an organizational vehicle for making better use of the services of the independent professional firm.

Dekom further defines this position,

Internal consulting may be defined, then, as a refinement in the evolution of the staff concept in management. It is a refinement that emphasizes making available to the manager a team of specialists to assist him by

1. Helping him to identify opportunities and problems.
2. Studying those opportunities and problems.
3. Preparing recommendations that emphasize the manager's point of view and to balance and integrate the recommendations of the specialist members of the team.
4. Being at hand to assist the manager in implementing the recommendations he accepts.  

This definition also adds to the justification of the position. Dekom suggests in this definition that having an internal consultant means that you do not have to use the services of an outside agency. He also says that if you do have to use an outside firm, that the internal consultant can help to expedite that usage, also saving time and money.

The four steps defined are very similar to the processes used in the health agency. Once invited, the health education consultant helps to identify the problem, then with the staff studies the problem. From the consultant's past experience and training, he then prepares suggestions for improving the situation and then, if accepted by the staff, assists in working through the problem. This procedure can be applied to a total program as well as a specific project.

Another section from Dekom's study states,

The impetus for establishing a "captive consultant" however, comes from the need to have someone in the company to implement recommendations, from the cost outside consulting represents, and from the need to create and keep know-how in the company. This impetus on top of the availability of flexible staff departments, which had already hacked out the road to becoming the company's own consultants, gave issue to a formal internal consulting function.

21 Ibid., p. 20.
What is meant here is that keeping the consultant internally, keeps his skills as a part of the agency. Also, from this paragraph one notices that the consultant must have some organizational flexibility. This is the same with a voluntary health agency. The consultant must have time and freedom of access to those he consults with, in order to be effective. In these terms the Area Health Educator, in our report the consultant, is better identified as an internal consultant.

2. The Educational Advisor as a Consultant

In the last of a series of eight publications for the International Institute for Educational Planning, Adam Curle describes the advisor's role in educational planning. This publication deals with what this author terms the outside consultant, directly the converse of Dekom's internal consultant. Also, this term "Advisor" is to be used interchangeably with "Consultant." In the educational terminology, consultants are business people and advisors deal in education.22

Curle describes the role of the education advisor in foreign countries.

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22 Fundamentals of Educational Planning, Educational Planning the Advisors Role, Adam Curle.
In the first place, the very role of advisor is a kind of an insult. It presupposes that the persons for whom the advice is intended are inadequately trained to do their own jobs properly and, at worst, stupid and incompetent. It is, of course, true that most high officials have advisors to guide them on technical matters which they could hardly be expected to understand themselves, but these advisors are, so to speak, their servants.23

This is a very real problem where advisors or consultants are invited in by the consultee. If the consultee does not understand the role of a consultant, then they might not accept their own weakness which may be a block to the consultative process.

In describing the ideal position for the education advisor, Curle states:

An ideal position for the adviser would give him both direct involvement with the work of the government he was advising and a measure of detachment which would prevent his being too closely dependent on it.24

This position well describes the placement of the health education consultant - some direct involvement but not a closeness of total involvement or total responsibility.

Curle also comments on the length of stay and the amount of effectiveness of the advisor:

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23 Ibid., p. 13.
24 Ibid., p. 11.
Another important factor affecting the adviser's performance is the duration of his assignment. It has been said that no adviser should spend less than three years or more than four in any one place. In the first year he constantly makes mistakes and is altogether more trouble than he is worth; in his second he functions effectively because he has established good working relations with the people in the administration, but does little more than compensate for the errors and waste of the first year. Only in the third year, then, does he make a real contribution; and if he stays for more than four, he gets out of touch with his professional background and becomes so involved with the country that he loses his asset of objectivity.  

This statement may be true and deserves consideration for those that settle into their positions. For an inside consultant, a change every four years may be difficult. In a health agency, a three to four year stay does not really give the consultant an historical framework for progress within the agency. Working with health agencies requires a degree of visible change and this change sometimes requires more than the stated three year period.

3. Process Consultation

Schein in his text *Process Consultation: Its Role in Organizational Development* defines several models for process consultation. Two of these models are relevant to the processes described in the case study. One model, the Purchase Model, describes what a client should expect

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25 Ibid., p. 11.
when he calls in a process consultant. These criteria are not too different from those when an education director calls in his consultant. They are,

The success of the consultation then depends on; 1. Whether the manager has correctly diagnosed his own needs; 2. Whether he has correctly communicated these needs to the consultant; 3. Whether he has accurately assessed the capability of the consultant to provide the right kind of information or service; and, 4. Whether he has thought through the consequences of having the consultant gather information, and/or the consequences of implementing changes which may be recommended by the consultant.

This author feels that these four basic principles are the key to understanding the role of the consultant. If the consultee used these four criteria for assessing when to call in the consultant, there would not be the difficult situations arising when the consultant once involved is either not really needed or when the consultee will not commit themselves to the suggested results.

In order to bring the decision-making process closer to the person asking for consultation, in another model, Schein touches on the basis of what process consultation is all about. He states, "It is a key assumption underlying process consultation that the client must learn to see the problem for himself, to share in the diagnosis, and to be actively involved in generating a remedy." 27


27 Ibid., p. 7.
Consulting on specific tasks and systems does not require that level of sharing and decision making. Training for a skill also doesn't lend to this process, but if the process is kept in mind, it may assist in doing an effective job of those routine chores.

In another section of Schein's test he is describing different types of group problem-solving and decision-making processes. In the case study, the most commonly used process is one that Schein calls "Decision by Consensus." This process seems to work best in a voluntary agency. Quoting Schein,

One of the most effective, but also most time-consuming methods of group decision-making is to seek concensus. It is important to understand that concensus, as I will define it, is not the same thing as unanimity. Rather, it is a state of affairs where communications have been sufficiently open and the group climate has been sufficiently supportive, to make everyone in the group feel that he has had his fair chance to influence the decision.\(^\text{28}\)

This feeling of participation in the decision-making process also brings the person closer to the project. Right or wrong, if the person's ideas are accepted or not, he has participated. If that person is properly listened to and the group comes to a concensus, the group decision contains a part of that person's thought processes.

\(^{28}\)Ibid., p. 56.
4. Consultancy and Professionalism

Most of the literature on all aspects of consultation, business and industry health education and others, have been generated from the United States. However, one text written by Frank Davidson, titled Management Consultants, gives another view of the subject. Frank Davidson lives and works as a consultant in the United Kingdom.

One section of his text describes an eight-point code of ethics that he feels should be characteristic of all those calling themselves professionals.

a. The professional is licensed to practice.

b. The license is conditional upon minimum standards of competence.

c. There is a code of social and moral conduct.

d. Professionals do not solicit business, nor do they accept clients of their fellow-practitioners without full agreement.

e. There is a controlling body, with power to revoke the license to practice in the event of a significant breach of the professional code.

f. Practitioners normally follow the profession through their working lives.

g. Developments in the profession, in terms of knowledge and skills, are made freely available to the whole profession.

h. Altruistic questions outweigh personal gain.29

29Management Consultants, Frank Davidson, p. 28.
At present, the field of health education is not this rigidly controlled. Some degree of professionalism is already built into the job from the training as professional health educators. This criteria may be interesting to pursue in developing either a section of a professional organization to deal with consultants, or to develop another organization.

In the text The School Counselor-Consultant, in a chapter titled, "Consulting: A professional function of the counselor," Fullmer places the emphasis on the process rather than the product. Fullmer feels that the degree of professionalism exhibited in the process, rather than being oriented, is truly the mark of a professional consultant.

When a counselor-consultant confers with a group, concern is with the process rather than the product. The product becomes a kind of secondary gain. This is one way to describe verbally the resolution of the paradox between product and process.  

Fullmer then goes on to define an eleven-point characterization of the occupation of the professional consultant. Many of these points are quite similar to those of Davidson.

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30 The School Counselor-Consultant, Fullmer/Bernard.
CHAPTER 3

CASE STUDY

A. CHATSWORTH HIGH SCHOOL PROJECT

The Chatsworth High School project has been chosen for the case study for several reasons. It is clearly not the ideal classical project as far as consultation is concerned, but this is why it is a good case study. This project presents difficult situations both in consulting and in project development, and it also shows how effective the results of good process and consultation can be. In the project, the author was directly involved from beginning to end as the health education consultant. This Chatsworth project not only was awarded State level "Special Recognition" from the American Cancer Society, but also was awarded a "National Honor Citation" from the board of directors of The National ACS.

This case study will begin with the inception of the program and follow its development through its entirety. As the project is developed, the author will make reference to the preceding chapters to crystalize the role of the health education consultant and bring the analysis to its logical conclusion.
1. Consultation Protocol

Sometime during the month of October, 1971, a young energetic woman volunteered to work for the ACS at one of its local unit offices. This volunteer (Jane) began her career, as a volunteer, working in the crusade department with low level clerical work. The crusade director, after working with Jane, noticed that she was capable of a much higher level of work. At this point the crusade director suggested, because of Jane's youth, that she might be interested in working with youth at the high school level on crusade activities. Jane enthusiastically accepted this suggestion as a challenge and an opportunity to use her talents to further the goals of the ACS.

Not known at that time, Jane was a college graduate with a secondary teaching credential. Jane began that month contacting the principals of four different local high schools. Each of these principals referred Jane to either the health education instructor or the health coordinator on campus. Jane received positive responses from all four of the schools that she contacted. Jane returned to the unit office and asked for the office's assistance in developing programs for those schools. The crusade director suggested that Jane call another young woman (Helen) who had shown an interest in youth activities. Jane called Helen and they shared their mutual interests.
One of the first mistakes on the part of the unit office was made at this time. The director had allowed Jane to make commitments to the schools before she was properly oriented and without the assurance that the office would conduct the programs. Jane was not informed of the role of the volunteer. She had thought that all she needed to do was to be the contact person and the ACS staff would do the rest. When the crusade director realized that she had not been entirely honest with Jane, she decided to involve the education director and to expand the program into that area. Crusade was at a very busy time and it was felt that education could better handle this energetic pair of volunteers.

The education director was put in a difficult position because she had not been working in the area of schools and did not have any other active volunteers to assist Jane and Helen. At this point the education director were uncertain about how to deal with the two volunteers and also with the commitments that they had made in the four schools. It wasn't until three months later that they went to their executive director to help with a solution. The executive director suggested that they cancel three of the programs and work on just the one. This executive was also aware that the area director of public education at the prep office had a great deal of experience with youth projects and might be of assistance in this situation.
The executive director initiated a call to the area office and issued an invitation to the consultant, the area director of public education. A meeting was then set up with the two volunteers, Jane and Helen, the crusade director, the education director and the executive. Another fundamental mistake was made here. The area education director met with the entire group without the proper background information on the history of the problem. Proper procedure would have been to have met with the staff first and discussed the history and made a tentative plan for action when the volunteers were to be involved.

2. Schedule of Meetings

The first meeting of the entire group took place at the unit office in early January. In the discussion with the education director from the area office, the executive had simply invited the consultant out to meet with a "group of interested volunteers that are thinking of developing an education project in the schools." The executive gave no further information on the frustration that had been built up in the volunteers for the past four months. Nothing was said about the lack of orientation or the fact that their only background was in crusade. The protocol for the consultation invitation was proper, but the procedure for effective consultation was broken. The
orientation meeting with the person that invites in the consultant is vital to a successful first meeting with such a group.

This first meeting was a difficult one that required much tact and orientation. The first step was to define the different levels of organization and to place into proper perspective the positions of those involved in the meeting. Jane and Helen had never met the executive director. It was the role of the consultant at that moment to take charge of the meeting and provide the necessary information to the group so that everyone understood the other's functions. During this short orientation the frustration was mounting both on the part of the staff and the volunteers. The volunteers came wanting the solution to the problem, not the assignment of responsibilities.

At this point it was time for the volunteers to express their interests. It turned out that they both had keen interests in the educational process but had not been asked what their needs had been from the first. The meeting then began to take on a different tone. The executive then suggested that the consultant describe some activities to the group that he had observed that may fill the needs of the volunteers and the staff. The consultant then began to describe some of the programs he was familiar with. The description of these programs is primarily to give the volunteers the opportunity to see the potentials for their
activities. The volunteer involvement is stressed in the discussions. Describing these other programs is a difficult area, without proper historical background, their value might not be comprehended. This description has to be done tactfully and discussed with the group rather than a lecture to the group. This area of bringing the group to a discussion requires much consultant expertise.

The consultant presents ideas and allows the group to accept or refuse these ideas and then make the decision. It is felt that the group decision is usually more superior to the decision of any of the group's members. It is also preferred to have the group make the decision rather than the outsider. This process brings the commitment to the group that will be responsible for its implementation.

The consultant should outline a procedure that is rather general to the working of good programming and identify resources that should be available to the local office for this particular program of project. The consultant also offers his assistance in areas that the local staff feels they have little experience. Then a schedule for future meetings is outlined. It is important that the time schedule allows sufficient time for the learning process. This new project is not a project in itself but also a training ground for the staff and new volunteers. This time table is usually set from prior experience that the consultant has dealt with directly.
In this case in dealing with the schools, as much advance planning as possible is appreciated. The group felt that there was enough time for the spring semester. The week selected as the target was April 24 - 28. Using this as a target date, a schedule of deadlines was drawn out.

a. Development

With the scheduling of meetings planned, it was time for program development. With the program aimed at the high school age student, the consultant suggested that we contact the school and see if we could find a few campus youth leaders that would be interested in developing such a program. Another suggestion was that the group involve the local department of health sciences at California State University, Northridge. The consultant was aware of a class at the university that dealt primarily with the evaluation of such projects. The local staff had worked with the university and volunteered to make the contact. Jane volunteered to recontact the school. It was then decided that Jane and Helen and the consultant meet with the two groups separately and orient them to the project. Local staff was also added to those at the meetings. The high school youth were hoped to give input on educational techniques for their age level and the university students to evaluate the project.
This first meeting now began to evolve into a real working session. The consultant had offered a structure to an unstructured situation and the group began to become comfortable with a project that they were most frustrated with in the beginning. Further discussion brought forth the question: "could this project become a pilot program?" The consultant viewed this suggestion as completely appropriate for the situation and further stated that the ACS had never measured the effectiveness of program types on youth and that this program could be of great value to the rest of the Country if the program was implemented and evaluated as outlined.

At the conclusion of this first meeting the local education director and the consultant met to document the activities of that meeting and wrote up brief minutes. More time should have been spent with the education director. It was later discovered that she had no real grasp of what had transpired at this meeting and had personally removed herself from a leadership role when the consultant arrived.

Jane and Helen contacted the high school and set up a meeting with the health education coordinator and the youth representatives. This next meeting's goals were already set and was to include the consultant and the local
staff. The consultant's role at this next meeting was to be the meeting coordinator and resource person for the justification of the program.

1) Justification of the Program

The first question asked by the youth was, "Who are all of these people and what are they doing here?" Orientation was in order. The consultant introduced and defined the roles of each of the members present at that meeting. The next question was, "Why should youth learn about cancer?" This is where the justification of the program began. Once again the consultant related to the students the facts that cancer is the leading cause of death of the school age child. That fact had not been known to the youth present. The second major point was that if youth become aware that they are responsible for their own health, that many cancers present in older age can be prevented by adopting good health habits in youth.

2) Goal Setting Process

a) Volunteer Goals

The next question is always, "What do you want us to do?" This is when the consultant must back out of the group discussion and allow the volunteer leaders to become responsible for the project. If these two volunteers were to have true control of their project, they must be
instrumental in assigning duties to their new recruits. The transition from the consultant or staff person delegating this operational leadership function can many times be awkward. It is the consultant's role to know when the volunteers are ready to assume this responsibility, and to make that transition as smoothly as possible. If this transition is smooth, the volunteers then begin to become a part of the project and the project becomes their and not an idea of the consultant.

The next meeting was with the newly recruited students from California State University, Northridge (CSUN) health science department. This meeting took place February 24, 1972. One of the local staff members set up the meeting to include the students, Jane and Helen, the consultant and her. The meeting was led by Jane and Helen, the chairwomen, and the consultant acted only as a resource person. Informally through the development of the leadership and the program, the volunteers have now assumed total responsibility. Their goal for the program has now become implementation of their plans.

b) Student Goals

At this first meeting the CSUN students were not too much different than the campus youth. The same questions of Who's Who and, "What do you want us to do?" arose. The chairwomen then asked the consultant to do a brief orientation which included the CSUN students so that
the group would understand their class requirements. The two chairwomen then told the students why they had been invited into the project. The idea of a thorough evaluation for justification for the program and later program replication was within the area of interest of these CSUN students. The only problem was that the students' class required that they be totally responsible for an entire program and not just a segment of one already planned. The consultant, because of his familiarity with the school and the instructors, suggested that he could approach their instructor and see if there could be an arrangement made for the two to be involved.

Following that contact, the students then accepted the assignment of working with the chairwomen to evaluate the effectiveness of the program. This group of students then selected a chairman to meet with the volunteers and the high school students as their representative so that the meetings didn't have to involve so many people. It was also suggested that the CSUN students meet separately at their convenience for updated activity information and that their chairman would be the primary liaison between the working committee and the students.

A brief review shows that we now have the two chairwomen oriented and trained, and assuming their leadership role. They now have a committee of four high school students, of seven students from CSUN as an evaluation
committee, the education director at the local office as backup and the consultant to the project. The students' goals have been informally set as being the evaluation arm of the project.

FURTHER DEVELOPMENT

The first real planning meeting to include all of those now involved was on March 6, 1972. Present at this meeting were, Jane and Helen, the chairwomen, the health education coordinator from the campus, the four youth from campus, the chairman of the CSUN student group, and the consultant. Conspicuously lacking was the local education director. This meeting was to be the final planning meeting to finalize the week's activities and further develop the types of programs and the methods that would come across to youth the best. The consultant's role at such a meeting is an observer and a resource person, not an active member.

The questions that were asked were, "What had gone on in the past?" "What type of programs does the ACS do regularly?" From previous experience with the ACS, the health education coordinator had used physician speakers, displays and exhibits and possibly a lay speaker well trained in programs for youth. These suggestions seemed to meet with limited acceptance to the high school students. These students then said that the educational sophistication of their fellow students was very low and that they needed actual visual support to help in the learning process.
They further suggested the fear-arousing techniques of showing real cancerous tissue on display. This suggestion met with limited acceptance by the professionals and the teacher. The CSUN students pointed out that fear-arousing education is usually of short duration. The high school students then asked if there were any students around that had had cancer. The answer from the consultant was that statistically there should be several students with cancer, possibly even at that school. The health education coordinator reminded the group that two years prior they lost a fellow student to leukemia. The question was then directed to the consultant as to how these students could be used in an educational program, and how could they be found. The consultant then volunteered to contact several local cancer specialists and the Childrens Hospital in Los Angeles to see if he could find such students. The group then came to a consensus that if these youth could be found, they could be the focal point of the entire project. The idea of a youth-patient panel then evolved.

c) Agency Goals

The project then began to take the form of a pilot project for the youth-patient panel at the high school level. This is what can happen if the consultant allows the group process to develop group ideas. The pilot project was allowed to be the goal of the entire group and not just a good idea from the consultant. The CSUN students
then suggested that they try several different types of programs and measure the difference in effectiveness of each. The consultant suggested that this was an excellent idea and the results could be used to help spread this type of program, if effective, throughout the County, and possibly throughout the ACS structure. The agency goals then centered around the implementation and evaluation of the program and the possible development of guidelines for future program spread.

FURTHER PROGRAM DEVELOPMENT

This group then began to move on to the scheduling of the program. Prior to the youth-patient panel the group thought that a key physician speaker would be most effective in setting the stage with basic cancer facts as they relate to youth. This introduction would save time for questions of the youth-patient panel. The consultant suggested having another physician on the panel so that the patients have a medical backup for questions they do not feel qualified to answer. As a follow up to the first two questions, it was felt that a lay volunteer as an agency spokesman could wrap up the program by describing what is the American Cancer Society and discuss further youth involvement in the agency. Another idea for developing student interest in the program was suggested. Displays and exhibits were planned to be manned by students on campus for the Monday prior to the
scheduled programs. The students on campus and the CSUN students felt that they could develop such exhibits.

A brief discussion of how to evaluate the project came up. The group decided on a pre and post test type evaluation with a follow up questionnaire on likes and dislikes and a rating scale for the different educational approaches. It was asked of the consultant to then design the exam because of his expertise in the area of cancer and youth. Often a work group such as this asks the consultant to do some of the work on the project. The consultant should recognize this and accept these tasks. When the consultant is used properly for high level contacts and development of new materials, this process adds a professional touch to the project and also involves the consultant as a member of the work group. The consultant agreed to develop a slate of questions for the pre and post test and offered to share these questions with the group for their approval and selection, once again giving the group the overall responsibility for their project. The consultant further agreed to contact the physician speakers and the lay speaker from the agency.

The four high school students said they were pretty turned off by medical speakers, and that for this project they would need to have a person with good speaking abilities. The consultant then suggested that when he recruits the physician speaker, the students meet with the
speaker and explain to him the needs of the high school audience and help that physician prepare his presentation. The CSUN students wanted to be involved as well and it was agreed that their chairman and two students from the high school group would meet with the speakers.

The speakers were recruited and the meetings held. The meetings were highly beneficial to the speakers and helped to sharpen their presentations. The group met in the hospital setting where the doctor practices; this gave the students a first hand view of a research facility which they enjoyed thoroughly. The physician was very open to the youth and the youth were open with the physician. The youth asked if the physician would use his lab coat and stethoscope instead of a stuffy suit so that the students would relate to him as a doctor. The physician agreed. This same physician was asked to recruit from his practice youth patient panelists and he agreed.

d) Development of Educational Objectives

This March 6th meeting was a rather lengthy meeting. Another meeting should have been scheduled to develop written educational objectives. As the program developed there seemed to be a misunderstanding developing between the CSUN students and the total group. The CSUN students developed an additional set of educational objectives for their class that didn't necessarily match those
of the project. This lack of scheduling for an additional meeting was the responsibility of the consultant. The consultant should be aware of needs such as those and should make provisions for further meetings.

In general, it was decided that the overall goal was to raise the level of knowledge of the student body about cancer and how it relates to youth, and to measure the effectiveness and acceptability of the four different approaches used in that week of activities.

b. Assessing Duties and Responsibilities

1) Problems in Communications

Communications become a major problem when there are as many people involved in a program such as this one. You have the local office involved through the education director; the school is involved through the health education coordinator; the university is involved through the CSUN students and the volunteers are involved because of their commitment to the project. All of these different people are leaders within their own grouping and tend to assume leadership.

The local office education director assumed that the consultant was totally in charge of the project. The consultant assumed that the education director was informing the local volunteers when he gave her additional information on the project. This lack in communication turned out to be
a frustrating situation between the formal and informal leaders. What should have happened is that the consultant should have kept a master file on all correspondence. This file should have been duplicated and kept in the hands of the local staff person and the volunteer leaders. When projects grow in size from one location to another, usually a newsletter can prevent these problems of communication.

On March 14, 1972 Jane and Helen met with the CSUN students in Jane's home. Jane had arranged the meeting and purposely omitted invitations to the local staff and the consultant. It seems that Jane felt that it was not necessary to involve the local staff and that she didn't need them to function in her new role as leader. Volunteers feeling superior to the staff and blocking the staff from meetings is a sign of problems. The root of this problem may have been too much identification with the consultant as the expert and a view that the local staff was not capable of handling the program. The consultant in this case should have given the local staff more behind-the-scenes responsibilities and orientation.

2) Organizational Resistance

Further developments from this March 14th meeting were outlined for the displays and exhibits. It seemed that this meeting developed a comradery among the chairwomen and the CSUN students and that this spirit developed into a task force to outdo the ACS and not purely
to cooperate with the staff or the school to further the overall agreed upon program goals. The reason for this organizational resistance is still not fully understood by this author. It may have developed from over developing the volunteer and building a confidence level above that person's real talents, or it could have also stemmed from conflicts between the volunteers and the local staff.

The next meeting of the group was initiated by the health education coordinator on campus. This meeting was held on March 20. The primary reason for this meeting was that the school was to notify the campus coordinator that there were no assembly schedule openings for the remainder of the school year, and another arrangement for the program would have to be made. This coordination invited both a representative from each of the respective physical education classes to the meeting. The representative was to have the chairwomen from the project describe to the physical education people the value of the program with the hopes that the PE department would turn fourth and fifth period classes over to the project. There were many pros and cons in using those periods. The campus youth were afraid that the students in the PE classes would be more restless than usual because that was their normal period for physical activity and that the fifth period was immediately before lunch, and the students may be edgy immediately preceding their lunch period. After a lengthy
discussion on trying to deal with the school's administration to develop another assembly schedule, the decision was made to go with the fourth and fifth period physical education classes. The representatives from PE both gave their permission to take over their classes for the entire week. Scheduling for these two difficult periods of the day put an additional load on the program. It now must be extremely interesting and able to keep the students interests at a high level.

3) Conflict with Local Staff

The education director was not in attendance at this meeting on campus. This should have been the second warning to the consultant that more work with that person was necessary. As a part of any pilot program of this nature it is vital to train the local staff so that they can continue the development of the program at that level. At this point the local staff completely gave up their role in the project. It was later determined that the local education director was forced not to attend because of a direct order from her executive director. It seems that a part of Jane and Helen's organizational conflict targeted in on the education director and branched out to the entire local staff. To further confuse the issue the chairwomen, because of this conflict with the local staff, began a letter-writing campaign to the prep office complaining about their treatment by the local staff.
The result from these rather bitter letters and hasty confusing replies was that both Jane and Helen, late in April, decided to resign from the project. The program was far too well planned to have this affect the implementation of the activities. The main loss in losing these two valuable persons was that they had become trained and were more than capable of leading another committee that could have brought these types of programs to the other schools.

4) Reconstruction

On March 21 and 23, the students from CSUN met on their own to further discuss their responsibilities in the area of evaluation of the project. They further discussed their class requirements and how they did or didn't match up with those of the project. At this meeting their timetable of activities was developed. On March 30, they met again to formalize their behavioral objectives for the program. These behavioral objectives were their own and not those of the entire group. In later evaluation of the project there was a conflict as to the educational success of the project as measured from the students versus the staff of the agency and the committee involved.

On April 10, 1972 the total committee met again at the high school. The purpose of this meeting was a final assessment of duties and responsibilities. The meeting was also an informal information sharing meeting. The consultant brought the group up to date on the arrangements for
speakers and panel members, and reported on the meeting of the speakers and the youth leaders. It was the consultant's role at this meeting, in the absence of the chairwomen, to make sure that everything is ready for the program. It is also important that each person has a significant contribution to make towards the success of the program. The consultant reported that all of the speakers had been confirmed and gave a brief sketch on each person's background. All of this reporting was to give all involved a feeling of security and to fill the gaps where there has been less action than necessary. This type of reporting is an excellent tool in the meeting situation for exposing weaknesses and building on strengths. Also, plans that have not been completed are brought up and assigned before the next meeting of the group.

The idea of orienting the faculty at the high school came up as a topic of discussion. It was decided that all of the faculty should be contacted and that the assemblies be invitational (Letter in Appendix C). The campus coordinator suggested that a physician speak to the faculty at their regular staff meeting. The consultant scheduled a speaker for the date suggested and prepared copies of the questionnaire for the faculty. Two days prior to the date of the presentation, the staff of the school changed the date of their meeting. The consultant, not knowing this, arrived at the last minute as the speaker.
After questioning the faculty, it was found that they really expected a medical speaker and, also, that they didn't appreciate being tested on their cancer knowledge. Because of this faculty negativism, it was decided not to post test the faculty. The questionnaire that the consultant had prepared listed 30 questions relevant to cancer and youth. The consultant had mailed the questionnaire to two pediatric cancer specialists for medical correctness. At this April 10 meeting the consultant shared the questions with the committee (Appendix D). This group felt that they needed only 15 questions so they began to narrow down the list (Appendix E). It is good procedure to have many more questions than needed and to let the committee make the decisions as to which ones to use because once again, the questionnaire becomes theirs. This process can, however, become threatening to the consultant.

When the consultant's work comes before the group that he has been instrumental in developing, and the group becomes critical of the consultant's efforts, there is a potential ego threatening situation. The consultant may have become close to his work and very critical of the group's criticism. The consultant must at this time remember the commitment to the group process.

On April 11, another unscheduled meeting took place in the absence of staff. The CSUN students met with the chairwomen. The CSUN students needed further information of the program development to help in their class
write up and the volunteers needed further ventilation. It was at this meeting the chairwomen announced their resignation from the project. Usually when a person resigns in a group situation such as this, they are actually asking the group to come along. The CSUN students were aware that the project had gone too far to allow the loss of these two persons to jeopardize the entire project.

The chairwomen's resignation shifted the leadership to two people, the on campus coordinator and the consultant. If the local education director had been involved as she should have, the leadership would have gone to her and the campus coordinator. Even though Jane and Helen had resigned, they both attended two of the sessions. They didn't attend any of the follow-up meetings, but were mailed copies of the results. These persons never again became involved in the ACS. The loss of Jane and Helen as continuing volunteers was a real loss to the agency goals. Any such program is designed for self-perpetuation through those involved in the pilot project. Without the volunteers, the only replication of the program would have to be done through staff. The consultant was caught between a difficult situation that he had little control over. He thought that the complaints these two had against the local office of the ACS were indeed valid. In order to try to salvage these two, the consultant met with them in the evening hours at their homes. Without changing the staff structure they absolutely refused to return to the ACS.
B. IMPLEMENTATION

1. THE MECHANICS

The mechanics of the implementation states are of ultimate importance to the smoothness of the program itself. To simplify their procedures, the author will review them as they were presented to the students.

a. The Physician Speaker

The physician speaker, the first presentation made to the students was by a physician speaker. The physician set the tone for the entire project. He had to be dynamic and able to captivate the students at a period of the day when they were not accustomed to listening.

Doctor James H. from a local tumor institute had been active with the ACS for over 15 years. (Appendix F) He had spoken to countless numbers of teacher workshops and many ACS annual meetings. His field is basically the epidemiological causes of cancer. His standard presentation gives an overview of the disease and the total problem of cancer. Education for the prevention and early treatment of cancer is presented in his presentation. The consultant was very familiar with Dr. H. and contacted him as first choice for this program. The initial contact was by telephone to Dr. H's secretary. This contact is to see if the proposed date is clear. The date was, the
consultant asked to speak with Dr. H. directly to describe in detail the program and the outline of what Dr. H. should cover in his presentation. Dr. H. was excited with the new approach and was happy to agree to be the "kick-off man." A letter was immediately sent to Dr. H. with the time and date and location, including a map and parking instructions. In the letter and outline of Dr. H.'s presentation was requested. The intent of this request was so that the outline could be shared with the other speakers to eliminate duplication. It is a rare speaker that will supply such an outline. Dr. H. returned the outline in less than a week. He also agreed to look over the questionnaire so that it could be medically correct and so he would have an idea of the basic subject matter. A follow up reminder letter was written the week prior to the program. This letter served as a progress report and a second confirmation. The second letter also included the names of all those involved in other presentations at the program and the key leaders on the planning committee. A follow up letter was written the week prior to the program. That letter served as a progress report and a second confirmation to Dr. H. Because of Dr. H.'s expertise and experience, it was felt that he didn't need to meet with the youth committee to help polish his presentation.
b. The Panel M. D.

The physician speaker for the youth patient panel, was initially contacted by the consultant. In an ideal situation the consultant would have directed a volunteer committee member to make this contact. The contact was made by the consultant because attempts in the past by others that were not professionals to reach Dr. H. never got past his secretary. Some physicians only take calls from patients, their family or others that the physician has worked with in the past. This physician was selected because of his activities with the ACS and because of his position at Childrens' Hospital.

Dr. J. has devoted his entire career to cancer and children. (Appendix G) The same procedure that was used with Dr. H. was used with Dr. J. The only difference was that Dr. J. agreed to meet with the youth group from the campus to discuss the approach taken at the high school. Dr. J. also was instrumental in recruiting the panel of cured cancer patients. Three of the four youth panelist were Dr. J.'s patients at Childrens' Hospital. A busy physician such as Dr. J. should be contacted six months in advance for any meeting date. The meeting that included the students was held in the evening so that it did not conflict with Dr. J.'s schedule. An extended role of the consultant often requires special efforts when working with youth. This meeting was held in the hospital
and proved very beneficial to both the speaker and the youth.

c. The Youth Patient Panelists

At that meeting Dr. J. gave several names of his patients to the consultant and asked that he call them direct and recruit them for the project. Any time a patient is used in any type of activity for the ACS, there must first be clearance gained from that person's physician. With Dr. J. this was done at that meeting. Parental consent is the next level of approval. Each of the panelists parents were very understanding and hoped that their children's presentations would help others in some way.

The procedure for contacting the panelists was this. They had already been approved by their physician and contacted directly by the consultant; they then received letters outlining the project and directions for finding the location. The letter further asked if the panelists would like to meet informally with the physician immediately before their presentations and share an outline for their presentations. The consultant's name and phone number was also given and an "if any questions arise please call" sentence was added. The names of all of the speakers on the program and the key leaders on campus were also listed. As with the M. D. speakers, a follow up letter was mailed one week in advance of the program as a reminder
and opportunity for further contact. The fourth panelist was recruited in the same manner but through another cancer specialist.

d. The High Level Lay Speaker

The lay speaker was the last formal segment of the program. The selection of a lay speaker was made to show that the fight against cancer is more than medical in nature and that the lay public has an important place in the cancer battle.

The top lay person in the ACS lived in the San Fernando Valley. Mrs. B., a volunteer that worked her way up through the ranks of the organization in the last 20 years, was at that time the president of the California Division. (Appendix H) Mrs. B.'s interest in youth program was very evident to the consultant who had worked with her in the past. Contact with this person is a complicated process. Because Mrs. B. was the president of the division, there is a protocol in reaching her and scheduling meetings. The usual procedure is to contact the executive vice president of the division and ask if the date is clear on her speaking calendar. If it is, then the consultant writes letters to both Mrs. B. and the executive requesting her for the time and date needed. This letter must include a concise section on program development and the need for such a high level speaker.
In this case, because of the closeness of the consultant to Mrs. B., a phone call was directed to her asking if she was personally interested in the project. Mrs. B. was highly interested and committed herself to speak, but further suggested that a confirming letter be sent. The consultant transmitted the necessary letters confirming her speaking time and dates with the division office.

Upon confirmation of all of these key speakers and the four panelists, letters were written to all of the committee members involved as a progress report. Copies of all correspondence was sent to the local office for their files and information.

e. Program Promotion

One of the members of campus committee invited the school paper editor to a meeting of the total group and asked for publicity support. This editor also had contacts with the local weekly paper in the valley. As a part of the CSUN students project they were asked to develop media material. The CSUN students developed the spots and articles and they were then distributed on campus by the editor in the school paper as well as in the local valley weekly. This editor then suggested video taping the presentations and developing a documentary on the entire project. The editor also was familiar with the video taping crew and made all of the arrangements. The presence
of the video taping crew at the presentations added a
dimension of professional importance to the project and
was of great assistance in gaining the audience respect.

The consultant's role in the development
of this program promotion is to see to it that wherever
possible the group that developed the project become the
project's spokesmen. Most media outlets prefer to see the
real people involved rather than a staff person from the
agency that they see all too often anyway. A key to being
a good consultant is to divorce yourself from the committee
and allow them to assume responsibility for the program
development and implementation. The rewards of being a good
consultant is first, a successful program, and secondly,
the development of a new on-going group that can function
independently from the consultant. The first priority is the
easiest, the program. The development of the group is the
most important and most difficult.

2. PROGRAM FORMAT

The on-campus group and the CSUN students were to
set up displays on campus Monday, April 24, 1972. There
were no ACS staff involved in this portion of the program.
The second session was the presentation of the medical
speaker, Dr. H. The on-campus coordinators acted as
moderators. This presentation was to be given twice;
one to the third period classes and again to the fourth
period classes. The Wednesday session was to be the Youth Patient Panel including the consultant as the health educator and Dr. J. as the medical resource person. Again this presentation was to be given to both classes in succession. The Thursday program was to be Mrs. B., the volunteer president of the division, with her wrap-up and charge to the youth.

For the first introduction the students picked the most popular girl on campus to introduce the program and the students that were involved in bringing the program on campus. This was an excellent approach. The students were then identified as leaders. Further they were now identified as resource persons on campus for cancer information. Presenting them as leaders also localized the program as a campus activity and not as something from the outside.

At the last minute the students requested background information on each of the speakers and in a rush this information was furnished by the consultant. Program planning should have taken care of these details far in advance to the program. When these small details are left uncared for, tension builds up about the entire program. The leaders involved wonder if there have been other details left out. Good communications is the solution to this problem. The resignation of the chairwomen added to the last minute tension. Also, no matter how good the planning, there is always a degree of last minute tension. The best
way to deal with this tension as a consultant is to keep calm yourself and depend on your own planning and follow up to keep the program running smoothly. As a good back-up to any program of this size, it is always good to have a filler type of presentation ready. In the case of this program the consultant arranged to have a 16mm projector and screen available as well as two excellent films. This would be used if for any reason a speaker did not attend. This type of advance planning is also helpful in easing the last minute tension.

The pre-testing took place Friday, April 21. The test group was selected from the P.E. classes by drawing class instructor names out of a hat. A large sample was taken to assure accuracy. The CSUN students administered the pre and post tests. The post test was given on April 28, the Friday of the project week. This group of students post tested were also randomized in the same manner as before.

Cancer literature was made available to the students following the presentations. Literature was not handed out. It was felt by the committee that if the program significantly motivated the students to read further about cancer that they would pick up the materials on their own; and the material would less likely be discarded.

For in-depth follow up the students volunteered to attend health education classes following the program
to question the students on the effectiveness of the program. This opportunity for one-to-one evaluation and feedback was excellent.

3. THE PRESENTATION

MONDAY

The displays and exhibits were set up at 8:00 A.M. These displays included a movie mobile that showed continuous movies about general cancer and smoking. A display on smoking was also presented. This display included actual lung specimens and a mannequin that smokes. "Smoking Sam." These displays were viewed between classes by instructors that brought their classes by to observe the presentations during class hours. The exhibits and displays were viewed all day. These displays were manned entirely by the students and the campus youth.

TUESDAY

The three assemblies scheduled for Tuesday, Wednesday, Thursday, of Cancer Week were held for all third and fourth period physical education and health education classes. The times were 10:05 to 11:04 A.M. for students in third period classes and 11:10 to 12:04 for those in fourth period classes. Each assembly had an attendance of roughly 900 people, 600 of which were selected to take the pre and post questionnaire.
The CSUN students and the consultant arrived at about 9:30 A.M. and assisted the student helpers in arranging the gymnasium for the presentation of the program. In addition to members of the sound stage crew, who organized most of the technical facilities, help was required in setting up banners and posters throughout the gym. The set-up arrangement was similar for Wednesday and Thursday's assemblies.

At approximately 15 minutes before the hour Dr. H. arrived and introduced himself to the on-campus health educator and the group from CSUN. Students were beginning now to file into the gym and took their places along either side of the room sitting on wooden bleachers.

Dr. H. was introduced to the audience and given a short biography of his work and accomplishments. Dr. H. then delivered a 40 minute prepared speech on cancer and its relationship to youth. A synopsis of that speech follows.

Dr. H. offered a layman's definition of what cancer can be said to be, how it develops, spreads, and how it is treated. In relating the problem to young people, he remarked that cancer is second only to accidents in bringing death to children from the ages of one to fifteen. Cancer knows no age limits, for it attacks all people without regard to one's socio-economic, religious or ethnic background. Several other statistics were presented, but
the one that appeared to have the most profound effect on
the audience was when he made the following remark.

    I want each of you to look about you and
count off three persons sitting next to
you. Of these three people, including
yourself, one out of this group will
develop some form of cancer in your life-
time.

The reaction was immediate and penetrating. The whole gym
began to fill with the sound of voices and stunned students
sought to express their disbelief, surprise and anxiety
over hearing statistics presented in such a meaningful
way. The looks on students' faces were evidence of the fact
that they showed concern. Dr. H. continued:

    But one need not be a victim of cancer and
die from it. Early detection, with a proper
diagnosis and treatment is absolutely
essential to saving lives and that is where
the emphasis should be placed. Moreover,
the success rate for treatment today is that
one patient out of every three is cured of
his disease, but this figure could be in-
creased to one in every two if only people
would go to see their doctor in time enough
to halt the spread of the disease.

Dr. H. went on to discuss current methods of treatment
describing and explaining what surgery, radiation therapy,
and chemotherapy entailed. He also outlined current
trends in research programs making special comment on the
University of Southern California Medical School Program
that had established a possible link between viruses and
cancer.

    At this point a new word in the vocabulary of many
students was introduced - Epidemiology. It was defined
simply as the study of diseases according to patterns. Its importance to cancer, Dr. H. pointed out, lay in the fact that it was possible to track down causitive agents responsible for causing cancer without knowing how or why these agents acted as they did. To illustrate his point, he noted that in 1775 an English surgeon, Percival Potts correctly attributed the frequent occurrence of scrotal cancer among chimney sweeps, to soot exposure. It was hypothesized that a carcinogen might exist in soft coal—but how and why it affected the body as it did was unknown to Potts. What was recommended, however, was that chimney sweeps bathe daily to cleanse themselves of accumulated soot (they had previously bathed only once a week). Soon afterwards the rate of scrotal cancer dropped from a rate of 300-400%, greater than the total population to a rate comparable to that of the general population who were not exposed to soft coal in such large amounts as were the chimney sweeps.

By using an illustrative anecdote, Dr. H. was able to explain how epidemiology could be used to show why it is not always necessary to know how or why a causative agent acts in such a way as it does in order to eliminate a given disease from a given population.

Along the same line of thought, Dr. H. made reference to cigarette smoking and its relationship to lung cancer. Admitting that medical science has not yet found
a cure or treatment for lung cancer, short of lung section removal, he advised the students that since research has strongly linked cigarette smoking to lung cancer, it would be far simpler for people to give up or never start smoking in the first place. Like the chimney sweeps of England, we do not absolutely need to know how and why tars/nicotine cause cancers, we can choose not to smoke and thereby greatly reduce our chances of ever having cancer in the first place.

That is not to say, however, that medical science is not curious as to how and why these agents act as they do - they are concentrating on such research, but for the layman who smokes, it should not be his or her primary concern.

In closing the program which, incidentally, was presented to the fourth period assembly in the same manner, Dr. H. offered some suggestions.

1) Students should have and should urge their parents to have a complete yearly physical exam.

2) Girls should have a Pap Smear test done yearly whenever sex becomes a part of their lives, or when reaching 18 years of age, and should conduct monthly breast exams themselves.

3) Avoid over exposure to the sun - get a suntan a little bit at a time but don't over expose yourself unnecessarily, especially if you've got fair skin. Be sure to use a preparation if you burn easily.
As an alternative to smoking Dr. H. suggested that students smoke only half as much of each cigarette, that they buy cigarettes by the pack instead of the carton, and that they try to gradually cut down on their consumption with the hope of eventually stopping.

It was at this time, about 40 minutes into the program, that Dr. H. opened the discussion for questions from students.

WEDNESDAY

Wednesday's assembly, which was quite possibly the most valuable and effective parts of the entire program, featured a panel of four cured or semi-cured cancer patients who were similar in age to that of the audience. They were joined by Mr. Barry Humphrey, Health Educator for the County of Los Angeles Cancer Society and Daniel M. Hays, M.D., of Children's Hospital in Los Angeles.

Each young person was asked to recount his personal experience with cancer, how and when he discovered it, what were his feelings about it, and how he was treated and cured. Several minutes were allotted after each speaker for questions from the audience after which the next individual was asked to continue. Briefly, then the four panelists in order of presentation included:

Philip M. - A high school sophomore who developed a form of muscle cancer in his right testicle, Rhabdomyosarcoma, approximately one year ago.
The testicle had become inflamed and had increased in size comparable to that of a grapefruit at the time it was surgically removed. In addition to surgery Phil had to undergo massive radium and cobalt treatment therapy which, to this day has had permanent effects upon his body. He is unable to undergo direct exposure to sunlight without a shirt, for if he burns, a skin graft will have to be performed.

Robert B. - Currently a junior at California State University, Northridge. Robert's cancer was detected at age 3 when his parents discovered an abnormality in his left eye when exposed to light at a certain angle. His parents sought the diagnosis of a physician who reported it to be "nothing of real concern, something that will just go away by itself."

Not fully satisfied with this answer, they sought the opinion of a second physician who later diagnosed it for what it really was - Retinoblastoma or cancer of the retina. The only course open to the doctor at the time was for complete removal of Robert's eye. Had this not been carried out or had his
parents listened to the advice of the first
doctor without consulting another, the cancer
would have spread to the brain, thereby
cauising death.

**Brenda H.** - A 19 year old sophomore at Pierce
Junior College. Brenda developed a sharp pain
and limp in her left leg, starting first at
the knee, then progressing upward into the
thigh. A biopsy was performed to determine
if any internal growth might prove to be
malignant. The test showed that this indeed
was the case and was spreading fast. A com­
plete amputation at the hip was indicated to
halt any spread. In spite of such a pro­
nounced loss, Brenda still keeps her spirits
high and still engages actively in sports
including snow skiing - an accomplishment
that many people having both legs still cannot
accomplish.

**Kim M.** - As the youngest member of the group, 16
years old, Kim recently underwent surgery
for removal of a cancerous growth in the lower
colon. As a result of the removal of tissue
that she described as being as large as that
of a football, a special operation called a
colostomy had to be performed. It entailed
reseccioning of the lower intestine so as to restore normal bowel functions. Kim, in addition to her massive surgery was still undergoing chemotherapy as of the date of the assembly, April 26, 1972.

The reason why this particular assembly was mentioned as being the most valuable, it was later learned in post-assembly classroom workshops, was that it provided an environment in which high school students could relate to other young people of their own age group who had had cancer in a way that far surpassed the comparatively technical presentation of Dr. H. or Mrs. B. Here indeed, were students that provided living proof that cancer knows no age limits, and that survival is indeed possible, in a way that far out-weighed the significance of statistics alone.

THURSDAY

The final program in the series of the week's three assemblies featured Mrs. Helene Browne, a 20 year veteran of the American Cancer Society, who is currently serving as President of the California Division.

Mrs. Browne's speech was to differ from that of Dr. H. and the youth panel discussion in one major respect. Whereas it had been the function of Dr. H. and the panel of former cancer patients to convince the audience that the problems of cancer were indeed relevant to their age group -
not only through statistics but also through actual living case histories. It was Mrs. Browne's function - once the students had been convinced that cancer could and would affect them - to point out to them alternatives to getting cancer, in addition to ways in which they could become actively involved with the American Cancer Society in attempting to "wipe out cancer in their life time?" What was to be stressed, were means by which interested students could involve the school and community in setting up educational workshops so as to educate the public on the dangers of cancer.

Mrs. Browne urged students to become involved in the newly formed Campus Cancer Awareness Club and by working through this club to establish a "quit smoking clinic" for students, their parents, and interested members of the local community. Under the guidance of the American Cancer Society, students could set up such clinics, which might function out of community hospital waiting rooms, school auditoriums, or private residences, whose functions would be to help individuals cut down or stop their intake of cigarettes. Throughout the first assembly, students were restless and talkative, seeming more anxious to leave the assembly for their next class than having to sit through what many students described as a "preachy" authoritative speaker. As a result, very few questions were directed to Mrs. Browne as compared to the barrage of questions directed at Dr. H. two days before.
In order to avoid the repetition of the first assembly (noise, restlessness, inattention), Mrs. Browne altered her second presentation, directing her emphasis away from cigarette smoking, and onto cancer quackery. She spoke also on quit-smoking clinics, as she had done during her first speech, but stressed mainly the dangers of entrusting one's life to a quack if one were to have cancer. Mrs. Browne related to the students the story of an 8 year old girl who had been diagnosed as having cancer of the eye. Doctors at U.C.L.A. Medical Center stressed the immediate need for surgery, which involved removal of the eye - a very disfiguring type of operation. The mother could not accept this fact and via a liaison agent of a practicing chiropractor who was a "quack" the mother was put in touch with a fraudulent health practitioner. He promised he could cure the child without removal of her eye and therefore save the child from any type of surgery. The distraught mother grabbed at any opportunity and the child was removed from the U.C.L.A. Hospital. She was then placed under the chiropractor's care and was given endless amount of drugs and physical therapy. There was no response to the treatment and within a period of 8 weeks the child was in very serious condition. The cancer had metastisized to her brain, when she was taken back to U.C.L.A. when within a very short period of time she ultimately died. Prosecution
was brought against the quack and he is now serving his time in prison.

As opposed to the first assembly, students at the second assembly were quieter and more attentive and showed greater interest by confronting Mrs. Browne at the end of her presentation and asking her a variety of questions.

FRIDAY

Friday's program differed from that of the previous days' activities in that no student assemblies were featured, but rather, post-assembly classroom workshops were made available to all of the four health education classes.

The purpose of these workshops was to obtain student feedback regarding.

1) their opinions of the week's activities as it affected them;

2) any questions they might have that were not answered in Tuesday's, Wednesday's or Thursday's assembly;

3) suggestions for improvement of future programs at other schools.

The CSUN students received close to 200 separate written replies from students in those health classes attended.

Included also in Friday's program, was the re-testing of all third and fourth period health and physical education classes. Since, the seven CSUN students were in those health classes, they were able to administer the post-test and student evaluation form and were able to collect
them within the hour. The collection of tests from the physical education department was done with the helpful cooperation of the on-campus health education coordinator.

Each of the assemblies were introduced to the students by the students from that campus that served on the development committee.

C. EVALUATION

Program evaluation within a voluntary health agency usually involves the counting of persons in the audience and multiplying by the number of speakers. In-depth evaluation is not the usual because of several factors. The first factor is that there is not enough manpower to provide for the number of programs necessary, let alone the evaluation of such programs. A second factor is the usual level of volunteer support, not of the type that can administer in depth evaluation, and third, such evaluation would not assist in furthering the goals of the agency because it would be too time consuming and other program areas would suffer if the staff time was diverted to this type of evaluation.

This project was blessed by the assistance from CSUN by allowing their students to become involved and add the evaluative expertise that otherwise would not have been available to this program. Because of the nature of the project, documentation and in-depth evaluation was necessary. Without the assistance and cooperation of the faculty and
students from CSUN this project may have ended at the con-
clusion of the programs.

The evaluation at best still does not constitute hard and fast statistical evaluation of behavior change, it does, however, measure the effectiveness of such a pro-
gram and the acceptance levels on the part of the students of differing types of programs.

First to be discussed here will be the numerical evaluation of the pilot project. Secondly, a discussion of a similar project and its evaluation as a replication of the pilot project. Lastly in the section on recognition the evaluative processes of the American Cancer Society on the merit of such programs will be discussed.

For the purpose of this paper the role of the con-
sultant in the evaluative process is more relevant than justification of the evaluation method or design.

In the early meetings with the CSUN students the evaluation method was discussed. It is once again important as a consultant not to tell the volunteers what method is best or more relevant. It is better to lead into the dis-
cussion methods of choice and allow the group to make the decision.

The students were presently attending a class on evaluation of health education programs. The course was an undergraduate course and not designed to deal at great depths in the statistical evaluation of programs. Rather
the evaluation system they were being taught was much more suitable to the voluntary health agency and this program. The students primarily wanted to measure the knowledge level change on the part of the students and to further survey their acceptance to differing types of presentations.

The consultant suggested a simple pre and post test design. The students thought that this was, from their background, appropriate. Initially the group wanted to test the entire group of students but after a discussion on the time necessary to evaluate the tests, a smaller sample was suggested and accepted. One student suggested that we test students that did not attend the program to see if the programs' messages reached those not in attendance through word of mouth from those that did attend. Another suggestion was to pre and post test the teachers to see if they learned anything from the programs as well. All of these ideas would be worth developing, but with the limited resources and time available the consultant tried to move the group to just the simple pre and post test. The group accepted this as appropriate for their goals and class requirements. The second measurement needed to help the American Cancer Society was the acceptance levels for the different types of programs. The CSUN students suggested a simple one-to-five rating for each category of program and then a simple percentage taken of the responses. The consultant agreed that this was sophisticated enough for the purpose of the American Cancer Society. A smaller
sample was decided upon for the rating plus a category for open opinion for those that desire to comment. The consultant agreed, because of the clerical back up and printing facilities of the American Cancer Society to take the responsibility for production of these forms.

The results from the pre and post test were extraordinary. (Appendix I) The acceptance survey likewise was perfectly clear in interpreting the students likes and dislikes. (Appendix J)

Two questions, Questions 3 and 9, on the pre and post test, showed an improvement of over the 40% level. Of the two, one was 47% more correctly answered on the post test. The next two most improved answers were for questions 4 and 10. Both of these increases were 28.9%. Three other questions, Questions 6, 14 and 15, ranked well above a 10% increase. All questions excepting one improved in correct number of answers. (Appendix I, question 12)

Question 3, the question with the greatest improvement was of great significance. The question was,

Ranging second only to accidents, Cancer is the number two killer of the school age student from 1 - 15 years of age.

65% of the students tested didn't know that fact and only 19% didn't know the correct answer on the post test. The committee felt that youth knowing where they stand among cancer statistics was an important objective of this project. Relevant to that objective, the level of knowledge about this one question seems significant. The second question
in the 40% category related to the statistics on female breast cancer — another important statistic for youth. The ACS feels that if a woman is aware of the risk of developing breast cancer and if that woman realizes that breast self-examination is her first defense against death from the disease, she will be much more apt to practice this early detection method regularly.

Question 4 relating to the fatality of Hodgkins Disease and Leukemia also showed a 28% increase in correct responses on the post test. Another objective of the project was to show that cancer is not always fatal and to improve the climate of hope. The question regarding the Pap Test should begin as an annual test to detect early cancer reflected a 28% increase. Only 15% of the students responding answered this question incorrectly; a good show of knowledge for this one question.

Four questions on the pre test were answered over 90% correctly. With this high an initial response, it is difficult to produce a significant percentage change.

A proper testing of these results would be a Chi Square test of expected results versus the actual. There should also have been a correction factor for loading on the post test by the student taking the pre test. It is not the intent of this paper to develop a proper statistical analysis of the data but to attempt to interpret the results of the case study. The average per question improvement was well over 13% and the total percent improvement was
just under 14% for the entire group. The pre test percentages can act as a measure for the effectiveness of further follow-up programs. If a group is pre-tested and ranks as high as the post test results, there may not be a need for further education programs on that area.

The second measurement tool was that of the acceptance level of the students for the varying types of programs presented. Once again, this is a presentation of the CSUN's students charts and not designed as a proper statistical evaluation of the project. The students were asked to rank on scale of 1 to 5 how they felt about the different presentations. Of the students that rates the youth panel, 77% rated it as the most valuable of all the programs presented. According to the other ratings for the other presentations, the youth patient panel ranked number one, well ahead of all the others. The medical speaker and the lay speaker tied for second and the literature and displays ranked third over the movie mobile.

The students were then asked to rank the total project. Over 80% ranked the total project as good or most valuable. And an additional 11% ranked the program as fair. This leaves only 8% of the total that felt the program was less than fair. (Appendix J)

This chart alone deserves further statistical evaluation beyond the purposes of this paper. The main use of this chart was the fact that the youth patient panel idea was best received by the students surveyed.
Evaluation of this nature is unusual for voluntary health agencies. The usual evaluation is a number counting of audience. There are several reasons for this lack of evaluation. Time is so important when it is voluntarily given. Staff members are spread so thin that if they took the time to evaluate each program, there would be little time left for program development. Usually in-depth evaluation is carried out for pilot purposes and then later dropped to give more time to program development.

The consultant's role in the development of this project's evaluation was primarily setting of deadlines. The students were self motivated and needed little instructions. Evaluation was part of their class project so this evaluation fit nicely into their original objectives.

D. CONTINUATION OF ACTIVITIES

Another role of the ACS consultant, after a program has been proven effective, such as this case study, is to develop a system of information flow so that other programs of this type can be presented throughout his consultative area.

1. Information Flow

The original report from the CSUN students was over 120 pages in length. This report would have been impossible to circulate in its original form. The consultant then felt it necessary to provide a summary of the information and the results, and distribute them throughout the information channels already set up in his area. The summary
was mailed with a loosely structured set of guidelines for developing such a program. This summary and the attached correspondence was sent to the five education directors working for the ACS in the consultant's area.

Each of these five education directors have the option of developing such a program within their time limits and their volunteer manpower abilities. The usual pattern for further information is that one of the education directors finds the program interesting and within their grasp and then calls in the Area Education Director as a consultant to assist in the development of a similar program. The consultative process is very similar to the original project. The consultant advises the Education Director and allows that person to assume responsibility for this project as he is capable.

2. New Consultative Patterns

The main difference between the consultative procedures, when the consultant is consulting to staff to develop a special project, is that the consultant is advising on how the staff should handle another group through their individual consultation style. What this means is that the consultant develops the staff to work in the same capacity as he did in the special project.

This new form of consultation can also become ego threatening. In reality, the consultant is bringing to the Unit Director first a program idea, and secondly, instructions on how to do a similar job as the original project
had been done. Usually, a consultant that has followed a project through completion feels attached to that program and also feels that it is the best program to date. This process becomes threatening when the consultant is confer­ring with a unit director that is more capable than he, or when that unit has programs that may be superior to the consultant's newest project. When this happens, the con­sultant, if he is perceptive enough to see the situation, should not spend as much time duplicating efforts because time once again is important. The only time necessary should be an occasional visit or written progress report on the activities of the unit education director and the program development. In most cases there will be other unit education directors that will need more time than the one that has the skills and/or the volunteers to do the program independently from the guidelines. This will free the consultant to work in areas of the greatest need of his services.

When the consultant has a new and effective pro­gram under his belt, this usually opens the door for con­sultation in areas that he has not been working. If the program is of greater value than the best operational level of a unit where the consultant has spent little time, this new program may open the door. In this manner, a good project can be an effective tool for reaching areas where the consultant hasn't been invited in before. This new program can also become a training device for new staff.
Usually when new staff come on the job, if they start their career with a successful program, they are much more enthusiastic about their position.

This same procedure, beginning with a successful program, can also be used to re-energize a weak or apathetic director. Usually a successful program provides a positive atmosphere in which future successes can be achieved.

E. RECOGNITION

Any project worthy of future expansion should be properly recognized. This recognition assists the project expansion in several different ways. First, recognition brings an awareness to the project that may not occur through other means of consultative patterns. Recognition also gives the project a certain value above other more routine programs. This recognition value also assists in expansion of the program. If properly recognized, the program sells itself and the consultant doesn't have to become a "project advocate." Depending on the level of recognition, the higher the level, the further the expansion, the relative ease in promotion is based. If the project receives national recognition, it becomes more irresistible to a greater number of units.

Recognition for newly developed projects is also a reward for those involved. Usually a group works to develop a good program in the beginning and does not engineer the program for special award. The recognition is truly the icing on the cake. Volunteers usually work for a
good program and not recognition.

1. The Recognition Process

There are several methods of recognizing worthy projects. For the purpose of this paper we will explore the in-agency recognition system and briefly explore those outside recognition sources that were involved in the case study.

For programs and projects within the ACS, there are several avenues to recognition. There are also as many levels of recognition as there are levels of administrative services. First, a project must be awarded local recognition by the unit board of directors. This is usually done by a presentation to the board and recording of the board's acceptance of the project. From that level programs that are awarded unit recognition are pooled and sent on to the state level education committee for review. This committee, by ranking these projects by using criteria developed over the years, select only a few projects of real merit and award them with a Letter of Special Recognition. The chairman of the board of directors signs the certificate as well as the division public education committee chairperson (Appendix K). In turn, these State level awarded programs are pooled and sent on to the National office in New York. Using a much more stringent criteria for evaluation, the national education committee reviews and selects only four programs or projects each year for a National Honor Citation (Appendix L). This awarding at
different levels creates quite a time lag. The case study project worked its way through the system and was awarded a National Honor Citation two years after the project was presented. This lag can have both positive and negative effects. The positive effect is that when awarded, it gives the local level a boost and further incentive to do more programming. Also, a positive aspect is that when the case study project was awarded a National Honor Citation, 20 other divisions of the ACS wrote California and requested copies of the guidelines so that they could implement the program within their divisions.

The negative aspects of this time lag is that the volunteers may not be active when the recognition finally comes through. In this case study the only volunteers that were still around and involved in the project were the youth patient panelists and not the committee members that were so instrumental in developing the project. A National Honor Citation is always a positive addition to any program; it is only the time lag that is of concern.

Outside sources of recognition for this project included the Vision Award from the Women's Division of the Los Angeles Chamber of Commerce. A committee of these women search out projects to pool for recognition. The case study was one of one hundred such projects to be submitted and received a commendation from that group.
2. The Consultant's Role in Recognition

The consultant's role in recognition of these projects is an important one. Usually a new group to the agency is not aware of the recognition system. It is important to use proper timing when discussing recognition. If recognition is used as bait to bring people into programs, there is some question of motivations. Recognition should be discussed following a successful program. This means that the consultant at the conclusion of a project makes a surface evaluation of the project and can begin the preparation of the project write-up. Ideally, the consultant can remain a consultant by assisting the group in developing their own recognition write-up. It is further necessary for the consultant to be aware of the projects in the past that have received this recognition and the criteria for recognition of current projects. Also, the consultant must be aware of outside resources for recognition.

3. Project Participants Recognition

Recognition also has a great effect on the individuals involved in the project. If properly awarded, each individual can share the recognition of doing an exceptional job and being a part of an exceptional program. This recognition also shows others that there are means for helping others. Proper recognition also requires some work with the news media. The media coverage of the case study was assisted through people involved in the project. This is an excellent avenue to further media development. As a result
from the media coverage of this program, several other youth patients were recruited and many, many requests for similar programs at schools arose.

In the fall of 1974 the National Honor Citation was awarded to the youth patient panel at a special news conference developed by the local staff and assisted by the area public information department. Five of the major Los Angeles County news stations attended the conference and carried five or more minutes of coverage on their stations that evening. This coverage is also a recognition of good program. From this coverage the panel of youth have been booked into schools for the remainder of the year and into next fall.

The consultant must be sensitive to the media's needs and be able to supply them with the necessary statistics so that their reporting is factual. This requires tact. If you present the facts in a manner that makes the media feel inferior, you are not likely to receive air time. Usually a project that brings the media shows a great deal of interest on the part of the media and they then become much more easy to work with.
CHAPTER 4

SUMMARY

A. IMPLICATIONS FOR HEALTH EDUCATION

The major implications for health education are these: 1. The role of the consultant is valuable for program development, implementation and evaluation. 2. That the consultant position is an economical way to provide maximum expertise with a minimum of overall staff expense. 3. Through proper methods of consultation, effective educational programs can be continued and spread throughout the Nation.

1. The Role of the Consultant

This first implication deals with the value of the consultant in developing high level programs. The consultant is usually a resource to existing staff. When the level of expertise is reached in a particular area and a program potential arises, that is felt to be beyond the local staff's ability, the consultant should be called in. When this occurs, it can result in two major actions. The consultant assists in the development, implementation and evaluation of a project that would not have happened otherwise. The second action is through sharing his skills with the local staff, that staff person will have some experience in handling programs that once were above his level of
expertise. Therefore, the consultant plays a dual role. One is the role of the health educator and the second the trainer of health educators.

2. The Consultant and Cost

Under the present system for hiring staff within the ACS there are not enough funds available to hire all of the MPH health educators that are really necessary. With the hiring of one such person and relieving him of the everyday burdens of office work and committee responsibilities, the high level expertise of a MPH health educator becomes available to those requesting it when a need for that level person is shown. The Los Angeles ACS operation hires one master level health educator as a consultant and two MPH health educators at the local level plus three other education directors at the BA level. The MPH local education directors have had little agency experience. It is, therefore, the role of the consultant to provide MPH level assistance to those without that level of education and to provide those with the MPH consultation on the agency structure and systems. This consultative position may be changing with the number of MPH health educators that are being added to the staff.

3. The Expansion of Program

The third implication for health education developed in this paper is that of the consultant's ability to spread the program throughout the State and National levels.
Because of the limitations on the local staff to office routine and local level activities, these education directors seldom travel outside their respective units. The consultant, on the other hand, routinely travels throughout the entire State and sometimes interstate. The consultant's role then becomes one of information sharing. This third aspect of program spread is developed in the chapter dealing with recognition.

In summary, this paper describes the activities of a health education consultant within a voluntary health agency. It justifies his existence from three standpoints: the first, high level program development; the second, cost accounting; and third, information sharing for expansion of recognized effective health education programs.

B. RECOMMENDATIONS

This author recommends that this text be used in training of health educators who will assume roles as health education consultants. This author further recommends that a greater amount of research be done on the role of the consultant. Another paper could be written on the effectiveness of consultants in other areas of health education. One could do a survey of all of the agencies that deliver health services and search out positions that relate to health education. And, if further study warrants, development of a consultative position to deal with these agencies. Another logical offshoot of this text would be further
study into the areas of developing health education consultant job descriptions for agencies that do not hire consultants. This text could be used as justification for such positions.
CHAPTER 5

CONCLUSION

The final section of this paper is the author's suggestions for the usage of this text in the training of health education consultants. The author further recommends that the teaching arm of the health education profession recognize the subtle differences between the role of the health education consultant and the role of the health educator, and that they develop training that will prepare consultants and health education staff for this expanding field.

This paper has explored the realm of health education consultation (Chapters 1 and 2). It has further identified a single consultant within a National voluntary health agency, and followed that consultant's activities through a complete health education project of National significance (Chapter 3). The case study, also Chapter 3, was chosen because it represented the ideal project. This project was ideal from the standpoint that it developed from a local level, proved effective, and through the efforts of the consultant, developed into a Nationally recognized program for youth.

The project was also chosen because it allowed in-depth study through all stages of programming. The
author, because of his closeness to the project, was able to relate both where effective consultation and ineffective consultation affected the desired results. Not only is the case study relevant to consultation, it gives an outline for planning, developing and evaluating a most effective health education project.

A thorough reading of this paper can assist the student in gaining an understanding of a voluntary health agency and the health educator's roles at the varying levels of organization. Also, professionals in the field can benefit from a thorough reading to assist in the understanding of the concepts of consultation and how the consultant can multiply his effectiveness through others that he work with, and how the staff member who shares the program with the consultant can also spread his effectiveness throughout an organized system of staff structure and determine whether this program merits further expansion. If so, potentials are limitless.

The case study also gives insight into the evaluation process used by voluntary health agencies. This evaluation process differs greatly from the in-depth statistical evaluation that may or may not measure behavior change. Evaluation is further discussed in the recognition of both the program and the volunteers involved and how that recognition can be used to further program effectiveness.
Fig. 1. Organizational Chart, American Cancer Society, Inc.
Field Notice Organization - 1, 2/22/72, National Staff
Fig. 2. Organizational Chart, American Cancer Society, Inc. Field Notice Organization - 1, Attach. 8. Public Education
Fig. 3. Chart from the Area Office Operating Handbook February 1973. National Areas.
Fig. 4. Organizational Chart Developed from Positions Outlined in the Area Operating Handbook, Feb. 1973, page 4.
Fig. 6. Organizational Chart, Area III Office, acquired from the Secretary to the Area III Executive Director, 1974.
Fig. 7. Map of California Divided Into the Four Area Offices.
Fig. 8. Map of California Showing the County Units.
Fig. 9. Organizational Chart Showing All the Levels of Health Education Administration and consultation. This chart developed as a compilation of several others, it is not all inclusive of the education positions, but does reflect the varying levels.
Fig. 10. Organizational Chart From the Los Angeles County Heart Association. Staff Structure Chart, July 1972.
Fig. 11. Organizational Chart for Divisions of the Los Angeles County Heart Association.
Fig. 13a. Organizational Chart for Los Angeles County Health Department, Administrative Structure Prior to Reorganization.
Fig. 13b. Organizational Chart for Bureau of Health Education, Community Health Services, Structure Prior to Reorganization, 1/15/73.
APPENDIX A

POSITION ANALYSIS

AREA DIRECTOR OF PUBLIC EDUCATION
POSITION ANALYSIS

POSITION TITLE: AREA PUBLIC EDUCATION DIRECTOR

MAJOR FUNCTION

Represents the Division in all matters within a geographical area and has primary responsibility for field implementation of Division Public Education plans and objectives within the area.

RESPONSIBILITIES

Participates with the Division Public Education Department in the development of Division Public Education plans and objectives.

Serves as a consultant on Public Education to the Units within the area.

Reviews Public Education organization and program within the area and assists the Units in implementing plans for improving program results.

Arranges Area Public Education training programs for both volunteer and staff and encourages and participates in Unit volunteer and staff Public Education training activities.

Provides opportunities for the training of new Unit Directors responsible for Public Education.

Collaborates with the Division and Units in the planning and implementation of special Demonstration projects and programs.

Provides written reports of field visits on a regular basis.

Meets periodically with Division Public Education Department staff to discuss Division program plans - and status of Public Education development within the area.

Assists other members of the Public Education Department in carrying out their duties and in handling special assignments.
Reports on new and effective Public Education programs.

RELATIONSHIPS

Reports to the Area Executive Director. Establishment of annual personal objectives and performance evaluation done in consultation with the Division Public Education Director.

QUALIFICATIONS

EDUCATION

A graduate degree in Public Health Education, Sociology, Psychology, or a closely related field. Preference will be given to candidates with a Master of Public Health in Health Education.

EXPERIENCE

At least three years of progressively responsible experience in a related health agency setting. Prior experience with the American Cancer Society is desirable. Must include at least two years of consultation experience.

June 1973
APPENDIX B

CORRESPONDENCE WITH MS. ANN HORTON, M.P.H.

HEALTH EDUCATION CONSULTANT
OFFICE OF COMMUNICATIONS
DEPARTMENT OF HEALTH
SACRAMENTO, CALIFORNIA

MAY 11, 1973
May 11, 1973

Mr. Barry R. Humphrey
Public Health Educator
American Cancer Society of
Los Angeles County
1550 West Eighth Street
Los Angeles, California 90017

Dear Mr. Humphrey:

Your request of April 20 has reached this office at a most embarrassing time. It was also delayed a bit with the move of our Berkeley offices to Sacramento. The reason it is embarrassing is that I cannot find our files which contain somewhat outdated job specifications for different levels of health educators within the state. I cannot even send you copies of job specifications for health educators within our Department because they also are outdated with the merger of the Bureau of Health Education into an Office of Communications; i.e., our consultants are no longer performing the same duties as outlined on the specs.

As to job specifications from the Los Angeles County Health Services Agency, I suggest that you contact Frank Stafford directly - 313 North Figueroa Street, Los Angeles 90012. Phone 625-3212, extension 241.

As to the other counties, I suggest that, if you have the time, you write to the director of health education directly. A listing is enclosed.

In addition, the Society for Public Health Education, inc., 655 Sutter Street, San Francisco, 94102, may have extra copies of their "SOPHE Statement of Functions" relating to the MPH, BA and aide level of worker.

I'm sorry I cannot be of any great help.

Sincerely,

Ann Horton, MPH
Health Education Consultant
Office of Communications

Enclosure
APPENDIX C

LETTER TO CHATSWORTH HIGH SCHOOL FACULTY

INVITING THEIR CLASSES TO THE

ASSEMBLIES AND OUTLINING THE PROJECT
TO: CHATSWORTH HIGH SCHOOL FACULTY

FROM: JO WOLF, CHAIRMAN, CHATSWORTH HIGH SCHOOL CANCER EDUCATION PROJECT
LORETTA DITLOW, CAMPUS COORDINATOR CANCER EDUCATION PROJECT
BARRY HUMPHREY, PUBLIC HEALTH EDUCATOR, LOS ANGELES COUNTY UNIT AMERICAN CANCER SOCIETY

Chatsworth High School has been chosen for the location of a pilot project — Cancer Education and Youth — a one week on campus intensive cancer education project.

The week's activities include:

Monday, April 24, 1972
American Cancer Society Movie Mobile on campus; various ACS displays and exhibits assembled and manned with Chatsworth students.

Tuesday, April 25, 1972
First invitational assembly — third period and fourth period P.E. classes; James T. Helsper, M.D., immediate past President, Los Angeles County Unit American Cancer Society and President, Pasadena Tumor Institute.

Wednesday, April 26, 1972
Second invitational assembly — third period and fourth period P.E. classes; youth panel including young cured and semi-cured cancer patients, a M.D., an oral surgeon and a health educator.
Prior to the week of activities, at one of your regular faculty meetings, a representative from the youth committee and a medical resource person will be present to answer any questions that you may have about the project or cancer in general. At that time the faculty will be given a pre-test similar to the one that the students will take. Participating students will be pre-tested prior to April 24.

San Fernando Valley State College has given the use of seven (7) of their graduate students in health sciences to do the evaluation of this program. These students will be available following the week of activities on an invitational basis as resource persons for your class, and will be prepared to answer questions and lead discussions on cancer and youth.

In order to make this week effective for the entire student body, those of you that cannot release your classes for the assemblies, we urge you to look over the enclosed list of materials and films and try to utilize them in your curriculum sometime during the project week or as a follow-up activity to the program.

We need your support in order to make this program a success.

For materials, films, or literature contact:

Mrs. Suzanne Purnell, Program Assistant
American Cancer Society
7242 Canby Avenue
Reseda, California 91335
Telephone number - (213) 987-3701

Following this program and before June, there will be a formal write-up on the activities and a study of the change in behavior and knowledge on the part of the students. This program packet will be reproduced and distributed County-wide; if proven successful, State-wide distribution will follow with the hopes that other high schools will be interested in using the Chatsworth High program as a model.
For your students to receive the total value from this program, all three assemblies should be attended; if you cannot release your students for the full three (3) days any one program within itself should be of value. It is important that you return the bottom half of this form to Loretta Ditlow (deposit in her school mail box) as soon as you have planned attendance at the assemblies.

Because I feel that cancer education is important, my class will attend all three (3) assemblies.

Because my class time is limited, my class will attend:

First Assembly, April 25, Medical Speaker;
Second Assembly, April 26, Youth Panel;
Third Assembly, April 27, Helene Brown, ACS President;

I cannot schedule my class for any of the three (3) assemblies.

I cannot schedule my class, but will use cancer education materials in my classroom during or following the project week.

INSTRUCTOR _______________ CLASS _____ NO. OF STUDENTS ____

BRH/vab
Enclosures
3/72
APPENDIX D

PRE-TEST QUESTIONS DESIGNED

BY THE CONSULTANT
1. Many environmentally induced Cancers, such as Lung Cancer and Skin Cancer, are 100% Preventable if you follow a few simple Safeguards?

2. Many Cancers are nearly 100% Curable following early detection and proper treatment? Cancers such as Skin, Cervix, Colon, Oral Cancer, and others?

3. Learning the Safeguards and practicing Cancer prevention methods in Youth will assure healthful habits, that will last for life?

4. There are known Carcinogenic (Cancer causing) substances within our environment that can be avoided to help prevent Cancer: cigarette smoke is one such substance?

5. Only five (5) of every hundred (100) diagnosed cases of Lung Cancer live past a five (5) year period?

6. Cancer is mostly curable in early stages: Cancer's seven (7) warning signals are signs that you may be developing Cancer in one of the early stages. If one of Cancer's seven signals is present you should see a qualified Doctor if that signal lasts longer than two weeks?

7. Educating Youth about Cancer is not the most effective means of facilitating results that may be life-saving?

8. The Pap Test is a test that should be taken annually by any and every woman when sex becomes a part of her life?

9. One in every twelve (12) live female births, at some time in their life, will develop Breast Cancer?

10. Monthly breast self examination for females should be started at the beginning of puberty and should be practiced throughout life . . . ?
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>11.</th>
<th>One of the Safeguards of Cancer is not to smoke cigarettes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>F</td>
<td>12.</td>
<td>In any one year period, the deaths from Cancer in young people under the age of 15 is equal to the total enrollment of Chatsworth High School? (3,500)</td>
</tr>
<tr>
<td>T</td>
<td>F</td>
<td>13.</td>
<td>Annual health examinations including Cancer detection tests, such as the Pap Tests, are not necessary for young adults?</td>
</tr>
<tr>
<td>T</td>
<td>F</td>
<td>14.</td>
<td>Leukemia and Hodgkins Disease (two forms of Cancer in Youth) are always fatal?</td>
</tr>
<tr>
<td>T</td>
<td>F</td>
<td>15.</td>
<td>Remission is a term used when a disease is arrested and not cured?</td>
</tr>
<tr>
<td>T</td>
<td>F</td>
<td>16.</td>
<td>X-ray will detect Lung Cancer in a stage that is highly curable?</td>
</tr>
<tr>
<td>T</td>
<td>F</td>
<td>17.</td>
<td>Suntaning lotion with sunguard helps in preventing over-exposure to the sun?</td>
</tr>
<tr>
<td>T</td>
<td>F</td>
<td>18.</td>
<td>Ranging second only to accidents, Cancer is the number two killer of the school age student, 5-15 years of age?</td>
</tr>
<tr>
<td>T</td>
<td>F</td>
<td>19.</td>
<td>One sign of maturity is when a young person accepts the responsibility of caring for his/her own body?</td>
</tr>
<tr>
<td>T</td>
<td>F</td>
<td>20.</td>
<td>There are 100,000 needless deaths each year from Cancer that was not diagnosed early enough to be treated successfully? Education is the tool that can significantly reduce this number?</td>
</tr>
</tbody>
</table>

SEVEN WARNING SIGNALS THAT MAY MEAN CANCER

- Change in bowel or bladder habits
- A sore that does not heal
- Unusual bleeding or discharge
- Thickening or lump in breast or elsewhere
- Indigestion or difficulty in swallowing
Obvious change in wart or mole
Nagging cough or hoarseness

**YOUR SEVEN SAFEGUARDS AGAINST CANCER**

<table>
<thead>
<tr>
<th>BODY</th>
<th>Have a health check-up annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>BREAST</td>
<td>Monthly self-examination</td>
</tr>
<tr>
<td>COLON-RECTUM</td>
<td>Procto annually after the age of 40</td>
</tr>
<tr>
<td>LUNG</td>
<td>Don't smoke cigarettes</td>
</tr>
<tr>
<td>MOUTH</td>
<td>Examinations regularly</td>
</tr>
<tr>
<td>SKIN</td>
<td>Avoid over-exposure to Sun</td>
</tr>
<tr>
<td>UTERUS</td>
<td>Pap Test once a year</td>
</tr>
</tbody>
</table>
APPENDIX E

PRE-TEST USED IN THE PROJECT
CIRCLE ANSWER: Boy-Girl
10, 11, 12. High School Major

CANCER AWARENESS TEST
SPECIAL HIGH SCHOOL PILOT STUDY

Circle correct answer.

T   F  1. There are 100,000 needless deaths each year from cancer that was not diagnosed early enough to be treated successfully. Education is the tool that can significantly reduce this number.

T   F  2. One sign of maturity is when a young person accepts the responsibility of caring for his/her own body.

T   F  3. Ranging second only to accidents, cancer is the number two killer of the school age student, 5 - 15 years of age.

T   F  4. Leukemia and Hodgkin's Disease (two forms of cancer in youth) are always fatal.

T   F  5. Annual health examinations including cancer detection tests, such as the Pap Test, are not necessary for young adults.

T   F  6. In any one year period in the U.S., the deaths from cancer in young people under the age of 15 is equal to the total enrollment of Chatsworth High School (3,500).

T   F  7. One of the safeguards of cancer is not to smoke cigarettes.

T   F  8. Monthly breast self-examination for females should be started at the beginning of breast development and should be practiced throughout life.

T   F  9. One in every twelve (12) live female births at sometime in their life will develop breast cancer.

T   F 10. The Pap Test is a test that should be taken annually by any and every woman when sex becomes a part of her life.
T  F  11. If one of cancer's seven signals is present, you should see a qualified doctor.

T  F  12. Only five (5) of every hundred (100) diagnosed cases of lung cancer live past a five (5) year period.

T  F  13. Learning the safeguards and practicing cancer prevention methods in Youth will assure healthful habits that will last for life.

T  F  14. Some cancers, skin cancer, cervical cancer, colon-rectal cancer, when found in their beginning stages are nearly 100 per cent curable following early detection and proper treatment.

T  F  15. Many environmentally induced cancers, such as most forms of lung cancer and skin cancer, are almost 100 per cent preventable if you follow a few simple safeguards.
APPENDIX F

BIOGRAPHICAL SKETCH OF

JAMES T. HELSPER, M.D. (DR. H.)
Dr. James T. Helsper is a Pasadena surgeon and oncologist. He has been associated with the Pasadena Tumor Institute and the Pasadena Foundation for Medical Research since 1958, and in 1963 was Chairman of the Los Angeles County General Hospital Tumor Board.

Prior to moving to California, Doctor Helsper received training for cancer and allied diseases at Memorial Hospital in New York City. He received his M.D. degree from Jefferson Medical College in Philadelphia, Pennsylvania.

He, too, has seen extensive service with both the Los Angeles County and California Division organizations of the American Cancer Society.

Currently member of the LAC Unit's Board of Directors and Executive Committee, he was president in 1970-71; served a two year term as vice-president in charge of program, (1967-69), a two year membership on the Education Committee, and a two year term as chairman of the professional Education Committee.

His California Division membership include the Board of Directors and the Public Information Committee.
APPENDIX G

BIOGRAPHICAL SKETCH OF PANEL MODERATOR

DANIEL M. HAYES (DR. J.)
DR. DANIEL M. HAYES

Associate Professor of Pediatric Surgery, Department of Surgery, Children's Hospital of Los Angeles.

Member of the American Cancer Society of Los Angeles County, Professional Education Committee.

Director of the Clinical Cancer Training Project for Physicians.

This project is sponsored by the National Institute of Health.
APPENDIX H

BIOGRAPHICAL SKETCH OF THE LAY SPEAKER

MS. HELENE BROWN (MS. B.)
HELENE BROWN BIOGRAPHY

She was born in New York City, is a graduate of Fairfax High School and attended UCLA School of Business Administration and School of Public Health. She has worked many years with volunteer organizations such as PTA, Welfare Planning Council, American Field Services, Foster Parents; and has served on the Executive Committee of the Medical Research Association of California. She is Past President of the Los Angeles County Branch of the American Cancer Society; Legislative Coordinator for Anti-Quack laws; lecturer and seminar instructor at Long Beach State College, USC and LA State Colleges. She is also active on the Cancer Advisory Council of the State Department of Public Health, and serves as part-time Executive Director of the Los Angeles Council of National Voluntary Health Agencies. Last year (1970) she was Chairman of the Public Affairs Committee for the California Division of the American Cancer Society. Mrs. Brown has been an American Cancer Society volunteer for almost 20 years and in September 1971 she was installed as President of the American Cancer Society, California Division.
<table>
<thead>
<tr>
<th>Ranking Percentage Change</th>
<th>Pre-Test Results</th>
<th>Post-Test Results</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>144</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Out of 600 people given the examination, the following results were obtained on questions missed.

<table>
<thead>
<tr>
<th>Question No.</th>
<th>Pre-Test Questions</th>
<th>Post-Test Questions</th>
<th>Percent Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. Missed</td>
<td>% Total</td>
<td>No. Missed</td>
</tr>
<tr>
<td>1</td>
<td>46</td>
<td>7.7%</td>
<td>40</td>
</tr>
<tr>
<td>2</td>
<td>28</td>
<td>4.7%</td>
<td>27</td>
</tr>
<tr>
<td>3</td>
<td>398</td>
<td>66.4%</td>
<td>115</td>
</tr>
<tr>
<td>4</td>
<td>352</td>
<td>58.7%</td>
<td>179</td>
</tr>
<tr>
<td>5</td>
<td>72</td>
<td>12.0%</td>
<td>68</td>
</tr>
<tr>
<td>6</td>
<td>261</td>
<td>43.5%</td>
<td>156</td>
</tr>
<tr>
<td>7</td>
<td>56</td>
<td>9.3%</td>
<td>30</td>
</tr>
<tr>
<td>8</td>
<td>99</td>
<td>16.5%</td>
<td>48</td>
</tr>
<tr>
<td>9</td>
<td>352</td>
<td>58.7%</td>
<td>102</td>
</tr>
<tr>
<td>10</td>
<td>268</td>
<td>44.7%</td>
<td>95</td>
</tr>
<tr>
<td>11</td>
<td>34</td>
<td>5.7%</td>
<td>22</td>
</tr>
<tr>
<td>12</td>
<td>191</td>
<td>31.8%</td>
<td>199</td>
</tr>
<tr>
<td>13</td>
<td>72</td>
<td>12.0%</td>
<td>54</td>
</tr>
<tr>
<td>14</td>
<td>97</td>
<td>16.2%</td>
<td>29</td>
</tr>
<tr>
<td>15</td>
<td>182</td>
<td>30.4%</td>
<td>94</td>
</tr>
</tbody>
</table>
APPENDIX J

PART 1 — STUDENT EVALUATION FORM
USED TO SURVEY ACCEPTANCE

PART 2 — RESULTS OF SURVEY AS PRESENTED
BY THE CSUN EVALUATION GROUP
YOUTH & CANCER

STUDENT EVALUATION FORM

CONTROL GROUP - Entire Program

Please rate from 1-5 the value, to you personally, of these programs:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Most valuable program</td>
</tr>
<tr>
<td>2</td>
<td>Good – well worth the time</td>
</tr>
<tr>
<td>3</td>
<td>Fair – needs improvement</td>
</tr>
<tr>
<td>4</td>
<td>Poor – wasn't worth the time</td>
</tr>
<tr>
<td>5</td>
<td>Least valuable program – didn't learn anything</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Movie Mobile</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Doctor Presentation</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Youth Panel</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Lay Speaker/Lecture</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Displays and Literature</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Total Project</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

I would like to know more about Cancer?  Yes  No

I would like to see other health problems presented in this manner?  Yes  No

PLEASE COMMENT ON ANY PART OF THE PROGRAM THAT YOU ESPECIALLY LIKED OR DISLIKED. WE NEED YOUR ADVICE AND CRITICISM IN ORDER TO BETTER PREPARE THESE PROGRAMS FOR OTHER STUDENTS. IF YOU FEEL PRAISE IS IN ORDER, FEEL FREE TO COMMENT.

4/72
vab
Results obtained from the students on a #1 - #5 basis (#1 considered the most valuable program).

<table>
<thead>
<tr>
<th>Program</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Results from Total Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Movie Mobile 163 Students</td>
<td>19</td>
<td>63</td>
<td>61</td>
<td>9</td>
<td>12</td>
<td>11.6%</td>
</tr>
<tr>
<td>Doctor Presentation 184 Students</td>
<td>37</td>
<td>81</td>
<td>51</td>
<td>12</td>
<td>3</td>
<td>20.1%</td>
</tr>
<tr>
<td>Youth Panel 183 Students</td>
<td>142</td>
<td>24</td>
<td>3</td>
<td>2</td>
<td>12</td>
<td>77.7%</td>
</tr>
<tr>
<td>Lay Speakers 178 Students</td>
<td>37</td>
<td>84</td>
<td>35</td>
<td>15</td>
<td>7</td>
<td>20.8%</td>
</tr>
<tr>
<td>Literature and Displays 181 Students</td>
<td>31</td>
<td>77</td>
<td>54</td>
<td>12</td>
<td>7</td>
<td>17.1%</td>
</tr>
</tbody>
</table>

INFORMATION CORRELATED FROM STUDENT EVALUATION FORMS.
APPENDIX K

COPY OF THE CERTIFICATE OF SPECIAL RECOGNITION

FROM THE CALIFORNIA DIVISION

AMERICAN CANCER SOCIETY

149.
THE AMERICAN CANCER SOCIETY
CALIFORNIA DIVISION

PRESENTS THIS
Certificate of Special Recognition

to the

Los Angeles County Unit-District Two

For the Chatsworth High School Project, which reached a large number of students and involved ACS Volunteers, Ex-Cancer Patients, San Fernando State College Students, and Chatsworth High School Faculty and Students in Planning, Implementation and Evaluation.

October 12, 1972

Date

Chairman, Public Education Committee
American Chaseworth Founding Inc.

Honor Citation

to the

California Division
Los Angeles Unit
for its
Chaseworth Youth Project

Done in the City of New York, N.Y. this
ninth day of November, nineteen hundred and seventy-three.

President

Chairman, Board of Directors
BIBLIOGRAPHY
BIBLIOGRAPHY


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