ANTI-CANCER COUNCIL OF VICTORIA

REPORT FOR SERVICE COMMITTEE

The Anti-Cancer Council has initiated a review of its welfare service and the services available for cancer patients throughout the State.

The review is taking place in three stages:

PHASE I: - Situation Audit - now completed and a summary of the findings is attached.

PHASE II: - Issues Report - in draft form only at this stage. This report integrates and interprets information collected through a series of consultations with health and welfare personnel conducted in nine defined regions in the State.

PHASE III: - To be completed by mid-May. The two documents already mentioned will input to the development of policy options to be submitted to the Council's Welfare Committee in May, 1983.

Our welfare grants program has continued throughout the review and over $47,000 was spent in the first six months of this financial year. A further $13,000 was spent on subsidized support systems such as Hospice Grant, BPS, Visiting Nursing Service, etc.

The usual regular meetings have been held for the BPS nurses with three different speakers:

(1) Mr. David Hill - Discussion between metropolitan nurses and volunteer mastectomee visitors.

(2) Ms. Isobel Attwood - "Psychological Aspects of Breast Cancer and its Treatment".

(3) Mr. Bryan Mendelson - "Breast Reconstruction - Physical and Psychological Aspects".

Adrienne J. Holzer
Secretary to the Council

18/3/1983

ANTI-CANCER COUNCIL OF VICTORIA

20/1/83.

SITUATION AUDIT - SUMMARY

1. Purpose of the Situation Audit.

1.1 The Situation Audit is the first phase of a three part policy development process being implemented by the Anti-Cancer Council of Victoria to determine its future welfare policy. Three related projects provided the basis for the audit. First, Federal and State Government stated policies influencing welfare services available to persons suffering from cancer and their families were reviewed. Secondly, policies and programs of the Anti-Cancer Council of Victoria - Welfare Service were examined. And thirdly a survey collecting opinion from personnel involved in providing welfare services to both persons suffering from cancer and their families about the problems facing these people and the adequacy of resources available to them was conducted.

1.2 A Situation Audit Report has been prepared which identifies and ranks the key problems facing both persons suffering from cancer and their families, in respect of the availability and accessibility of welfare services in the state of Victoria. The report was prepared to provide the framework for a series of consultations to be conducted with a range of health welfare staff at nine centres throughout Victoria. Participants will be asked to examine the Situation Audit Report and use it, together with their own knowledge and expertise, to identify, analyse and rank the broad issues which should be addressed in determining the future welfare policy of the Anti-Cancer Council of Victoria. The Situation Audit Report therefore, completes the first phase of the three-part policy development process being implemented by the Anti-Cancer Council of Victoria.

The Issues Report which will be prepared following the series of consultations, together with the Situation Audit Report will input to the development of policy options to be submitted to the Welfare Committee of the Anti-Cancer Council of Victoria in May 1983.

2. Priority Problems Identified By Respondents To The Questionnaire Survey

2.1 Respondents rating of each problem as serious or very serious is aggregated to provide the basis for ranking the problems. The 20 problems which were rated by the highest percentages of all respondents to be serious or very serious are presented in Table 1 and represent the State ranking of problems.

TABLE 1
State Ranking of Problems

Problem	Rank	% all respondents rating serious/ very serious
Health Insurance	1	56.3
Nursing Home Care	2	49.8
Distance from the treatment centre for the family	3	46.9
Family Relief (Domiciliary)	4	46.6
Information available to the patient/family	5	44.0
Distance from the treatment centre for the patient	6	42.3
Group support/counselling	7	42.4
Information available to the community generally	8	39.8
Special accommodation	=9	38.0
Cost of transport	=9	38.0
Short stay accommodation for the patients	=11	37.7
Terminal care	=11	37.7
Financial advice	13	36.3
Short stay accommodation for the family	=14	36.0
Family support/counselling	=14	36.0
Patient support/counselling	=16	34.5
Co-ordination of services	=17	32.2
Family relief beds	=17	32.2
Knowledge of IPTAAS	19	31.8
Weekend nursing services	20	30.8

2.2 The ranking of these twenty problems by GPs, agencies, and respondents who had had contact with more than 100 cancer patients was determined using the procedure applied at the State level. The ranking of the problems by these groupings of respondents is presented in Table 2

TABLE 2
State, GP, Agency and Respondents Who Had contact With More Than 100 Cancer Patients Ranking of Problems

Problem	Rank State	GP	Agency	100+
Health Insurance	1	1	1	1
Nursing home care	2	2	5	3
Distance from the treatment centre for the family	3	6	3	8
Family Relief (Domiciliary)	4	12	2	2
Information available to the patient/family	5	7	4	=8
Distance from the treatment centre for the patient	6	=8	7	=8
Group support/counselling	7	11	8	4
Information available to the community generally	8	17	6	=8
Special accommodation	=9	4	17	
Cost of transport	=9	16	9	=5
Short stay accommodation for the patient	=11	5	=14	
Terminal care	=11	3	18	=5
Financial advice/counselling	13	=8	=14	
Short stay accommodation for the family	=14	=8	20	
Family support/counselling	=14	13	=11	=16
Patient support/counselling	16	15	=11	12
Co-ordination of services	=17		=14	=16
Family relief beds	=17	14		=16
Knowledge of IPTAAS	19	=19	10	12
Weekend nursing services	20	=19		

Four problems which were not listed in the State ranking are ranked as priority by one or more of the groupings of respondents. These problems and their ranking are presented in Table 3.

TABLE 3
GP, Agency And Respondents Who Had Contact With More Than 100 Cancer Patients Ranking of Additional Problems

Problem	Rank GP	Agency	100+
Support groups/networks			=10
Domiciliary nursing benefit		13	=10
Voluntary drivers			16
Invalid pensions		20	

3. Summary Of Problems Identified In The Situation Audit Report

3.1 Difficulty with Health Insurance was ranked as the priority problem facing both persons suffering from cancer and their families. The type of Health Insurance cover taken out by the patient and the family will have a bearing on the range of institutional services available to them. For example, private hospital care for terminal patients will not be a viable option for persons who are either not insured or who have only basic hospital cover. This type of care is also not an option for pensioners. The opportunity for a family to use the available short stay accommodation or family relief beds may be limited as a result of the type of Health Insurance they have in relation to the cost of the services. The adequacy of these two resources are ranked as priority problems.

3.2 Distance from the treatment centres and problems associated with travel to and from the centres are identified as priority problems facing both persons suffering from cancer and their families. The transport costs incurred cannot be insured against. The fact that IPTAAS is only available to persons who reside 200 km or more from the treatment centre means that the majority of the population are not eligible for assistance under this scheme. Although free travel is available for patients to attend treatment centres on state owned public transport the nature of the treatment can limit the extent to which public transport can be considered as a viable option. Ambulance transport which is generally only available to the patient not to the family can be insured against. However, the priority ranking of these transport related problems indicates that the available schemes are not adequate to counter the problems faced by either persons suffering from cancer or their families.

3.3 Insufficient suitable patient, family and group counselling/support services are ranked as priority problems as is the adequacy of financial advice and counselling. The insufficiency of the information available to the community generally and to patients and their families specifically about cancer and its treatment were also ranked as priority problems. This lack of information may increase the need for counselling and support services. The availability of information presented in direct and simple terms will not prevent the need for counselling but it may lessen the fear and anxiety experienced by both patients and their families when they are faced with the unknown.

3.4 Many of the problems which were ranked as priority can be related to cost and the financial position of the individual or family requiring the services. If the family is faced with a reduction of income due to illness and at the same time is required to meet the costs associated with the treatment and management of the disease the resultant financial difficulties may restrict access to the services and resources available. The eligibility criteria in respect of Sickness Benefits creates problems for persons suffering from cancer and adds to their financial difficulties. The requirement of one week off work before the Benefit is payable means that those patients who require intensive short term treatments on a regular basis may, over time, incur substantial income losses but not meet the criteria for the Benefit. Health Insurance, nursing home care, short stay accommodation, family relief and transport problems, for example, may all be exacerbated for both the patient and the family by financial factors.

Adrienne J. Holzer
Secretary to the Council

Eryl away 2–7th Aug.

15th July, 1982

Mr. T. Cole,
Social Work Department,
Peter MacCallum Hospital,
481 Little Lonsdale Street,
MELBOURNE, 3000

Dear Mr. Cole,

The Anti-Cancer Council of Victoria has recently initiated a review of its welfare program encompassing the range of welfare services provided in this State for persons suffering from cancer.

It is hoped that key issues and problems facing both people and agencies concerned with cancer will be identified so that the Council will be able to design and develop appropriate policies to face up to the 1980's.

We have engaged Miss Eryl Morgan, a management consultant with social work background, to undertake this review. Miss Morgan has most recently completed reviews with both the Alfred and Box Hill hospitals.

As a starting point we need to establish a Project Team of five members - three of whom should have experience in providing social work services to persons suffering from cancer. We wondered if you or your nominee would be interested in joining the Team.

I have taken the liberty of enclosing a copy of the Planning Process and the schedule for the Project Team is outlined on pages 3-4.

The Council considers this review of vital importance and we would be very grateful for your support.

Perhaps I can take the liberty of telephoning you late next week to discuss the proposal with you.

Yours sincerely,

Adrienne J. Holzer (Miss)
Secretary to the Council

Enc:

15th July, 1982

Miss Louise Bowen
Social Worker
Austin Hospital
HEIDELBERG, 3084

Dear Miss Bowen,

The Anti-Cancer Council of Victoria has recently initiated a review of its welfare program encompassing the range of welfare services provided in this State for persons suffering from cancer.

It is hoped that key issues and problems facing both people and agencies concerned with cancer will be identified so that the Council will be able to design and develop appropriate policies to face up to the 1980's.

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Yours sincerely,

Adrienne J. Holzer (Miss)
Secretary to the Council

347 6731

- V. happy if no nitty gritty b'tween resp.
- doesn't mind reading etc
feel not physical ...

15th July, 1982

Ms. Kathy Sanders
78 Carlton Street
CARLTON, 3053

Dear Miss Sanders,

The Anti-Cancer Council of Victoria has recently initiated a review of its welfare program encompassing the range of welfare services provided in this State for persons suffering from cancer.

It is hoped that key issues and problems facing both people and agencies concerned with cancer will be identified so that the Council will be able to design and develop appropriate policies to face up to the 1980's.

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Yours sincerely,

Adrienne J. Holzer (Miss)
Secretary to the Council

15th July, 1982

MEMO TO: Dr. Nigel Gray, Director
Mr. David Hill, Education Director

MEMO FROM: Miss Adrienne Holzer, Secretary

RE: WELFARE SERVICES - REVIEW

Eryl Morgan spent a couple of hours with Sue Rawlyk and I today as a preliminary/exploratory exercise.

She had asked Fran Bass to join the Project Team, but owing to a restructure of her commitments she is unable to help us. She and Helen Goodwin (Senior Social Worker at the Alfred) did, however, come up with a couple of suggestions:

(1) Louise Bowen, Social Worker, Austin Hospital, does case work but more interested in policies, etc.

(2) Kathy Sanders, former Social Worker in Oncology Unit, St. Vincent's Hospital now doing Masters Degree at Melbourne. Have checked Ray Snyder and he says she would be a good source of information.

(3) Tony Cole, a nominee from Peter MacCallum. I have written to these people enclosing a copy of Eryl'e re-drafted submission (copies of both attached).

I have agreed with Eryl that the Council (i.e. me) could probably undertake the administrative work and typing of reports, etc. could either be absorbed or done by volunteers. This will cut costs, but more importantly get me much more involved in an area which up until now I have had only limited knowledge.

Eryl's plan of action is as follows:-

1. Letters of invitation by 16th July - A.J.H.

   Follow-up phone call by 23rd July - A.J.H.

   First meeting of Project Team hopefully second or third week in August.

2. By the time of the 1st meeting, the following ground work will have been done:

   (a) Lists obtained of interested/involved institutions, agencies, etc.

   - community health centres
   - municipal councils
   - citizens advice bureaux
   - cancer support groups / crusade units
   - hospices

/2...

- ? church organisations
- ? nursing homes
- social security - State and Federal
- hospitals - public and private (to be screened)

(b) Lists of specialist services, organisations:

- New Voice
- Colostomy

etc.

(c) List of Oncology Departments

It is proposed that an initial questionnaire be sent to a random sample of 2 (a) above (except public hospitals) and that results could be fed into the computer.

Check David - (1) Nos. for statistically viable result

(2) ACCV computer or SPSS

3. According to Base Hospitals, Victoria should be divided into a number of regions. These regions will be visited by Eryl Morgan and preferably an ACCV staff member to conduct a series of one day workshops -

a.m. - define key issues in their region

p.m. - analysing these issues to provide back-up evidence

Maximum number in each workshop - 20.

Of the above, 2 is nearly complete and 3 is completed.

(Adrienne J. Holzer)

Geelong District Nursing Society

39 SWANSTON STREET
GEELONG, 3220
Tel. 9 9449

11th. August, 1982.

The Secretary,
Anti Cancer Council of Victoria,
90 Jolimont St.,
EAST MELBOURNE 3002.

Dear Sir,

I am enclosing a copy of the Annual Report and a detailed list of visits made to cancer patients during each month.

It appears that the number of cancer patients is increasing, and we are attempting to document the number of cancer patients living in different areas in Geelong. It appears that the number of Lung Cancer patients in the North Geelong area is increasing, but due to insufficient staff to collect data, we cannot at this stage produce figues to substantiate this. We shall endeavour to do so over the next twelve months.

The Society greatly appreciates the assistance it has received from your Council and would be most grateful if it could again be considered in this years allocation of funds.

Yours sincerely,

G. Cooper.

Mrs. G. Cooper,
Director of Nursing.

DETAILS OF CANCER PATIENTS AND VISITS FOR THE YEAR 1981/82

	MONTH	PATIENTS	VISITS
1981	July	104 some of same patients	697
	August	101	606
	September	94	785
	October	95	665
	November	92	737
	December	94	679
1982	January	97	671
	February	87	705
	March	83	610
	April	82	561
	May	83	567
	June	87	606
		1,119	7,889

Office — 1 f/t assist super.
p/t clerical
— 15 f/t nurses & part weekday
Full establishment — 20.

Geelong District Nursing Society

FOR TRAINED NURSING OF THE SICK
IN THEIR OWN HOMES

(Founded 1st February, 1907)

ANNUAL MEETING 5th AUGUST, 1982

75th REPORT

FOR THE YEAR ENDING 30th JUNE, 1982

SEVENTY - FIFTH REPORT

of the

Geelong District Nursing Society

FOR THE YEAR ENDING 30th JUNE, 1982

For Nursing the Sick in their Own Homes

(Founded 1st February, 1907)

39 Swanston Street, Geelong

COMMITTEE OF MANAGEMENT

President: MRS. J. M. RICHARDSON

Vice-Presidents: MRS. E. M. VORRATH, MRS. G. FIELDING

Assistant Treasurer: MRS. R. D. STABB

MISS N. M. PATERSON (Ex-Officio)

Committee:

MISS H. BOTTERILL, MESDAMES W. ARMSTRONG, G. BELCHER, A. AUSTIN GRAY, D. G. HANCOX, J. D. HEDE, W. HUFFAM, R. INGPEN, J. G. MORRISON, B. MURPHY, W. McCANN.

Life Members:

MESDAMES H. C. FALLAW, R. V. MOON, P. THORNLEY, D. W. HOPE.

Trustees:

THE UNION FIDELITY TRUSTEE COMPANY OF AUSTRALIA

Auditor:

MR. G. T. PYLE, F.A.S.A., F.C.I. (Aust.)

Director of Nursing:

MRS. G. COOPER

Assistant Supervisor:

SR. P. WILLIAMS

Nursing Staff:

SISTERS B. BARFOOT, A. BURNS, G. CASHMORE, B. CRELLIN, A. CUTTRISS, M. FITZGERALD, M. FLANDERS, L. FOX, J. GUTHRIE, P. HILL, S. HUBE, I. LONGTON, D. McCARTNEY, M. McMAHON, E. MARSH, M. NEWBOLD, M. PYLE, H. RANKIN, E. ROBERTS, J. SMITH, H. TAYLOR, B. THOMSON, D. WHITEHEAD, A. WISHART.

President's Report

On behalf of the Committee of Management, it gives me great pleasure to present the 75th Annual Report and Financial Statement of the Geelong District Nursing Society, for the year ending June 30th, 1982.

Regretfully, during the year, Mrs. D. W. Hope, Mrs. G. A. Boyle and Mrs. D. Olliff resigned from the Committee and we sincerely thank them all for the varying years of service they gave to the Society. We congratulate Mrs. Hope on her election as a Life Member, in recognition of the 23 years she spent on the Committee.

This year we redesigned our G.D.N.S. information leaflets, updated minor items of office equipment and painted the front fence.

Equipment that is lent to patients has been purchased for the Society, with money that has so kindly been donated to us. We gratefully acknowledge, and wish to thank most sincerely those many individuals and organizations who have donated money and equipment to the Society and who have also given us Christmas presents for the patients.

We are most appreciative of the grants and bequests that we have received from the Anti-Cancer Council, the Percy Baxter Trust, the Estates of the late A. N. and Miss E. Shannon, the George Scott Trust, the William Angliss Charitable Trust and Vincentian House.

We thank the Victorian Health Commission and the Federal Government for their financial support, and the Geelong City Council for the exemption of annual rates and the R.A.C.V. for our membership concession.

The close co-operation that exists between this Society and the Geelong Hospital and Grace McKellar House is exemplified by their student nurses, who as part of their course, accompany our sisters as observers. We believe that the medical course should also include a similar, first hand, practical appreciation of district nursing. It could only improve communication between the medical fraternity, the community and district nurses.

Sr. Cooper, Sr. Williams and Sr. Whitehead have attended many conferences, meetings and lectures and given talks to a variety of groups. Many other sisters have attended lectures, both in Melbourne and Geelong, on a wide range of topics related to domiciliary nursing.

We are very appreciative of the Royal District Nursing Service for continuing to allow our sisters to attend their in-service educational programme. This has been invaluable to the experience of our sisters and to the Society.

We offer our congratulations to Sr. Cooper on her election as a committee member of the Victorian Branch of the Australian Council of Community Nursing. This gives Sr. Cooper the valuable opportunity to obtain an overall view of domiciliary nursing.

Our Society has had a close and mutually beneficial relationship with the Hospice Care Association, since it began on March 1st. There has been no duplication, only mutual advantages for both organi-

zations. Recently our Sr. Marsh joined the Hospice Association, and this can only help to strengthen the already strong bonds, understanding and feelings that now exist.

The Home Health Aides pilot project, studying the role of a non-professional worker in domiciliary care and run by R.D.N.S., has been a success. It seems a logical way of being able to look after more people in the community, and to give personal and environmental care in the home, alongside medical and nursing care, particularly to the elderly. To be able to give quality care in the home, all staff do not necessarily have to be highly qualified, but one would complement the other.

It is imperative that the administrative and nursing areas in our Society be divided. Our director of nursing administers not only the nursing but also the business sphere, and this we don't believe occurs in other government funded organizations.

Despite continual submissions for extra staff, there has been no increase for 2 years. In fact during the last 6 years we have been allowed to increase our nursing team by only 2. This in an intolerable situation. We don't know of any health agency that reaches such a large number of people in the community or, that represents such value for each dollar spent, that has had such harsh restrictions placed on it, while still being expected to do more. The statistics show that, since 1976, each extra sister has enabled the Society to care for 209 new patients each year and make 5,647 more visits per annum. This year the Society has made 67,584 visits to 1,677 patients, compared to 67,980 visits to 1,613 patients in 1980-81. These figures represent an average of 16 visits per day per sister.

Reflected in the statistics of, 64 more patients for the year but 396 less visits, is the fact that the patients we are now nursing are generally sicker than in previous years. This is a direct result of their earlier discharge from hospital and the specialized care that they are now receiving at home, instead of, as previously, in hospital. Naturally, the visits to these patients are taking longer than in the past.

The figures also reflect the distressing fact, that, more patients and less visits by the same number of staff, means that the frequency of visits to some patients has unfortunately but necessarily been reduced. Mostly it is the elderly, in need of general care and support who suffer. This has happened at a time when our population is rapidly ageing, as can be seen by our life expectancy, which has rapidly increased from 40 years to an average of 70 plus years. Old age is ordinary now, not extraordinary. Old age was once a privilege but it has now become a condition and it is up to us not to let it become a punishment.

The workload of our Society has become absolutely desperate with 30 new patients admitted to our books in the last few days. There are no nursing home beds and no hospital beds available. People now have to stay at home and more and more very sick patients are being discharged from hospital. Someone has to be responsible for them, to look after them. They just can't be left.

There are more terminating patients, more elderly because each year the population is ageing and more patients requiring specialized techniques and intensive nursing because of early post-operative discharge from hospital and more patients who have to be barrier nursed at home because of staph infection.

Now, our policy of a small amount of care for a large number of people has run its course; now, there are just too many people in need of care; now, we just don't have the staff to go around; and now, we will be forced to close our books and stop accepting new admissions unless we get more staff.

It is very short sighted not to realize the enormous and widespread benefits that can be derived from the extension of domiciliary care, at a cost that is cheap in comparison to other institutional forms of care, while also being desirable. Relatively few funds can reach and benefit a large number of people in the community, people who are increasingly calling out for nursing care and help. There is a ridiculous imbalance between funding for domiciliary care and funding for institutional care. We are not talking millions of dollars but a very small amount in proportion to the overall health dollar. This year the total average cost to nurse a patient at home was $229.23 per annum, the equivalent of $4.41 per patient per week, of which $3.36 per patient per week is funded by government.

District Nursing is by far the cheapest method of nursing and if it is the cheapest and also in line with peoples' wishes and current thought, we just cannot see why finance is not provided to expand domiciliary services. It seems such an obvious solution to part of the health enigma. Naturally we all hope to remain in our own homes for as long as possible and given a realistic domiciliary policy, this can be done. Health insurance schemes could also encourage this by adjusting their scales of payment, to at least give equality to patients nursed at home, rather than to disadvantage them, as happens in some instances, at present.

Not only is our ageing population a fact of life but also early discharge from hospital is a fact of life. Nothing will reverse these trends, so please let some policies be handed down that will cope with the situation in the most practical and cheapest way, that also is in line with peoples' wishes and choices.

Even though I seem to be repeating myself, year after year, I do not apologize for it and will keep repeating myself until something realistic is done. Even though it has been widely recognized that domiciliary nursing is at the cheap end of the health system scale and is desirable and that a dramatic amount can be accomplished at such a small cost, still nothing has been done financially to make it happen in practice.

We have redeployed our staff and resources to the absolute maximum. We suggest that redeployment of government money into the domiciliary field must now be instituted, as the only recourse left, in order to obtain maximum and widespread benefits, from the funds available, over the whole health field.

Until the Geelong District Nursing Society is allocated more staff, governments will have to take the responsibility for people left in the community without adequate care, both the sick and the elderly. We just can't do any more.

District Nursing Sisters are some of the most hardworking, dedicated and compassionate people working in the community today. We say this without any qualification whatsoever and we thank them. We are honoured to be associated with them.

We can't speak highly enough of our Director of Nursing, Sister Cooper and her assistant, Sister Williams. We congratulate and thank

them both for their complete dedication and devotion to the caring for people in the community.

Our thanks go to the clerical staff, both past and present, Mrs. Gibbs and Mrs. Kemmis and to Mrs. Hand, who is to be commended for her highly efficient record keeping.

In conclusion I wish to thank the Executive and Committee for their advice and assistance.

JEAN RICHARDSON

Nurse's Annual Report

It is with pleasure that I present the Nursing Report for the year ended 30th June, 1982.

In many ways it has been a difficult year, primarily due to staff restrictions and the constant demand for our service as the following figures indicate. Patients treated for the year totalled 1,677 to whom 67,584 visits were made, an increase of 64 patients on the previous year.

It has been necessary to reduce the frequency of visits to some patients contrary to assessment of needs, in order to attend to the ever increasing number of patients requiring our care. Improved education of the diabetic patient, both in hospital and community has proved rewarding. The number of diabetic patients attended by us has decreased by 20 per cent. This means that numerous visits requiring minimum time, i.e. 10 to 15 minutes, have been replaced by visits requiring a longer period of time up to one hour.

Since the inception of the Geelong Hospice Association, with whom we are closely associated, it is gratifying to know that the care available to some of the dying cancer patients in the Geelong Area has been extended to a 24-hour service.

The patients and families who depend on the care and support provided by G.D.N.S. have the right to expect quality care from the service. It is becoming increasingly more difficult to maintain such care due to the unrealistic workload demanded of the sisters. I pay tribute to the dedicated, caring, professional service given by all nursing staff at all times. It is reassuring to receive numerous letters of appreciation from grateful patients for the care given by the staff.

Education continues to play a major role in our service. We are grateful to the Royal District Nursing Service for their continued support in allowing the staff to participate in their education progamme. We are delighted that through the formation of the Victorian Branch of the Australian Council of Community Nursing, additional education is available to community nurses throughout Victoria in the form of study days. The dedication of nurses caring for the community is made obvious by the large attendance at these meetings.

In addition to the staff who attended the ongoing education programme, Sister Phyllis Williams completed the Middle Management Course conducted by the R.D.N.S., instigated by A.C.C.N.

Great efforts are made to maintain liaison with other health agencies, but this is often inadequate due to insufficient staff. Pathology service is made available only to the terminally ill patients attended by the Sister.

To Grace McKellar House and Geelong Hospital Staff in all departments, I would like to express our appreciation of their continued help and support. The help and advice given to us by Hospital Doctors and General Practitioners is greatly appreciated.

I would like to convey our gratitude to all the organizations for the gifts donated to our patients at Christmas. They bring joy to many.

Special thanks also to Sister Phyllis Williams, Assistant Supervisor, Mrs. Sheila Kemmis, and Mrs. Gwen Hand, Clerical, for their loyal support and efficiency.

Finally I would like to express my deep appreciation to the President and Members of the Committee of Management for their support and assistance throughout the year.

GLYNETH COOPER

STATISTICS 1981 - 1982

Areas:

WEST GEELONG

NORTH-WEST
(West Geelong, Manifold Heights)

NEWTOWN/HERNE HILL

NORTH
(North Geelong, Norlane)

EAST GEELONG

BELMONT
(Belmont, Grovedale)

HIGHTON
(Highton, Belmont)

SOUTH
(South Geelong, Belmont)

COUNTRY
(Inverleigh, Bannockburn, Lethbridge, Marshall, Maude, Leopold, Moolap, Meredith, Ceres, Waurn Ponds)

DRUMCONDRA
(Drumcondra, North Geelong)

CHILWELL

HAMLYN HEIGHTS/BELL PARK/BELL POST HILL

CORIO/LARA

THOMSON
(Breakwater, Whittington, Newcomb)

CITY
(South Geelong, City)

FEMALE PATIENTS	1,065
MALE PATIENTS	579
CHILDREN	33
CANCER PATIENTS	226
TOTAL:	1,677

AGE GROUPS:

Under 10 years	21
10 - 20 years	35
20 - 40 years	73
40 - 60 years	197
60 - 80 years	917
Over 80 years	434
TOTAL:	1,677

STATISTICS 1981 - 1982

PATIENTS REMAINING ON BOOKS	720
TOTAL PATIENTS TREATED	1,677
VISITS	67,584
DISCHARGED AND RE-ADMITTED	95
KILOMETRES TRAVELLED	230,917
PETROL USED (LITRES)	22,431

1967/68 — 29,191 visits
674 patients

1968/69 — 31,944 visits
869 patients

1969/70 — 35,476 visits
938 patients

1970/71 — 40,637 visits
1,031 patients

1971/72

1972/73 — 44,895 visits
1,110 patients

1973/74

1974/75 — 52,863 visits
1,149 patients

1975/76 — 56,290 visits
1,258 patients

1976/77 — 58,104 visits
1,232 patients

1977/78 — 61,063 visits
1,368 patients

1978/79 — 62,374 visits
1,514 patients

1979/80 — 62,315 visits
1,507 patients

1980/81 — 67,980 visits
1,613 patients

1981/82 — 67,584 visits
1,677 patients

GEELONG DISTRICT NURSING SOCIETY

MAINTENANCE ACCOUNT FOR YEAR ENDED 30 - 6 - 82

1981	RECEIPTS	1982
$154,700	Health Commission	$163,190
114,250	Commonwealth Dept. of Health	158,444
79,203	Fees paid by (or on behalf of) Patients	87,002
1,280	Donations and Subscriptions	3,553
361	Interest Received	769
—	Rent	—
510	Sale of Equipment	183
10,063	Deficit for year	—
$360,367		$413,141

1981	EXPENDITURE	1982
$322,145	Salaries	$351,201
14,323	Car Running Expenses	16,010
7,142	Car Replacements (Net)	5,770
5,472	Phone, Postage and Stationery	6,254
1,110	Advertising	61
1,540	Drugs and Dressings	1,352
1,333	Cleaning, Repairs and Maintenance	1,946
2,534	Replacements	379
2,394	Uniforms and Allowances	2,874
938	Travelling, Conference and Lecture Fees	1,516
418	General Expenses	374
792	Light and Power, Gas and Rates	950
226	Insurances, Fees and Subscriptions	274
—	Surplus for year	24,180
$360,367		$413,141

BALANCE SHEET AS AT 30th JUNE, 1982

1981	LIABILITIES	1982
$2,059	National Bank (Maintenance Account)	—
58,513	Specific Purpose Fund	$70,785
941	Maintenance Fund	21,395
142,481	Society Capital Account	147,000
$203,994		$239,180

1981	ASSETS	1982
—	National Bank — Maintenance Account	$18,395
$5,513	National Bank — Specific Purpose Fund	4,785
53,000	Investments — Specific Purpose Fund at Cost	66,000
3,000	Investments — Maintenance Account at Cost	3,000
80,975	Motor Vehicles at Cost	83,349
48,105	Land and Buildings at Cost	48,535
13,401	Equipment and Furniture at Cost	15,116
$203,994		$239,180

NOTES ON ACCOUNTS:

1. **In accordance with the requirements of the Health Commission,** the accounts have been prepared on a cash basis.
2. Motor Vehicles, Equipment, etc. are shown at cost, and no provision has been made for depreciation. Net cost of replacements is charged against income.
3. Source and application of funds, see over.
4. Agreement for replacement of 2 cars at a cost of $5,000 (Net) was signed on 26/5/82 but vehicles had not been delivered or paid for as at 30/6/82.

AUDITOR'S REPORT:

I report that I have examined the accounts of the **Geelong District Nursing Society** for the year ended 30/6/82 and in my opinion the Balance Sheet and Maintenance Account are properly drawn up so as to give a true and fair view of the state of the Society's affairs as at 30/6/82.

G. T. PYLE, F.A.S.A., Licensed Auditor.

APPLICATION OF FUNDS STATEMENT (SUMMARY)

Source of Funds

SURPLUS FOR YEAR	$24,180
TRANSFER FROM SPECIFIC PURPOSES FUND	792
	24,972
NON CASH ITEM (CAR DEPRECIATION)	5,770
	$30,742

The above Funds were applied as follows:

CAR REPLACEMENTS	$8,144
FENCING	430
SUNDRY EQUIPMENT	1,714
INCREASE IN BALANCE, NATIONAL BANK	20,454
	$30,742

ASSOCIATE MEMBERS

MR. AND MRS. W. BAIRD
MRS. B. BLACK
MR. R. BURTON
MRS. F. CALLAHAN
MRS. CRUIKSHANK
MRS. DIXON
MR. D. G. HANCOX
MRS. W. JAMIESON
MRS. LANGLANDS
MRS. H. A. LEES
MISS E. LEIGH
MRS. H. MARFELL
MRS. S. NICHOLAS
MRS. PATERSON
MRS. P. PESCOTT
MRS. T. PHILLIPS
MRS. SPENCELEY
MRS. J. F. STRACHAN
MRS. SULLIVAN
MRS. A. WATTS
MRS. B. WILSON

DONATIONS

Mr. Wood	$5.00
Mrs. Willson	25.00
Mr. and Mrs. Betts	4.00
J. E. Mullen	20.00
Mrs. N. W. Bush	50.00
Mrs. E. Carlon	20.00
Mr. C. Stocks	25.00
Mrs. Melville	5.00
Mr. Vaughan	2.00
Mrs. Beks	5.00
Mrs. A. Moreton	20.00
Mrs. N. Anderson	20.00
Mr. E. Williams	50.00
Mrs. McIntyre	50.00
Mrs. Crotty	5.00
T. H. Stannard	20.00
Mrs. Fierenzie	1.00
Mrs. Crottie	5.00
Miss Monahan	20.00
Mr. Gael	4.00
Mrs. Bartlesche	5.00
Miss Collins	20.00
Mrs. E. Martin	16.00
Mrs. Fairnie	10.00
Mrs. Thomas	20.00
Mrs. Larkins	5.00
M. L. Wilson	25.00
Mr. H. G. Westman	20.00
Mrs. E. Winter	40.00
Mrs. Barretta	5.00
Mr. J. W. Dillon	25.00
Mrs. J. Fraser	5.00
Mr. Battye	20.00
Mr. Tullo	10.00
Mrs. Sharp	50.00
Mrs. L. Diamond	4.00
Barwon Heads All Saints Guild	6.00
Society of St. Vincent de Paul	350.00
Shire of Barrabool	10.00

CHRISTMAS DONATIONS 1981

Red Cross Centre
Highton Rotary Club
Barwon Heads All Saints Ladies Guild
Barwon Heads Uniting Church
Uniting Churches within the Barwon Presbytery
St. Pauls Ladies' Guild
Mrs. Ham, Waurn Ponds
Alexander Thomson Uniting Church, Belmont

THE GEELONG DISTRICT NURSING SOCIETY WISH TO THANK THE ABOVE INDIVIDUALS AND ORGANISATIONS FOR THEIR GENEROSITY, AND ALSO TO THANK THOSE WHO DONATED EQUIPMENT

ROYAL DISTRICT NURSING SERVICE
452 ST. KILDA ROAD, MELBOURNE, 3004 TELEPHONE 26 6791

21st September, 1982

Miss A.J. Holzer,
Secretary,
Anti-Cancer Council of Victoria,
90 Jolimont St,
East Melbourne, 3002

Dear Miss Holzer,

We have pleasure in enclosing our statement showing the treatment of cancer patients for the year ended 30th June 1982.

Yours sincerely,

W.W.Roach
Chief Executive Officer

P. Welfare
C. Hea

CANCER PATIENTS

TOTAL: PATIENTS = 4,605 (including 428 Repatriation)

VISITS = 60,684 (including 5,397 Repatriation)

ESTIMATED AMOUNT = $84,352

SOURCE OF ADMISSION:

Local Doctor	751
Hospital	3,117
Repatriation	428
Other	309
TOTAL:	4,605

Patients currently treated on 30th June 1982 = 1,031

Patients discharged in 1981-82 financial year = 3,574

90 JOLIMONT STREET,
EAST MELBOURNE,
AUSTRALIA, 3002.

TELEPHONE: 654 2411
Cables: ACCOVIC MELBOURNE

Telex: VCCG AA 34158.

Director: Dr. Nigel Gray, A.M.
MB, BS, FRACP, FRACMA.

Anti-Cancer Council of Victoria

BREAST PROSTHESIS SERVICE -
VOLUNTEER VISITING SERVICE

REPORT for M.R.S. SEMINAR - CANBERRA - APRIL 1982

Although the Victorian Breast Prosthesis Service is run along different lines to the Mastectomy Rehabilitation Service in other States, our main objective is no doubt the same - that is to help women who have had breast surgery resume their normal lifestyle as quickly as possible, and assist them with any problems they may have.

All the major public hospitals in Victoria have appointed B.P.S. Sisters and the private sector is looked after by the Royal District Nursing Service. In addition we have many liaison nurses from other hospitals where breast surgery is performed, and these are increasing - in time we hope every mastectomy patient will have the opportunity to benefit from our service.

The B.P.S. nurse sends us a Patient Profile after each interview - we received profiles on 765 women who had surgery during 1981, as well as a large number who had surgery prior to this and the Sisters have been unflagging in their dedication and willingness to co-operate. Any woman who has had breast surgery, irrespective of where or how long ago, is welcome to make an appointment with a B.P.S. nurse to see the breast forms currently available, and discuss her individual needs. Apart from keeping the prosthesis "kits" up to date, each season we collect a range of suitable swimwear and this can be viewed by appointment at R.D.N.S. centres.

Retail Lists are updated as necessary and we also advise patients of benefits provided by the various health funds to cover the cost of breast forms. Government Entitled patients are provided with the first breast form by their treating hospital, however replacement is more difficult. Although we were able to make use of the Government's P.A.D.P. scheme for a time, it proved inadequate and we have had to fall back on the Anti-Cancer Council's Welfare Fund to pay for breast forms in cases of hardship. In Victoria the P.A.D.P. money was distributed amongst 28 registered hospitals and geriatric centres, each then administering it according to their own interpretation of the rules. The person in charge could be a social worker, occupational therapist, doctor, or other health professional, but at hospitals where we have a B.P.S. Sister we were able to use the funds with a minimum of red tape - until the funds dried up. The Health Commission has advised there will be no further funds allocated until after the August Budget is brought down and if they are again limited it would seem appropriate to introduce some sort of Means Test. Also in the case of breast forms, unless the applicant has had bi-lateral surgery, one should be sufficient. Any P.A.D.P. Prescriptions we processed were assessed along these lines.

During the last 12 months there has been renewed interest in developing the Volunteer Visiting Service alongside the B.P.S. In November last year 14 mastectomees joined the V.V.S. and, together with 2 from our original intake, underwent an intensive one-day training session. Referral slips to the V.V.S. are distributed to surgeons, hospitals, and given by the B.P.S. nurse to each patient she sees. Visits can be arranged in hospital although sometimes it is more appropriate after discharge in the patient's own home. It can be difficult to have privacy whilst in hospital and often it is not until she gets home that the full realization of the implications of breast surgery for cancer hits her, particularly if she is alone for lengthy periods.

P.T.O.

So far the V.V.S. covers only the metropolitan area, but we hope to train a small group of volunteers in each country area where they will be able to work with the B.P.S. Sister at the base hospital. One difficulty we are experiencing is that of trained volunteers becoming unavailable for varying lengths of time through holidays, ill-health, accident and so forth. It appears we could need a much larger number of volunteers if calls for the V.V.S. continue to increase as we anticipate. Sometimes telephone contact is sufficient so we may have to consider providing a back-up telephone counselling service, which would solve some transport problems and we would be able to use women who do not have a car, or for family reasons are unable to go out to visit.

Breast reconstruction surgery is becoming more popular and we have had lectures at our B.P.S. meetings regarding this. Some of our volunteers have had reconstruction - some have had radiotherapy - some chemotherapy - however we stress during training that it is not their function to advise patients in any way on medical matters, and questions relating to treatment could present problems. The Breast Prosthesis Service has been very well accepted by surgeons and we are very concerned that this is continued with the inclusion of the volunteers into our system.

S. Rawlyk

Sue Rawlyk (Mrs.)
Social Worker's Assistant
Anti-Cancer Council of Victoria.

Pat. Wilson
Enf Morgan

16 Blair St,
Bentleigh
3204.

22 JUL 1982

Dear Sir or Madam,

May I commend your organization for the fine work they are doing.

My father died of Lymphthoma this January after being diagnosed the previous March 1981. Looking back on this now I feel again the sense of inadequacy that overcomes the family — the deep need to help and assist fettered by the lack of information. Information on what to expect in the form of treatment. We went to the library for Medical books, personally spoke to the local doctors and the hospital specialists and Oncologists. And sifted through what my father was told. We wasted the time of the hospital staff asking for explanations of statements that went over our heads and yet what else could we do? our father was dying, we wanted to know everything so we could help him and make his time with us loving and filled with dignity. finally Dad was lent a book by the hospital social worker. This explained the Cytoxic drugs used to fight different cancers and the side effects caused by them. This little book passed among family and friends became the anchor when the days darkened. When our time with Dad became shorter and shorter and the times when he lay in pain lengthened we returned to the book- pre warned we functioned better. This book helped to dispell many myths kind souls told us - the cold facts were our solace against this disease.

I feel that your organization could fill this gap with a booklet - possibly along the lines of the one published by the heart foundation - for heart attack victims and their families. To many people facing a doctor in a major hospital is an ordeal and they cannot remember all that was said after the interview - a booklet read in the quiet of ones home, can be a great aid to handling the illness and imminent death of a special person. We found and too late that the Peter Macallum hospital offered at home services - possibly these services could also be listed. and the book waned need to be published in many languages. and freely available at clinics and the local doctors surgery. If I or my family could assist you and your organization in compiling such a booklet we would be delighted.

Yours Sincerely

Lorraine Upakeen (MRS.)

22 JUL 1982

Headquarters Building, 302 Armstrong Street North, Ballarat

Ballarat & District Nursing Society

Annual Report

1982

BALLARAT & DISTRICT NURSING SOCIETY

President: Mrs. A. E. BEAUMONT

Vice-presidents: Mrs. W. P. DELANY
J. L. TREVENEN, Esq., M.B.E., E.D.

Honorary Secretary: Mrs. H. S. TREVENEN, M.B.E.
527 Barkly Street South. Phone: 32 1300

Honorary Treasurer: J. L. TREVENEN, Esq., M.B.E., E.D.

Committee:

Dr. J. ACHESON	Mrs. T. BEAUMONT
Mrs. A. BEAUMONT	Mrs. M. OATES
Mrs. A. BENJAMIN	Mrs. J. F. OWEN
Mrs. J. CHAMBERLAIN	Mrs. J. RIDDELL
Mrs. W. P. DELANY	Mrs. H. S. TREVENEN, M.B.E.
Mrs. T. J. GREENHILL	Mr. J. L. TREVENEN, M.B.E., E.D.

Honorary Solicitor: W. H. HEINZ, Esq.

Honorary Physician: Dr. J. R. COUSINS

Trustees: UNION-FIDELITY TRUSTEE CO. OF AUST. LTD.

Auditors: DRISCOLL, McIVOR & CO.

Life Members: Mrs. H. S. TREVENEN, M.B.E.
Mrs. G. COOPER
Mrs. W. P. DELANY
Mrs. A. BENJAMIN
J. L. TREVENEN, Esq., M.B.E., E.D.
Mrs. T. J. GREENHILL
Mrs. J. F. OWEN
Mrs. J. CHAMBERLAIN

Director of Nursing: Sister P. L. DEAN. Phone: 32 3225, 31 4937

Nursing Staff: 20.5 TRAINED SISTERS

Office Staff: Mrs. V. SPIERS
Miss A. HORGAN

Headquarters: 302 ARMSTRONG STREET NORTH, BALLARAT
Phone: 32 7741 and 31 4937

The Headquarters is equipped with a phone answering service. Should there be no person in attendance, the service will advise you of the telephone number to contact for nursing service.

Honorary Secretary: Mrs. H. S. TREVENEN. Phone: 32 1300

71st Annual Report

1981-82

It is my pleasure on behalf of the Committee of the Ballarat and District Nursing Society to present this Annual Report and Financial Statement for the year ended 30th June, 1982.

The requests for the nursing services provided by our Society continue to increase at a somewhat alarming rate — and there is every indication that this will continue. This increase has placed a very heavy burden on our Director of Nursing, Sister P. L. Dean, and her staff of trained nursing sisters; but they have met this demand and have again rendered splendid service to our community. Our sisters not only make this large number of visits, but they carry them out with great efficiency and cheerfulness and become completely involved with their patients. Their one regret is that they are unable to spend more time with each patient. Our sisters who are on duty at weekends deserve particular praise.

Currently we have approval to employ 19.5 trained nursing sisters. However, because of the increased work load, it became absolutely necessary to employ an additional sister during the year. Despite this, there is need for approval for additional trained nursing staff to be employed to cope with the current work load, and to provide the necessary time for advanced staff training. There can be no doubt whatsoever that the nursing of the sick in their own homes is the most desirable and economic course of action.

During the year we have continued to enjoy excellent co-operation with the Ballarat Base Hospital, the Queen Elizabeth Geriatric Centre, the Ballarat Ambulance Service, the St. John of God Hospital, Medical Practitioners and Welfare Officers. The Society has continued to be represented at Central Highlands Regional Council meetings and find the discussions very helpful.

From the financial statement it will be observed that we have recorded a deficit on our year's operation for the first time for many years. Rising costs and the heavy demands for our home nursing services have contributed greatly to this situation. Great care has been exercised to control administrative and operational expenses.

However, we are most grateful to both State and Federal Governments for the grants that have been made available during the year.

We are also grateful to our many donors, and in particular the major donors who are listed at the head of our subscribers' list. It will be appreciated that many bequests and donations are received on our annual basis and greatly assist our work. Special mention should be made of the continuing contribution from the Collier Charitable Trust, which provides for dressings and assistance for patients in poor circumstances.

During the year many patients and relatives have forwarded donations with their letters or cards expressing their appreciation for the service of our Society. We are grateful to the Service Groups who have helped us during the year in various ways — particularly one group who enabled a telephone service to be installed in the country home of a very sick boy. At Christmas time small gifts were distributed to all patients. It would be appreciated if members of Church and like clubs could see their way clear to assist at Christmas time in providing items such as biscuits, sweets, powder, soap, etc., for distribution to our patients.

During the year Mrs. T. Beaumont retired from our office staff and was elected and welcomed to our Committee. At the last Annual Meeting Life Membership was awarded to Mrs. J. F. Owen and Mrs. J. Chamberlain

in recognition of 20 years of excellent service to the Society.

Our Headquarters building was erected in 1968 when we had only a quarter of the number of staff employed today. Each day now our headquarters building bustles with activity as nursing sisters prepare reports on their day's activities and receive their instructions for the following day. It has been necessary to re-design the layout in several rooms to provide additional facilities for the nursing staff. These alterations, including air conditioning of the building, have been carried out very effectively and at minimal cost. I am grateful to our Honorary Treasurer for his ideas and supervision of these important alterations.

I would also like to record my very sincere thanks to Sister Dean and her nursing and administrative staff for their excellent work during the year. I am also most grateful to the office-bearers and the members of the Committee for their loyal support. I have enjoyed the opportunity to be president of this important Society for two years, and I wish Mrs. W. P. Delany, our incoming President, a very profitable and enjoyable term of office.

AVENEL BEAUMONT, President

NURSING REPORT

In presenting the nursing report for the year ended June 30th, 1982, one cannot help but have a sense of stimulation and challenge in considering the year in retrospect.

It is extraordinary to find that, from year to year, we are confronted with new challenges requiring adaptions, new skills, increased knowledge and adjustments.

A total of 85,901 visits have been made, an increase of 4,546 visits on the previous year. Kilometres travelled increased accordingly from 182,518 to 194,717.

The 1981 preliminary census figures illustrate that the 60 years and over age group is continuing to increase both in numbers and as a proportion of the total population. For Ballarat City the 60 years and over age group constitutes 22 per cent. of the population, a significantly large component of the community.

Our services, together with domiciliary services provided by other agencies in Ballarat, including the Queen Elizabeth Geriatric Centre, Ballarat City Council, Meals on Wheels, Kelaston Home for the Blind, the Ballarat Ambulance Service and many others, has enabled many elderly people to remain in their own homes for a much longer period. With this we are proud to be associated, but for how long can we expect to maintain this service without increased staff?

The patients and families who depend on the care and support provided by the Ballarat and District Nursing Society have the right to expect high quality health care from the service and I cannot adequately express my gratitude for the dedicated, caring, professional services given by all nursing staff at all times.

It is with regret that we are unable to participate in the education programmes offered by the Royal District Nursing Service due to staff shortage.

The Committee of Management is very conscious of the strains put on our staff with the ever-increasing work load and I pay tribute to the Committee for their support and encouragement at all times. Working with the Committee and all members of the staff has been abundantly worthwhile.

PHYLLIS L. DEAN, Director of Nursing

BALLARAT & DISTRICT NURSING SOCIETY

STATEMENT OF BALANCES
AS AT 30th JUNE, 1982

	1982	1981
Maintenance Fund		
Accumulated surplus	$68,095	$81,394
Provision for long service leave	7,660	10,986
	$75,755	$92,380
Represented by:		
Cash at bank	$18,755	$54,380
Investments — redeemable within one year	9,000	21,000
redeemable after one year	18,000	17,000
	$75,755	$92,380
Special Purpose Fund		
Balance	$43,480	$38,780
Represented by:		
Cash at bank	$10,480	$5,780
Investments — redeemable within one year	—	—
redeemable after one year	33,000	33,000
	$43,480	$38,780
Capital Fund		
Balance	$105,142	$97,876
Represented by:		
Cash at bank	$11,601	$6,205
Investments — redeemable within one year	4,700	8,100
redeemable after one year	7,200	7,400
Land and buildings	31,849	31,849
Furniture and equipment	9,001	8,401
Motor vehicles	40,791	35,921
	$105,142	$97,876

MAINTENANCE ACCOUNT
STATEMENT OF RECEIPTS AND PAYMENTS
FOR THE YEAR ENDED 30th JUNE, 1982

	1982	1981
Receipts		
Government grants:		
Health Commission of Victoria	$106,540	$144,210
Commonwealth home nursing subsidy	124,721	85,730
Fees received:		
Patients	89,770	85,376
Department of Veterans' Affairs	45,444	52,098
Income from investments	8,248	4,312
Charitable contributions	1,478	2,487
Sundry	350	—
	$376,551	$374,213
Payments		
Salaries and wages	$347,461	$290,444
Motor vehicle expenses	29,159	23,290
Maintenance of buildings, furniture and equipment	503	6,401
Administration expenses	4,052	3,345
Uniforms	952	1,505

Power, light and heating	1,419	1,166
Postage, freight and telephone	1,490	1,229
Printing and stationery	1,877	1,167
Medical supplies	1,974	1,681
Training, registration and course fees	963	—
	$389,850	$330,228
Surplus (Deficit) for the year ended 30th June, 1982	($13,299)	$43,985
Add Accumulated Surplus at 30th June, 1981	$81,394	$37,409
Accumulated Surplus at 30th June, 1982	$68,095	$81,394

BALLARAT & DISTRICT NURSING SOCIETY

STATEMENT OF RECEIPTS AND PAYMENTS

FOR THE YEAR ENDED 30th JUNE, 1982

Special Purpose Fund	**1982**	**1981**
Add—		
Interest received	$4,700	$3,181
Fund balance 30th June, 1981	38,780	35,599
Fund balance 30th June, 1982	43,480	38,780
Capital Fund		
Receipts—		
Interest received	$2,225	$2,916
Donations received	5,041	—
Government grants	—	9,898
Other	—	(643)
	$7,266	$12,171
Fund balance 30th June, 1981	97,876	85,705
Fund balance 30th June, 1982	$105,142	$97,876

J. L. TREVENEN,
Treasurer

NOTES TO AND FORMING PART OF THE ACCOUNTS FOR THE YEAR ENDED 30th JUNE, 1982

1. Summary of significant accounting policies

(a) These financial statements have been prepared on a cash basis in accordance with the accounting instructions issued by the Government departments controlling funding to the society. Accordingly the following have not been brought to account:

(i) income earned but not received;
(ii) expenditure incurred but not paid;
(iii) depreciation on buildings, plant, machinery, furniture and equipment;
(iv) provisions for long service leave, annual leave and other accruals.

(b) As a result of (a) above, payments of a capital nature (purchase of buildings, plant, machinery, motor vehicles and furniture and equipment) are expensed in the year of payment and are not brought to account as fixed assets. Accordingly depreciation of fixed assets is not charged.

2. Cash collections

At 30th June, 1982, patient fees collected of $5,851 had not been deposited in the maintenance fund bank account and donations received of $1,500 had not been deposited in the capital fund bank account.

3. Long service leave

In past years funds were set aside out of the maintenance fund to a provision for long service leave. Funds transferred to the provision did not represent recognition of specific commitments for long service leave. Accordingly the balance of $7,660 at 30th June, 1982, does not represent any specific long service leave commitment at that date. The movement in the account during the year represents long service leave of $3,633 paid to an employee who resigned during the year ended 30th June, 1981.

4. Land and buildings

The title to land owned by the society is held in the name of The Union Fidelity Trustee Company of Australia Limited as trustees for the society in accordance with a declaration of trust dated 28th May, 1953.

AUDITOR'S REPORT

We report that we have examined the accounts of the Ballarat and District Nursing Society for the year ended 30th June, 1982, being the statements of receipts and payments of the maintenance account, special purpose account and capital account for the year then ended and the statement of balances.

Subject to note 1, in our opinion the accompanying accounts are properly drawn up so as to give a true and fair view of the receipts and payments of the society for the year ended 30th June, 1982, and of the financial position of the society as at that date.

DRISCOLL, McIVOR & CO.,
Chartered Accountants

LIST OF DONATIONS AND SUBSCRIBERS

Only donations of $1.00 upwards are acknowledged in this report.

Collier Charitable Trust	$1,000.00
Joe White Bequest	1,000.00
Estate of Mrs. G. F. Hunichon	1,000.00
Percy Baxter Trust	500.00
Estate of Hilton White	500.00
Anti-Cancer Council of Victoria	500.00
"Walter Eliza Hall"	250.00
M. B. John Charities Fund	100.00
Bishop Mulkearns	100.00
Ballarat Group Practice	200.00
Sunball Competitions	30.00
Pryor, Houghton & Mitchell, Drs.	100.00

COUNCILS

Ballarat City Council
Buninyong
Ballarat Shire
Creswick Shire

$50

Peter Stevens Datsun

$35

Hassett, Dr. B.

$25

Crawford, Dowling Pty. Ltd.
Clark, Miss N.
Ramsay, Gaunt & Fraser
Shell Oil Co. of Aust. Ltd.
Hoskin, J. A. & Son
Dr. D. M. O'Sullivan

$20

Butler, Miss U.
Butler, A. L. (Scotts)
Curwen Walker, J.
Davis, H. A. (Buses)
Evans, H. A. & Sons
Ellis, Miss P.
Ellis, Miss B.
Faulds, Miss L.
Gilmer, Miss E.
Garden City Flour Mill
Mildren, John, M.P.
Jones, C. V. (Antiques)
Mentay Constructions P/L.
Pirie & Sutton
Picot & Widmer
Water & Sewerage Staff Social Club
Selkirks Pty. Ltd.

$15

Membrey, Mrs.

$10

Ballarat Courier Pty. Ltd.
Baird & McGregor
Carlton & United Breweries
Begonia Florists
Darling Smith Pty. Ltd.
Driscoll & McIvor
Evans, A. T., M.L.A.
Evans & Metcalfe
Hotline Bakeries
Heinz Bros.
Hobill, Mrs J.
McCrimmon, Mrs B. H.
Nicholson, Lady B.
Raceys
Royal Insurance Company
Sheehan, F. M., M.L.A.
Sunicrust Bakeries
Titheridge & Growcott
Wright & Govan
Waller & Chester

$5

Alexander, Dr. D. A.
Benjamin, Mrs. J.
Bartrop, Edgar Pty. Ltd.
Banfield, Mrs.
Doepel, Lilley & Taylor
Heinz & Gordon
Hollway, John & Sons
Jones, Mr. J. D.
Rogers, Mr. and Mrs. F.
Rimmington Bros.
Stewart, Mrs. M.
Sage, Miss R.
Tunbridge's
Baxter & Stubbs
Kings Marine Stores

UNDER $5

Quayle & Hutton
Reifisch, H. & Co.
Chamberlain, Mrs. J.
Benjamin, Mrs. A. E.
Beaumont, Mrs. A. E.
Beaumont, Mrs. T.
Clark, Louise
Delany, Mrs. J.
Greenhill, Mrs. J.
Hill, Mr. and Mrs. G.
Owen, Mrs. J. F.
Oates, Mrs. M.
Riddell, Mrs. B. W.
Trevenen, Mrs. H. S.
Trevenen, J. L.

THE BALLARAT & DISTRICT
NURSING SOCIETY
INVITES YOU TO SHARE IN ITS WORK

DONATIONS OF $2 AND OVER
ARE EXEMPT FROM INCOME TAX
AND
LEGACIES FROM PROBATE ESTATE DUTIES

Hoskin Print, Ballarat

REPORT ON V.C.O.S.S. MEETING - 26TH AUGUST, 1982

(Victorian Council of Social Service)

Attended by B. Todd

In his introduction, Hayden Raysmith, Executive Director of V.C.O.S.S., quoted Professor Mathews, Director of the Centre for Research on Federal Financial Relations at the Australian National University; member of Grants Commission; and Head of the Committee of Inquiry into Inflation and Taxation:-

> "If Governments were to set out deliberately to design a taxation system which would redistribute income from the poor to the rich, which would substantially relieve the rich of the cost of financing social welfare transfers and public services, which would consciously discrimate against wage and salary incomes in favour of other incomes and capital gains, which would distort the pattern of consumption and production, and which would provide a major stimulus to wage inflation and industrial conflict, it would be difficult for them to develop a set of tax arrangements that would be more successful in meeting such perverse objectives than the existing Australian system."

This gloomy outlook was reinforced by Alison McClelland and John Dickson of V.C.O.S.S. and Penny Farrar of Shelter Victoria as they each gave their opinions on the 1982/83 Budget. In their opinion this year's Budget gave no relief from the effects caused by the devastating Budget of 1981/82 and a large proportion of the Australian community will continue to receive incomes which are far below the poverty line. They believe tinkering with the system in such a fragmented way means that inequality will not only continue, it will worsen.

A report from the Australian Industry Development Association says living standards in Australia are dropping in relation to the rest of the world - they quoted figures to support this. The gap in living standards between sections of the Australian community is also widening and it was felt the Budget does nothing to rectify this and, in fact, the situation will probably deteriorate.

Health:

Of the $466m. increase in direct Commonwealth health funding (a 16% increase on 1981/82), over 80% goes directly to doctors, chemists and private nursing homes. $52m. of the increase for medical benefits is to cover higher scheduled medical fees.
In contrast, public sector funding has been slashed. It was said that to keep pace with inflation, Victoria would have required an increase of $34m. to maintain hospital, Community Health and School Dental services, whereas the $26m. cut represents an 18% reduction in real terms. Probable results will be rising hospital charges, insurance premiums and a cut back on services provided. The overall effect on the average Victorian will be that "what he gains on the round-a-bout he loses on the swings".

Government funding once again appears to show a preference towards funding of institutions - rather than, for example, home care schemes and self help organisations.

/2.....

Housing:

There is extra pressure on the States to provide funds for housing. Public housing is less of an option now than ever before for low income families in need of housing and already there are 150,000 people homeless in Australia and 280,000 living in sub-standard housing. Family crisis housing received $4m., of which Victoria gets about $1m.

Although home loan interest rebates have been given to home buyers, no real assistance has been given for homeless people and tenants.

All resident buyers, regardless of their income, will now be able to claim a tax rebate on the interest paid over and above 10% on mortgages of up to $60,000. This rebate will provide more relief for people in higher income brackets.

Family Allowance:

Low income families will receive some help through family income supplement and increased family allowances for the first and second child but high income groups will get very substantial benefits from income tax cuts.

Unemployment:

Since 1979 the average duration of unemployment has risen rapidly. The two examples below typify the hardship experienced by the unemployed:-

Unemployed - under 18 - receive $40 p.w. - poverty line $94.70

Couple with 2 children - receive $161 p.w. - poverty line $117.80

At a time of record unemployment, the Federal Government has brought down a Budget which could increase the number of unemployed and provide little real help through employment programs.

General Comments:

It was felt that, generally, this Budget does not help people who are in the greatest need and is not a Budget for low income people - as promised. The grants are inadequate to rectify the problems which have grown over the past few years.

Hayden Raysmith believes that in the last five years we have experienced a redistribution of Government funds from the poor to the rich. Taxation and public expenditure policies have been used as a means of maintaining wealth and privilege as well as increasing the gap between lower and higher income groups.

It was said we should be working towards establishing a "Social Wage", i.e. an amount paid to tax payers or non-taxpayers by the Government when unemployed, etc.

Attended

Apology from
Tony Cole for
Welfare Review
meeting on Sunday
26th November.

Leg.

11/11/82.

5th November, 1982

Ms. Rikki Bewley
Occupational Therapy Department
Royal Children's Hospital
Flemington Road
PARKVILLE 3052

Dear Ms Bewley

Thank you for taking the trouble to reply to our questionnaire on Welfare Services.

The covering letter with the questionnaire actually suggested the respondent to be the staff member responsible for the provision of welfare services, and unfortunately it would bias the study if we were to accept additional questionnaires from the Royal Children's Hospital.

I hope you will understand therefore that we cannot include your reply in the study.

With best wishes,

Yours sincerely,

Adrienne J. Holzer (Miss)
Secretary to the Council

c.c. Medical Director

Office Use Only

Col no:
1-4 ID
5 Region
6 C of R

Anti-Cancer Council of Victoria

REVIEW OF WELFARE SERVICES AVAILABLE TO

PERSONS SUFFERING FROM CANCER AND THEIR FAMILIES

Name of Agency: ROYAL CHILDREN'S HOSPITAL
OCCUPATIONAL THERAPY DEPT.

Address: FLEMINGTON ROAD
PARKVILLE Postcode: 3052

Telephone: 03 347 5522 x 390
Area Code Number

Question 1

Estimate the number of persons suffering from cancer for whom your agency provided welfare services during the 12 months to October 1982.

(Please tick the appropriate box)

7

1 - 50	1	☑
51 - 100	2	☐
more than 100	3	☐

Question 2

What services does your agency provide which are available to cancer patients and/or their families?

Include all services provided by your agency whether or not you are directly involved in the provision of the service.

Please do not include services which your agency can arrange to have provided by other agencies.

(Please tick appropriate box)

Office use only

Col no:		
	Transport	
8	Volunteer driver service	
9	Transport service provided by agency employee	
	Accommodation	
10	Hostel/special accommodation house	
11	Self-contained units	
12	Hospice	
13	Nursing Home	
14	Family relief accommodation	
15	Short term accommodation near treatment centre	
	Legal	
16	Legal advice	
	Financial	
17	Financial aid	
18	Financial counselling	
	Employment	
19	Vocational counselling	
20	Employment advice	
	Domiciliary and community services	
21	Meals on wheels	
22	Home help	
23	Home handyman service	
24	Weekend nursing service	
25	Visiting nursing service	
26	Chiropody service	

Office use only

Col no:		
27	Volunteer visiting service	
28	Child care	
29	Day centre	
30	Activity groups	✓
31	Self-help groups	
	Rehabilitation	
32	Occupational therapy	✓
33	Physiotherapy	
34	Speech therapy	
35	Household and personal aids	✓
36	Prosthesis	✓
	Counselling	
37	Individual counselling	✓
38	Child counselling	✓
39	Family support counselling	✓
40	Bereavement counselling	✓
41	Group counselling	
42	Social assessment and referral	✓
43	Interpreters	
	Other (please specify)	
44	.....	
45	.....	
46	.....	

Office use only

Col no:

Question 3

In this section potential problems have been listed under specific headings. Some of them may appear repetitive. This is to enable a more accurate analysis of the information you are providing. We are drawing upon your experience of working with people suffering from cancer. Your perceptions of the problems they face will be valuable to this review.

Would you rate according to the scale below the following problems which may face persons suffering from cancer or their families.

Can't answer	0
No problem	1
Minor problem	2
Serious problem	3
Very serious problem	4

(Please place the appropriate rating number in the box provided).

Transport

Transport for treatment and weekend leave:

47	Ambulance transport difficulties	0
48	Insufficient voluntary drivers	0
49	Distance from treatment centre for patient	3
50	Distance from treatment centre for family	3
51	Car park facilities at treatment centres	3
52	Cost to cancer patients and their families	0
53	Insufficient knowledge about the isolated patients travel and accomodation assistance scheme (IPTAAS)	0
54	Complexity of procedures in order to make use of the isolated patients travel and accommodation assistance scheme (IPTAAS)	0

Other transport problems (please specify)

55 .....

56 .....

57 .....

Office use only

Col no:

Rating scale:

Can't answer	0
No problem	1
Minor problem	2
Serious problem	3
Very serious problem	4

(Please place the appropriate rating number in the box provided)

Accommodation

58	Insufficient suitable nursing home care	0
59	Terminal care	3
60	Special Accommodation	0
61	Private Hospitals	0
62	Family Relief Beds	0
63	Insufficient suitable short stay accommodation in or near treatment centre for patients	2
64	Insufficient suitable short stay accommodation in or near treatment centre for visiting relatives	2

Other accommodation problems (please specify) There is a need

65 for hospice type accommodation in

66 Melbourne. Many parents do not want their child to die in hospital, but are unable to provide appropriate care at home.

Legal services

67	Insufficient low cost legal assistance and advice * e.g. workers' compensation, occupational health rights, wills, hire purchase contracts, etc.	0

Other legal problems (please specify)

68 .....

69 .....

70 .....

* Examples are given as suggestions only. Please do not rate the problems exclusively on the basis of the examples given. You may have quite different issues in mind as you rate each question.

Office use only

Col no:

Rating scale:

Can't answer	0
No problem	1
Minor problem	2
Serious problem	3
Very serious problem	4

(Please place the appropriate rating number in the box provided)

Information/Education

71 Insufficient information available to the community generally about issues relating to cancer and its treatment. [3]

72 Insufficient information available to cancer patients and their families about cancer treatment and management [3]

Other information problems (please specify)

73 One of the most common complaints from

74 parents is of the lack of sufficient verbal and written information

Employment

75 Insufficient employment advice and counselling
* e.g. Negotiating flexible hours, timing of employment termination, exploring other options [0]

Other employment problems (please specify)

76 .....

77 .....

Financial advice

78 Insufficient financial counselling and advice
* e.g. investment, adjustment to a sudden loss of income, long term financial commitments [0]

Other financial problems (please specify)

79 .....

80 .....

* Examples are given as suggestions only. Please do not rate the problem exclusively on the basis of the examples given. You may have quite different issues in mind as you rate each question.

Office use only

Col no:

Rating scale:

Can't answer	0
No problem	1
Minor problem	2
Serious problem	3
Very serious problem	4

(Please place the appropriate rating number in the box provided)

Statutory benefit

7	Lack of flexibility with regard to sickness benefit	0
8	Lack of flexibility with regard to invalid pensions	0
9	Lack of flexibility with regard to domiciliary nursing care benefits	0

Other (please specify)

10 .....

11 .....

Health insurance

12	Difficulties with regard to health insurance * e.g. Confusing policies, cost of health insurance, hidden costs to privately insured patients	0

Domiciliary and community services

Insufficient suitable:

13	Home help services	0
14	Meals on wheels services	0
15	Home handyman services	0
16	Visiting nursing services	1
17	Chiropody	0
18	Family relief, e.g. daysitters, nightsitters	3

* Examples are given as suggestions only. Please do not rate the problem exclusively on the basis of the examples given. You may have quite different issues in mind as you rate each question.

Office use only

Col no:

Rating scale:

Can't answer	0
No problem	1
Minor problem	2
Serious problem	3
Very serious problem	4

(Please the appropriate rating number in the box provided)

Domiciliary and community services cont.

19	Volunteer visiting services	0
20	Weekend nursing services	1
21	Activity groups	2
22	Support groups/networks	2

Rehabilitation services

Insufficient suitable:

23	Physiotherapy	1
24	Occupational therapy	1
25	Speech therapy	1
26	Personal and household aids	1
27	Prosthesis	1

Counselling services

28	Inadequate counselling services available to persons suffering from cancer and/or their families * e.g. Anticipatory grief, bereavement, pain control by non-medical means, stigma, stress, sexuality, etc.	
29	Inadequate patient support/counselling	3
30	Inadequate family support/counselling	3
31	Insufficient opportunity for group support/counselling	3

* Examples are given as suggestions only. Please do not rate the problem exclusively on the basis of the examples given. You may have quite different issues in mind as you rate each question.

Office use only

Col no:

Rating scale:

Can't answer	0
No problem	1
Minor problem	2
Serious problem	3
Very serious problem	4

(Please place the appropriate rating number in the box provided)

Coordination

32 Inadequate coordination between those providing services for cancer patients and their families — 3

Question 4

This section lists persons suffering from cancer in identifiable groups. These groups may or may not be disadvantaged with regard to resources within your region.

Would you please rate the adequacy of resources as you perceive them to be for each of these groups of people suffering from cancer according to the following scale:

Can't answer	0
Adequately catered for	1
Minor shortage of resources	2
Serious shortage of resources	3
Very serious shortage of resources	4

(Please place the appropriate rating number in the box provided)

Life stage

33	Children	3
34	Adolescents	3
35	Parents with dependent children	0
36	Single Isolated Patients	0
37	Middle age group	0
38	Elderly	0

Office use only

Col no:

Rating scale:

Can't answer	0
Adequately catered for	1
Minor Shortage of resources	2
Serious shortage of resources	3
Very serious shortage of resources	4

(Please place the appropriate rating number in the box provided)

Specific groups

39	Privately treated patients	0
40	Country patients	3
41	Patients with obvious visible physical disfigurement or disability	3
42	People with a non-Anlo-Saxon background	0

Other (please specify)

43 Siblings of children with cancer...

44 receive insufficient counselling... and support.

Office use only

Col no:

Question 5

List the services that you are aware of which are available to persons suffering from cancer and/or their families through the Anti-Cancer Council of Victoria Welfare Service.

If you wish to make any brief comments on the services you have listed please use the space provided.

	Service	Comment
45	Peter MacCallum Cancer Institute 278 William St. Melbourne.	
46	Provides counselling service for cancer patients and their families.	
47	Home nursing service in Melbourne area.	
48		
49	Candlelighters Support Group. A support system organized by parents of children with cancer. Phone: 7639798 (Melbourne)	
50		

Office use only

Col no:

Question 6

Does your agency have any plans for change during the period October, 1982 to October 1983?

(Please tick the appropriate box and state the change planned in the space provided)

51 No ☐

52 In services ☐ .....

.....

53 In geographical location ☐ .....

.....

54 In eligibility ☐ .....

.....

55 In timetable ☐ .....

.....

Other ☐ .....

56 .....

57 Possibly more home visits to .....

58 children between hospital admissions .....

In the event of needing to clarify any points arising from the questionnaire please supply the name of someone who is willing to act as the contact person in your agency.

Name RIKKI BEWLEY

OCCUPATIONAL THERAPY DEPT.

ROYAL CHILDREN'S HOSPITAL

Thank you for your participation in this project.

5th November, 1982

Mr. Allan Edwards
Secretary
Chaplains Advisory Committee
Royal Children's Hospital
Flemington Road,
PARKVILEE 3052

Dear Mr. Edwards,

Thank you for taking the trouble to reply to our questionnaire on Welfare Services.

The covering letter with the questionnaire actually suggested the respondent to be the staff member responsible for the provision of welfare services and, unfortunately, it would bias the study if we were to accept additional questionnaires from the Royal Children's Hospital.

I hope you will understand, therefore, that we cannot include your reply in the study.

With best wishes,

Yours sincerely,

Adrienne J. Holzer (Miss)
Secretary to the Council

c.c. Medical Director

Office Use Only

Col no:
1-4 ID
5 Region
6 C of R

Anti-Cancer Council of Victoria

REVIEW OF WELFARE SERVICES AVAILABLE TO

PERSONS SUFFERING FROM CANCER AND THEIR FAMILIES

Name of Agency: ROYAL CHILDREN'S HOSPITAL CHAPLAINCY SERVICE

Address: FLEMINGTON RD

PARKVILLE Postcode: 3052

Telephone: 03 347 5522
Area Code Number

7

Question 1

Estimate the number of persons suffering from cancer for whom your agency provided welfare services during the 12 months to October 1982.

(Please tick the appropriate box)

1 - 50	1	☐
51 - 100	2	☐
more than 100	3	☑

Question 2

What services does your agency provide which are available to cancer patients and/or their families?

Include all services provided by your agency whether or not you are directly involved in the provision of the service.

Please do not include services which your agency can arrange to have provided by other agencies.

(Please tick appropriate box)

Office use only

Col no:		
	Transport	
8	Volunteer driver service	
9	Transport service provided by agency employee	
	Accommodation	
10	Hostel/special accommodation house	
11	Self-contained units	
12	Hospice	
13	Nursing Home	
14	Family relief accommodation	
15	Short term accommodation near treatment centre	
	Legal	
16	Legal advice	
	Financial	
17	Financial aid	
18	Financial counselling	
	Employment	
19	Vocational counselling	
20	Employment advice	
	Domiciliary and community services	
21	Meals on wheels	
22	Home help	
23	Home handyman service	
24	Weekend nursing service	
25	Visiting nursing service	
26	Chiropody service	

Office use only		
Col no:		
27	Volunteer visiting service	
28	Child care	
29	Day centre	
30	Activity groups	
31	Self-help groups	
	Rehabilitation	
32	Occupational therapy	
33	Physiotherapy	
34	Speech therapy	
35	Household and personal aids	
36	Prosthesis	
	Counselling	
37	Individual counselling	✓
38	Child counselling	✓
39	Family support counselling	✓
40	Bereavement counselling	✓
41	Group counselling	
42	Social assessment and referral	
43	Interpreters	
	Other (please specify)	
44	"Spiritual" support	
45	liaison / contact with local church / support	
46		

Office use only

Col no:

Question 3

In this section potential problems have been listed under specific headings. Some of them may appear repetitive. This is to enable a more accurate analysis of the information you are providing. We are drawing upon your experience of working with people suffering from cancer. Your perceptions of the problems they face will be valuable to this review.

Would you rate according to the scale below the following problems which may face persons suffering from cancer or their families.

Can't answer	0
No problem	1
Minor problem	2
Serious problem	3
Very serious problem	4

(Please place the appropriate rating number in the box provided).

0

Transport

Transport for treatment and weekend leave:

47 Ambulance transport difficulties

48 Insufficient voluntary drivers

49 Distance from treatment centre for patient

50 Distance from treatment centre for family

51 Car park facilities at treatment centres

52 Cost to cancer patients and their families

53 Insufficient knowledge about the isolated patients travel and accomodation assistance scheme (IPTAAS)

54 Complexity of procedures in order to make use of the isolated patients travel and accommodation assistance scheme (IPTAAS)

Other transport problems (please specify)

55 .....

56 .....

57 .....

Office use only

Col no:

Rating scale:

Can't answer	0
No problem	1
Minor problem	2
Serious problem	3
Very serious problem	4

(Please place the appropriate rating number in the box provided)

Accommodation

58	Insufficient suitable nursing home care	0
59	Terminal care	0
60	Special Accommodation	0
61	Private Hospitals	0
62	Family Relief Beds	0
63	Insufficient suitable short stay accommodation in or near treatment centre for patients	3
64	Insufficient suitable short stay accommodation in or near treatment centre for visiting relatives	4

Other accommodation problems (please specify)

65 .....

66 .....

Legal services

67	Insufficient low cost legal assistance and advice * e.g. workers' compensation, occupational health rights, wills, hire purchase contracts, etc.	0

Other legal problems (please specify)

68 .....

69 .....

70 .....

* Examples are given as suggestions only. Please do not rate the problems exclusively on the basis of the examples given. You may have quite different issues in mind as you rate each question.

Office use only

Col no:

Rating scale:

Can't answer	0
No problem	1
Minor problem	2
Serious problem	3
Very serious problem	4

(Please place the appropriate rating number in the box provided)

Information/Education

71 Insufficient information available to the community generally about issues relating to cancer and its treatment. [3]

72 Insufficient information available to cancer patients and their families about cancer treatment and management [2]

Other information problems (please specify)

73 .....

74 .....

Employment

75 Insufficient employment advice and counselling
* e.g. Negotiating flexible hours, timing of employment termination, exploring other options [0]

Other employment problems (please specify)

76 .....

77 .....

Financial advice

78 Insufficient financial counselling and advice
* e.g. investment, adjustment to a sudden loss of income, long term financial commitments [0]

Other financial problems (please specify)

79 .....

80 .....

* Examples are given as suggestions only. Please do not rate the problem exclusively on the basis of the examples given. You may have quite different issues in mind as you rate each question.

Office use only

Col no:

Rating scale:

Can't answer	0
No problem	1
Minor problem	2
Serious problem	3
Very serious problem	4

(Please place the appropriate rating number in the box provided)

Statutory benefit

7	Lack of flexibility with regard to sickness benefit	0
8	Lack of flexibility with regard to invalid pensions	
9	Lack of flexibility with regard to domiciliary nursing care benefits	

Other (please specify)

10 .....

11 .....

Health insurance

12	Difficulties with regard to health insurance * e.g. Confusing policies, cost of health insurance, hidden costs to privately insured patients	0

Domiciliary and community services

Insufficient suitable:

13	Home help services	
14	Meals on wheels services	
15	Home handyman services	
16	Visiting nursing services	
17	Chiropody	
18	Family relief, e.g. daysitters, nightsitters	2

* Examples are given as suggestions only. Please do not rate the problem exclusively on the basis of the examples given. You may have quite different issues in mind as you rate each question.

Office use only

Col no:

Rating scale:

Can't answer	0
No problem	1
Minor problem	2
Serious problem	3
Very serious problem	4

(Please the appropriate rating number in the box provided)

Domiciliary and community services cont.

19	Volunteer visiting services	
20	Weekend nursing services	
21	Activity groups	
22	Support groups/networks for families	3

Rehabilitation services

Insufficient suitable:

		0
23	Physiotherapy	
24	Occupational therapy	
25	Speech therapy	
26	Personal and household aids	
27	Prosthesis	

Counselling services

28	Inadequate counselling services available to persons suffering from cancer and/or their families * e.g. Anticipatory grief, bereavement, pain control by non-medical means, stigma, stress, sexuality, etc.	
29	Inadequate patient support/counselling	2
30	Inadequate family support/counselling	2
31	Insufficient opportunity for group support/counselling	

* Examples are given as suggestions only. Please do not rate the problem exclusively on the basis of the examples given. You may have quite different issues in mind as you rate each question.

Office use only

Col no:

Rating scale:

Can't answer	0
No problem	1
Minor problem	2
Serious problem	3
Very serious problem	4

(Please place the appropriate rating number in the box provided)

Coordination

32 Inadequate coordination between those providing services for cancer patients and their families [2]

Question 4

This section lists persons suffering from cancer in identifiable groups. These groups may or may not be disadvantaged with regard to resources within your region.

Would you please rate the adequacy of resources as you perceive them to be for each of these groups of people suffering from cancer according to the following scale:

Can't answer	0
Adequately catered for	1
Minor shortage of resources	2
Serious shortage of resources	3
Very serious shortage of resources	4

(Please place the appropriate rating number in the box provided)

Life stage

33 Children [2]

34 Adolescents [3]

35 Parents with dependent children [0]

36 Single Isolated Patients [0]

37 Middle age group [0]

38 Elderly

Office use only

Col no:

Rating scale:

Can't answer	0
Adequately catered for	1
Minor Shortage of resources	2
Serious shortage of resources	3
Very serious shortage of resources	4

(Please place the appropriate rating number in the box provided)

Specific groups

39	Privately treated patients	0
40	Country patients	4
41	Patients with obvious visible physical disfigurement or disability	0
42	People with a non-Anlo-Saxon background	2

Other (please specify)

43 .....

44 .....

Office use only

Col no:

Question 5

List the services that you are aware of which are available to persons suffering from cancer and/or their families through the Anti-Cancer Council of Victoria Welfare Service.

If you wish to make any brief comments on the services you have listed please use the space provided.

	Service	Comment
45		
46		
47		
48		
49		
50		

Office use only

Col no:

Question 6

Does your agency have any plans for change during the period October, 1982 to October 1983?

(Please tick the appropriate box and state the change planned in the space provided)

51 No ☐

52 In services ☐ .....

.....

53 In geographical location ☐ .....

.....

54 In eligibility ☐ .....

.....

55 In timetable ☐ .....

.....

Other ☐ .....

56 .....

57 .....

58 .....

In the event of needing to clarify any points arising from the questionnaire please supply the name of someone who is willing to act as the contact person in your agency.

Name Allen Edwards ... (see 7. Chaplain Advisory Committee)

Thank you for your participation in this project.

Anti-Cancer Council of Victoria

KEOGH HOUSE
90 JOLIMONT STREET
EAST MELBOURNE
AUSTRALIA, 3002

TELEPHONE: 654 2411
Cables: ACCOVIC MELBOURNE

Telex: VCCG AA 34158

Director: Dr. Nigel Gray A.M.
MB, BS, FRACP, FRACMA.

October 6, 1982

Budget $14,000
$10,000 already paid

27-47

To: The Director of Nursing Services

Dear Sir/Madam,

The Anti-Cancer Council of Victoria is currently reviewing its welfare policies and is seeking your assistance in this regard.

The first stage in this review is the preparation of a profile of welfare resources available to persons suffering from cancer within Victoria.

In order to achieve this, a questionnaire has been designed which will identify the welfare resources currently provided; the major problems in respect of availability and access to welfare services; and the gaps and/or overlaps in welfare provision for persons suffering from cancer.

A range of organisations throughout the State, which are involved in the provision of welfare services to persons suffering from cancer, are being requested to complete the enclosed questionnaire.

Visiting nursing services have direct and consistent contact with persons suffering from cancer and may be involved in the provision and organisation of welfare services to those persons. For this reason your contribution is essential.

The selection criteria of respondents to the questionnaire are first that they are involved in the provision of welfare services, and second that they have had direct contact during the last 12 months with persons suffering from cancer, or their families, through the provision of welfare services.

We realise that many of the problems listed are not unique to cancer patients and that many people in our community require access to welfare services. However, under the terms of its Act of Parliament, the Council has to confine itself to cancer patients and their families.

Your participation in this study will ensure an accurate and well represented profile of welfare resources available, and the identification of the major problems facing persons suffering from cancer with regard to access and availability of these resources.

This profile will provide a sound basis for the development of pertinent policy options for the Anti-Cancer Council to explore.

Thank you for your contribution and participation in this project.

Yours sincerely,

Adrienne J. Holzer (Miss)
Secretary to the Council

Encl.

13th October, 1982

Dr. L. J. Leask
28 Station Street
FERNTREE GULLY 3156

Dear Dr. Leask,

Thank you for taking the trouble to complete our recent questionnaire.

I have enclosed a copy of our last Annual Report which outlines all the activities of the Council.

In particular I would like to draw your attention to the Patient Welfare Report on pages 11-12. The basic aim of our service is to ensure that patients are able to utilize available treatment facilities without suffering financial hardship, and to help families adjust to altered lifestyles and lowered incomes.

If you would like any further information, please let me know.

With best wishes,

Yours sincerely,

Enc:

Adrienne J. Holzer (Miss)
Secretary to the Council

Re question 5

Could I please be sent, at some time, some information about services other than educational which the Council can offer?

Thank you

Leask

Dr. J. K. FULLAGAR & Dr. L. J. LEASK
28 STATION ST., FERNTREE GULLY, 3156

PO BOX 56
FTG. 3156.

Anti-Cancer Council of Victoria

KEOGH HOUSE
90 JOLIMONT STREET
EAST MELBOURNE
AUSTRALIA, 3002

TELEPHONE: 654 2411
Cables: ACCOVIC MELBOURNE

Telex: VCCG AA 34158

Director: Dr. Nigel Gray A.M.
MB, BS, FRACP, FRACMA.

October 6, 1982

27-48

Dear Doctor,

The Anti-Cancer Council of Victoria is currently reviewing its welfare policies and is seeking your assistance in this regard.

The first stage in this review is the preparation of a profile of welfare resources available to persons suffering from cancer within Victoria.

In order to achieve this, a questionnaire has been designed which will identify the welfare resources currently provided; the major problems in respect of availability and access to welfare services; and the gaps and/or overlaps in welfare provision for persons suffering from cancer.

As a General Practitioner we recognise that primarily your role is not the provision of welfare services. However, because you have direct and consistent contact with your patients you are in a good position to have knowledge of the sorts of problems that may confront cancer patients and their families.

For this reason we have enclosed two questions from the questionnaire which we would like you to complete for this profile. One question asks you to rate a list of problems which may confront cancer patients and their families. The second asks you to rate the adequacy of welfare services available to certain groups of persons suffering from cancer within your region.

We realise that many of the problems listed are not unique to cancer patients and that many people in our community require access to welfare services. However, under the terms of its Act of Parliament, the Council has to confine itself to cancer patients and their families.

Your participation in this study will ensure an accurate and well represented profile of welfare resources available, and the identification of the major problems facing persons suffering from cancer with regard to access and availability of these resources.

This profile will provide a sound basis for the development of pertinent policy options for the Anti-Cancer Council to explore.

Thank you for your contribution and participation in this project.

Yours sincerely,

Adrienne J. Holzer (Miss)
Secretary to the Council

8th October, 1982

Sister Norma Bryan,
Royal District Nursing Service
452 St. Kilda Road
MELBOURNE 3004

Dear Sister Bryan,

At Ann Richards' suggestion I have enclosed 13 copies of our questionnaire to be circulated to your centres.

I do not know whether you would prefer the questionnaires to be returned to you, but I have enclosed Reply Paid envelopes if they are to be sent back here direct.

The Council greatly appreciates your assistance.

With best wishes,

Yours sincerely,

Adrienne J. Holzer (Miss)
Secretary to the Council

Enc:

ANTI-CANCER COUNCIL OF VICTORIA

WELFARE SERVICE REVIEW

NOTES on MEETING of PROJECT TEAM - 24th September, 1982:

Following results from a pilot run of the questionnaire where 26 were returned, a re-draft was presented to the Project Team for finalisation.

The final circulation list per region is as follows:

Hospitals - Medical Director
Community Health Centres - Administrator
Nursing Services - Sister-in-Charge
Municipal Councils - Town Clerk
Oncology Clinics
Bush Nursing Hospitals/Centres
Random sample of GPs - 1 per 5,000 head of population.

TIME SCALE:

Mailing of questionnaires -
Week beginning October 4, 1982

Return date - 22nd October

Computer Analyses -
Week beginning 24th October, 1982

1st Draft - 12th November, 1982

Next Meeting of Project Team - 16th November @ 2.00 p.m.

Final Draft - end of November

Meeting of Project Team - 3rd December @ 10.00 a.m.

6/10/82

Louise, Carol, Tony, Sue, Engl., me.

General — ok at ideas of cutting back detail.

58
50
5

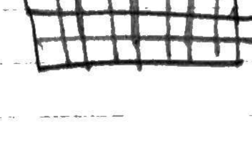
RDNS — all offices will get one.
— specific letter to RDNS. (Supervising Sister)
(annual report list all districts)

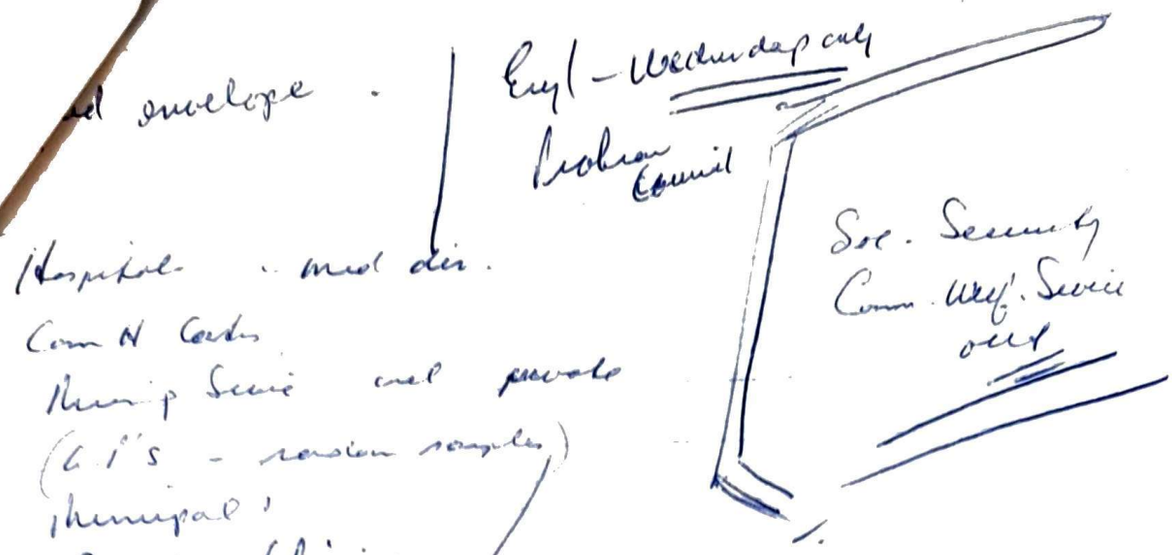
(Ann Richards deputy) Questions — Ring Sister Norma Begg & ask which is best way of handling questionnaires to regions.

Insert definition of agency
+ " " welfare services. | pt 2

Contact numbers on instruction sheet.

The aim of this questionnaire is to ~~to~~ gain your opinion of the welfare services provided & its ~~especially~~ ~~[illegible]~~ ~~especially an importan~~





ed envelope.

Hospitals – med dirs.
Comm H Cords
Hosp Servs and private
(GP's – random samples)
Municipal
Consultancy Clinics.

10% of 5,000.

Time scale

Mail out UK. begin 4th Oct.

followed by 22nd Oct.

Computer analyses — UK. 26th Oct.

1st Draft. 12th Nov.
Rest mtg wk by 15th Nov.

Final draft by end of Nov.
last mtg 29th Nov.

* 2.00 pm. Project Team 16th Nov.

* Friday 3rd Dec. 10.00 am.

Drs.

THE SELECTION AND TRAINING OF VOLUNTEERS FOR A RURAL, HOME-BASED HOSPICE PROGRAM

PAUL T. WERNER, M.D.
Mercer University School of Medicine, Macon, Georgia; former Care Team Director, Bay de Noc Hospice, Escanaba, Michigan

PHILLIP S. CHARD, M.S.
Upper Peninsula Medical Education Program, Michigan State University; Training Director for Bay de Noc Hospice, Escanaba, Michigan

CARL HAWKINS, and THOMAS MARSHALL
Upper Peninsula Medical Education Program, Escanaba, Michigan

ABSTRACT

Volunteers are essential to smaller hospice care programs. These volunteers must be selected and trained to provide these services. The training program has several goals: content acquisition, experiential learning, mutual screening and selection, team building, and public relations. Selection processes avoid persons who have rigid beliefs, unresolved grief, or negative personalities as well as those who talk too much. The training uses many teaching methods to emphasize hospice philosophy, team building, communication skills, death awareness, empathy skills, basic nursing skills, impact of death on family, cancer information, pain control, and physician-care factors. Concrete examples of how each of these themes is accomplished are included in the paper. This program has worked well in preparing a group of volunteers for a rural, home-based hospice program in northern Michigan and represents one example of an effective approach.

INTRODUCTION

Hospices in rural settings depend on volunteers, including physicians, nurses, social workers, psychologists, clergy, and nonprofessional workers. These workers must be properly trained before they become involved in direct patient care.

Little has appeared in the literature concerning the pragmatic specifics of selecting and training volunteers. This paper outlines one method for developing relatively uninitiated community members—both professional and nonprofessional—into prepared hospice volunteers. Broader concepts will be followed by more precise instructions.

THE SETTING

Escanaba, a community of about 15,000 persons in Michigan's Upper Peninsula, serves a county service area of about 35,000 to 40,000 persons. The service area is about 1,300 square miles. It has a Catholic 127-bed acute-care hospital and four nursing facilities, as well as a community mental health center. The nearest tertiary care center, with full oncology and radiation therapy services, is about 70 miles north. A family practice teaching module of Michigan State University is located in the community and makes its resources available. Approximately 35 physicians are divided equally between primary care and other specialties.

The people are primarily of northern European background and are employed in forestry, manufacturing, tourist, and service industries. Sixty percent are Roman Catholic, with a broad group of Protestant denominations also represented. Approximately 350 to 370 deaths are recorded in the county each year, with about 50 to 60 of the deaths from causes likely to have a terminal phase, such as cancer and advanced organ failures.

Bay de Noc Hospice is a nonprofit organization which charges nothing for its services and pays its volunteer staff only expenses. The hospice has no inpatient facility; it assigns one nurse to each family unit and attempts to coordinate care no matter what the setting. Most care and deaths occur in the patient's home. The nurse provides daily contact and serves as the conduit for other services from volunteers, pastoral counsellors, physicians, and social services. The family's own physician and pastor are incorporated as part of the care team for each patient. Bereavement services for the

family continue for up to 18 months after the patient's death. Community support, both in terms of new referrals and financial aid, has been outstanding, and feedback from those served is extremely gratifying.[1]

GOALS OF THE TRAINING PROGRAM

Broadly, the training effort seeks to accomplish five goals:

1. Content acquisition: Each hospice worker should learn the history and principles of the hospice movement and the local program. Principles of care from the nursing, medical, social work, and pastoral perspectives are included.
2. Experiential learning: It is essential that each worker face and deal with his or her own mortality and feelings about death, dying, pain, debility, cancer, and related subjects. An opportunity to discover one's personal strengths and weaknesses in listening, empathy, stress management, and support systems is a central component. No attempt is made to analyze the participant or to solve intrapersonal problems; rather, the approach is one of self-discovery.
3. Mutual screening and selection: The training process and the choosing of prospective workers cannot be separated. Workers need the opportunity to acquire content and experience self-discovery before making a commitment to the program, while the trainers need the opportunity to see how potential workers interact in group settings before accepting them as care givers.
4. Team building: By requiring both professional and nonprofessional program workers to participate in the volunteer training sequence, a common phase of experience is acquired by all. This creates a sense of group identity and clearly marks the point in each individual's life when he or she begins to identify as a hospice worker. This component of the training also builds the interpersonal relationships upon which later support at times of stress, loss, and grief depends.
5. Public relations: Not all persons participating in the classes elect to serve patients, but they do spread the hospice message in the community. Those completing the work and caring for patients are the strongest exemplars of hospice, and this aspect must be reinforced.

AREAS OF EMPHASIS

The program intends to refine the interpersonal skills of each volunteer, paying attention to both verbal and nonverbal (tone of voice, facial expressions, body language, timing) communication. Volunteers usually have a basic caring attitude, which motivates involvement, but most have not explored their own communication style and basic attitudes. Focusing the learner's attention on hospice issues forces self-examination and self-discovery. Using experiential modes of learning, such as role play, allows the volunteer to try out new ways of interacting.

Each volunteer must come to terms with his or her personal mortality and beliefs about death. Unless the volunteer resolves these areas first, there may be confusion of personal feelings with those of the patient and family. Exercises are included to increase the volunteer's personal awareness of death and dying.

Death awareness is intimately related to ethical, spiritual, and cultural beliefs about dying. Training sessions explore some commonly held systems of thought, encouraging resolution of conflicts between the volunteer and alternate beliefs.

Beliefs and attitudes related to cancer—the most common disease in hospice patients—must be clarified and explored. Medical aspects of cancer care are explained by the physician coordinator, allaying fears that cancer is contagious or inevitably painful. Pain control is covered in detail to develop an optimistic view of pain control prognosis, so that volunteers will not inadvertently have a negative influence on pain control efforts. Volunteers are assured that they will not be asked to assume responsibility for aspects of patient care that they are either unwilling or unable to perform. Appropriately trained professionals will be in charge of those aspects of care.

Because nonnursing volunteers spend large amounts of time with patients, they are taught basic nursing skills, such as bedmaking, patient transfer, and bed bathing. Volunteers see catheters, oxygen equipment, and other paraphernalia encountered with patients.

This training program forms the foundation for ongoing monthly in-service meetings at which nonprofessional and nursing volunteers review experiences, explore new skills, and expand previously acquired skills. These regular sessions provide time for mutual support and emotional release needed after experiencing the death of a patient. Focusing on the group support dynamic in the initial training encourages the volunteer to rely on this source for future support.

SELECTION OF VOLUNTEER WORKERS

Selection proceeds from two aspects: the volunteer self-selects, while the trainers observe and direct this process. Candidates are told initially that they must attend all training sessions, that they need not accept responsibility that they are unable or unwilling to accept,

and that actual selection of the level of involvement will occur near the end of training.

An initial questionnaire[2] may be used to focus the candidate's attention on key issues, such as: (1) Why are you personally interested in hospice work? (2) What experience have you had with grief, loss, death, and severely ill patients? (3) What do you feel you have to offer the hospice program? (4) What will you receive by being a hospice worker? (5) What are your current obligations to work, family, church, and other areas? (6) To whom do you turn when you need someone to support you? (7) What interests or hobbies do you have? (8) How much time will you reserve for hospice work?

Group discussion and individual review of the answers may provide insights into the expectations (often unrealistic) of the volunteer and reveal possible hidden resources or problems.

WHO TO AVOID IN HOSPICE WORK

Almost every volunteer can be utilized in some facet of hospice work, but patient contact might best be restricted for volunteers in four distinct groups:

1. Those with rigid belief systems: Such individuals have only one way of looking at the world and suffering, often negative or highly focused on a single religious viewpoint. Their inflexibility hinders their working with patients who have differing or vacillating beliefs and may lead to interpersonal clashes.
2. Those with unresolved grief: Training programs may attract persons who have experienced losses for which the grieving response is still unresolved. These persons need to be detected and referred for care. There is no definite time limit to enforce, but it may be wise to adopt a time limit of one year after a major loss. This allows the program an official way to reject those who may want to be involved too early, while the rule can be waived for appropriate persons.
3. Those with a negative personality: Such individuals can be identified by the manner in which they easily arouse anger in the persons around them. They often are fault-finders or nit-pickers; they may insist on having their own opinion prevail or talking all the time. These traits emerge during the group sessions and indicate someone who is best restricted to nonpatient activities in the hospice.
4. The talkers: Often symptomatic of personal nervousness or discomfort with terminal or severely ill patients, the talker fills every empty space with words. Although the words are rarely harmful, the content of the speech may be platitudes, personal anecdotes, or unsolicited advice. Such individuals eliminate opportunities to practice empathic listening and avoid the anxiety of the patient's speaking on topics that may be painful or frightening. Since the goal is to be with the patient in ways that allow the patient to be heard, these talkers are best kept with nonpatient duties. Extra time spent on the issues causing the anxiety and on improving listening skills may assist these persons to be involved with patients directly.

EDUCATIONAL METHODS

There are several educational methods that help convey the training goals, each with advantages and disadvantages.

Lectures

Lectures are good for conveying factual content. If possible, time for questions and answers should be provided, and each listener should receive a handout of the important teaching points with room to take additional notes. Keep the lectures short—about 20 minutes—to avoid overloading or boring the audience. Whenever possible, intersperse other methods, such as slides, movies, or overhead projections. If anything on the slides or movies should be retained by the learner, the material should be provided in handout form as well. Lectures can be effective, but the learning remains passive without active involvement of the audience.

Panel Discussions

Bring together several persons who can speak about hospice experiences and answer questions, including patients, hospice survivors, experienced workers, and representatives of community resource agencies. Each can offer small presentations and answer questions. A moderator is needed to facilitate discussion and encourage panel members to interact with each other. Unless the audience can be induced to participate, this can be passive learning.

Small Groups

Divide the group into small sections and give each subgroup a task to accomplish or an exercise to do. Posing a problem with a written vignette and asking the group to solve it can be an effective group project. Using an experienced group leader or hospice worker is helpful. The advantages are that everyone can participate and that practical experience in interpersonal skills can be given; drawbacks are centered on the intimidation some volunteers may feel. This method is less suitable for disseminating factual information.

Films, Slides, Tapes, and Filmstrips

These tools can bring actual experiences from faraway places and different programs into the class. Many fine hospice-oriented materials are available and can punctuate, with "living" examples, the various other sessions planned. This method requires time for viewers to react and ask questions. If used this way, media materials can serve as potent tools to initiate small-group discussion or to highlight factual content. Media may allow listeners to lapse into passive learning and must be carefully used to avoid losing the audience.

Experiential Exercises

There are many experiential tasks that can be given to large or small groups, as well as individuals, to promote learning. Examples include: writing one's own obituary; role-playing exercises; solving paper cases typical of hospice patients; answering questionnaires that solicit feelings or opinions on death, hospitals, suicide, or physicians; projects that encourage learners to graphically depict death, cancer, pain, life; and discussion groups focusing on readings from literature, such as Tolstoy's *The Death of Ivan Illych*. Many other such exercises can be planned, all of which actively involve the learner in a new experience that simulates actual hospice efforts or issues.

THE TRAINER

The primary consideration in planning the training sessions is selection of the persons to conduct them. A background in group process skills and death awareness is important. Persons with such skills include hospital social workers, public school, college, or mental health center psychologists, private practitioners from the community with known group skills, and local clergy. (Bay de Noc Hospice training is directed by a master's level clinical psychologist whose past experience included group process and work with patients and caregivers in settings where stress and death were frequent.) Key qualities to look for in the trainer include flexibility, openness, lack of dogmatism, an ability to draw out the learner's own experience, and a nonjudgmental, warm attitude toward others.

PUTTING IT ALL TOGETHER

How do all these principles work in practice? Bay de Noc Hospice sessions are three-hour meetings one night a week for six consecutive weeks. All candidates must attend all meetings unless excused by the chief trainer. The sessions are held in a lounge-like meeting room with comfortable seating and nonglare lighting. Class size varies from 15 to 20. Each meeting will be described in detail to illustrate pragmatically our methods.

SESSION 1

Orientation to Hospice

Objective: To detail the history and functional structure of the local hospice program.

The first session may begin with a quick review of what a hospice is. This is followed by a somewhat more detailed history of the local hospice program, its leaders, and the way it functions. Funding sources and relationships to community agencies are explored. The importance of confidentiality in all matters of patient care is discussed next, with the understanding that workers who violate rules of confidentiality will be dismissed from the program.

Introductions

Objective: To facilitate candidates' getting to know each other and the coordinator on a nonsuperficial basis.

After a formal introduction by the coordinator to briefly explain the goals and format of the training course, the candidates are asked to introduce themselves from personal, not social, perspectives.[3] Each candidate and the instructor offers a description of himself or herself as a person, using no demographic data such as name or occupation. Then introductions using the usual social information are made. Everyone is asked to tell which introduction technique was most comfortable or meaningful and why.

Introduction to Communication

Objective: To experience the importance of verbal and nonverbal communication.

After a brief discussion of important aspects of communication, such as listening, asking clarifying questions, and silence, an exercise is carried out to experience three modes of communication: verbal and visual, verbal without visual, and nonverbal.[3] The trainees pair up, with one of each pair designated "listener," the other, "speaker." For several minutes the speaker communicates with the listener on any topic using normal verbal-visual mode. Then both persons close their eyes while the conversation continues for a few more minutes. Finally, both persons open their eyes, and the speaker is asked to express his or her feelings toward the listener nonverbally. The participants then discuss which mode of communication was most comfortable or seemed most effective.

Recollections of First Encounter with Death

Objective: To begin to sort out personal feelings about death.

Since early experiences with death often help formulate attitudes toward death, all members of the group are asked to recall to the group their earliest encounter with

death. More important than relating the circumstances surrounding the death, participants are asked to share the feelings they experienced, as they best remember them. The feelings that surface are remarkably varied, including awe, guilt at not being sad, fear, acceptance, inadequacy, lack of comprehension, sadness with anger at the callousness of others, and confusion.

SESSION 2

Death—Spiritual and Social Perspectives

Objective: To consider spiritual and mystical aspects of death and consider the issues and controversies concerning death that arise in a typical hospice case.

The hospice pastoral care and social services coordinators catalyze group discussion of social and spiritual aspects of death by presenting a typical case of a terminally ill patient who has problems communicating with his family and doubts about his own beliefs about death and life after death. Discussion is spurred in part by a "What would you say now?" approach by the presenting team and lasts about an hour. Topics include feelings of doubt about religion and what to say to a doubting patient; lack of communication in a family and what steps may or may not be helpful to bridge the gap; anger and guilt of a family before and after a death; expenses of funerals and caskets in light of patient's wishes versus family wishes; and deciding when to ask for help from the hospice core team. This exercise demonstrates the importance of listening skills and utilization of the care team.

Personal Awareness of Mortality

Objective: To allow oneself to see how he or she perceives death, especially his or her own.

A guided fantasy technique[4] is used. Each participant closes his/her eyes and imagines for a few moments his/her own death and the circumstances surrounding it: how it occurs, at what age, cause, accompanied by whom. Each person is asked to imagine what feelings will occur at death, such as fear, peace, joy, anger, neutrality, despair, and how one will act. Emphasis is placed on clearing the mind and allowing the scenario to appear, rather than to "think it up." The imagery from the unconscious mind is more likely to reflect the true attitude toward one's own death. Furthermore, attitudes toward one's own death are likely to reflect attitudes involved in dealing with another's death. Each person shares the vision with the group. A large variety of deaths are described, from the elderly and peaceful to the young and violent.

Another technique is word association. Each participant is asked to give the first word that comes to mind when the word "death" is spoken. These tend to give some further insight as to how one perceives death.

Introduction to Empathy

Objective: To define empathy and illustrate its importance in hospice care, and to expose candidates to basic features of empathic communication.

Candidates' ideas as to the nature of empathy are discussed with the instructor, who subsequently offers such succinct definitions as "being with" another or "recognizing and entering into another's feelings." The characteristics of empathy are discussed, such as feelings of compassion through identification with another, active listening, conveying compassion, and body messages. This leads to a discussion of how these activities can be crucial to a hospice patient and family.

The group then breaks into triads of talker, listener, and observer.[5] After several minutes of conversation, the observer shares his/her impressions as to how well the principles of empathic communication were utilized. The speaker and listener likewise share their feelings about the course of the interaction, and a handout on how not to be empathic[6] is issued.

SESSION 3

Nursing Skills for Nonnurses

Objective: To introduce candidates with no nursing background to basic nursing care essential to care of hospice patients.

The convenience of knowing some basic home nursing and comfort skills is emphasized. Techniques of making beds, bathing, giving rubs, and transferring patients into and out of wheelchairs are demonstrated by the nursing coordinators. A handout covering these skills is distributed. Candidates are informed that, as volunteers, they would never have to perform any nursing skills with which they do not feel comfortable.

Empathic Listening

Objective: To further illustrate empathic listening skills and demonstrate that emotional communication is not a function of language.

One trainee plays the role of a hospice volunteer in conversation with a hospice patient, played by the instructor. The conversation focuses on situations common in hospice, such as anger and frustration on the part of the volunteer or patient, depression or acceptance on the part of the patient, and guilt on the part of family members. This interaction, conducted for about 15 minutes before the group, points out some of the difficult or embarrassing conversation topics that can arise and the pitfalls that the volunteer may encounter in dealing with them. Emphasis is placed on accepting the patient's feelings, such as anger toward the spouse, no matter how distasteful or foolish they may seem.

Two other trainees watching the interaction draw their impressions in color of the feeling between the two role players and then explain them to the group. This art therapy technique[6] illustrates the significance of nonverbal cues in communication. This entire exercise is repeated with other trainees, with the instructor playing another role.

SESSION 4

Impact of Death on the Family

Objective: To provide firsthand exposure to the many problems of a dying patient, with emphasis on the family.

A middle-aged hospice volunteer who had lost her husband shares with the group her personal feelings and reactions during her husband's illness with cancer, at his death, and afterwards. A lengthy question-and-answer discussion focuses on her family's feelings, reactions, and adaptations. Although no hospice was available at the time of her husband's death, as a volunteer she presents a positive view of the value of the hospice.

Emotional Acceptance

Objective: To emphasize the importance of being aware and accepting one's own emotions before helping others.

From the following list, candidates pick the emotion with which they feel most comfortable: anger, guilt, sorrow, or fear. The group divides into threes, and each person discusses in a personal sense (instructed specifically to use the word "I") the following three aspects of their chosen emotion: (1) how the emotion feels physically and otherwise, (2) why he/she feels that way, and (3) what he/she does when feeling that way (specific behavior).

After about 20 minutes, each small group receives colored markers and a large sheet of paper and proceeds to illustrate, either as a group or individually, the emotions discussed.

Each group then displays and explains the illustration to the entire class. The ensuing discussion clarifies the way some emotions are hidden: guilt, for instance, is anger directed inward. Depicting an uncomfortable emotion and displaying it to others can make the emotion easier to identify and accept. One's own emotions must be acceptable before one can help another person with emotional concerns.

SESSION 5

Empathic Listening

Objective: To demonstrate the importance of skillful listening, especially the importance of respecting silence.

The group breaks up into triads of listener, speaker, and observer. The speaker talks and the listener responds, using the verbal-visual mode, about how the speaker's perception of his/her own mortality has changed since beginning hospice training. After about ten minutes, the observer provides feedback on the conversation, emphasizing the perceived emotions of the speaker and empathy of the listener. Spontaneous conversation invariably follows, which is identified as spontaneous empathy.

The group then pairs up into speakers and listeners. The speakers talk for about ten minutes, using the verbal-visual mode, about the uncomfortable emotion chosen in session 4 and how to deal with it. The listener can respond only in a nonverbal mode. The listener then explains to the speaker how he/she felt about not being able to use words—invariably frustrated. The speaker expresses feelings of less frustration, since the speaker could understand the listener's feelings consciously and unconsciously through nonverbal cues. This exercise demonstrates how Americans are a word-oriented society, although much can be communicated without words. Indeed, even without words, there is constant unconscious communicating. Often a speaker ruins valuable silence with irrelevant, disruptive words because he or she is not accustomed to silence.

Experience with Silence

Objective: To experience relaxation and silence and see the difference between now centered and then centered outlook.

After becoming comfortable and closing eyes, all members of the group concentrate on their bodies from toes to head, watch their thoughts, and finally banish all thoughts. Concentrating on breathing is recommended to help clear the mind. After several minutes of this, a discussion of how people felt during the exercise takes place. It is pointed out that it is hard not to think, that thoughts are "then" or "other time" centered, whereas concentrating on breathing often removes thoughts and is "now" or "here" centered. Dying patients often live moment by moment—now centered—and sometimes it is hard for another person, who is usually then centered, to understand.

Trust

Objective: To experience what it is to trust another person for an often taken-for-granted function.

The group pairs up, and the members of each pair take turns closing their eyes and walking around the building, totally depending on the other for safe guidance.

Death Awareness

Objective: To understand what one's own feelings might be if death were imminent.

Each participant is asked to think about and share with the group how he or she would spend tomorrow if it were going to be the last day of life. Responses range from doing something extravagant as a final fling, to calling all friends and relatives to say goodbye, to going on a picnic with spouse and children, to going to work as usual. Participants disagree whether the knowledge of impending death should be shared with family or kept inside. Discussing this fantasy may enhance understanding of a dying person's wishes.

The role of the funeral in American society also can be discussed, with participants taking time to discuss their own funeral ideas and to write personal obituaries.

SESSION 6

Definition of Death

Objective: To explain some legal and practical aspects of death.

The hospice physician discusses, with a handout, legal and scientific aspects of death.

Because the legal right to declare a patient dead varies by state, all hospice personnel should become familiar with the laws in their own states.

Cancer: Social and Scientific Aspects

Objective: To briefly expose trainees to basic etiologies and clinical courses of cancer; to point out the stigma our society holds regarding cancer.

The physician focuses on basic definitions of cancer, the differences between malignant and benign, sites of cancer, relationship to the immune system, reasons for the threat to life, and basic treatment modalities and their drawbacks. A handout is provided on these topics.

The following list of medical conditions is distributed, and each participant ranks them in the order he or she is willing to experience them:

Heart failure (weakness and severe shortness of breath)
Diabetes (insulin-dependent, strict diet)
Stroke (loss of speech, right-handed weakness)
Insanity
Paraplegia (total uselessness of both legs)
Total blindness
Cancer
Multiple sclerosis
Emphysema (needing oxygen at home)
Arthritis (crutches to walk, requiring medication)

According to the results, cancer stands out as being one of the most dreaded conditions. People often envision the worst possible disease when considering cancer, ignoring the fact that there are many types of cancer, many of which are curable. This thinking is consistent with societal attitudes, that cancer is a punishment.

Pain in the Terminal Patient

Objective: To briefly explain the physiological basis of pain and its pharmacological control.

The physician describes in ordinary terms the basic mechanisms of pain and pain medication, including concepts of receptors, nerve fibers, chemical transmitters, endorphins, analgesics, and the mechanisms of analgesic actions. After explaining that acute pain serves a protecting function but that chronic pain is physically and psychologically detrimental, the physician introduces some basic goals and concepts of chronic pain control in the terminal patient. This includes full removal of pain, avoidance of PRN administration so the patient does not have to anticipate the return of pain, and ignoring concerns about addiction.[8]

Dichotomy of Physician Role and Patient Expectation

Objective: To help candidates become aware of some basic causes of dissatisfaction of dying patients and their families with their physicians.

Each trainee is asked to recall the last time he/she saw a physician for a problem and how he/she felt about the encounter: what features made it a positive experience, what could have made it better, what made it a bad experience. Nearly all positive feelings are in response to such physician behaviors as taking time to explain things, eliciting the patient's help in decision making, and appearing to care for the patient as a person.

Patients define a good physician mostly on the basis of how much the physician really cares about them. They assume that physicians are medically competent or they would not be licensed and allowed to practice. Patients believe the physicians' roles usually go much beyond the concept of being trained "curers of disease": good physicians must also care about their patients. This means that even though a physician cannot cure a patient or help him/her medically, the physician must still care about the patient and not abandon him or her.

Physicians are rarely trained this way; their worth as physicians is measured by their peers and superiors in terms of their medical judgments and their success as healers. Physicians often regard the untreatable, dying patients as failures and may have little more to do with such patients than prescribe pain medication. Patients perceive this as abandonment. This dichotomy in perceptions of what constitutes a responsible physician can lead to anger and bitterness on the part of a dying pa-

tient toward the doctor. A volunteer who understands this conflict may be able to explain it to patients and their families and may help ameliorate this detrimental situation.

FINAL SELECTION OF THE VOLUNTEERS

After the sixth session, the trainees are given an application/questionnaire, which solicits demographic information on the candidate and asks for a commitment. By completing and submitting the application, the volunteer signals that involvement is desired and indicates the exact duties he or she is willing and able to assume. Professional volunteers are asked to append a formal resume or curriculum vitae to document their education and experience.

The trainers review the applications and questionnaires and compare the data with observations made during the sessions. Volunteers deemed acceptable are issued formal certificates identifying them as graduates of the training course. Each accepted volunteer is referred to the appropriate hospice coordinator for assignment to patient-care duties. Work in the chosen capacity begins with an apprenticeship, in which the new volunteer works with an experienced worker until both are confident that the newer volunteer can work alone.

OUTCOMES

No one, including professionals, has served patients on behalf of the hospice without having first participated in the training session. At this writing, the fourth training sequence is beginning, the first three having involved more than 60 individuals. Each sequence of sessions has differed with respect to exact format, but the goals and methods described have been used each time. It is too early to assess long-term impact of the training, but ample anecdotal feedback suggests that the volunteers view the sessions as both educational and productive of personal growth. Feedback from coordinators and patients reveals a competent core of volunteers. All active volunteers continue with monthly in-service meetings, which give the hospice coordinators valuable feedback and provide a medium for further team development.

Some volunteers are disappointed that they are not called on patient cases as often as they wish. Extended families, neighbors, and friends often spontaneously assist hospice families, and trained volunteers supplement these natural supporters. A limited patient census—approximately six to nine—also modulates demand for volunteer time.

Fewer than 10% of trainees completing the sessions have chosen not to become volunteer workers.

The common orientation-training sessions have created group identity and prepared the workers. This, in turn, provides the basis of a support system for future workers. The program allows the trainees to examine their motivations and limitations and properly match themselves with the roles the hospice needs filled. This has been effective to the extent that the trainers have rarely needed to redirect the workers to other tasks or eliminate them from patient-care contact.

ACKNOWLEDGMENT

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Additional material on the hospice training program will be furnished by the author on request (Dr. Paul T. Werner, % Mercer University School of Medicine, Macon, GA 31207).

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QUESTIONNAIRE FRAMEWORK

1. AGENCY DETAILS:

1.1. NAME OF AGENCY

1.2. ADDRESS TELEPHONE

1.3. REGION (CODED - OFFICE USE)

1.4. CATEGORY OF RESOURCE (CODED - OFFICE USE)

1.5. NAME OF PERSON COMPLETING QUESTIONNAIRE

1.6. POSITION IN AGENCY

1.7. DOES YOUR AGENCY HAVE ANY PLANS FOR CHANGE DURING THE PERIOD OCTOBER 1982 to OCTOBER 1983?

(PLEASE CIRCLE APPROPRIATE NUMBERS AND SPECIFY IN EACH CASE)

0 NO

1 IN SERVICES

2 IN GEOGRAPHICAL LOCATION

3 IN ELIGIBILITY

4 IN TIMETABLE

5 IN PHYSICAL PLANT

6 OTHER

2. PROFILE OF WELFARE SERVICES AVAILABLE TO PERSONS SUFFERING FROM CANCER:

2.1. WHAT SPECIFIC SERVICES DOES YOUR AGENCY OFFER WHICH ARE AVAILABLE TO CANCER PATIENTS AND THEIR FAMILIES (CIRCLE APPROPRIATE NUMBER)

For Example:	0	No answer
	1	Home Help
	2	Meals on Wheels
	3	Financial Advice
	4	
	5	
	6	
	7	
	8	
	9	
	10	
	11	
	12	
	13	
	14	
	15	
	16	
	17	
	18	
	19	
	20	
	21	
	22	
	23	
	24	
	25	

2.2. DOES YOUR AGENCY OFFER ANY SERVICES SPECIFICALLY FOR CANCER PATIENTS AND/OR THEIR FAMILIES?

YES (If "YES" go to Q.2.3.)

NO (If "NO" to to Q.3.

2.3. WHAT SERVICES DOES YOUR AGENCY OFFER SPECIFICALLY FOR CANCER PATIENTS AND/OR THEIR FAMILIES?

(CIRCLE APPROPRIATE NUMBERS)

0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20

3. PROBLEMS FACING PERSONS SUFFERING FROM CANCER IN RESPECT OF AVAILABILITY AND ACCESS TO WELFARE SERVICES.

3.1. WOULD YOU PLEASE RATE THE FOLLOWING PROBLEMS WHICH MAY FACE PERSONS SUFFERING FROM CANCER IN YOUR REGION ACCORDING TO THIS SCALE:

0 CAN'T ANSWER

1 NO PROBLEM

2 MINOR PROBLEM

3 SERIOUS PROBLEM

4 VERY SERIOUS PROBLEM

4. GAPS IN WELFARE SERVICES AVAILABLE IN VICTORIA TO PERSONS SUFFERING FROM CANCER:

4.1. WHICH GROUPS OF PEOPLE SUFFERING FROM CANCER DO YOU CONSIDER ARE INADEQUATELY CATERED FOR WITH REGARD TO RESOURCES IN YOUR REGION?

WOULD YOU PLEASE RATE EACH GROUP ACCORDING TO THIS SCALE:

0 CAN'T ANSWER
1 ADEQUATELY CATERED FOR
2 MINOR SHORTAGE OF RESOURCES
3 SERIOUS SHORTAGE OF RESOURCES
4 VERY SERIOUS SHORTAGE OF RESOURCES

ANTI-CANCER COUNCIL OF VICTORIA

PROJECT TEAM - WELFARE SERVICES REVIEW

1st MEETING - FRIDAY, 13th AUGUST, 1982

PRESENT:	Miss Louise BOWEN	-	Austin Hospital
	Mr. Tony COLE	-	Peter MacCallum Hospital
	Ms. Kathy SANDERS	-	University of Melbourne
	Miss Eryl MORGAN	-	Consultant
	Mrs. Sue RAWLYK	-	Anti-Cancer Council of Victoria
	Miss Adrienne HOLZER	-	Anti-Cancer Council of Victoria

Dr. Gray welcomed members of the Project Team and outlined the past philosophy of the Council's welfare service.

The brief of the Project Team is to review the current welfare situation as it affects cancer patients, develop policy options for the Council, and recommend the best way to administer those options.

Miss Morgan outlined the proposed schedule for the review.

Phase I (Questionnaire) should begin early October and be completed by the end of November.

Phase II (Consultations) will begin in late January or early February.

A report will then be completed by mid March and policy options should be available by the end of April ready for a May meeting of the Welfare Committee.

A free ranging discussion took place over the question as to what groups of people/organisations should receive the questionnaire.

The subject of consumer feedback was discussed at length. Whilst everybody agreed it was desirable, the magnitude of the task was such that it could become an option for a special project in itself. One option available as a pilot project was the use of higher degree students on one day in all major hospital clinics in Melbourne interviewing cancer patients. Miss Holzer agreed to discuss the question with Dr. Gray and the subject of consumer feedback remained unresolved.

The Team resolved that the following groups or divisions should be included in the questionnaire and that because of the large numbers involved, a random sample would be taken in each group except -

/2...

DIVISIONS

HOSPITALS
- MEDICAL
- SOCIAL WORKERS
- CHAPLAINS

COMMUNITY HEALTH CENTRES

NURSING SERVICES
- BUSH
- R.D.N.S.
  - BALLARAT DISTRICT N.S.
  - GEELONG DISTRICT N.S.
- PETER MacCALLUM VISITING SERVICE

MUNICIPAL

G.P's

SPECIALISTS

WELFARE SERVICES
- COMMUNITY WELFARE SERVICE
- SOCIAL SECURITY
- EDUCATION DEPARTMENT - COUNSELLOR & GUIDANCE

PALLIATIVE CARE SERVICES

ACCOMMODATION SERVICES
- PRIVATE NURSING HOMES
- SPECIAL ACCOMMODATION HOUSES

The next two meetings of the Project Team will be THURSDAY, 19th AUGUST 2-5 p.m. and FRIDAY, 24th SEPTEMBER 10.00 a.m.

16/8/1982

EM

PROPOSED PLANNING PROCESS

PETER MacCALLUM HOSPITAL - SOCIAL WORK UNIT

1. INTRODUCTION

1.1 The planning process proposed in this paper is designed to establish the future directions of Peter MacCallum Hospital Social Work Unit. The Future Directions Plan, developed in the final stage of the process, will establish the position the Social Work Unit desires to work towards. Every issue facing the Unit will not be resolved through the preparation of a plan. The Future Directions Plan will provide a framework within which programs designed to counter issues identified can be systematically developed, implemented and reviewed.

1.2 The development of a Future Directions Plan is the first step in an ongoing planning process. It will provide the means through which the Social Work Unit can continuously plan, control and review its activities as a whole and be responsive to the changes in the environment in which it operates.

2. THE STATUS OF THE PROPOSED PLANNING PROCESS

2.1 The proposed planning process has been designed in response to the recommendations contained in a paper titled 'Future Development of the Social Work Unit' prepared by the Head Social Worker. (16th March, 1982).

2.2 It is presented in this paper to provide a framework for discussion with staff of the Social Work Unit. Two questions should be addressed by staff in assessing this proposal:

First, does the proposed planning process take account of the characteristics of the Unit and the Hospital?

ERYL MORGAN and ASSOCIATES. Social Planning and Management Consultants.

32 McLACHLAN ST. NORTHCOTE. VIC. 3070. Telephone: 481 4230

Second, has the Unit the capacity to implement the proposed process?

3. THE OBJECTIVE OF THE PROPOSED PLANNING PROCESS

To develop a Future Directions Plan for the Social Work Unit at Peter MacCallum Hospital which provides a framework for the Unit to continuously plan, control and review its services as a whole in the context of the Hospital and the Community in which it operates.

4. THE PROPOSED PLANNING PROCESS

The process has three major components; a situation audit, identification and analysis of key issues facing the Social Work Unit and the development of a Future Directions Plan. The aims of each of these components and an outline of the methods to be used are presented in the following sections. The inter-dependence of the three components is illustrated in the flow chart which is displayed in the Social Work Unit.

4.1 THE SITUATION AUDIT

Aims: To identify, analyse and report on the current social work services at the Peter MacCallum Hospital.

To identify, analyse and report on the changes and trends that have occurred in social work services at the Peter MacCallum Hospital over the previous five years.

Methods: (1) Questionnaire completed by Social Work Unit to collect the following data in respect of case loads in a specified month:

- Number of new referrals
- Number of patients carried forward from previous month

- Number of inpatients
- Number of out-patients
- Number of patients from defined geographical areas
- Classification of problems being dealt with

(2) PATIENTS SURVEY - POSTAL QUESTIONNAIRE SAMPLE - 100 RANDOMLY SELECTED PATIENTS FROM EACH OF PREVIOUS 5 YEARS. SELECTED FROM SOCIAL WORK UNIT MASTER INDEX THUS WOULD REPRESENT ALL CLINIC POPULATIONS SERVED, INCLUDING BOTH PUBLIC & PRIVATE PATIENTS.

(STAFF AMENDMENT TO PROCESS SUBMITTED)

(2) Case Study prepared by Social Work Unit Staff of one patient from each of the defined geographical areas to assess the adequacy of social work services available in those defined areas.
Each case study would utilize Medical & Social Work Unit Records for basic data. An interview with the patient and/or his family may be conducted.

(3) Review of services provided by the Social Work Unit in addition to individual work with patient and/or their families.

(4) Questionnaire completed by Social Work Unit staff to collect data in respect of the Social Work Unit Management system. Staff perceptions of the following would be examined:

- Motivational forces
- Communication process
- Interaction-influenced Process
  Decision Making Process
  Goal setting process

(5) Unit Review Schedule to collect the following data for the previous five years.

- Social Work Unit - Staff establishment
  - positions
- Social Work Unit Staff - case loads in respect of
  (1) defined patient areas
  (2) defined geographical areas
- Hospital beds in defined patient areas
- Average length of stay

- Occupancy Rates
- Number of patients attending outpatient clinics
- Number of patients seen by Regional Teams

4.2 IDENTIFICATION AND ANALYSIS OF KEY ISSUES

Aim: To identify, analyse and report on the key issues which will have impact upon the future provision of social work services at the Peter MacCallum Hospital.

Methods: (1) SWOP Analysis through which Social Work Unit Staff identify the Strengths and Weaknesses of the Unit and the Opportunities and Problems in the environment, both the Hospital and the Community. The Situation Audit Report inputs to this analysis. The SWOP analysis presented in a Cruciform Chart provides a means to integrate, in concise form, the objective and subjective data to identify the key issues.

(2) Consultations with selected Hospital and Community Resource personnel to identify the key inter-departmental issues facing the Social Work Unit.

(3) Analysis of the key issues using the Delphi approach. This analysis has two stages. In the first stage staff of the Social Work Unit are asked to complete a questionnaire examining each of the issues identified. The object is to collect independent opinion and analysis of each issue. Staff are therefore asked not to discuss the questionnaire at this stage. In the second stage differences between the independent responses are discussed and debated in order to achieve a consensus position in respect of the impact the key issues will have on the future provision of social work services at the Peter MacCallum Hospital.

4.3 DEVELOPMENT OF A FUTURE DIRECTIONS PLAN

Aims: To establish the purpose and broad goals of the Social Work Unit at the Peter MacCallum Hospital.

To determine objectives, aims and action plans for the Social Work Unit which are consistent with the provision of quality social work services to patients of the Peter MacCallum Hospital and are responsive to the changing expectations of patients, the Hospital and the Community.

Method: The methodology for this component of the project is not finally fixed until the completion of the situation audit and the issues analysis. The Future Directions Plan is designed to build on the Units strengths and the environmental opportunities and at the same time to counter weaknesses and work towards meeting the problems identified. The methods used to develop the plan must therefore be designed to reflect the specific characteristics of the Social Work Unit at the Peter MacCallum Hospital.

In broad terms the process will involve staff of the Social Work Unit in establishing the purpose and broad goals of the social work service in the context of the Hospital and the Community in which it operates. Secondly, the broad statements of direction will be translated into objectives, aims and action plans which are achievable within the defined 5 year time frame.

5. CONCLUSION

5.1 This proposed planning process is designed to focus on the Social Work Unit as a whole taking account of the environment in which it operates. It is a participating process which involves staff of the unit in the identification and analysis of issues and the development of a Future Directions Plan.

5.2 To successfully implement this planning process would require the participation and committment of all staff of the Social Work Unit. It would also require the support of Hospital Management and Administration.

ERYL MORGAN
7th MAY 1982.

ANTI-CANCER COUNCIL OF VICTORIA

ACCV SUB-COMMITTEE ON THE FUTURE OF WELFARE PROGRAM

MINUTES OF MEETING HELD AT 4.30 P.M. TUESDAY, JUNE 6, 1978

PRESENT: Sir Edward DUNLOP, Mr. W. A. DICK, Dr. T. HURLEY, Dr. Nigel GRAY, Miss Adrienne HOLZER, Miss Betty DOW.

Miss Dow presented a document which reviewed the present status of the welfare programme. This may be summarised -

1. A general welfare programme supervised closely by Miss Dow; generally mediated through social workers with public hospitals but with occasional references from outside doctors or nurses; with clearcut policies as laid down in Miss Dow's situational report dated 1/5/1978 - attached.

   The major emphasis is on family groups mostly under 50 years of age and upon patients in the public sector of medicine.

2. The breast prosthesis service: This project involves a co-ordinating role for Miss Dow, who designed and established the service, which depends upon the services of 34 nurses situated in the RDNS and general hospitals and paid by other bodies.

Discussion dealt firstly with the prosthesis service and it was generally concluded that the service was first quality, involved a coordinating role and minimal expense and that it was appropriate for the Council to continue running the service. It seems unlikely that any Government agency would or could run a service which is so heavily orientated to private patients (the majority of breast cancer patients are in the private sector) and the alternative groups such as mastectomy associations have not proved satisfactory.

General Welfare Policy: A number of questions were considered including the basic one "should the Anti-Cancer Council be involved in any type of welfare programme?" There was considerable discussion, which emphasised the philosophical view that the Council, in general, should avoid routine service commitments; that our research and development role should be emphasised and that our analytical work should lead to policy developments which ought to be presented to Government in order to change the welfare scheme. The following points were then generally agreed upon -

1. That we should continue to employ our own Social Worker. Alternative approaches such as Government grants to other social workers or employing a part-time social worker for co-ordinating purposes were thought to be inadequate.

2. It was agreed that there are certain patients who enter crisis situations which cannot either now or conceivably in the future be dealt with by the statutory benefits available. It was appropriate on humanitarian grounds and consistent with the image of the Council, that we should allocate funds for the assistance of these patients. These funds should not exceed 7-10% of available funds.

/2...

3. It was agreed that a major objective of our social worker should be the delineation of problems within the welfare system and that the only way our worker could obtain an appropriate information flow was by spending a proportion of time working within the orthodox patient management framework. For reasons cited in (2) she should have funds to disburse.

4. Under Medibank Standard patients in the lower socio-economic group can now be diagnosed and treated by their general practitioners and consultants but lack the support systems provided in hospitals (including financial counselling). Miss Dow has seen small numbers of these patients but it seems likely there are many more we do not contact. Attention ought to be given to this overall problem.

It was noted here that the public hospitals are providing an increasing level of social work for cancer patients and that they are meeting their responsibilities in this area and in the provision of care and beds, much more satisfactorily than in the past.

5. The basic objectives of the programme were spelt out as follows:

5.1. The ACCV should work towards improving welfare programmes and the social management of cancer patients.

5.2. That the ACCV should maintain a significant research bias.

5.3. That a continuing emphasis should be placed upon the need to delineate problems, to alert the appropriate Government agency to these and where necessary exert pressure.

5.4. The ACCV should contribute towards informing appropriate sections of the health care system, e.g. doctors, nurses, of developments within Government welfare programmes. The possibility of a newsletter was raised here.

The 10% increase in units helped with grants is probably accurate and was perhaps aggravated by the widespread unemployment - drought conditions - industrial unrest and the effects of strikes etc. ..... only a "guesstimate" is possible as our procedures are set up to provide annual comparative figures.

6. The above figures do not include the BREAST PROSTHESIS SERVICE figures which are reported separately or patients covered during the phase-out of the terminal care program.

7. This SITUATIONAL REPORT should be read in conjunction with the memo dated 12th April 1978 prepared for the Finance Committee setting out expenditure from 1970 to 1977 on -

- individual grants - Para. 6(i)
- subsidized support systems - Para. 6(ii)

and forecasting expenditure for the next 3 years - Para. 4.

III. COUNTER-PRODUCTIVE SEQUELA - FRAGMENTED ONCOLOGY:

8. It is postulated that fragmented Oncology programs achieve technicological advances in physical management at the debasement of the quality of life of the individual and family systems. Cancer care calls for a unified and balanced approach covering both technology and situational/life stress - Oncology in Melbourne bears a marked resemblance to a double-headed penny with "technology" rampant.

9. Not only do patients now face complex treatment protocols which are physically and psychologically debilitating but the increase in life expectancy can create severe environmental problems and changes in their families' lifestyle.

The most simple basic example being where one parent - usually the mother - can spend up to fifty percent of her time away from her family and care of other siblings etc. - in some cases putting these siblings at risk of becoming psychological cripples.

10. The psycho-social disorder that follows in the wake of this lopsided Oncology approach is not just an Australian phenomenon. In the States - where the word "welfare" is anathema - the Sidney Farber Cancer Institute in Boston developing a model "cancer care system" found the team approach to the development of cooperative programs was inadequate - a second model was necessary to meet care of cancer patients <u>outside</u> as well as <u>inside</u> the hospital.

> "A whole life situation has changed. Patient and family must adjust to a chronic illness and temporary or possibly permanent changes in roles ..... problems with arrangements for transportation to and from the source of treatment ..... the patient may run out of sick leave, lose employment, and ultimately exhaust health insurance benefit. The

SITUATIONAL REPORT - WELFARE SERVICE

1st May 1978

I. TERMS OF REFERENCE:

1. The concern of the Welfare Service is cancer care - the continuing care of patients who are cured or have a reasonable prospect of cure as well as those with advanced incurable malignant conditions - and to maintain as healthy functioning units cancer families devastated and immobilized by diagnosis and long drawn out treatment protocols.

II. BACKGROUND OF WELFARE GRANT PROGRAM and CURRENT STATISTICS:

2. Circa 1973 the welfare grant program was extended to cover the socio-economic needs of cancer families who prior to diagnosis had been "coping families" financially and emotionally.

3. It was decided to phase out the terminal care program because escalating hospital and nursing home fees and insurance costs were clearly beyond the Council's funding capacity. Monies previously expended on terminal care were diverted to meeting domestic and environmental needs incurred by cancer families.

4. In the 10-month period to the end of April 432 cancer patients/families had been individually counselled or their management discussed or planned with other helping disciplines - only 237 of these units needed welfare grants against a "guesstimate" of 215 patients/families at the same period 1977.

An attempt is made to stabilize a family's financial affairs and indicate areas in which they can anticipate help in the future. This financial stability generates a ripple effect on the emotional life of the family - financial stability being precursory to emotional stability.

20. Grants should be carefully interpreted so they are seen as a partnership commitment in which both the Council and the family play distinct roles and there is no hint of mendicacy. It is a two-way relationship - the family's role in the contract being to manage their day-to-day living expenses and treatment protocols within their reduced income.

21. In some cases families are also relieved of the responsibility of saving for "oncers" - Council/Water Rates - Medical/Hospital Insurance - Life Insurance - Car Registration - 'Phone Rentals - until their finances stabilize.

22. Many families once they see the light at the end of the tunnel appear to get a second wind ..... they demonstrate an ability not only to meet their treatment protocols but to plan their day-to-day domestic arrangements more constructively - they begin to sort out priorities and find innovative ways of balancing their reduced budget without resorting to the vicious circle engendered by borrowing monies at high interest rates.

V. YARDSTICK - DETERMINING BASIS FOR GRANTS:

a) Philosophy

23. The paramount philosophy of the grant program is the emphasis on helping families use their own abilities to grapple with the treatment demands and domestic crises aggravated by cancer.

The first step is to make sure they are aware of or have the know-how to utilize the statutory and other resources that are available in the community - the Council's welfare funds supplement but never duplicate statutory allowances.

b) Skill in Problem Solving Process

24. Stabilizing and budgeting the income of families "at risk" calls for a high level of skill in the problem-solving process. It is necessary to assess the physical and domestic implications of the treatment protocols in conjunction with the family's financial and emotional stability.

25. N.B. The newly created Oncology protocols make it increasingly difficult to predict prognosis and survival with any degree of accuracy and to work out a viable budgeting plan that will keep domestic pressures under some degree of control.

family is faced with a change in its standard of living and a change in life plans. Superimposed on all these problems is the fact that both the patient and family must live with a life-threatening disease. ..... The problems cover a wide range. They include cancer's life-threatening aspects, the complications of therapy, problems related to transportation, finances, vocation, body image, stigma, and family and social roles."

11. In Australia the media recently quoted Dr. Gray calling for "fresh attitudes in handling the psychological management of cancer patients".

IV. CATEGORIES OF GRANTS:

12. Individual welfare grants which absorb 52% of the budget fall into two categories:

a) Facilitating treatment grants
b) "Bridging Contracts".

APPENDIX A illustrates typical situations where grants have been able to mitigate/palliate the "cancer toll" a previously "coping family" has to meet.

A. Facilitating treatment grants

13. enable cancer families whose income remains static make the maximum use of all treatment resources available.

B. "Bridging Contracts"

14. have an added dimension to Facilitating grants - the income of a previously "coping family" is completely disrupted.

15. When the breadwinner gets cancer a family income can change overnight from wage-earning to statutory allowances below the poverty line.

16. In a similar position are those families whose financial commitments (Hire Purchases - Loans - Mortgages - etc.) were undertaken on the basis of the husband and wife's combined earning capacity. Once one parent becomes ill - or a mother has to give up work to care for a sick child - these families are "at risk

17. This year I started a "bridging contract series" exploring the feasibility of negotiating settlement of some of the high interest commitments taken on prior to diagnosis on the basis of the family's then earning capacity.

18. This can often increase by $20 or more a week a family's spending capacity for day-to-day living expenses. It is postulated that in the long run it is more viable economically than from time to time meeting a payment (inevitably in arrears) carrying a 60% interest component as well as being less damaging to a family's self esteem and self worth.

26th May, 1978.

MEMO TO: Committee Members - ad hoc sub-committee on Welfare Programme

FROM: Nigel Gray

1. Attached is a set of views presented by Betty Dow relating to the Welfare Services. I thought it might be helpful to put on paper some of the questions which we should consider:

2. Preamble

The Welfare Programme has been established for almost two decades, over which time we have employed a half-time and later a full-time Social Worker currently supported by a 60% secretary and a junior assistant.

3. Until Betty Dow joined the staff we had very little real understanding of what our welfare funds were actually being spent upon. She has documented in detail the disbursement of individual grants so they reflect areas of need or gaps in the community and has itemised the cost of the other subsidised support systems for which she is responsible

The following points arise:

4. (i) Should we abandon our welfare programme altogether? - both the research programme and the public education programme are money hungry and the Council's funds are limited at the moment. Is it appropriate to review the priorities of the welfare programme in relation to our other commitments?

5. (ii) There are approx. 7000 new cancer patients being diagnosed and treated in Victoria each year.

6. This year Betty Dow will have had direct or indirect contact with over 500 patients/families and grants will have been made to between 270 and 300 of them - i.e. we gave money to about 4% of new cancer patients/families occurring in the State each year.

7. (iii) She has also developed and runs the Breast Prosthesis Service which to my mind is an excellent service which we should continue. It is highly efficient.

It is highly unlikely that any Government agency would take it on and it is a suitable activity for a co-ordinating body such as ours as 65% of the women involved are in the private treatment stream. The Australian Cancer Society has a commitment to this area of rehabilitation.

The N.S.W. Mastectomy Rehabilitation Service and our Breast Prosthesis Service both started in February 1975 - by Decembe 1977 the N.S.W. service had reached 582 patients against over 200 by our Breast Prosthesis Service.

c) Regular Monitoring

26. The criteria for grants can never be static - there must be continuous study and review - current policies need constant monitoring -

(i) to meet fluctuating Government policies and the economic climate

(ii) to stay within the Council's funding capacity

(iii) to learn from experience the most constructive and acceptable ways of rehabilitating families

(iv) studying and measuring ways of helping families without damaging their independence - with the use of "partnership technique" a viable budget often can be achieved.

VI. COUNTER-PRODUCTIVE SEQUELA - MEDIBANK MARK II.

27. A health service should provide a complete state of physical emotional and social wellbeing - not just the physical treatment of disease.

28. In Medibank Mark II there is provision for excellent universal physical care - patients in the lower socio-economic group can now be diagnosed and treated by their general practitioners and consultants but lack the support systems provided in hospitals (including financial counselling).

29. When the new Terms of Reference for welfare grants was implemented 3 years ago most applications came from social workers in the large hospitals - now an increasing number of community social/welfare workers and community health nurses ring to discuss cancer management and care.

Some patients/families can be referred to Social Work Departments in hospitals but a growing number remain in the private stream at considerable financial hardship.

30. For example: The costs of remaining in the private radiotherapy stream can be astronomical to a lower income family. The biblical camel would have a better chance of passing through the eye of a needle than a radiotherapy patient has of transferring from private stream to P.M.C. public clinic. In the private stream they face a considerable cash outlay meeting the gap between fees charged for radiotherapy machines - pathology - etc. and the rebate from health insurance. They also have to meet pharmaceutical costs - transport expenses - board/motel accommodation - surgical appliances such as wigs - breast forms - porta potties - urinals - etc.

31. Even patients in the private stream at P.M.C. do not have automatic access to the support systems provided by P.M.C. public clinics - patients treated at Epworth etc. are completely uncovered.

Betty F. Dow
Social Worker.

Questions that arise at this time are:

8. (i) Is it our job to meet the "service" type commitment of actually giving money direct to patients or should this be a purely Government responsibility?

9. (ii) Is the changing pattern of cancer management (notably combined therapy and the newer regimes of chemotherapy) creating new personal problems for cancer patients as is suggested in Betty Dow's report?

10. (iii) Is the 4% of the patients whom we help financially a drop in the bucket or a substantial percentage of those in serious financial need?

11. (iv) By working with such a small percentage of cancer patients are we analysing the financial domestic needs of all cancer patients or only those who happen to contact us or other paramedicals with their problems - i.e. have we reached a plateau or a ceiling?

12. (v) Should we consider phasing out our direct individual grants and phasing in a research-orientated (? action research) programme which could conceivably operate through social workers (perhaps partially funded by us) attached to the new oncology clinics established in the past 12 months?

13. (vi) If the above is a viable objective, would we be able to find a research-orientated but practical social worker to organise such a programme, which would involve considerable analysis of patients' needs and co-operation/discussion with the oncology social workers?

14. (vii) Could such an action research programme operate effectively without oncology social workers having access to funds of the sort Betty Dow has been administering?

15. (viii) Is it feasible for us to develop a programme which would give us sufficient information to allow sensible submissions to be made to Federal and State governments which might help them modify their welfare systems - i.e. the Health Costs for Country People suggested prior to the last election? - the mind boggles a bit at the problems involved!

16. (ix) Should we take the research approach even further and offer research grants for sociological analyses of cancer patients' problems and abandon the idea of having our own social worker directing a programme? What would we do with the sociological problems that emerge?

N.G.

APPENDIX A.

6. Country Patients:

living allowances and/or accommodation for both patient and relatives

N.B. Patients from drought areas - floods - etc. - do not have access to ready cash to cover the cost of staying in Melbourne - in some cases those on the land are even receiving Social Security allowances. With this group the wisdom of Solomon would be extended to differentiate between meeting essential crisis needs and maintaining a valuable capital asset.

7. Industrial disruption

last year because of strikes and industrial unrest a number of metropolitan and country patients would have been unable to meet treatment protocols without grants from the Council in the form of living allowances/"oncers".

8. Arrears of Mortgages/Rents

where families have fallen behind during the diagnostic or treatment period and the alternative solution would have been a loan at exhorbitant interest rates.

9. Negotiating Settlement of High Interest Loan/Hire Purchase taken out prior to diagnosis

for an essential item such as refrigerator - washing machine - hot water service - etc. often absorbing 25% of the reduced takehome I

10. Health Insurance Levies etc.

including maintaining hospital insurance cover so patient is covered for terminal stages of his illness (Medibank standard beds are rarely available).

VII. APPENDIX A.

SITUATIONAL REPORT - WELFARE SERVICE - 1st May 1978

Illustration of situations where grants have rehabilitated/stabilized families or enabled them to make maximum use of treatment resources.

A. FACILITATING TREATMENT GRANTS:

1. Transport to and from treatment

petrol allowance - essential car repairs - replacement of threadbare tyres - Registration - Insurance - etc.

2. Installation of telephone and payment of rental

not only so that patients/families can call out in an emergency but also to allow relatives and friends to check everything is under control.

As a matter of policy the Council does not meet the cost of 'phone calls.

3. Essential Surgical Equipment (for discharge)

Although there is statutory provision for these to be provided by Medibank hospitals under the Commonwealth-State Agreement many hospitals do not implement.

Under this would come - wigs - stirrup pumps - breast prostheses - wheel chairs - water beds - etc. etc.

Even the most enlightened hospitals will not consider meeting the cost of domestic items essential for a patient's adequate care at home - such as washing machines - vitamizers - refrigerators - heaters - etc. Where patients/families cannot afford these items the Council's funding is used.

4. "Oncers"

such as Council and Water Rates - Life and House Insurances etc. - Medical/Hospital Insurances - Car Registrations.

These are items which the average "coping family" normally could have saved for if the non-medical peripheral expenses had not absorbed all their weekly income and often savings.

5. Home Help

$30 weekly grant that allowed a 33 year-old mother with 4 children under 9 years of age to remain in her own home supervising their care until hospitalized in the last week.

SITUATIONAL REPORT - WELFARE SERVICE 1st May 1978.

COMPARATIVE ANALYSIS - SPENDING PATTERN

10 Months July to April 1977/78 against 12 Months July to June 1976/77

CODE		GRANTS July to April $		APPROX. % of total over 10 mths. '77/78	APPROX. % of total over 12 mths. '76/77
1.	TERMINAL SUBSIDY:				
	Private Hospital Nursing Home	-			5%
2.	PRE-TERMINAL SUBSIDY:				
	Nursing Hostel Board	30	(.04%)	-	-
3.	INSURANCES:				
	Medical/Hospital	3,578		5%	3%
	* Life	1,322		2%	- *
4.	LIVING ALLOWANCES	4,813	(7%)		
	HOME HELP	1,278	(2%)	11%	9%
	HOUSEHOLD EXPENSES	1,266	(2%)		
5.	HOUSING:				
	Rent	7,247	(10%)		
	Mortgage	5,489	(8%)	19%	21%
	Insurance	351	(.5%)		
	Other	904	(1%)		
6.	RATES:				
	Council	7,746	(11%)		
	Water	3,876	(5%)	16%	12%
	Other	157	(.2%)		
7.	TRANSPORT:				
	Fares	492	(.7%)		
	Petrol	1,344	(2%)		
	Registration	4,598	(6%)	14%	14%
	Insurance	1,155	(2%)		
	Repairs	1,220	(2%)		
	Car Payments	634	(1%)		
8.	HIRE PURCHASE	2,260	(3%)	8%	8%
	FINANCE CO.	3,857	(5%)		
9.	TELEPHONE	5,915		8%	7%
10.	*ACCOMMODATION/PER DIEM	2,760		4%	- *
11.	MEDICAL EQUIPMENT	662		1%	2%
12.	FUNERAL	5,861		8%	7%
13.	OTHER	2,970		4%	12%
	TOTAL	$71,785			

* These items were listed under "OTHER" last year.

APPENDIX A.

B. BRIDGING CONTRACTS:

12. 3 year-old girl - carcinoma of vagina - chemotherapy increased tumour - hysterectomy. According to surgeon prognosis is good - child could have normal lifespan - will always need treatment.

3 other siblings under 11 years of age - Geelong family.

Father had takehome pay of $120 - prior to diagnosis had additional weekend part-time job and mother also had part-time job.

Both parents encouraged by R.C.H. to be involved in treatment - father gave up part-time job and mother hers - savings soon exhausted.

Originally given travelling expenses of $3 a day for 4 weeks - then grant for Council and Water Rates.

During early diagnostic and treatment period family continually falling behind with Hire Purchase payment of $74 a month for their car.

R.C.H. Social Worker negotiated a settlement with Finance Company - less $200 interest charges.

May 1977 - total of $1,214 expended - 12 months later family coping - meeting R.C.H. protocols - despite recession father got another part-time job.

Council and Water Rates were due mid-April but family did not seek grant - indicated to S.W. coping.

13. Married man - aged 29 - acute myeloid leukaemia and died within 7 months of diagnosis.

Wife - 3 children aged 9, 7 and 3 - Geelong family.

Concerned family man - good employment record - no Sick Pay due to technicality.

Local Social Worker able to finalize settlement of 3 Hire Purchases totalling $997 for $492 bringing in additional $10 a week to family income.

$275 grant for Mortgage which had a Death Clause.

Patient arranged his own simple basic funeral for $400 - met by Council.

Total of $1,158 expended - wife and 3 children have reasonable chance of making out on Widow's Pension etc.

Some time after funeral a letter received from wife promising annual donation and saying "help you gave enabled us to make the most of the time we had left and gave Andrew some peace of mind to know I would not be burdened down with debt."

ANTI-CANCER COUNCIL OF VICTORIA

ACCV SUB-COMMITTEE ON THE FUTURE OF WELFARE PROGRAM

MINUTES OF MEETING HELD AT 4.30 P.M. TUESDAY, JUNE 6, 1978

PRESENT: Sir Edward DUNLOP, Mr. W. A. DICK, Dr. T. HURLEY, Dr. Nigel GRAY, Miss Adrienne HOLZER, Miss Betty DOW.

Miss Dow presented a document which reviewed the present status of the welfare programme. This may be summarised -

1. A general welfare programme supervised closely by Miss Dow; generally mediated through social workers with public hospitals but with occasional references from outside doctors or nurses; with clearcut policies as laid down in Miss Dow's situational report dated 1/5/1978 - attached.

   The major emphasis is on family groups mostly under 50 years of age and upon patients in the public sector of medicine.

2. The breast prosthesis service: This project involves a co-ordinating role for Miss Dow, who designed and established the service, which depends upon the services of 34 nurses situated in the RDNS and general hospitals and paid by other bodies.

Discussion dealt firstly with the prosthesis service and it was generally concluded that the service was first quality, involved a coordinating role and minimal expense and that it was appropriate for the Council to continue running the service. It seems unlikely that any Government agency would or could run a service which is so heavily orientated to private patients (the majority of breast cancer patients are in the private sector) and the alternative groups such as mastectomy associations have not proved satisfactory.

General Welfare Policy: A number of questions were considered including the basic one "should the Anti-Cancer Council be involved in any type of welfare programme?" There was considerable discussion, which emphasised the philosophical view that the Council, in general, should avoid routine service commitments; that our research and development role should be emphasised and that our analytical work should lead to policy developments which ought to be presented to Government in order to change the welfare scheme. The following points were then generally agreed upon -

1. That we should continue to employ our own Social Worker. Alternative approaches such as Government grants to other social workers or employing a part-time social worker for co-ordinating purposes were thought to be inadequate.

2. It was agreed that there are certain patients who enter crisis situations which cannot either now or conceivably in the future be dealt with by the statutory benefits available. It was appropriate on humanitarian grounds and consistent with the image of the Council, that we should allocate funds for the assistance of these patients. These funds should not exceed 7-10% of available funds.

/2...

3. It was agreed that a major objective of our social worker should be the delineation of problems within the welfare system and that the only way our worker could obtain an appropriate information flow was by spending a proportion of time working within the orthodox patient management framework. For reasons cited in (2) she should have funds to disburse.

4. It was noted that a significant problem had developed within the private sector in that many patients who were insured with funds other than Medibank, found themselves in the private sector, were devoid of adequate resources to cope with the extra costs and were also devoid of any sort of social worker service. Miss Dow has seen small numbers of these patients but it seems likely there are many more we do not contact. Attention ought to be given to this overall problem.

It was noted here that the public hospitals are providing an increasing level of social work for cancer patients and that they are meeting their responsibilities in this area and in the provision of care and beds, much more satisfactorily than in the past.

5. The basic objectives of the programme were spelt out as follows:

5.1. The ACCV should work towards improving welfare programmes and the social management of cancer patients.

5.2. That the ACCV should maintain a significant research bias.

5.3. That a continuing emphasis should be placed upon the need to delineate problems, to alert the appropriate Government agency to these and where necessary exert pressure.

5.4. The ACCV should contribute towards informing appropriate sections of the health care system, e.g. doctors, nurses, of developments within Government welfare programmes. The possibility of a newsletter was raised here.

COMMUNITY HEALTH CENTRES

69 64 Community Health Centres of which 33 are 'country'

Ballarat/Bendigo	-	6
Horsham/Hamilton/Warrnambool	-	3
Shepparton/Wangaratta/Wodonga	-	2
Traralgon/Sale	-	9
Geelong	-	~~12~~ 7
Mildura	-	1

BUSH NURSING CENTRES

12 Bush Nursing Services

Ballarat/Bendigo	-	1
Horsham/Hamilton/Warrnambool	-	3
Shepparton/Wangaratta/Wodonga	-	-
Traralgon/Sale	-	5
Geelong	-	2
Mildura	-	1

NB. Royal District Nursing Service
Community Health Resources Group
Ethnic Health Service
Central Health Interpreter Service

D R A F T

ANTI-CANCER COUNCIL OF VICTORIA

REGIONS - BASED UPON BASE HOSPITALS

1. BALLARAT
   BENDIGO

2. HORSHAM
   HAMILTON
   WARRNAMBOOL

3. SHEPPARTON
   WANGARATTA
   WODONGA

4. TRARALGON
   SALE

5. GEELONG

6. MILDURA

Base Hospital Regions

Douglas Heald

NB - p. 157 - Municipal Directory

35
3

Regions - Based upon Base Hospitals

1. Ballarat
   Bendigo

2. Horsham
   Hamilton
   Warrnambool

3. Shepparton
   Wangaratta
   Wodonga

4. Traralgon
   Sale

5 Geelong

6 Mildura

Community Health Centres.

69 Community Health Centres
of which 38 are 'country'.

Ballarat/Bendigo	: 6
Horsham/Hamilton/Warrnambool	: 3
Shepparton/Wangaratta/Wodonga	: 2
Traralgon/Sale	: 9
Geelong	: 12
Mildura	: 1

Bush Nursing Centres

12 Bush Nursing Services

Ball/Ben.	: 1
H/H/Warr	: 3
Sh/Wang/Wod	: –
Tra/Sale	: 5
Geelong	: 2
Mildura	: 1

N3 Royal District Nursing Service
Community Health Resources Group
Central Ethnic Health Service
Central Health Interpreter Service.

Regions.

? ((Grampians Mall).

Ballarat }
Bendigo }

Broadford CHP, Eaglehawk [CHC], Kangaroo Flat [CHC], Inglewood [CHC], Quambatook
Stanhope

Dingee BNS

Horsham
Hamilton +
Warrnambool }

Goroke [CHC], Portland, Warrnambool
Balmoral BNS, Dartmoor BNS, Harrow BNS

Shepparton
Wangaratta +
Wodonga }

Mt Beauty, Yarrawonga.

Traralgon
Sale }

Churchill CHP, Ensay [CHC], Moe [CHC], Nowa Nowa, Orbost, Rosedale [CHC]
San Remo, Traralgon, Lakes Entrance

Buchan BNS, Cann River BNS, Dargo BNS, Mallacoota BNS, Swifts Creek BNS

Geelong

- Apollo Bay [CH/P], ~~Clifton~~ Newtown, Corio [CHC], Lara, Lorne, Portarlington, Pt. Lonsdale
Jan Juc, ~~Sebastopol~~, Werribee, Winchelsea, Rockwood.

- Anglesea BNS, Drysdale BNS

~~Horsham~~

Mildura, Merbein [CHC], Ouyen/Woomelang BNS

PILOT STUDY

The questionnaire that you have before you and have kindly consented to fill in is for a pilot study. This means that we want to test out the questionnaire and refine it prior to the full study.

IT IS IMPORTANT THAT YOU DO NOT DISCUSS THE QUESTIONNAIRE WITH COLLEAGUES PRIOR TO COMPLETING IT.

Simply read through the instructions and the questions and then complete the questionnaire.

Space has been provided for you to make comments about each question section. Please feel free to do so in whatever way you feel necessary.

Thank you for your participation and assistance.

ANTI-CANCER COUNCIL OF VICTORIA

This questionnaire is designed to enable a profile of welfare resources available in Victoria to persons suffering from cancer.

For the purposes of this study, welfare services/resources are defined as all non-medical services which may be required by cancer patients and their families in order to assist them to achieve optimal levels of functioning.

The criteria for respondents to the questionnaire are first that their primary role is the provision of welfare services, and second that they have had direct contact during the last 12 months with persons suffering from cancer, or their families, through the provision of welfare services.

If you do not provide welfare resources do not fill in the questionnaire.

If you have not had direct contact with persons suffering from cancer, or their families, within the last 12 months, do not fill in the questionnaire.

Please read each question and the instructions carefully before you attempt to fill it in.

You may feel that you do not have sufficient objective information available to answer this questionnaire. However, as the aim of this questionnaire is to collect opinion from a range of personnel involved in the provision of welfare services, your perception of the issues, whether based on 'objective' data or not will provide an adequate data base for this project.

The map attached will show you what region you belong to for the purposes of this study.

Please respond to the questionnaire in respect of the area in which your agency is placed.

If there are several people within your agency who fit the respondents criteria, it is quite allowable to pool your collective resources and together complete ONE questionnaire.

Thank you for your participation.

Q.1. AGENCY DETAILS

1.1. Name of Agency:

1.2. Address: Telephone:

Office Use Only	
1.3. Region:	
1.4. Category of Resource:	

1.5. Name of Person Completing the Questionnaire:

1.6. Position in the Agency :

1.7. Does your agency have any plans for change during the period October, 1982 to October 1983?

(Please circle appropriate numbers and specify in each case).

0. No
1. In Services
2. In Geographical Location
3. In Eligibility
4. In Timetable
5. In Physical Plant
6. Other

1.8. Please estimate the number of persons suffering from cancer your agency provided welfare services for during the 12 months to October, 1982.

(Please tick the appropriate box)

0	
1 - 9	
10 - 19	
20 - 29	
30 - 39	
40 - 49	
More than 50	

Q.2. PROFILE OF WELFARE RESOURCES AVAILABLE TO PERSONS SUFFERING FROM CANCER:

2.1. What services does your agency offer which are available to cancer patients and/or their families?

(Circle appropriate number/s)

TRANSPORT:

1. Volunteer Driver Service

ACCOMMODATION:

2. Nursing Home Care
3. Terminal Care: Hospice
4. Family Relief Beds

LEGAL SERVICES:

5. Legal Advice

INFORMATION:

6. Information Services

EMPLOYMENT:

7. Employment Counselling/Advice

FINANCIAL:

8. Financial Aid
9. Financial Advice

DOMICILIARY / COMMUNITY RESOURCES:

10. Meals on Wheels
11. Home Help
12. Visiting Nursing Service
13. Volunteer Visiting Service
14. Child Care
15. Aids / Prosthesis
16. Occupational Therapy
17. Physiotherapy
18. Speech Therapy
19. Home Handyman Service
20. Day Centre
21. Self Help Groups

COUNSELLING SERVICES

22. Counselling
23. Psychiatric Care
24. Family Support Counselling
25. Bereavement Counselling
26. Group Counselling
27. Interpreters

Q.2. (Ctd.)

2.1.

28. OTHER: Please specify

2.2. Does your Agency offer any services specifically for persons suffering from cancer and/or their families?

YES ☐ If 'Yes' go to Q.2.3. NO ☐ If 'No' go to Q.3.

2.3. What services does your Agency offer specifically for persons suffering from cancer and/or their families?

(Please circle the appropriate number/s)

1. Prosthesis
2. Household & Personal Aids, e.g. Rails, Commodes
3. Visiting Nursing Service
4. Bereavement Counselling
5. Bereavement Groups
6. Volunteer Visiting Service
7. Child Counselling
8. Individual Counselling
9. Couple Counselling
10. Family Counselling
11. Driving Service
12. Physiotherapy
13. Occupational Therapy
14. Speech Therapy
15. Financial Aid
16. Information Services
17. Accommodation
18. Other - Please Specify

(For Municipal Social Service Departments only)

Q.2.4. Would you please list below all those community resources/services that you are aware of in your municipality/shire which are available to persons suffering from cancer and/or their families. We are interested in those resources/services available in respect of meeting problems relating to their illness.

Name of Service/Resource	Address	Service/Resource Provided
TRANSPORT:		
ACCOMMODATION:		
LEGAL:		
INFORMATION:		
EMPLOYMENT ADVICE:		
FINANCIAL ADVICE:		
DOMICILIARY/COMMUNITY:		
COUNSELLING:		
OTHER:		

Q.3. PROBLEMS FACING PERSONS SUFFERING FROM CANCER IN RESPECT OF AVAILABILITY AND ACCESS TO WELFARE SERVICES:

In this section potential problems have been listed under specific headings. Some of them may appear repetitive. This is to enable a more accurate analysis of the information you are providing. We are drawing upon your experience of working with people suffering from cancer. Your perceptions of the problems they face will be valuable to this review.

3.1. Would you please rate the following problems which may face persons suffering from cancer, or their families, in your region, according to the following scale :

Can't Answer	0
No Problem	1
Minor Problem	2
Serious Problem	3
Very Serious Problem	4

Please place the appropriate rating number in the box provided:

TRANSPORT:

Transport for Treatment and Weekend Leave:

Ambulance Eligibility	
Insufficient Voluntary Drivers	
Distance from Treatment Centre for Patient	
Distance from Treatment Centre for Family	
Car Park Facilities at Treatment Centres	
Cost to Cancer Patients and their Families	

Isolated Patients Travel & Accommodation Assistance Scheme:

Insufficient Knowledge of this Scheme	
Procedures Required to Access this Scheme	
Inflexible 200K Distance Criteria of this Scheme	
The Need for a Cash Outlay Before Reimbursement	

3.1. (Ctd.) Please rate according to the preceding scale.

ACCOMMODATION:

Insufficient Nursing Home Care

Terminal Care: Hospices

Special Accommodation

Private Hospitals

Family Relief Beds

Hostels

Insufficient Suitable Accommodation in or near Treatment Centre for Patients

Insufficient Suitable Accommodation in or near Treatment Centre for Visiting Relatives.

LEGAL SERVICES:

Insufficient Low Cost Legal Assistance and Advice

* e.g. Workers' Compensation, Occupational Health Rights, Wills, Hire Purchase Contracts, etc.

INFORMATION / EDUCATION:

Insufficient Information on Resources Available to Persons Suffering from Cancer and their Families

Insufficient Information on the Rights of Persons Suffering from Cancer and their Families in Respect of Service Provision

Insufficient Information about Cancer Treatments and Management

EMPLOYMENT:

Insufficient Employment Advice & Counselling

* e.g. Negotiating Flexible Hours, Timing of Employment Termination, Exploring Other Options.

FINANCIAL ADVICE:

Insufficient Financial Counselling and Advice

* e.g. Investment, Adjustment to a Sudden Loss of Income, Long Term Financial Commitments.

* Examples are given as suggestions only. Please do not rate the problems exclusively on the basis of the examples given. You may have quite different issues in mind as you rate each question.

3.1. (Ctd.) Please rate according to the preceding scale.

STATUTORY BENEFITS:

Lack of Flexibility with Regard to Sickness Benefits

Lack of Flexibility with Regard to Invalid Pensions

Lack of Flexibility with Regard to Domicilary Nursing Care Benefits.

HEALTH INSURANCE:

Difficulties with regard to Health Insurance
*e.g. Confusing Policies, Cost of Health Insurance, Hidden Costs to Privately Insured Patients.

DOMICILIARY AND COMMUNITY SERVICES:

Insufficient Home Help Services

Meals on Wheels

Visiting Nursing Services

Family Relief, e.g. Day Sitters, Night Sitters

Child Care Services

Physiotherapy

Occupational or Diversional Therapy

Personal and Household Aids

Handyman Service

Weekend Nursing Services

Day Centre Facilities

Support Groups/Networks

COUNSELLING SERVICES:

Inadequate Counselling Services Available to Persons Suffering from Cancer and/or their Families
*e.g. Anticipatory Grief, Bereavement, Pain Control by Non-Medical Means, Stigma, Stress, Sexuality, etc.

Inadequate Patient Support/Counselling

Inadequate Family Support/Counselling

Insufficient Opportunity for Group Support/Counselling

Insufficient Recognition of Spiritual Needs

* Note: Examples are given as suggestions only. Please do not rate the problem exclusively on the basis of the examples given. You may have quite different issues in mind as you rate each question.

Q.4. GAPS IN WELFARE SERVICES AVAILABLE IN VICTORIA TO PERSONS SUFFERING FROM CANCER:

This section lists persons suffering from cancer in identifiable groups. These groups may or may not be disadvantaged with regard to resources within your region.

4.1. Would you please rate the adequacy of resources as you perceive them to be for each of these groups of people suffering from cancer according to the following scale:

0	Can't Answer
1	Adequately Catered For
2	Minor Shortage of Resources
3	Serious Shortage of Resources
4	Very Serious Shortage of Resources

Please place the appropriate rating number in the box provided.

LIFE STAGE:	
Children	
Adolescents	
Young Families	
Single Isolated Patients	
Middle Age Group	
Elderly	

SPECIAL GROUPS:	
Privately Insured Patients	
Country Patients	
Patients with Rare Cancers	
Patients with Obvious Visible Physical Disfigurement or Disability	
Patients and Families Receiving Attention from a Number of Different Agencies	
People with a Non-Anglo-Saxon Background	

Q.4.1. (Ctd) Please rate each group according to the preceding scale.

TYPE OF CANCER - MALES:

LUNG

PROSTATE

COLON

STOMACH

PANCREAS

LYMPHOMAS

RECTUM AND R.S. JUNCTION

BLADDER

LEUKAEMIAS

BRAIN

MELANOMA - SKIN

OESOPHAGUS

TYPE OF CANCER - FEMALE:

BREAST

COLON

LUNG

STOMACH

OVARY

PANCREAS

LYMPHOMAS

RECTUM AND R.S. JUNCTION

CERVIX (INV)

BRAIN

CORPUS UTERI

MELANOMA - SKIN