Government of Western Australia
Mental Health Commission

Mental Health Commission

# Western Australia Mental Health Non-Government Organisation Establishment

## In-Brief

## 2014/15

Information Development
Performance Monitoring & Evaluation Directorate
Mental Health Commission

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Mental Health Commission

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Our vision, is to build a Western Australian mental health, alcohol and other drug service system that: prevents and reduces mental health problems, suicide and suicide attempts; prevents and reduces the adverse impacts of alcohol and other drugs; promotes positive mental health; and enables everyone to work together to encourage and support people who experience mental health, alcohol and other drug problems to stay in the community, out of hospital and live a satisfying, hopeful and contributing life.

# CONTENTS

# 1 ACKNOWLEDGEMENTS

We would like to acknowledge the members of the WA Mental Health NGO Information Development Technical Working Group whose valued contribution to the development of the web based collection instrument enabled the system to go a long way to meeting the goals of both the Mental Health Commission and the mental health NGO sector.

We would also like to acknowledge the staff at WebSurvey who provided outstanding work to help implement a system that met the needs of the Mental Health Commission and of the system end-users.

Our gratitude is also given to the contract managers at the Mental Health Commission whose contribution to both the development of the collection instrument and preparation of the report was extremely valuable.

Finally and most importantly, we would like to thank all the non-government agencies themselves who provide the data that underlies this report. We hope that this feedback is useful.

Performance, Monitoring and Evaluation
Mental Health Commission
February 2016

# 2 EXECUTIVE SUMMARY

The contribution made by Western Australia's non-government organisations (NGO) in providing mental health-related services has increased significantly over the past 10-years. Traditionally the reporting of this contribution has been limited to very high level summary expenditure information. A report describing the activity and characteristics of the services delivered by the NGO sector in WA, using data sourced from the Western Australian Non-Government Organisation Establishment State Data Collection for the 2013/14 year was published on the Mental Health Commission's website in May 2015. This is the second edition of the report and includes data for the 2014/15 year, with some comparisons with 2013/14 also included. In this report some service types have been broken down into more detailed cohorts to enable a greater understanding of the different types of activity delivered.

The objective of this report is to describe the activity and characteristics of the services delivered by the non-government sector in Western Australia. This can then be utilised by the Mental Health Commission to better inform policy, practice and planning of mental health services for the state. NGOs can also utilise this information to better understand how their service performs in comparison across each service type within the sector.

The mental health services being delivered by the non-government sector can be categorised into either direct care or population based largely depending upon the target population. Direct care services can be further categorised as community treatment, community support or community bed-based services.

In 2014/15, across both direct care and population based services there was a total of 1,013 full-time-equivalent staff engaged by the 81 Mental Health Commission funded NGOs in Western Australia. Of these staff, 967 FTE were paid and 46 unpaid/volunteer, with 795 FTE directly involved in service delivery.

There were 20,825(1) clients reported as receiving direct care services with over 340,000 hours of service provided through community treatment and community support(2). From the community beds supported through Mental Health Commission funding, over 280,000 days of care were provided.

A total of $74.8 million was reported as being expended on the Mental Health Commission funded services in 2014/15. Of this $70.5 million was on direct services with the remaining $4.3 million(3) for population based services.

**Summary Table: Summary of average full-time-equivalent staff per service type and activity per service contract, by service focus, 2014/15**

| Service Focus | No. of services(a) | FTE(b) per service type | No. of contract schedules(a) | Clients(c) per contract | Service Hours per contract | Funding per contract |
|---|---|---|---|---|---|---|
| ***Direct Care*** | ***105*** | ***6.76*** | ***159*** | ***131*** | ***3,795*** | ***$443,195*** |
| Community Treatment | 12 | 1.54 | 13 | 160 | 1,163 | $233,909 |
| Community Support | 75 | 4.28 | 104 | 168 | 4,874 | $352,634 |
| Community Bed Based | 18 | 20.58 | 42 | 30 | .. | $732,220 |
| ***Population Based(3)*** | ***18*** | ***3.02*** | ***18*** | ***..*** | ***..*** | ***$241,263*** |
| **Total Average** | **123** | **6.11** | **177** | **131** | **3,795** | **$422,660** |

. . Not applicable

(a) Not an NGO count as one NGO may be funded for multiple services and have multiple schedules under each funded service.

(b) Total includes both paid and unpaid (or volunteer) staff

(c) Clients are counted multiple times where they receive more than one service or services from more than one organisation

(1) this is likely to be an over estimate as a client will be counted multiple times where they have received more than one service or services from more than one organisation

(2) Hours of service is not collected for Community bed based or Population based services.

(3) This does not include expenditure relating to Mental Health Commission funded grants

# 3 BACKGROUND

The contribution made by non-government organisations (NGOs) in providing mental health-related services to people living with a mental illness, their families, and carers has increased significantly over the past 10 years. As the information capacity of this sector is developed in line with the growing reporting requirements, at both a state and national level, it is important that the information is utilised to gauge progress against key goals.

In December 2013, the Mental Health Commission of Western Australia (the Commission) implemented a web-based data collection system to assist with the collection and analysis of mental health services provided by Western Australian NGOs. As part of the planning for the collection it was recognised that there should be a mechanism for feedback to NGOs to enable opportunities for benchmarking against each service type and/or a performance indicator set (yet to be developed). The report is not intended to make any judgements about specific organisations or services.

The first report describing the activity and characteristics of the services delivered by the NGO sector in WA, using data sourced from the Western Australian Non-Government Organisation Establishment State Data Collection (MH NGOE SDC) for the 2013/14 year was published on the Commission's website in May 2015. This is the second edition of the report and includes data for the 2014/15 year, with some comparisons with 2013/14 also included. It should be noted that 2013/14 data presented in the previous report may not match data in this report as some updates and resubmissions from organisations have occurred. Caution should also be taken when comparing data across the two periods due to continuing improvement in data reporting requirements. As more years of data are collected additional comparisons and analyses will included in this report.

## 3.1 Mental Health Non-Government Organisation Establishment State Data Collection

The MH NGOE SDC was developed to ensure alignment with the national specifications known as the Mental Health Non-Government Establishment Data Set Specifications (MH NGOE DSS) (AIHW 2014) developed by the Australian Institute of Health and Welfare and endorsed by the National Health Information Standards and Statistics Committee.

The MH NGOE SDC goal was to improve the collection of consistent information on the activity of mental health NGOs funded by the Commission and reduce the reporting burden by removing reporting duplications for State and National requirements.

Commission funded NGOs are currently required to report against the MH NGOE SDC data elements for the purpose of contract acquittal using the Mental Health Non-Government Organisation Establishment Web-Based Reporting System (NGOE System). This data provides an evidence base to better inform policy, practice and planning of NGO activities at a state level.

## 3.2 Service types

The scope of the MH NGOE SDC is Western Australian mental health-related non-government organisations which are funded by the Commission to provide services under one or more of the following service types included in the MH NGOE DSS service taxonomy (see Appendix B for detailed description):

- Counselling—face-to-face
- Counselling, support, information and referral—telephone
- Group support activities

- Mutual support and self-help
- Staffed residential services
- Personalised support—linked to housing
- Personalised support—other
- Family and carer support
- Individual advocacy
- Education, employment and training
- Sector development and representation
- Mental health promotion
- Mental illness prevention.

## 3.3 Service focus

The service types can be classified as either direct care or population based[4].

### Direct Care Services

'Direct care' is where care is provided directly to the client, their family, or their carer. Direct care services can be further broken into three sub categories in accordance with the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives. (MHC 2015).

1. Community Treatment

Community treatment provides clinical care in the community and generally operates within multidisciplinary teams and includes specialised community clinical services (the majority of which are currently delivered through the Western Australian Department of Health). Services provided to individuals are non-residential, and can be intensive, acute or ongoing and fit within the service type:

- Counselling—face-to-face

2. Community Support

Community support services provide individuals with mental health issues access to the help and support they need to participate in their community. Community support service types include:

- Group support activities
- Mutual support and self-help
- Personalised support—linked to housing
- Personalised support—other
- Family and carer support
- Individual advocacy
- Education, employment and training

3. Community Bed Based

Community bed based services are focused on providing recovery oriented services in a residential style setting and include the service type:

- Staffed residential services

(4) Caution should be used when comparing data reported by service focus to other reports due to the fluidity of the service categorisation and contracting (i.e. a service type or service contract may be reclassified into a different service focus through greater awareness of the service being delivered).

## Population Based Services

Population based mental health services are "*actions that are applied either to collectives (e.g. mass health education, promotion) or to the non-human components of the environment*"[(5)] (Murray & Frenk 2000). Population based services align with the “Prevention” service stream in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives. (MHC 2015).

There are a broad range of prevention and early intervention strategies. Some prevention strategies target the whole population - for example, mass-media campaigns. By their nature, these interventions are a one size fits all type, with no allowance for targeting specific populations. While these programs are usually expensive, they are quite economic when calculated on a cost-per-person basis. Service types that fit this service focus are:

- Counselling, support, information and referral—telephone[(6)]
- Sector development and representation
- Mental health promotion
- Mental illness prevention.

(5) An example of a non-human component of the environment would be a structure/barrier erected to prevent suicide from a public building or bridge.
(6) While this service does have a direct care element, it is classified as population based due to the target being the whole population.

# 4 DIRECT CARE SERVICES

## 4.1 Community Treatment Services

In 2014/15, there were 12 NGOs providing 13 contract schedules for Community Treatment services (see Appendix A for summary of all service types).

### Counselling—face-to-face

Workforce

In 2014/15 each counselling—face-to-face funded service had 1.54 FTE on average, including approximately 51 hours of volunteer service. These figures were slightly below the averages for 2013/14.

**Table 1: Average workforce reported for Counselling—face-to-face funded services**

| | Average FTE[(a)b)] | Average Paid FTE | Average Volunteer hours | Average Peer FTE |
|---|---|---|---|---|
| 2013/14 | 1.69 | 1.67 | 52 | 0.00 |
| 2014/15 | 1.54 | 1.51 | 50 | 0.00 |

(a) Workforce includes both paid and unpaid (or volunteer) staff
(b) Total FTE calculated by adding Paid FTE and Volunteer FTE (based on 40 hr week)

Activity

On average during 2014/15 each *counselling—face-to-face* funded service had 160 clients and provided almost 1,100 hours of service of individual—and 87 hours of group—counselling sessions. Assuming all clients participated in both individual and group sessions, this equates to around 7 individual sessions per client and approximately 5 clients per group. On average an individual session is approximately one hour in length, while each group session takes almost 3 hours.

**Table 2: Average activity reported for Counselling—face-to-face funded services**

| | Average No. of Clients | Average No. of Individual Sessions | Average No. of Individual Session Hours | Average No. of Group Sessions | Average No. of Group Session Hours |
|---|---|---|---|---|---|
| 2013/14 | 166 | 1,111 | 999 | 36 | 91 |
| 2014/15 | 160 | 1,082 | 1,076 | 30 | 87 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.

As a proportion of total FTE, on average in 2014/15, 36% of staff time is directly associated with counselling sessions (increase from 31% in 2013/14). On average, each FTE counselled 104 clients and carried out 705 individual sessions in 2014/15.

Service costs

In 2014/15, for each *counselling-face-to-face funded service* $233,909 was provided, which equated to $1,461 per client or $201 per service hour.

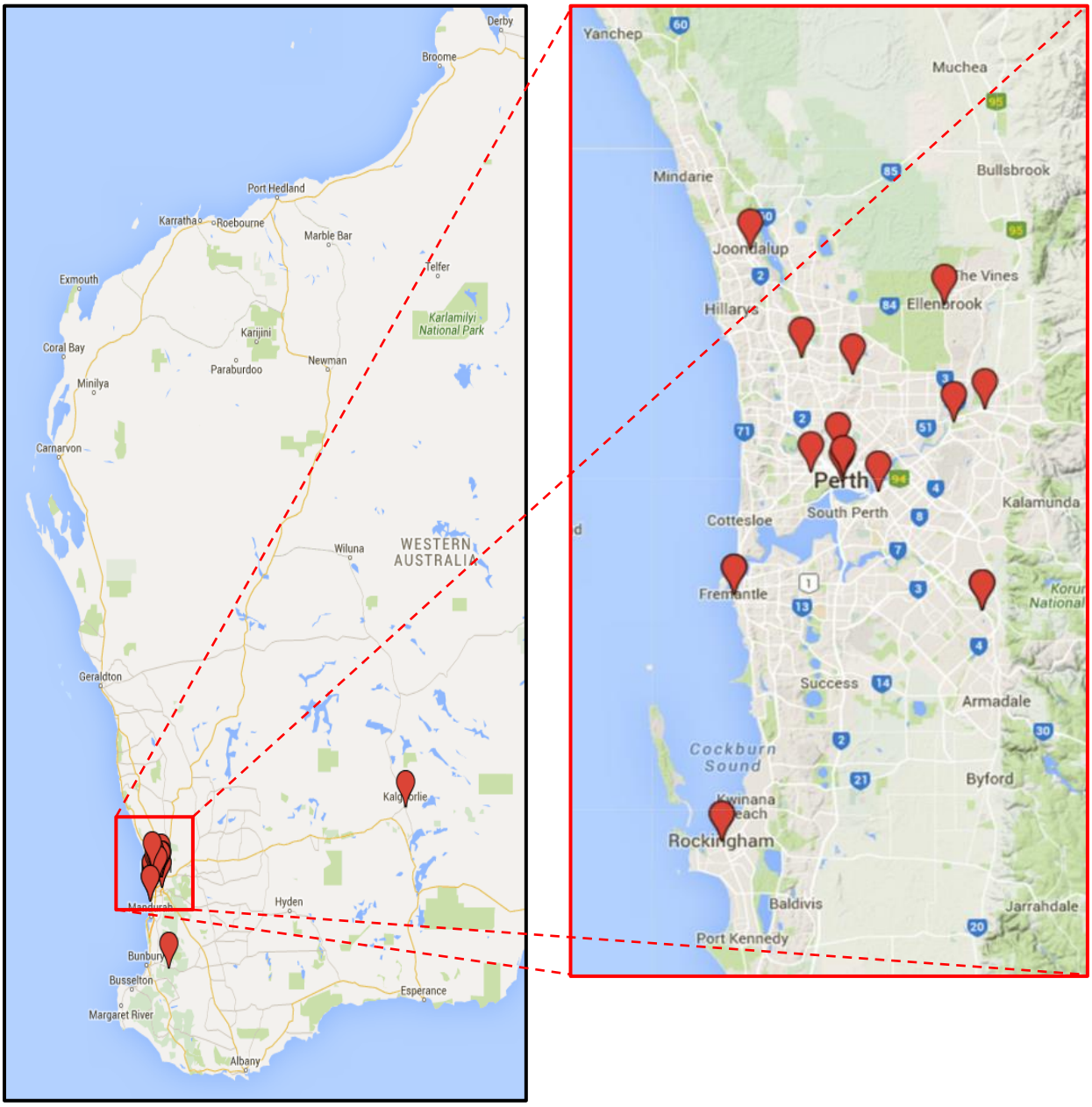
**Table 3: Average funding provided for Counselling—face-to-face funded services**

| | Average funding[(a)] | Average funding per client | Average funding per service hour |
|---|---|---|---|
| 2013/14 | $197,046 | $1,185 | $181 |
| 2014/15 | $233,909 | $1,461 | $201 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements.

Locations

**Figure 1. Counselling – face-to-face funded service locations**




Note: The location is based on the suburb of where staff providing the particular service are based as reported by organisations. It does not necessarily reflect catchment area or where the service is provided from. It should also be noted that duplicates within a service type have been removed (i.e. the mark does not indicate number of times where this service type is being provided in the same location)

## 4.2 Community Support Services

### Summary of Community Support Services

In 2014/15, there were 47 NGOs delivering Community Support services. These NGOs were contracted to provide 75 services and 104 contract schedules (see Appendix A for summary of all service types).

Workforce

In 2014/15, on average across all service types under the Community Support service stream, each organisation reported 4.28 FTE, included approximately 751 volunteer hours. Both of these figures were increases from 2013/14.

**Table 4: Summary of average workforce reported for Community Support service stream**

| | Average FTE[(a)(b)] | Average Paid FTE | Average Volunteer hours | Average Peer FTE |
|---|---|---|---|---|
| 2013/14 | 4.07 | 3.73 | 726 | 0.36 |
| 2014/15 | 4.28 | 3.92 | 750 | 0.31 |

(a) Workforce includes both paid and unpaid (or volunteer) staff
(b) Total FTE calculated by adding Paid FTE and Volunteer FTE (based on 40 hr week)

Activity

In 2014/15 each organisation under the Community Support service stream saw 168 patients on average and delivered 2,903 individual – and 411 group – sessions each. On average each client had 14 individual sessions, each lasting 74 minutes and there were 17 attendances per group session.

**Table 5: Summary of average activity reported for funded services under Community Support service stream[(a)]**

| | Average No. of Clients | Average No. of Individual Sessions | Average No. of Individual Session Hours | Average No. of Group Sessions | Average No. of Group Session Hours | Average No. of Attendances | Average No. of Calls |
|---|---|---|---|---|---|---|---|
| 2013/14 | 164 | 2,458 | 3,404 | 768 | 3,358 | 4,518 | 591 |
| 2014/15 | 168 | 2,355 | 2,903 | 411 | 1,971 | 2,826 | 566 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) One organisation has been excluded from all columns except for 'Average no. of clients' due to data quality issues.

Service costs

In 2014/15, on average each organisation in the Community Support service stream received $352,762 in funding, which equated to $2,097 per client and $73 per service hour.

**Table 6: Summary of average funding provided to services under Community Support service stream**

| | Average funding[(a)] | Average funding per client | Average funding per service hour[(b)] |
|---|---|---|---|
| 2013/14 | $379,027 | $2,308 | $56 |
| 2014/15 | $352,634 | $2,096 | $73 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements.
(b) One organisation has been excluded from the average funding per service hour due to data quality issues.

## Group support

### Workforce

In 2014/15 each *group support* funded service had 3.05 FTE on average, including approximately 463 hours of volunteer service. Compared with 2013/14, the average paid FTE was lower however the average volunteer hours were considerably higher.

**Table 7: Average workforce reported for Group support funded services**

| | Average FTE[(b)(c)] | Average Paid FTE | Average Volunteer hours | Average Peer FTE |
|---|---|---|---|---|
| 2013/14 | 4.09 | 4.03 | 131 | 0.10 |
| 2014/15 | 3.05 | 2.83 | 463 | 0.11 |

(a) Workforce includes both paid and unpaid (or volunteer) staff
(b) Total FTE calculated by adding Paid FTE and Volunteer FTE (based on 40 hr week)

### Activity

Each *group support* funded service had 158 clients, on average, during 2014/15 and conducted 1,660 hours of group sessions. On average there were 7 people in attendance per group session, lasting over 3 ½ hours. Assuming clients participated equally in group sessions, this equates to each client attending 21 sessions in 2014/15. Based on this each service would be providing each client with approximately 77 hours of support in group sessions.

It should be noted that additional services were funded in 2014/15 for *group support* activities which had lower funding and lower activity numbers than other services in this service type. This has resulted in the overall averages reported in both the activity table below and the service costs table on the following page decreasing significantly from 2013/14.

Activity for *group support activities* is predominately based on group sessions, however, it has been identified that a component is provided though individual sessions for some service providers. This information was identified separately in the NGOE system for the first time in 2014/15. On average, each client received 11 individual sessions, each lasting just over half an hour.

**Table 8: Average activity reported for Group support funded services**

| | Average No. of Clients | Average No. of Individual Sessions | Average No. of Individual Session Hours | Average No. of Group Sessions | Average No. of Group Session Hours | Average No. of Attendances |
|---|---|---|---|---|---|---|
| 2013/14 | 261 | N/A | N/A | 924 | 2,424 | 4,828 |
| 2014/15 | 158 | 1,803 | 1,140 | 450 | 1,660 | 3,297 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.

As a proportion of total FTE, on average 44% of staff time in 2014/15 was directly related to facilitating sessions (increase from 28% in 2013/14). On average each FTE interacted with approximately 52 clients and undertook 738 sessions in 2014/15.

## Service costs

In 2014/15, on average $234,487 in funding was provided to each *group support* funded service, which equated to $1,485 per client and $84 per hour.

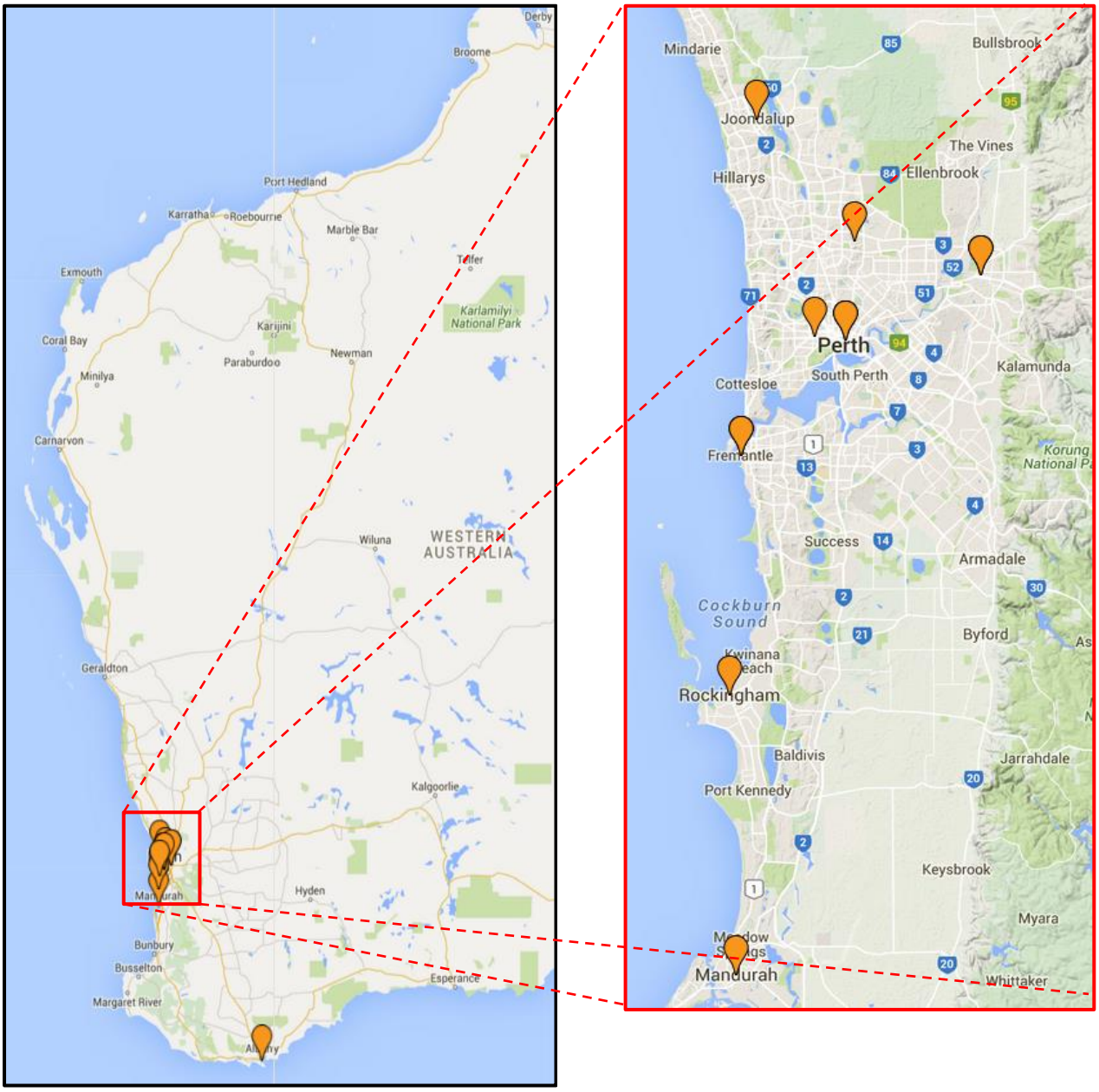
**Table 9: Average funding provided for Group support funded services[(a)]**

| | Average funding[(a)(b)] | Average funding per client | Average funding per service hour |
|---|---|---|---|
| 2013/14 | $462,067 | $1,774 | $191 |
| 2014/15 | $234,487 | $1,485 | $84 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements.

Locations

**Figure 2. Group support funded service locations**




Note: The location is based on the suburb of where staff providing the particular service are based as reported by organisations. It does not necessarily reflect catchment area or where the service is provided from. It should also be noted that duplicates within a service type have been removed (i.e. the mark does not indicate number of times where this same service type is being provided in the same location)

## Mutual support & self-help

### Workforce

In 2014/15 each *Mutual support and self-help* funded service had 4.25 FTE on average, including approximately 3,969 hours of volunteer service. The increase in total average FTE from 2013/14 was due to an increase in volunteer hours.

**Table 10: Average workforce reported for Mutual support and self-help funded services**

| | Average FTE[(a)(b)] | Average Paid FTE | Average Volunteer hours | Average Peer FTE |
|---|---|---|---|---|
| 2013/14 | 3.98 | 2.36 | 3,358 | 0.46 |
| 2014/15 | 4.25 | 2.34 | 3,969 | 0.61 |

(a) Workforce includes both paid and unpaid (or volunteer) staff
(b) Total FTE calculated by adding Paid FTE and Volunteer FTE (based on 40 hr week)

### Activity

There were, on average, 504 clients seen by each *mutual support and self-help* funded service during 2014/15 and over 2,700 hours of group session service. There were seven people in attendance per session and each group session lasted, on average, over 8 hours[7]. Assuming clients participated equally in group sessions, this equates to each client attending almost 5 sessions in 2014/15. Based on this, each service would be providing each client approximately 37 hours of support in group sessions.

Activity for *mutual support and self-help activities* is predominately based on group sessions, however, it has been identified that a component is provided though individual sessions for some service providers. This information was identified separately in the NGOE system for the first time in 2014/15. On average, each service delivered 184 individual sessions, each lasting approximately 50 minutes.

**Table 11: Average activity reported for Mutual support and self-help funded services**

| | Average No. of Clients | Average No. of Individual Sessions | Average No. of Individual Session Hours | Average No. of Group Sessions | Average No. of Group Session Hours | Average No. of Attendances | Average. No of calls |
|---|---|---|---|---|---|---|---|
| 2013/14 | 469 | n/a | n/a | 561 | 4,602 | 4,104 | 591 |
| 2014/15 | 504 | 184 | 150 | 364 | 2,731 | 2,482 | 566 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
n/a not available

As a proportion of total FTE, on average 33% of staff time is directly related to facilitating sessions (decrease from 56% in 2013/14). On average each FTE interacted with approximately 119 clients and undertook 129 sessions in 2014/15.

(7) This length can be attributed to a 'retreat' type group session where the attendees are invited to stay for a number of days

Service costs

In 2014/15, on average $257,880 in funding was provided to each *mutual support and self-help* funded service. This equated to $512 in funding per client and $90 per service hour.

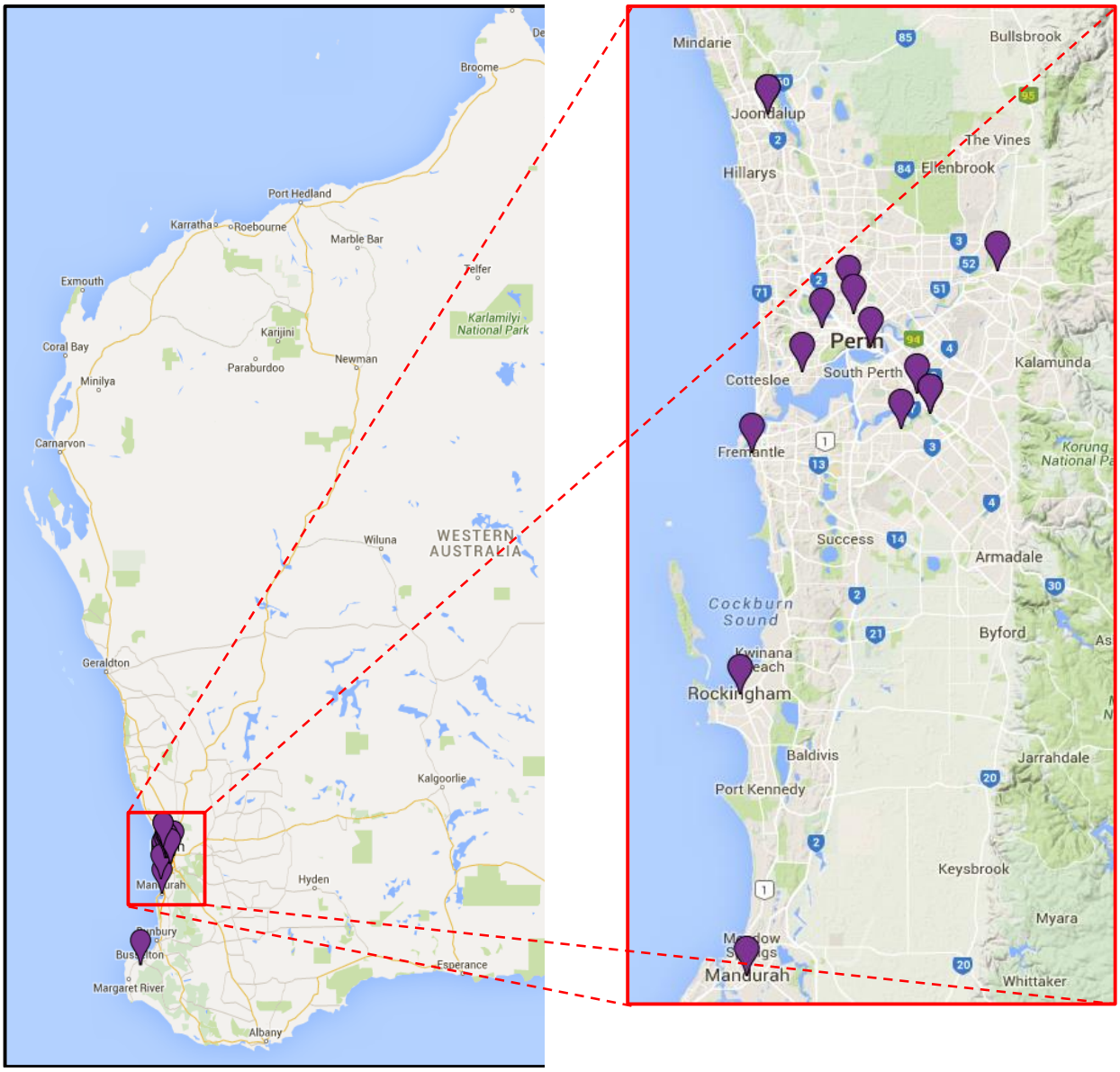
**Table 12: Average funding provided for Mutual support and self-help funded services**

| | Average funding[(a)] | Average funding per client | Average funding per service hour |
|---|---|---|---|
| 2013/14 | $335,000 | $714 | $73 |
| 2014/15 | $257,880 | $512 | $90 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements.

Locations

**Figure 3. Mutual support and self-help funded service locations**




Note: The location is based on the suburb of where staff providing the particular service are based as reported by organisations. It does not necessarily reflect catchment area or where the service is provided from. It should also be noted that duplicates within a service type have been removed (i.e. the mark does not indicate number of times where this service type is being provided in the same location)

## Personalised support—linked to housing

### Workforce

In 2014/15 each *Personalised support – linked to housing* funded service had 4.94 FTE on average, including approximately 1,227 hours of volunteer service. Both were increases from 2013/14.

**Table 13: Average workforce reported for Personalised support – linked to housing funded services**

| | Average FTE[(a)(b)(c)] | Average Paid FTE | Average Volunteer hours | Average Peer FTE |
|---|---|---|---|---|
| 2013/14 | 4.29 | 3.95 | 716 | 0.10 |
| 2014/15 | 4.94 | 4.35 | 1,227 | 0.20 |

(a) Workforce includes both paid and unpaid (or volunteer) staff
(b) Total FTE calculated by adding Paid FTE and Volunteer FTE (based on 40 hr week)
(c) Includes Individualised Community Living Strategy FTE as this cannot be separately identified

### Activity

In 2014/15, on average, each *personalised support—linked to housing* service managed 44 dwellings, provided support to 49 clients and 1,107 hours of service. This suggests that each client received almost 22 hours of personalised service. On average each service provided each client over 16 contacts with each contact about 1 ½ hours in duration.

**Table 14: Average activity reported for Personalised support – linked to housing[(a)] funded services**

| | Average No. of Clients | Average No. of Contacts | Average No. of Contact Hours | Average. No of dwellings |
|---|---|---|---|---|
| 2013/14 | 66 | 702 | 1,449 | 61 |
| 2014/15 | 49 | 804 | 1,107 | 44 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Excludes services delivering the Individualised Community Living Strategy

Activity and funding related to service funded under the Individualised Community Living Strategy (ICLS) have been reported separately due to the differences in the model of care and the cohort treated compared with other *personalised support – linked to housing* services.

On average each ICLS service managed 12 clients and provided 7,411 hours of service. This suggests that each client received 622 hours of service, or 385 contacts on average, with each contact lasting over 1 ½ hours. This higher level of activity is to be expected given the intensive nature of the personalised program designed for each client.

**Table 15: Average activity reported for Personalised support – linked to housing - ICLS funded services**

| | Average No. of Clients | Average No. of Contacts | Average No. of Contact Hours |
|---|---|---|---|
| 2013/14 | 10 | 4,815 | 7,311 |
| 2014/15 | 12 | 4,590 | 7,411 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.

Service costs

For each *personalised support – linked to housing funded service* (excluding ICLS services) in 2014/15, on average $150,587 in funding was provided, which equated to approximately $3,047 per client or $136 per service hour.

**Table 16: Average funding provided for Personalised support – linked to housing[(a)] funded services**

| | Average funding[(b)] | Average funding per client | Average funding per service hour |
|---|---|---|---|
| 2013/14 | $156,187 | $2,356 | $108 |
| 2014/15 | $150,587 | $3,047 | $136 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Excludes services delivering the Individualised Community Living Strategy.
(b) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements.

Funding for each service delivering the ICLS was comparatively higher, at $672,043 per service and $56,365 per client in 2014/15. A package of care delivered through the ICLS is tailored to individual requirements and funded according to the specific requirements of the Individual's Plan. The package may include direct services provided by the non-government organisation, services brokered from a third party and access to community based activities.

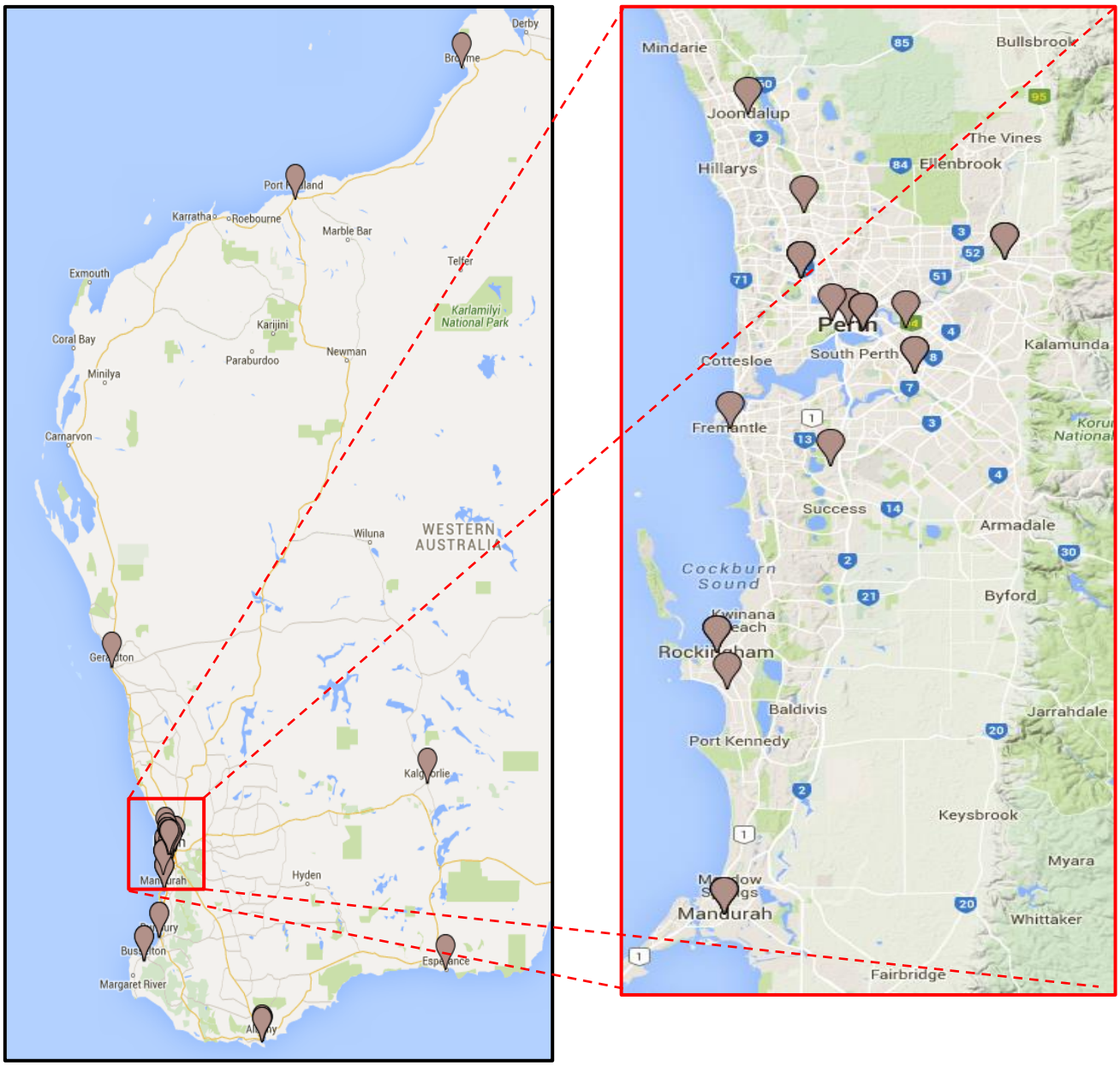
**Table 17: Average funding provided for Personalised support – linked to housing – ICLS funded services**

| | Average funding[(a)] | Average funding per client | Average funding per service hour |
|---|---|---|---|
| 2013/14 | $675,031 | $64,525 | $92 |
| 2014/15 | $672,043 | $56,365 | $91 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements

Locations

**Figure 4. Personalised support – linked to housing funded service locations**




Note: The location is based on the suburb of where staff providing the particular service are based as reported by organisations. It does not necessarily reflect catchment area or where the service is provided from. It should also be noted that duplicates within a service type have been removed (i.e. the mark does not indicate number of times where this service type is being provided in the same location)

## Personalised support—other

### Workforce

In 2014/15 each *Personalised support - other* funded service had 4.99 FTE on average, including approximately 269 hours of volunteer service. The average Paid FTE increased from 2013/14 however volunteer hours were considerably lower.

**Table 18: Average workforce reported for Personalised support - other funded services**

| | Average FTE[(a)(b)] | Average Paid FTE | Average Volunteer hours | Average Peer FTE |
|---|---|---|---|---|
| 2013/14 | 4.96 | 4.47 | 1,012 | 0.65 |
| 2014/15 | 4.99 | 4.86 | 269 | 0.44 |

(a) Workforce includes both paid and unpaid (or volunteer) staff
(b) Total FTE calculated by adding Paid FTE and Volunteer FTE (based on 40 hr week)

### Activity

In 2014/15 each *personalised support—other* service provided, on average, support to 131 clients and 4,418 hours of service. This suggests that each client received almost 34 hours of personalised service. On average each service provided each client 31 contacts with each contact just over an hour in duration.

**Table 19: Average activity reported for Personalised support - other funded services**

| | Average No. of Clients | Average No. of Contacts | Average No. of Contact Hours |
|---|---|---|---|
| 2013/14 | 146 | 3,367 | 4,107 |
| 2014/15 | 131 | 4,011 | 4,418 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.

As a proportion of total FTE, on average 43% of staff time is directly related to client contact. On average each FTE interacted with approximately 26 clients and undertook 886 hours of support in 2014/15.

### Service costs

In 2014/15, each *personalised support – other* funded service received $462,951 on average, equating to $3,531 per client and $105 per service hour.

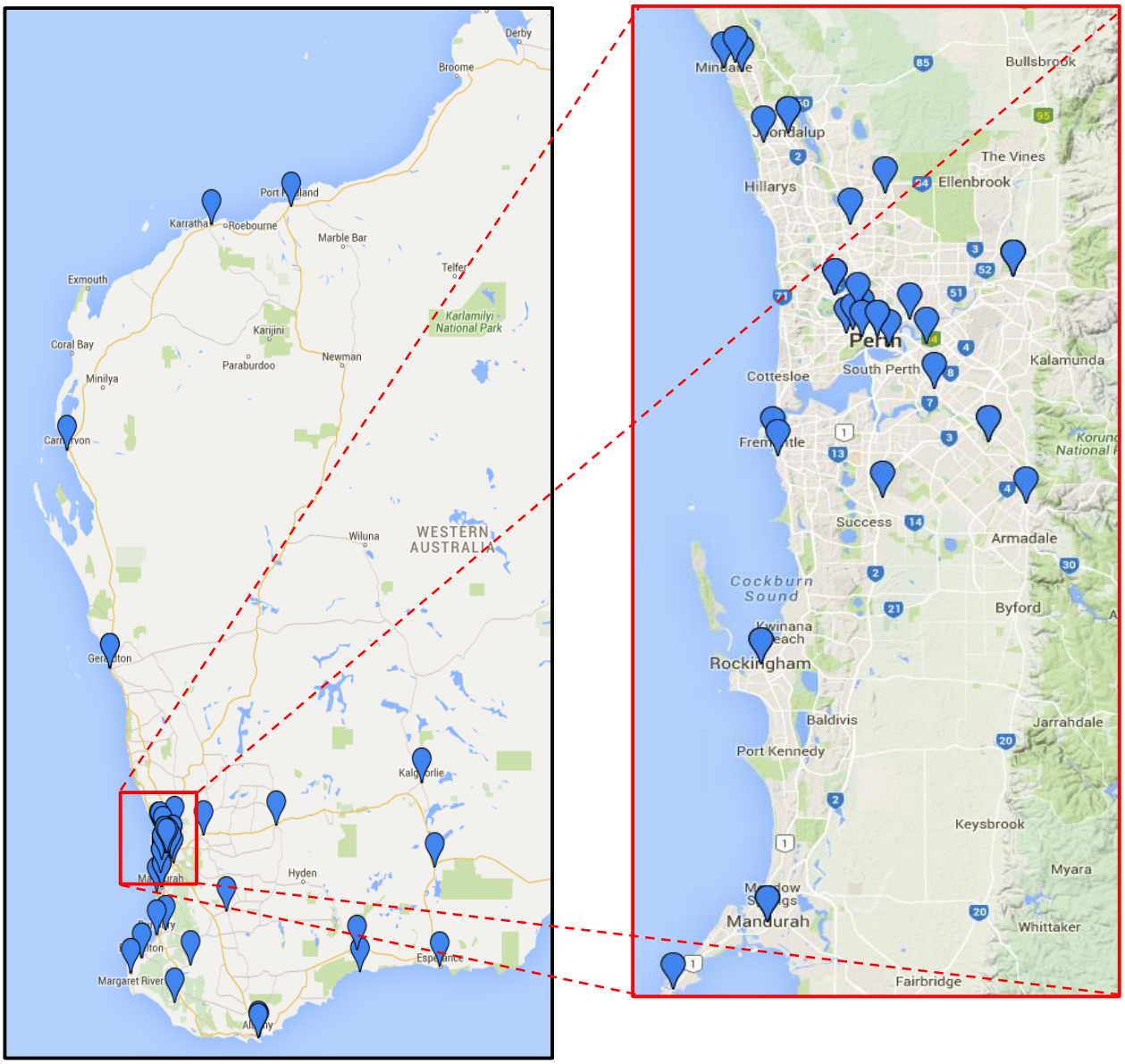
**Table 20: Average funding provided for Personalised support - other funded services**

| | Average funding[(a)] | Average funding per client | Average funding per service hour |
|---|---|---|---|
| 2013/14 | $428,834 | $2,937 | $104 |
| 2014/15 | $462,951 | $3,531 | $105 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements.

Locations

**Figure 5. Personalised support - other funded service locations**




Note: The location is based on the suburb of where staff providing the particular service are based as reported by organisations. It does not necessarily reflect catchment area or where the service is provided from. It should also be noted that duplicates within a service type have been removed (i.e. the mark does not indicate number of times where this service type is being provided in the same location)

## Family & carer support

### Workforce

In 2014/15 each *family & carer support* funded service had 3.20 FTE on average, including approximately 239 hours of volunteer service. Both were increases from 2013/14 averages.

**Table 21: Average workforce reported for Family & carer support funded services**

| | Average FTE[(a)(b)] | Average Paid FTE | Average Volunteer hours | Average Peer FTE |
|---|---|---|---|---|
| 2013/14 | 2.90 | 2.87 | 77 | 0.41 |
| 2014/15 | 3.20 | 3.09 | 239 | 0.38 |

(a) Workforce includes both paid and unpaid (or volunteer) staff
(b) Total FTE calculated by adding Paid FTE and Volunteer FTE (based on 40 hr week)

### Activity

In 2014/15 each *family and carer support* service had an average of 333 clients and provided 1,460 hours of support. This suggests that each client received over 4 hours of support. On average each service provided each client almost 4 contacts with each contact about $1^1/_4$ hours in duration.

**Table 22: Average activity reported for Family & Carer support funded services**

| | Average No. of Clients | Average No. of Contacts | Average No. of Contact Hours |
|---|---|---|---|
| 2013/14 | 274 | 1,111 | 1,539 |
| 2014/15 | 333 | 1,229 | 1,460 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.

As a proportion of total FTE, on average 22% of staff time is directly related to client contact. On average each FTE interacted with approximately 104 clients and undertook 456 hours of support in 2014/15.

### Service costs

In 2014/15, on average each *family & carer support* funded service received $292,887 in funding. This represented $881 in funding per client and $201 for each service hour.

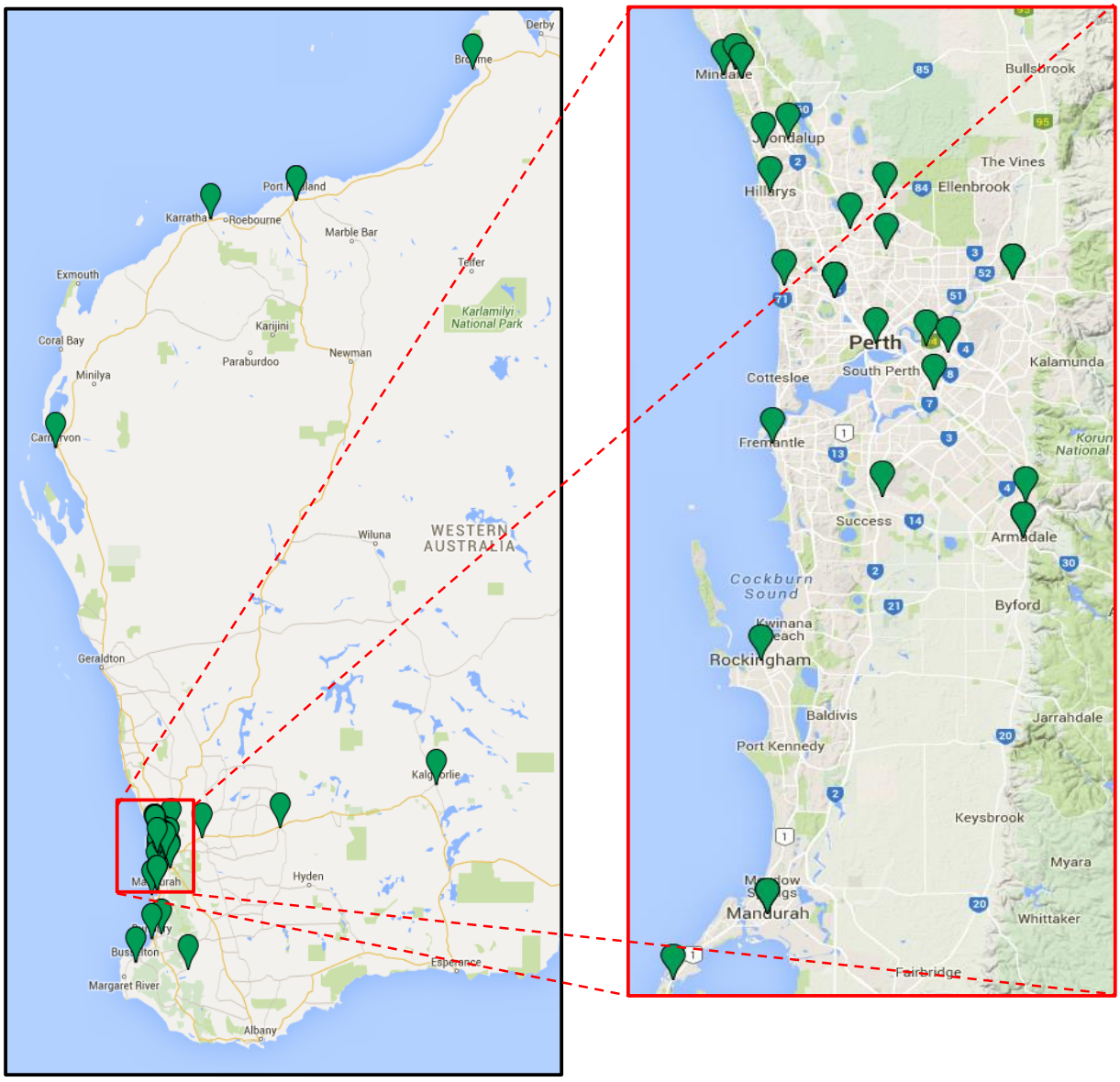
**Table 23: Average funding provided for Family & carer support funded services**

| | Average funding[(a)] | Average funding per client | Average funding per service hour |
|---|---|---|---|
| 2013/14 | $301,383 | $1,098 | $196 |
| 2014/15 | $292,887 | $881 | $201 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements.

Locations

**Figure 6. Family & carer support funded service locations**




Note: The location is based on the suburb of where staff providing the particular service are based as reported by organisations. It does not necessarily reflect catchment area or where the service is provided from. It should also be noted that duplicates within a service type have been removed (i.e. the mark does not indicate number of times where this service type is being provided in the same location)

## Individual advocacy

### Workforce

In 2014/15 each *individual advocacy* funded service had 2.55 FTE on average, including approximately 133 hours of volunteer service. This compares with 2013/14 where no volunteer hours were reported.

**Table 24: Average workforce reported for Individual advocacy funded services**

| | Average FTE[(a)(b)] | Average Paid FTE | Average Volunteer hours | Average Peer FTE |
|---|---|---|---|---|
| 2013/14 | 2.00 | 2.00 | 0 | 0.40 |
| 2014/15 | 2.55 | 2.48 | 133 | 0.03 |

(a) Workforce includes both paid and unpaid (or volunteer) staff
(b) Total FTE calculated by adding Paid FTE and Volunteer FTE (based on 40 hr week)

### Activity

In 2014/15 each *individual advocacy* service provided, on average, 184 clients with 2,281 hours of support. This suggests that each client received over 12 hours of support. On average each service provided each client 8 contacts with each contact 1 ½ hours in duration.

**Table 25: Average activity reported for Individual advocacy funded services**

| | Average No. of Clients | Average No. of Contacts | Average No. of Contact Hours |
|---|---|---|---|
| 2013/14 | 214 | 1,709 | 2,483 |
| 2014/15 | 184 | 1,490 | 2,281 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.

As a proportion of total FTE, on average 43% of staff time is directly related to client contact. On average each FTE interacted with approximately 72 clients and undertook almost 900 hours of support in 2014/15.

### Service costs

For each *individual advocacy* funded service in 2014/15, $274,631 in funding was provided. This represented $1,493 per client and $120 per service hour.

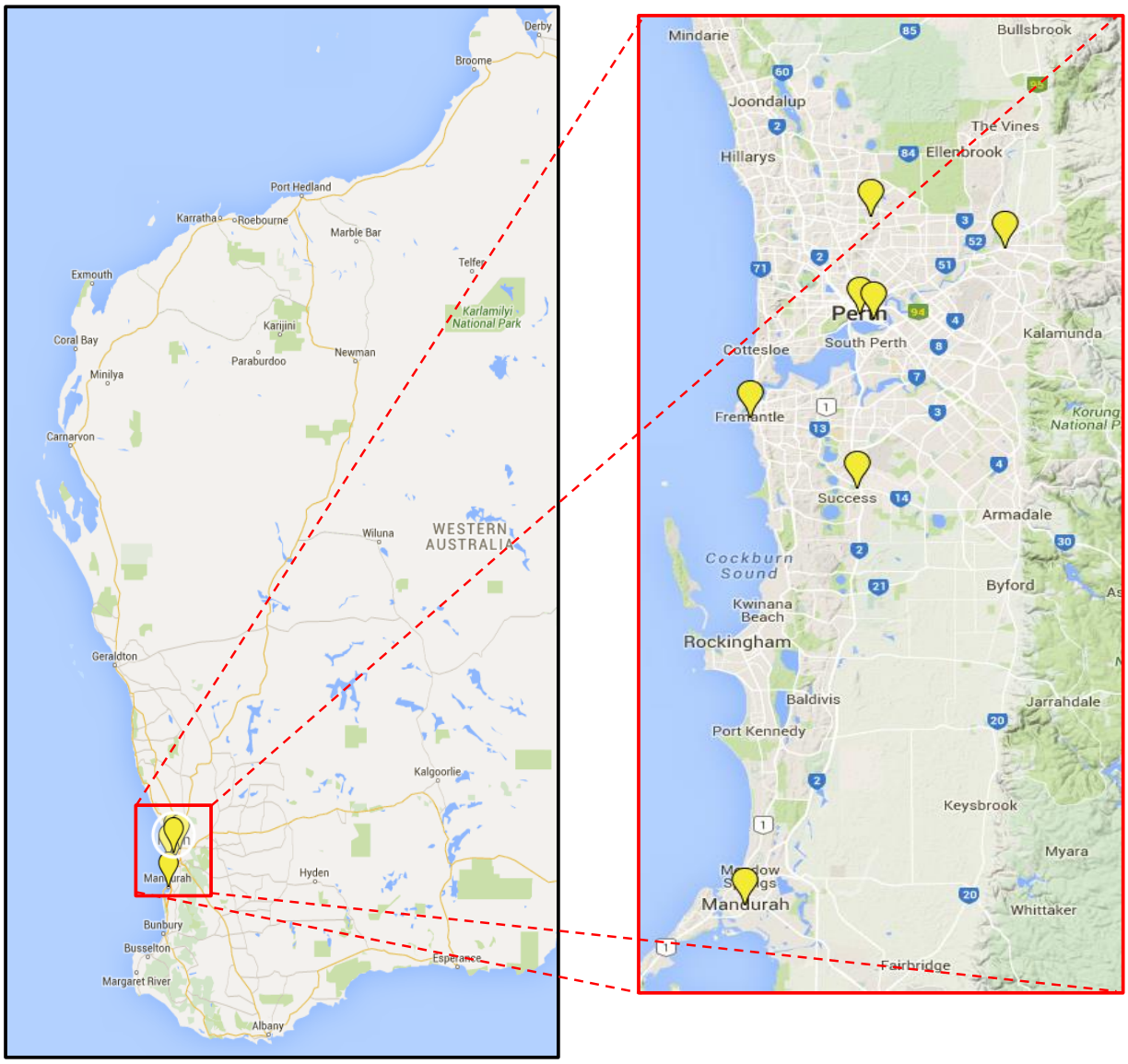
**Table 26: Average funding provided for Individual advocacy funded services**

| | Average funding[(a)] | Average funding per client | Average funding per service hour |
|---|---|---|---|
| 2013/14 | $258,158 | $1,206 | $104 |
| 2014/15 | $274,631 | $1,493 | $120 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements.

Locations

**Figure 7. Individual advocacy funded service locations**




Note: The location is based on the suburb of where staff providing the particular service are based as reported by organisations. It does not necessarily reflect catchment area or where the service is provided from. It should also be noted that duplicates within a service type have been removed (i.e. the mark does not indicate number of times where this service type is being provided in the same location)

## Education, employment & training

### Workforce

In 2014/15 each *education, employment and training* funded service had 2.45 FTE on average, including approximately 110 hours of volunteer service. These results were slightly higher than the 2013/14 averages.

**Table 27: Average workforce reported for Education, employment and training funded services**

| | Average FTE[(a)(b)] | Average Paid FTE | Average Volunteer hours | Average Peer FTE |
|---|---|---|---|---|
| 2013/14 | 2.35 | 2.30 | 100 | 0.00 |
| 2014/15 | 2.45 | 2.40 | 110 | 0.00 |

(a) Workforce includes both paid and unpaid (or volunteer) staff
(b) Total FTE calculated by adding Paid FTE and Volunteer FTE (based on 40 hr week)

### Activity

*Please note that issues relating to the definition and counting of activity by organisations providing this service type are still being investigated and therefore the below analysis should be interpreted with caution.*

In 2014/15 each *education, employment, and training* service provided services to 65 clients on average. This was a considerable decrease from 2013/14 due to a change in the model of service for one organisation.

Activity education, employment, and training is predominately based on individual sessions, however, it has been identified that a component is provided though group sessions for some service providers. This information was identified separately in the NGOE system for the first time in 2014/15.

**Table 28: Average activity reported for Education, employment and training funded services[(a)]**

| | Average No. of Clients[(b)] | Average No. of Individual Sessions | Average No. of Individual Session Hours | Average No. of Group Sessions | Average No. of Group Session Hours | Average No. of Attendances |
|---|---|---|---|---|---|---|
| 2013/14 | 229 | np | np | n/a | n/a | n/a |
| 2014/15 | 65 | np | np | np | np | np |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
np not published
n/a not available
(a) Further investigations into the activity reported by organisations under this service type are required and therefore some activity information could not be included in this report.
(b) The decrease in the average number of clients from 2013/14 to 2014/15 should be interpreted with caution due to small numbers of organisations funded under this service type.

On average each FTE interacted with 26 clients in 2014/15.

Service costs

In 2014/15, on average each *education, employment and training* funded service received $198,852 in funding, which equated to $3,083 per client.

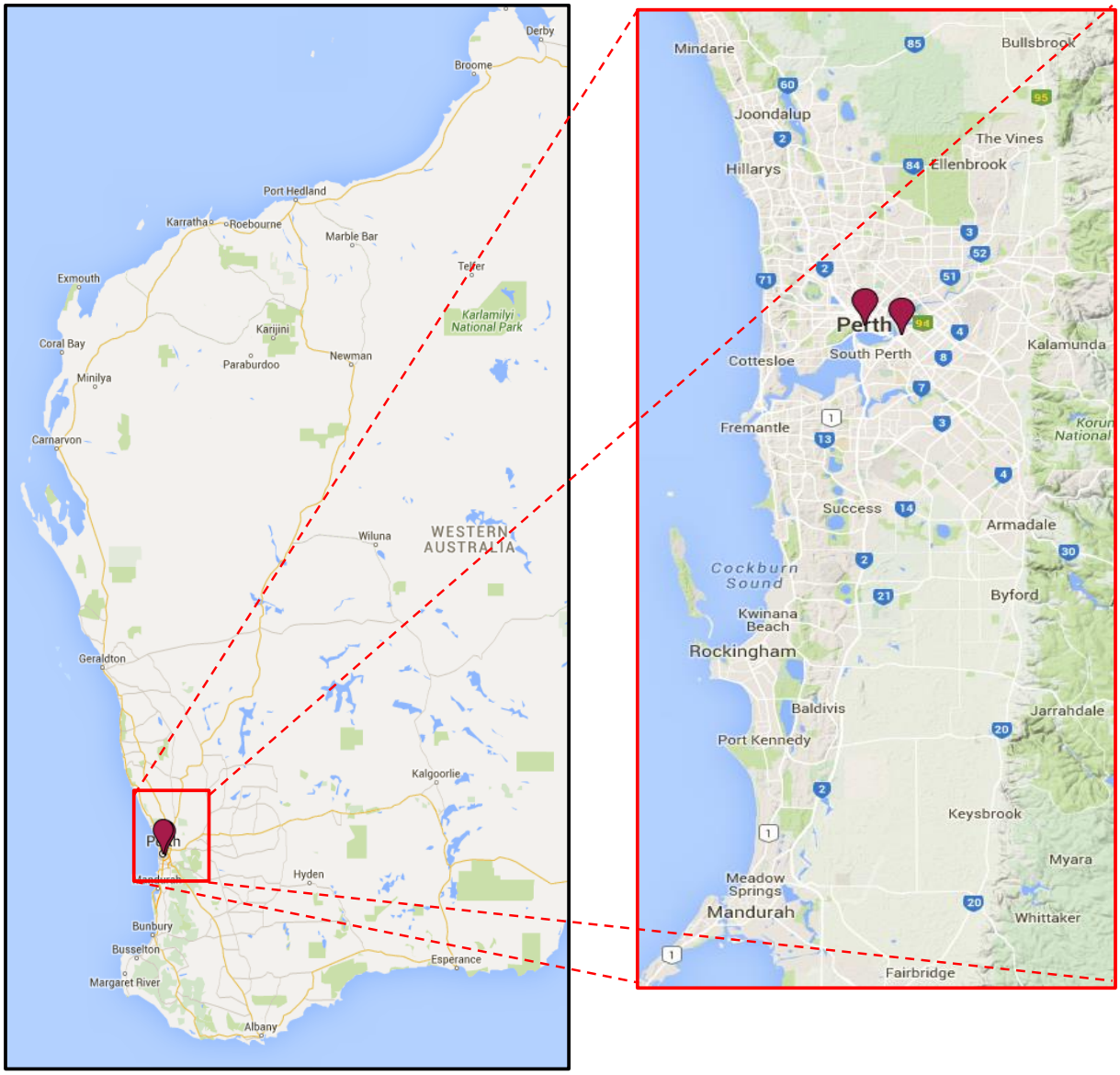
**Table 29: Average funding provided for Education, employment and training funded services**

| | Average funding[(a)] | Average funding per client | Average funding per service hour |
|---|---|---|---|
| 2013/14 | $189,203 | $826 | np |
| 2014/15 | $198,852 | $3,083 | np |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
np not published
(a) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements.

Locations

**Figure 8. Education, employment and training funded service locations**




Note: The location is based on the suburb of where staff providing the particular service are based as reported by organisations. It does not necessarily reflect catchment area or where the service is provided from. It should also be noted that duplicates within a service type have been removed (i.e. the mark does not indicate number of times where this service type is being provided in the same location)

## 4.3 Community Bed Based Services

In 2014/15, there were 18 NGOs providing 42 contract schedules for Community Bed Based services (see Appendix A for summary of all service types).

### Staffed residential

Workforce

In 2014/15 each *Staffed residential* funded service had 20.47 FTE on average, including approximately 276 hours of volunteer service. The number of paid FTE had increased from 2013/14 but the average number of volunteer hours decreased considerably.

**Table 30: Average workforce reported for Staffed residential funded services**

| | Average FTE[(a)(b)(c)] | Average Paid FTE | Average Volunteer hours | Average Peer FTE |
|---|---|---|---|---|
| 2013/14 | 19.41 | 19.10 | 644 | 0.34 |
| 2014/15 | 20.58 | 20.44 | 278 | 0.13 |

(a) Workforce includes both paid and unpaid (or volunteer) staff
(b) Total FTE calculated by adding Paid FTE and Volunteer FTE (based on 40 hr week)
(c) Includes FTE for psychiatric hostels and step-up, step-down facilities.

Activity

In 2014/15 the average occupancy for *staffed residential* services (excluding psychiatric hostels, hospital based services and step-up, step-down services) was 89% (increase from 85% in 2013/14). On average throughout the year each client occupied a bed for 186 days and had 19 days of leave[8].

**Table 31: Average activity reported for Staffed residential funded services[(a)]**

| | Average No. of Clients | Average No. of Beds | Average No. of Episodes | Average No. of MH Care Days | Average No. of Leave Days |
|---|---|---|---|---|---|
| 2013/14 | 18 | 11 | 19 | 3,244 | 313 |
| 2014/15 | 20 | 12 | 20 | 3,651 | 369 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Excludes psychiatric hostels, hospital based services and step-up, step-down services

By comparison, occupancy in step-up, step-down staffed residential services was 76% in 2014/15, with a much lower length of stay of 25 days on average. This is due to the nature of these services being a transitional service either following discharge from inpatient facilities (step-down) or as an alternative to inpatient admission (step-up).

**Table 32: Average activity reported for Step-up, step-down staffed residential funded services**

| | Average No. of Clients | Average No. of Beds | Average No. of Episodes[(b)] | Average No. of MH Care Days | Average No. of Leave Days |
|---|---|---|---|---|---|
| 2013/14 | 174 | 22 | 200 | 3,035 | 0 |
| 2014/15 | 242 | 22 | 283 | 6,117 | 0 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.

Occupancy in psychiatric hostels was very high in 2014/15 (96%), with most beds occupied by one client for the majority of the year. The average length of stay for each resident was 326 days with 8 days of leave.

**Table 33: Average activity reported for Psychiatric hostels staffed residential funded services**

| | Average No. of Clients | Average No. of Beds | Average No. of Episodes[(a)] | Average No. of MH Care Days | Average No. of Leave Days |
|---|---|---|---|---|---|
| 2013/14 | 28 | 31 | 24 | 8,745 | 333 |
| 2014/15 | 31 | 30 | 33 | 10,210 | 258 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) episode data for some services is not reliable

Across all *staffed residential* services, (assuming each service is staffed 24 hours a day seven days a week, as a proportion of total FTE), on average there are almost 5 staff working at any time within each service in 2014/15.

Service costs

In 2014/15, each *staffed residential* funded service (excluding psychiatric hostels, hospital based services and step-up, step-down services) received $74,144 per bed on average. This corresponded to $46,695 per client or $250 per mental health care day (bed day).

**Table 34: Average funding provided for Staffed residential funded services[(a)(b)]**

| | Average funding per bed | Average funding per client | Average funding per MH care day |
|---|---|---|---|
| 2013/14 | $70,073 | $43,796 | $248 |
| 2014/15 | $74,144 | $46,695 | $250 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Excludes psychiatric hostels, hospital based services and step-up, step-down services
(b) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements.

In contrast, average funding per mental health care day was higher for step-up, step-down services ($160,221 per bed and $576 per day). This higher cost is expected due to the nature of the service. The average cost reduced from 2013/14 due to the increased number of mental health care days resulting from the ongoing establishment of this new service.

**Table 35: Average funding provided for Step-up, step-down staffed residential funded services[(a)]**

| | Average funding per bed | Average funding per client | Average funding per MH care day |
|---|---|---|---|
| 2013/14 | $157,189 | $19,875 | $729 |
| 2014/15 | $160,221 | $14,566 | $576 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements.

The Commission provides a personal care subsidy to clients in psychiatric hostels to assist them to maintain and further develop their current skills, autonomy and self-management in the area of personal care to improve their overall quality of life. Each psychiatric hostel service received $10,397 per bed on average in 2014/15, which equated to $9,910 per client or $30 per day.

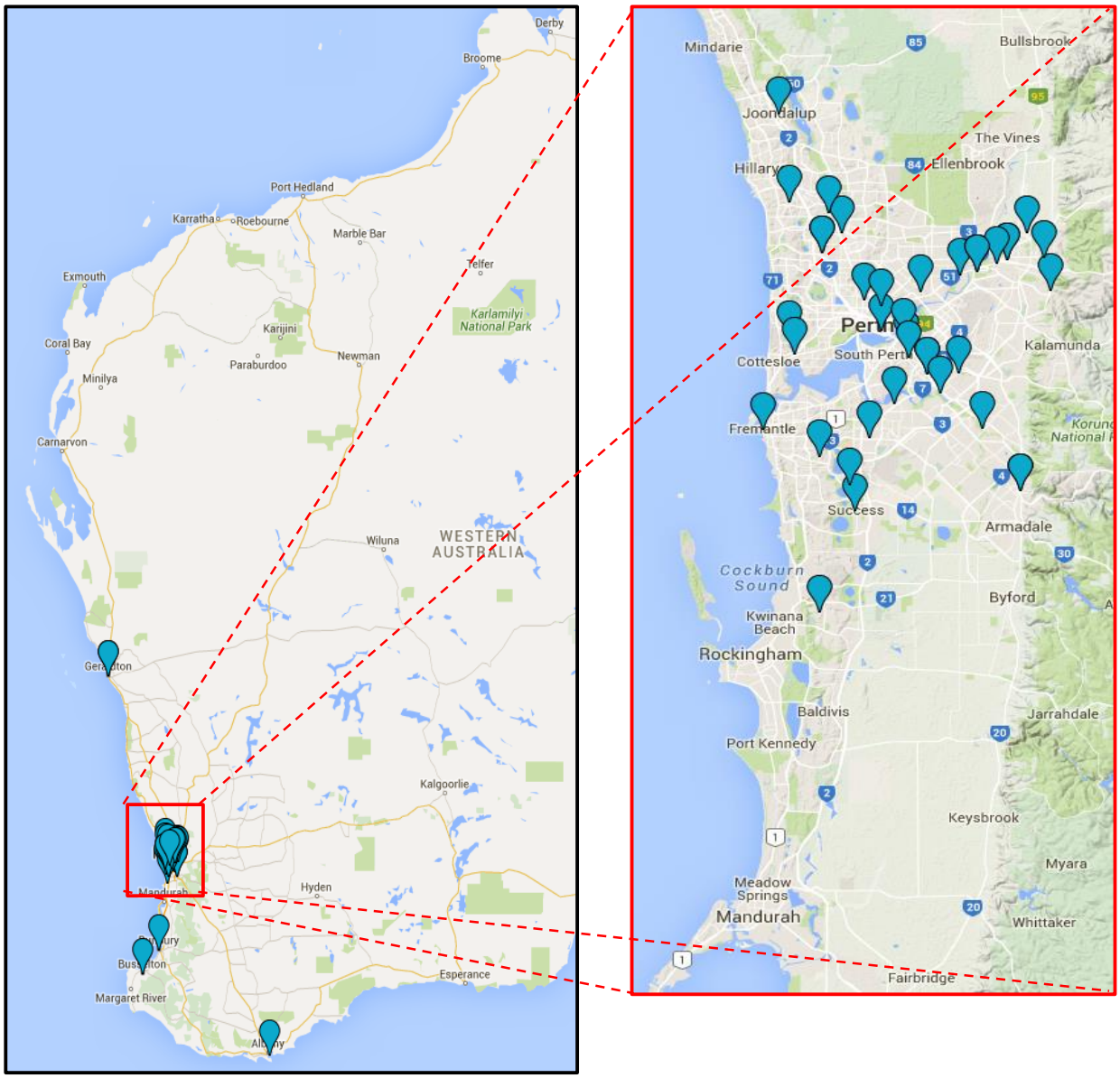
**Table 36: Average funding provided for Psychiatric hostels staffed residential funded services[(a)]**

| | Average funding per bed | Average funding per client | Average funding per MH care day |
|---|---|---|---|
| 2013/14 | $9,983 | $10,931 | $35 |
| 2014/15 | $10,397 | $9,910 | $30 |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
(a) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements.

Locations

**Figure 9. Staffed residential funded service locations**




Note: The location is based on the suburb of where staff providing the particular service are based as reported by organisations. It does not necessarily reflect catchment area or where the service is provided from. It should also be noted that duplicates within a service type have been removed (i.e. the mark does not indicate number of times where this service type is being provided in the same location)

# 5 POPULATION BASED SERVICES

In 2014/15, there were 14 NGOs delivered Population Based Services[9]. These NGOs were contracted to provide 18 services and 18 contract schedules (see Appendix A for summary of all service types).

Workforce

In 2014/15, the population based service type that had the highest average FTE per service was *Counselling, Support, Information and Referral – Telephone,* with 10.56 FTE on average, including 12,911 hours of volunteer service. On average population based services had double the number of volunteer hours than Direct Care services.

**Table 37: Average workforce reported for Population Based funded services**

| | 2013/14 | | | | 2014/15 | | | |
|---|---|---|---|---|---|---|---|---|
| **Service type** | **Average FTE[(a)(b)]** | **Average Paid FTE** | **Average Volunteer hours** | **Average Peer FTE** | **Average FTE[(a)(b)]** | **Average Paid FTE** | **Average Volunteer hours** | **Average Peer FTE** |
| Counselling, Support, Information & Referral—Telephone | 9.10 | 4.30 | 9,988 | 0.00 | 10.56 | 4.35 | 12,911 | 0.00 |
| Sector development & representation | 6.11 | 3.76 | 4,890 | 0.50 | 3.03 | 2.81 | 457 | 0.25 |
| Mental health promotion | 2.38 | 1.88 | 1,048 | 0.01 | 1.22 | 1.09 | 277 | 0.03 |
| Mental illness prevention | 3.39 | 3.01 | 790 | 0.18 | 3.35 | 3.05 | 623 | 0.18 |
| **Total Population Based** | **4.54** | **2.97** | **3,279** | **0.20** | **3.02** | **2.28** | **1,539** | **0.13** |

Activity

Each *counselling, support, information and referral—telephone* service, on average, handled over 23,068 calls in 2014/15. This is over 63 calls a day or 444 calls a week.

As a proportion of total FTE, on average each FTE was responsible for handling over 2,185 calls, or over 42 calls per week, in 2014/15.

For mental health promotion services, in 2014/15 the setting most frequently attended was *secondary schools* (average of 89.9 services) followed by *Other* (41.8 services). *Secondary schools* also had the broadest variety of locations being provided a promotional service (average of 35.1 unique locations), followed by *community* (31.3 locations).

[9] Population based services align with the "Prevention" service stream in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives. (MHC 2015).

**Table 38: Average activity reported for Mental Health Promotion(a) funded services**

| | 2013/14 | | | 2014/15 | | |
|---|---|---|---|---|---|---|
| **Setting** | **Unique Locations** | **Programs** | **Program Hours** | **Unique Locations** | **Programs** | **Program Hours** |
| Community | 28.43 | 95.67 | 101.83 | 31.25 | 24.43 | 217.50 |
| Primary School | 8.00 | 10.50 | 40.50 | 4.40 | 3.75 | 18.25 |
| Secondary School | 26.17 | 92.60 | 284.80 | 35.13 | 89.86 | 171.67 |
| Tertiary | 5.67 | 144.83 | 129.00 | 4.17 | 6.00 | 34.00 |
| Healthcare | 7.00 | 99.20 | 64.83 | 12.60 | 14.75 | 28.50 |
| Workplace | 5.80 | 127.50 | 51.50 | 6.67 | 8.00 | 14.80 |
| Other(b) | n/a | n/a | n/a | 4.00 | 41.80 | 188.25 |
| **Total** | **81.06** | **570.30** | **672.47** | **98.21** | **188.59** | **672.97** |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.
n/a not available
(a) Exclude non-recurrent grants
(b) 'Other' was only included as a category from 2014/15

## Service costs

In 2014/15, on average population based services received $241,263 per service. This equated to $1.69 per capita. Note that this excludes expenditure relating to Commission funded grants.

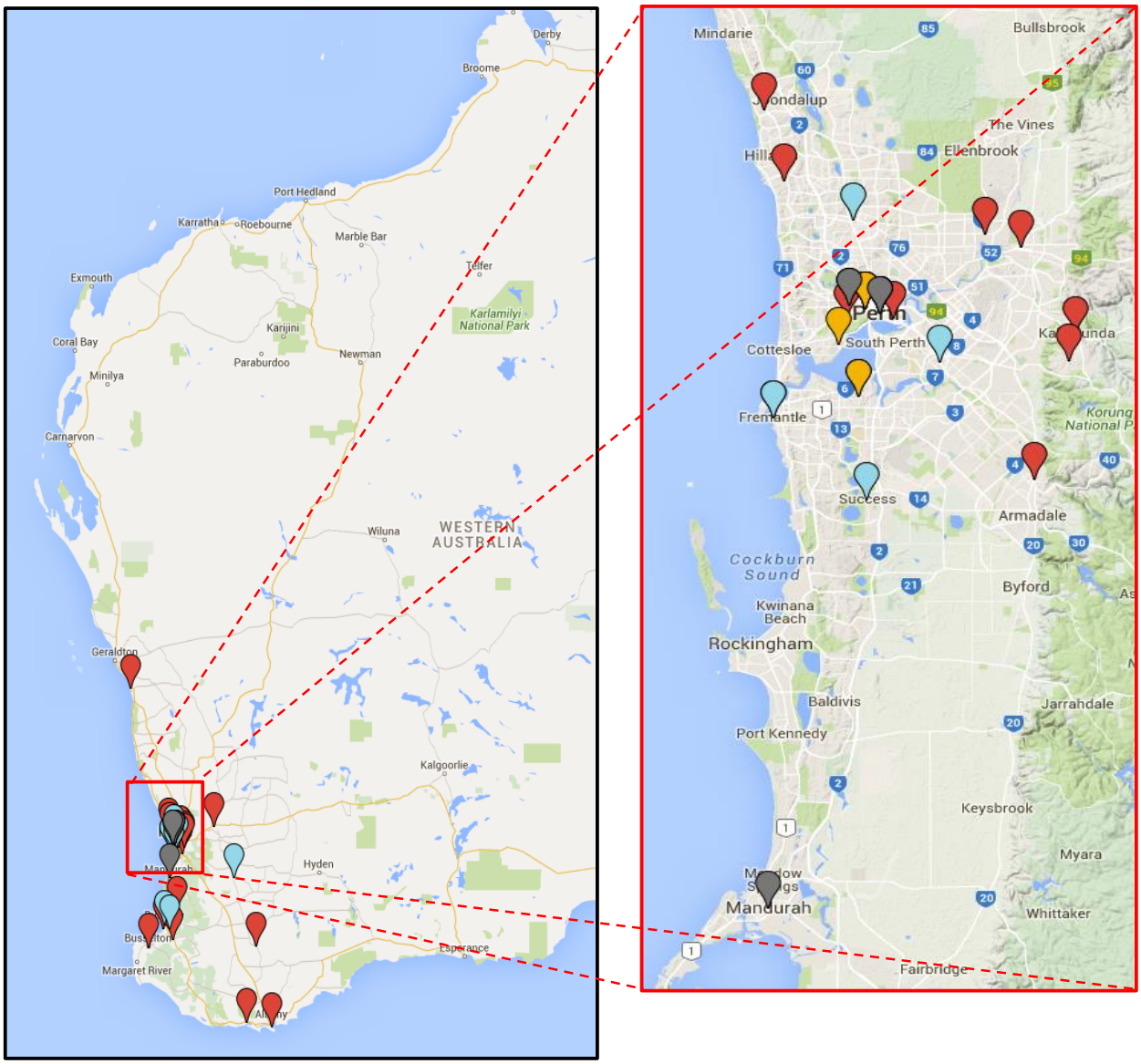
**Table 39: Average funding provided for Population Based funded services**

| | 2013/14 | | 2014/15 | |
|---|---|---|---|---|
| | **Average funding** | **Average funding per capita** | **Average funding** | **Average funding per capita** |
| Counselling, Support, Information & Referral—Telephone | $308,350 | $0.24 | $318,885 | $0.25 |
| Sector development & representation | $455,661 | $1.08 | $327,728 | $0.77 |
| Mental health promotion | $221,031 | $0.52 | $134,513 | $0.37 |
| Mental illness prevention | $225,001 | $0.27 | $265,669 | $0.31 |
| **Total Population Based Services** | **$314,815** | **$2.11** | **$241,263** | **$1.69** |

Note: comparisons between years should be made with caution due to continuing improvement in data reporting requirements.

Locations

**Figure 10. Population Based service locations**




Note: The location is based on the suburb of where staff providing the particular service are based as reported by organisations. It does not necessarily reflect catchment area or where the service is provided from. It should also be noted that duplicates within a service type have been removed (i.e. the mark does not indicate number of times where this service type is being provided in the same location)

# 6 CARERS RECOGNITION ACT

In Western Australia, the Carers Recognition Act 2004 recognises the important role of carers in our community and requires carers to be considered and involved in the planning and delivery of services by agencies which provide services that impact on carers.

Under Part 2 s.7(d) of the Carers Recognition Act 2004 any person or body providing a service under contract with a health or disability service is required to comply with the Western Australian Carers Charter. The following information may be used by NGOs and the Commission to inform improved compliance with the Carers Charter.

In 2014/15, the largest proportion (86.6%) of funded organisations reported they were compliant with the *Carers must be treated with respect and dignity* element of the WA Carers Charter, followed by the element *Complaints made by carers in relation to services that impact on them and the role of carers must be given due attention and consideration* (82.1%).

Compared with 2013/14, the proportion of organisations reporting compliance against the *Respect and Dignity* element remained the same in 2014/15, while there were decreases in reported compliance for *Assessment, planning, delivery and review inclusion* (75.0% in 2013/14), *Views and needs taken into account* (76.7% in 2013/14) and *Complaints given due attention and consideration* (86.7% in 2013/14). However these reductions may partially be due to an increase in the number of organisations responding as well as the addition of a 'not applicable' response option in 2014/15.

**Table 40: Funded organisations self-reported compliance against the WA Carers Charter elements, 2014/15**

| | Achieved compliance | Working towards compliance | Not compliant | Not applicable |
|---|---|---|---|---|
| Respect and dignity | 86.6% | 4.5% | 0.0% | 9.0% |
| Assessment, planning, delivery and review inclusion | 73.1% | 11.9% | 0.0% | 14.9% |
| Views and needs taken into account | 74.6% | 10.4% | 0.0% | 14.9% |
| Complaints given due attention and consideration | 82.1% | 7.5% | 0.0% | 10.4% |

When organisations were asked to report their compliance against related actions to the WA Carers Charter elements, organisations were most likely to report they were fully compliant in *ensuring carers have the opportunity to provide feedback on their experience in the organisation* (70.1%), followed by *Informing carers of the organisation's complaints policy and their ability to make a formal complaint if the Carers Charter is not upheld* (62.7%). By comparison, they were less likely to report that they were fully compliant in *including training on the Carers Charter and the role of carers in staff inductions and ongoing staff training* (37.3%), and in *including carers in the organisation's strategic management processes* (40.3%).

Compared with 2013/14, the proportion of organisations reporting they were fully compliant decreased for most related actions in 2014/15, most notably for *Include training on the Carers Charter and the role of carers in staff inductions and ongoing staff training* (48.3% in 2013/14) and *Acknowledge the role of carers in all relevant organisational policies and protocols* (56.7% in 2013/14). However, a notable increase in compliance was reported for *Acknowledge the role of carers in all relevant organisational publications* (50.0% in 2013/14). As noted earlier, these comparisons may have been impacted by an increase in the number of organisations responding as well as the inclusion of a 'not applicable' response option in 2014/15.

**Table 41: Funded organisations self-reported compliance against WA Carers Charter related actions, 2014/15**

| | Fully compliant | Almost fully compliant | Mostly compliant | Partially compliant | Not compliant | Not applicable |
|---|---|---|---|---|---|---|
| Acknowledge the role of carers in all relevant organisational policies and protocols? | 47.8% | 16.4% | 14.9% | 9.0% | 3.0% | 9.0% |
| Acknowledge the role of carers in all relevant organisational publications? | 56.7% | 7.5% | 11.9% | 10.4% | 1.5% | 11.9% |
| Include training on the Carers Charter and the role of carers in staff inductions and ongoing staff training? | 37.3% | 19.4% | 6.0% | 13.4% | 13.4% | 10.4% |
| Inform carers of the Carers Charter and relevant organisational policies and protocols? | 46.3% | 7.5% | 13.4% | 19.4% | 4.5% | 9.0% |
| Include carers in the organisation's strategic planning processes? | 40.3% | 7.5% | 11.9% | 16.4% | 9.0% | 14.9% |
| Include carers on the Board/Management Committee of the organisation? | 41.8% | 3.0% | 3.0% | 9.0% | 17.9% | 25.4% |
| Include carers in the assessment process for direct services? | 47.8% | 17.9% | 13.4% | 7.5% | 3.0% | 10.4% |
| Include carers in the ongoing monitoring of direct services? | 47.8% | 17.9% | 10.4% | 9.0% | 4.5% | 10.4% |
| Inform carers of the organisation's complaints policy and their ability to make a formal complaint if the Carers Charter is not upheld? | 62.7% | 7.5% | 7.5% | 11.9% | 1.5% | 9.0% |
| Ensure carers have the opportunity to provide feedback on their experience of the organisation? | 70.1% | 9.0% | 7.5% | 6.0% | 1.5% | 6.0% |
| Provide avenues for carers to access peer support? | 44.8% | 10.4% | 11.9% | 16.4% | 6.0% | 10.4% |

# 7 DISABILITY ACCESS AND INCLUSION PLANS

The Disability Services Act 1993, amended in 2004, requires all local government and selected State Government agencies to develop a Disability Access and Inclusion Plan (DAIP).

DAIPs ensure that people with disability can access services, facilities, buildings and information provided by public authorities in Western Australia in a way that facilitates increased independence, opportunities and inclusion within the community.

Organisations were asked to report their alignment with the Commission's DAIP, to assist the Commission to plan and implement improvements to access and inclusion across seven outcome areas.

In 2014/15, 83% of organisations on average agreed that they aligned with each of the Commission's DAIP Outcome Statements. The tables on the following pages provide the level of reported agreement with each outcome statement, and the corresponding specific initiatives and comments[10] provided by organisations again each outcome area.

NGO's may be able to utilise the comments from other organisations to assist them with developing additional initiatives for disability access and inclusion within their own organisations.

[10] Please note that not all comments have been included and organisation identities have been removed.

**Outcome 1. People with disabilities have the same opportunities as other people to access services and events**

| Statement | Agree | Unsure | Disagree | N/A |
|---|---|---|---|---|
| **The organisation has acknowledged within strategic business plans their responsibility for providing access to people with disabilities to all services and events run by the organisation.** | 86% | 3% | 7% | 4% |
| **Employees and contractors are made aware of their responsibilities for providing access to people with disabilities to services and events run by the organisation.** | 95% | 3% | 1% | 1% |
| **The organisation clearly states services and events run by the organisation as available for people with disabilities.** | 75% | 12% | 8% | 4% |

**Specific initiatives/comments reported by organisations against Outcome 1 are below (names of organisations have been removed)**

| |
|---|
| *-Transport assistance is available for Carers, Clients and Family Members both one on one and in small groups.*<br>*-Notices about upcoming / current programs, services, activities and events are disseminated via phone calls, emails, monthly newsletters, in group sessions, via flyers, on Facebook, in reception area and verbally.*<br>*- Partnerships with other agencies have been developed that aim to provide clients and Carers with access to services that they may not usually be able to access.*<br>*- works with other agencies to try to cover gaps in service access to support clients and Carers of persons with mental illness, physical disabilities, frail and aged etc*<br>*- works with other agencies to support complex clients and Carers who have not previously accessed services.* |
| *-The organisation has a comprehensive Equal Opportunities policy in place which applies to staff, Board members as well as the customers. This is complemented by a statement of intent which allows for regular review. The policy and procedure aims to identify which groups are at risk and allow for any remedial actions to be taken should discrimination occur.*<br>*-A component of the services care planning process includes a disability assessment and a corresponding support plan for this group.* |
| *-One of our carers has attended a Deaf language course in order to connect with and build a close relationship with one of our independent residents that is deaf.*<br>*-We have a new resident that will be joining us in a few weeks that is also deaf, which has now prompted two more staff to go and attend the course so they are able to converse and have a greater understanding of the resident. Although there is no set 'need' for this, the benefit to both resident and supervisor alike will be tremendous.*<br>*We are lucky to have staff willing to take on this learning activity in addition to their demanding roles.* |
| *Annual venue assessments check for appropriate access for persons with disabilities, with disability access and appropriate amenities.* |
| *On request can provide a range of additional supports depending on event type, eg.*<br>*- portable hearing loop at events*<br>*- iPad viewing and electronic material*<br>*- Skype for meetings*<br>*- additional personal support for individuals*<br>*- transport support*<br>*Facilitate commercial gallery exposure, e.g. Regional Arts Australia conference*<br>*Focus on the needs of Aboriginal and Torres Strait Island (ATSI) artists with disability with access to major events and exhibitions, e.g. Revealed 2015, touring NAIDOC exhibition and artist yarn eves* |

*Strategy 1 of the group strategic plan is- Build Capacity in the Australian Health and Aged Care System. The aim of this strategy is to restructure and reform for greater efficiency, accessibility and a higher quality overall service, the Health and Aged Care System. We continuously aim to act in the best interest of the community it serves. In order to achieve this we have developed and implemented a Consumer Engagement Strategy conducting initial workshops with all key stakeholders to define and agree the scope of the Consumer Engagement initiative. people with disabilities are involved in reviewing and evaluating services. No individual is denied access to service where these services for which we are funded are available.*

*- We ensure all of our residents attend any external Events by providing a bus with wheel chair access to venues, wheelchair taxi and volunteer transport Services residents engaged In many Events and not limited to weekly bus outings to picnic areas, flower shows, river visits, annual Resident Party which is a formal event.*

*- Appropriate staff have had Cultural Awareness training, Disability Awareness training, and Mental Health Awareness training.*
*- We apply the same policies on joint tenancies, succession of tenancies, etc. to all our tenants, irrespective of whether they are married or not, or in different or same sex relationships*
*- We collect information on disability which enables us to shape our services to tenants in ways such as sensitive allocations, support needs, ability to understand English (provide interpreting service TIS - Translating & Interpreting Services or use of translation service).*
*- We have translated our key information documents, including our Tenancy Agreements, into the three top languages, other than English, spoken as first languages by our tenants*
*- Where we are aware a tenant is illiterate we will make arrangements with them to communicate in the best way to suit them, evidenced on our Tenant database.*
*- Tenant Database and Property Dept. records evidence that we allow tenants to make alterations to the property to suit their needs, including our assisting with the installation of grab rails, etc. where required*
*- We assist tenants to access air conditioners via the Independent Living Centre grants scheme whenever they qualify for age or disability reasons*
*- We also are an agent for WANILS and our Resource Officer assists in lodging applications for no interest loans, up to $1500, for eligible tenants*

*Develop & Implement an Accessible Events checklist for staff when planning events. Checklist is operational and available for use via the intranet*

*- The use of interpreters and translators from The National Auslan Interpreter Booking Service (NABS) for people who have a hearing impairment.*
*- Make use of The Disability Services Commission (DSC)*
*- Creating Accessible Events checklist when choosing a venue for a community event.*
*- In our annual client survey, ask specific questions about accessibility to Services for people with disabilities. Act on The feedback where possible.*
*- Staff will provide relevant verbal information to clients who experience literacy difficulties.*

**Outcome 2. People with disabilities have the same opportunities as other people to access buildings and other facilities**

| Statement | Agree | Unsure | Disagree | N/A |
|---|---|---|---|---|
| **All building and facilities provided are currently accessible for people with disabilities.** | 82% | 1% | 14% | 3% |
| **Fire wardens are trained in the evacuation procedures for people with disabilities.** | 75% | 12% | 4% | 8% |
| **The organisation ensures physical access for people with disabilities is considered during the planning for (re)development of buildings and other facilities.** | 92% | 1% | 1% | 5% |

**Specific initiatives/comments reported by organisations against Outcome 2 are below (names of organisations have been removed)**

*-Disability access is available at both the office location and our group activity home.*
*- The office and house are both able to support disabled access throughout the premises as well as entry and exit areas.*
*- Neither premises currently has a disabled toilet, however, the office premises landlord has been requested to assist with disability toilet access being made available at the office and funding opportunities are being investigated that could support a disabled access toilet.*
*- Clients and Carers are able to be assisted to access transport to attend the office or House if needed.*
*- The office premises and group home are used for many different types of activities such as community forums and working group meetings, training and education, board meetings, videoconferencing, programs such as DRUMBEAT, Computing, Art Therapy etc*
*- Clients and Carers report satisfaction with the location, layout and modifications to both the office premises and group home.*
*- Clients and Carers report satisfaction with the type and frequency of activities provided at the office and group home premises.*

*-Provide specific training to fire wardens in evacuation procedures.*
*-A pap smear clinic is to be held at a facility for women with physical disabilities who are unable to attend the service. This is anticipated to be an ongoing clinic which will expand to include general physical and mental health issues.*

*-Customers of the service identified as having a disability have full access to the facilities including bedrooms, communal areas which are located at ground level and accessible by wheelchair.*
*-Disability parking is also available on the premises.*

*-We ensure that staff who accompany clients on outings in their local community, are aware of buildings, facilities & venues that allow or hinder access to persons with disability.*

*-The building we use for weekly rehearsals complies with the above requirements.*
*-When we deliver services at various locations we make an assessment of the venue to determine that access facilities are available and evacuation procedures are in place.*

*-Certainly our office is accessible for people with disabilities as are a number of newly built properties (19 are universal and adaptable design). Under the Department of Housing's CCB program, there have been 7 purpose built and spot purchase properties for people with disabilities and mental health issues acquired in the region.*

*-We work with local governments and state government partners to develop, build and manage inclusive arts centres and studios*
*-made access improvements to the building. The inaccessible fences and gate have been pulled down, allowing easier access to the building.*

*All facilities are accessible to people with disabilities. All fire wardens receive on-going training in emergency evacuation procedures. in some areas of our business, facilities are not owned but leased. Should access prove challenging to people with disabilities, services i.e. wound and continence management advisory services is provided in the clients home as opposed to a clinic in these instances*

*Our Service location is built to enable all residents and visitors to have free access. We ensure our residents have access to external venues by providing a special bus that allows any residents with physical disabilities to use. We are currently undergoing a building redevelopment project included in the planning stages is a comprehensive plan to include physical access for people with disabilities, wheelchair access, wide doorway entrances for hospital beds, shower chairs and mobility equipment.*

*The current head office is in an old building that does not allow disabled access up stairs. All training and forums are conduct downstairs which does have access.*
*If a worker based at Head Office has a physical disability and is not able to take the stairs provisions are made for them to be based in a downstairs office areas and any meetings are conducted in accessible areas. A parking bay is provided for disabled workers. Other local offices vary, for example some of our offices are disability friendly in one story building with disability access including a designated car bay.*

*All of our most recent developments have had accessibility design inclusions*

*We are replacing our current flooring new carpet tiles to enable easier wheelchair access/movement for our volunteers who use them.*

*Over the last couple of years we have undertaken various work to improve our offices, which includes:*
*-Leasing or relocating offices to ensure office space is ground level*
*-Seeking assistance from disability access consultants, engineers and designers*
*-Consulting with supported people and staff*
*-Ensuring office space is free from obstructions and has appropriate signage and lighting*
*-Securing accessible car parking bays*
*-Installing an accessible new lift that has lower buttons and brail included*
*-Installing door bells at offices as an interim solution where the external doors are not independently accessible, and pending sufficient budget to replace heavy doors with sensor operated ones.*
*-If we need to hire venues to host events, we ensure the venue is suitable to meet the needs of people attending i.e. ramp, wheelchair access, lift etc.*

*-Review and implement, where possible, strategies to increase the accessibility of buildings and facilities to people with a disability.*
*- Ongoing, Property Manager Developed a check list and commenced review of existing properties.*
*-Incorporate into future premise & building designs, the needs and requirements of people with disabilities.*
*-Ongoing Property Manager Will be incorporated in all new building designs including the accommodation project.*

*-All new branches have easy access for people using mobility aids.*
*-Where branches are inaccessible for people with disabilities, an alternative venue will be arranged.*

**Outcome 3. People with disabilities receive information in a format that will enable them to access information as readily as other people are able to access it.**

| Statement | Agree | Unsure | Disagree | N/A |
|---|---|---|---|---|
| **The organisation's internet and intranet websites (where applicable) are compliant with Web Content Accessibility Guidelines or similar.** | 58% | 22% | 7% | 14% |
| **Staff are provided appropriate training/guidance for writing accessible content for the web** | 60% | 15% | 7% | 18% |

**Specific initiatives/comments reported by organisations against Outcome 3 are below (names of organisations have been removed)**

*Ensure that all information is in pictorial format for those with little or no English or who have intellectual disability. At present the majority of information is in various forms to suit needs of clients and the television screen in reception is available for dissemination of relevant information.*

*-Where a person is hearing impaired, information is provided in written form.*
*-Where a person has low vision or is sight impaired, information is provided in larger fonts for ease of reading.*
*-It is standard practise following a customer's initial intake that all written information provided is read out verbatim by the case worker.*

*Our organisation is currently updating the web site in part to incorporate more simplicity and accessibility for people with disabilities via our web designer. One extra feature will be the capacity for tenants to request maintenance via the website, as well as a free call 1800 number. Our Receptionist is co-ordinating the changes to be in line with accessibility guidelines set by Government.*

*-Currently reviewing all literature to ensure we can provide people with audio access to our Program. Our new edition of our publication is available in large print and we are currently working with Vision Australia to develop an audio copy. We are in the process of including a wheelchair symbol against each venue address on our national website.*

*-Website is being redesigned to improve accessible features and functionality*
*- will redesign business cards with significant colour contrast and easy-to-read font size*
*- State Government access guidelines are used in designing material for projects such as exhibition*

*We are working on a new website and investigating the possibility of implementing systems to present information in alternative formats.*

*We have recently reviewed our Website. This review was completed in collaboration with clients/carers thus ensuring ease of navigation, applicable content shared in an easy to understand manner. The website can be adapted for the visually impaired. The content can also be viewed in a range of different languages.*

*-Our new Marketing Manager is fully conversant with the requirements regarding managing accessible website content and a new website will be launched this quarter concurrently with the re-branding launch.*

*We have adapted our training material to ensure accessibility to those volunteers (of which there are two) who are sight impaired. Also investigating the use of 'screen reading' software.*

*We have launched a new website this year and adheres to WCAG Level A Accessibility Compliance.*

*A major project that we are undertaking is the provision of resources and services to more diverse needs and expectations than now. The project involves creating a wider range of more closely targeted publications and projects to cater for people from backgrounds including those with a disability (hearing/visual impairment, physical disability and cognitive disability).*

*Have a dedicated Community Relations Officer who oversees web content*

**Outcome 4. People with disabilities receive the same level and quality of service from staff as other people receive.**

| Statement | Agree | Unsure | Disagree | N/A |
|---|---|---|---|---|
| **Staff are provided disability awareness training to provide them with the appropriate skills.** | 82% | 4% | 8% | 5% |
| **The organisation has formal process that considers people with disabilities in the (re)development and planning of services.** | 84% | 7% | 4% | 5% |

**Specific initiatives/comments reported by organisations against Outcome 4 are below (names of organisations have been removed)**

*-Provides a person centred recovery focused approach.*
*-policies and procedures undergo regular reviews and amendments to ensure that they reflect inclusive practice that is of a high standard.*
*-We have an OHS Committee who in conjunction with the Board monitor, update and ratify policies and procedures to ensure that they consider the best interests of all who are involved with the organisation.*
*-All staff receive regular and ongoing training in recovery oriented inclusive practices and approaches.*
*-Feedback is sought on a regular basis from clients and carers to determine if the service is effective at being inclusive.*

*-As part of our ongoing training and supervision obligations, all staff are provided with ongoing information concerning requirements under specific legislation i.e. Disability Services Act (1993).*
*-Knowledge of this policy and its application features a regular as an agenda item within staff meetings held monthly.*
*-The area is also covered as part of the induction organisational orientation process with all new staff members.*
*-The quality of services provided to customers is regularly evaluated through purposely designed customer exit questionnaires. Customers are invited to provide feedback on the services that they have received. Date is then analysed by the General Manager.*

*Our Team Assessment process will review new residents with disabilities providing consideration into their needs and how we can provide services to meet those needs.*

*We continue to ensure we receive feedback from people with disabilities via one on one surveys with tenants with the assistance of support agencies*

*Our Training Plan includes Disability Awareness Training Workshops conducted by representatives from the Disability Commission.*

*All staff are trained to care for all residents equally, policies and procedures are in place to ensure staff have guidelines to follow in relation to equality of care, we are accredited by the Aged Care Standards and Accreditation Agency in all 44 outcomes however some are specifically relevant to this section as follows:*
*3.2 Regulatory Compliance, we have systems in place to identify and ensure compliance with all relevant legislation, requirements, professional standards and guidelines relating to resident lifestyle.*
*3.5 Independence: Consumers are assisted to achieve maximum independence, maintain friendships and participate in life of the community within and outside the residential care service.*

*In November last year we introduced a monthly client feedback meeting where clients from all day centre programs (including those with disabilities) where able to provide feedback and suggestions which are minuted, shared with management and the board and used where applicable in strategic planning and development of new services.*

*DSC video is accessible to all staff on the intranet.*
*Disability awareness training provided by staff viewing the video at induction and through regular updates in the quarterly staff newsletter.*
*Discuss quality of service for people with disabilities at management meetings as a regular agenda item.*

*All group Facilitators receive a copy of the updated DAIP with their term contracts. Feedback on group participants indicates that a majority of women attending programs are experiencing physical and mental health disabilities.*

*Disability awareness training is compulsory for all staff. Focus groups have been held to gain feedback on services. Clients have been included in forward planning of future projects.*

**Outcome 5. People with disabilities have the same opportunities as other people to make complaints**

| Statement | Agree | Unsure | Disagree | N/A |
|---|---|---|---|---|
| **All feedback mechanisms in place within the organisation to make complaints and/or provide feedback are accessible to people with disabilities.** | 96% | 1% | 1% | 1% |
| **There is a formal process in place to acknowledge and address issues raised by people with disabilities.** | 93% | 1% | 3% | 3% |

**Specific initiatives/comments reported by organisations against Outcome 5 are below (names of organisations have been removed)**

*We have a Client Complaint Policy and Procedure. Clients who are not literate are assisted by staff (or management if it is about a staff member) if they wish to make a complaint.*

*Our Complaints Policy outlines the principles for effective complaints management including:*
*-People's right to complain*
*-Their right to use an advocate*
*-Their right to seek support and advice from external supports*
*-Our responsibilities in actioning and managing complaints*
*We have further developed the management of our complaints over the last year, which includes:*
*-Participating in the HaDSCO pilot*
*-Developing a Suggestions, Compliments and Complaints leaflet*
*-Introducing a Customer Liaison Officers role*
*-Improving recording and reporting of complaints*
*-Development of monthly complaints reports*
*-Delivering complaints training to Area Teams & Exec*
*-Incorporating complaints training in induction*
*We receive complaints verbally, via phone, mail, email, advocacy and general feedback to staff. Complaints are recorded onto our database and are reviewed by Management. We ensure any concerns raised are addressed specifically, as well as, systemically.*

*Establishment & implementation of a complaints process that incorporates accessibility in various formats. - Process developed and the interim procedures are being reviewed An interim system has been implemented across the service until the ICT plan is implemented. The ICT Plan Implementation project has commenced with completion due Jan 2019.*

*The organisation developed in February new resources, processes and practice guidelines to improve communication in a proactive and much more accessible way in the complaints management process. These new guidelines and resources will foster best practice in complaints resolution.*

*Staff can assist with complaints by scribing or accessing an interpreter service.*

**Outcome 6. People with disabilities have the same opportunities as other people to participate in any public consultation.**

| Statement | Agree | Unsure | Disagree | N/A |
|---|---|---|---|---|
| **The organisation enables people with disabilities equitable access to public consultations or forums run by the organisation.** | 92% | 3% | 0% | 5% |
| **The input from people with disabilities is actively sought in consultations or forums run by the organisation.** | 82% | 8% | 1% | 8% |

**Specific initiatives/comments reported by organisations against Outcome 6 are below (names of organisations have been removed)**

*The organisation does not run any public consultations or forums, however, consumers with disabilities have equitable access to internal forums like residents meeting recent examples include use of Auslan interpreter for consumers with hearing impairment, involvement of consumers with mobility issues.*

*All venues are checked to ensure access for people with a disability.*

*-The organisation's buildings are more broadly community assets and are available for external users to hire for their own consultations and meetings. One building was used many times by external hirers seeking an accessible community venue and will host other disability groups in 2015-2016.*
*-The organisation encourages young people to have their voices heard, and in 2014-2015 engaged another group of young and emerging artists with disability through the Nexus Grants rounds;*
*- The Community Reference Group increased its reach to include new members and run group sessions and meetings. The CRG increases opportunities for involvement by people with disability in our business and strategic planning processes, policy review and governance.*

*The organisation runs regular consultation forums inviting input from clients and/or carers past or present. People with Disabilities regularly attend these forums as part of our Consumer Engagement process. All venues used for public forums must have adequate disability access.*

*-People with disabilities have the same opportunities as other people to participate in any public consultation. All residents and their representatives are informed of any opportunities to participate in public consultation and can be supported by the staff to do this.*
*-The service is accredited by the Aged Care Standards and Accreditation Agency with the following outcome being relevant to this section - 2.6 Other health and related services - Consumers are referred to appropriate specialists in accordance with the consumer's needs and preferences.*

*We are mindful of running training events and others in disability accessible buildings.*

*At the organisation, public consultation is about sharing information and eliciting feedback from a targeted market. The organisation provides information about its services and employment opportunities to a diverse range of people in the community, with the aim of reaching its target group. We also elicit feedback from our clients, in an attempt to ensure that services meet the needs of our end-users. Consultation may involve:*
*-The use of printed literature distributed in the community.*
*-Use of the Website.*
*-Ability for people to call and speak to an employee.*
*-Use of audiovisual technology to impart information about employment at the organisation to the wider community.*
*-Client feedback forms, complaints and feedback form and client survey forms are available in hard copy as well as electronic format.*
*-Feedback via our funding bodies.*

*Women with disabilities were consulted on planning the new Pap Smear flyer.*

**Outcome 7. People with disabilities have the same opportunities as other people to obtain and maintain employment**

| Statement | Agree | Unsure | Disagree | N/A |
|---|---|---|---|---|
| **The organisation formally acknowledges positions are available to people with disabilities when recruiting employees.** | 82% | 8% | 7% | 3% |
| **The organisation has a formal process to ensure employees with disabilities are not discriminated against or disadvantaged in any way.** | 93% | 3% | 3% | 1% |

**Specific initiatives/comments reported by organisations against Outcome 7 are below (names of organisations have been removed)**

| |
|---|
| *-The organisation runs several programs that aim to provide people with learning opportunities to develop skills that may assist them in finding employment, such as our Introduction to and Intermediate computing classes.*<br>*- The organisation links clients and Carers into other agency opportunities for skill development such as Escare's Dress for Success programs in which people can learn skills around resume writing and dressing for job interviews etc.*<br>*-We also work with Clients, Carers and local employment agencies to link individuals into education and training and employment opportunities.*<br>*-We also provide volunteer opportunities within our organisation and work closely with the Volunteer Resource Centre to create opportunities for people to gain workplace skills.* |
| *We recently started including in our job advertising an indication that we actively encourage people with a lived experience of mental illness to apply for any roles within our organisation.* |
| *The office had disability access and toilet. Over the last 6 years I have employed at least 3 people who were physically challenged in the positions of Receptionist and Property Manager. The organisation has an Equal Opportunity Policy in relation to Human Resource Recruitment, and Management, and the Recruitment Policy includes awareness of equal opportunity principles in regard to selection and interviews.* |
| *Yes, we have recently formed a partnership with a provider who is currently working with a number of our consumers to re-skill, train up, and find suitable employment. We have recently employed a person with a disability and this is our part of our proactive strategy.* |
| *The organisation developed and delivered opportunities for people with disability to promote themselves professionally through conferences, forums and panels.* |
| *The organisation's Recruitment and selection Policy is underpinned by:*<br>*Aged Care Act 1997*<br>*Equal Opportunity for Women in the Workplace Act 1999*<br>*Sex Discrimination Act 1984*<br>*Racial Discrimination Act 1975*<br>*Fair Work Act 2009*<br>*Equal Opportunity Act 1984*<br>*Spent Conviction Act 1988* |
| *We currently provide employment opportunities for people with a disability, such as:*<br>*-Supporting people to develop their skills to deliver our Vision and Values training sessions for new staff. There are 6 supported people now paid to deliver these sessions as Co-Facilitators*<br>*-People with disabilities are engaged and paid to be part of our recruitment panels*<br>*-We provide work experience in administrative duties to high school students with disabilities* |
| *PDs and job advertising have been upgraded to reflect a person-centred approach. The Learning & Development strategy provides for targeted training for individuals based on identified need. People with Disability division is working with HTA to employ people with a disability within the division.HR provides volunteers with opportunities to develop skills for employment.* |
| *In 2015-16 the organisation will develop an EEO policy and formally acknowledge positions are available to people with disabilities when recruiting.* |
| *The organisation has a comprehensive anti discrimination policy.The organisation undertakes to ensure the elimination of discrimination and harassment on the basis of the following attributes: physical features, disability (past, present or imputed), medical record.*<br>*The organisation conducts an annual bullying survey to identify and deal with any occurrence of bullying, this would include any incidence of bullying based on disability.* |

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# GLOSSARY

**Attendances**
The total number of client attendances at events facilitated by a service provider organisation.

**Beds**
The number of beds available in staffed residential services for overnight accommodation as stated within the contract (or similar) agreement.

**Calls**
The total number of telephone calls in which direct service activities were delivered by a service provider organisation.

**Clients**
The total number of people or clients who received services provided by a service provider organisation. A client is the individual with a mental illness who receives the mental health service or, in the case of Family and carer support services, the carers or family members of the person living with a mental illness.

**Contact hours**
The total number of hours of service in which two or more individuals or groups are placed in communication with one another.

**Contacts**
The number of service contacts provided to individual clients by a service provider organisation.

**Dwellings**
The total number of dwellings under the management of a service provider organisation.

**Episodes**
The total number of episodes of completed residential care occurring during the reference period (between 1 July and the end of the reporting period). This includes both formal and statistical episodes of residential care.

**Group sessions**
The total number of group sessions provided to clients by a service provider organisation. A group is defined as two or more clients receiving a service together where all individuals are not members of the same family.

**Group session hours**
The total number of hours of group sessions provided to a client by a service provider organisation.

**Individual sessions**
The total number of individual sessions provided to clients by a service provider organisation. A service contact is recognised as any communication in person, by telephone, by video link or by any other means, including travel with clients. Service contacts can either be with a client, or with a third party such as a carer or family member, other professional or mental health worker or other service provider, where the nature of the service would normally warrant a dated entry in the record of the client in question (e.g. excludes organising appointments).

**Individuals session hours**
The total number of hours of individual service provided to a client by a service provider organisation.

**Leave day**
The number of days spent on leave from a residential care service during an episode of residential care.

**Mental Health care days**
The total number of accrued mental health care days provided by residential mental health care services within the reference period (from 1 July to the end of the reporting period). Mental health care days are days of care for residents in residential mental health services. Accrued mental health care days can also be referred to as occupied bed days.

**Program hours**
The total number of hours a mental health program was provided.

**Program setting**
The type of setting/s which a mental health program is being run.

**Programs**
The total number of occasions a mental health program was provided.

**Unique locations**
The count of unique locations where a mental health program has been provided.

# APPENDIX A – SERVICE ACTIVITY SUMMARY MATRIX

| | WORKFORCE | | | | ACTIVITY | | | | | | | | | | | | FUNDING | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total FTE[c] | Paid FTE | Volunteer Hours | Peer FTE | Average clients | Average individual sessions | Average individual session hours | Average Group Sessions | Average Group session hours | Average attendances | Average calls | Average dwellings | Average beds | Average episodes | Average MH Care Days | Average leave days | Average funding provided[d] | Average funding per bed |
| **DIRECT CARE** | **6.76** | **6.48** | **590** | **0.24** | **131** | **2,213** | **2,699** | **234** | **1,096** | **2,826** | **566** | **29** | **20** | **32** | **6,364** | **315** | **$443,195** | |
| *Community Treatment* | *1.54* | *1.51* | *51* | *0.00* | *160* | *1,082* | *1,076* | *30* | *87* | | | | | | | | *$233,909* | |
| Counselling—face-to-face | 1.54 | 1.51 | 51 | 0.00 | 160 | 1,082 | 1,076 | 30 | 87 | | | | | | | | $233,909 | |
| *Community Support* | *4.28* | *3.92* | *751* | *0.31* | *168* | *2,355* | *2,903* | *411* | *1,971* | *2,826* | *566* | | | | | | *$352,762* | |
| Group support activities | 3.05 | 2.83 | 463 | 0.11 | 158 | 1,803 | 1,140 | 450 | 1,660 | 3,297 | | | | | | | $234,487 | |
| Mutual support and self-help | 4.25 | 2.34 | 3,969 | 0.61 | 504 | 184 | 150 | 364 | 2,731 | 2,482 | 566 | | | | | | $257,880 | |
| Personalised support—linked to housing (all) | 4.94 | 4.35 | 1,227 | 0.20 | 34 | 2342 | 3668 | | | | | 29 | | | | | $362,429 | |
| All except ICLS | | | | | 49 | 804 | 1,107 | | | | | 44 | | | | | $150,587 | |
| ICLS only | | | | | 12 | 4,590 | 7,411 | | | | | 7 | | | | | $672,043 | |
| Personalised support—other | 4.99 | 4.86 | 269 | 0.44 | 131 | 4,011 | 4,418 | | | | | | | | | | $462,951 | |
| Family and carer support | 3.20 | 3.09 | 239 | 0.38 | 333 | 1,229 | 1,460 | | | | | | | | | | $292,887 | |
| Individual advocacy | 2.55 | 2.48 | 133 | 0.03 | 184 | 1,490 | 2,281 | | | | | | | | | | $274,631 | |
| Education, employment and training | 2.45 | 2.40 | 110 | 0.00 | 65 | np | np | np | np | np | | | | | | | $198,852 | |
| *Community Bed Based* | *20.58* | *20.44* | *279* | *0.12* | *30* | | | | | | | | *20* | *32* | *6,364* | *315* | *$732,220* | |
| Staffed residential services (all) | 20.58 | 20.44 | 279 | 0.12 | | | | | | | | | 20 | 32 | 6,364 | 315 | $732,220 | |
| All except psychiatric hostels, hospitals, step-up,step-down | | | | | 20 | | | | | | | | 12 | 20 | 3,651 | 369 | np | $74,144 |
| Psychiatric hostels only | | | | | 31 | | | | | | | | 30 | 33 | 10,210 | 258 | np | $10,397 |
| Step-up, step-down only | | | | | 242 | | | | | | | | 22 | 283 | 6,117 | 0 | np | $160,221 |
| **POPULATION BASED[a]** | **3.02** | **2.28** | **1,539** | **0.13** | | | | | | | | | | | | | **$241,263** | |
| Counselling, support, information and referral—telephone | 10.56 | 4.35 | 12,911 | 0.00 | | | | | | | 23,068 | | | | | | $233,909 | |
| Sector development and representation[a] | 3.03 | 2.81 | 458 | 0.25 | | | | | | | | | | | | | $327,728 | |
| Mental health promotion[a] | 1.22 | 1.09 | 278 | 0.03 | | | | | | | | | | | | | $134,513 | |
| Mental illness prevention[a] | 3.35 | 3.05 | 623 | 0.18 | | | | | | | | | | | | | $265,669 | |
| **TOTAL** | **6.11** | **5.75** | **754** | **0.22** | **131** | **2,213** | **2,699** | **234** | **1,096** | **2,826** | **6,995** | **29** | **20** | **32** | **6,364** | **315** | **$422,660** | |

np not published

(a) Exclude non-recurrent grants

(b) Workforce includes both paid and unpaid (or volunteer) staff

(c) Total FTE calculated by adding Paid FTE and Volunteer FTE (based on 40 hour week)

(d) Average funding represents the final funding amounts as audited for the Commission's 2014/15 financial statements

For further information please contact MHC NGOE Helpdesk at NGOESDC.Helpdesk@mhc.wa.gov.au

# APPENDIX B – SERVICE TYPE DEFINITIONS

This section outlines the definition of each of the 17 service types in the taxonomy. These definitions have been created to assist funders in allocating funded services delivered by each NGO to a service type within the MH NGOE NMDS. In addition to a general description of services that fall within each service type, each definition contains a section for distinguishing features, inclusions, exclusions and examples.

## Counselling–face-to-face

Counselling services operate through a range of mediums including face-to-face, telephone and online. This service type is intended only for services providing face-to-face counselling.

Counselling services provide a structured process that is concerned with addressing and resolving specific problems, making decisions, working through feelings and inner conflicts, or improving relationships with others (BAC 1986). Counselling facilitates personal growth, development, self-understanding and the adoption of constructive life practices.

The counselling process will depend on the individual counsellor, the individual client and the specific issue.

*Distinguishing features:*

- Delivered face-to-face
- Primarily centre-based
- Includes individual, family and group counselling

## Counselling, support, information and referral–telephone

Counselling, support, information and referral services can be provided both via telephone and online. This service type is intended only for those services provided via telephone.

Counselling services provide a structured process that is concerned with addressing and resolving specific problems, making decisions, working through feelings and inner conflicts, or improving relationships with others (BAC 1986). Counselling facilitates personal growth, development, self-understanding and the adoption of constructive life practices.

The counselling process will depend on the individual counsellor, the individual client and the specific issue.

Mental health support, information and referral services are those that provide support for people experiencing mental illness and which offer reliable referrals, information and self-help resources to empower people to take steps towards maintaining mental health and emotional wellbeing (Lifeline 2012).

*Distinguishing features:*

- Delivered via telephone
- Primarily delivered on a one-on-one basis

## Counselling, support, information and referral–online

Counselling, support, information and referral services can be provided both via telephone and online. This service type is intended only for services provided online.

Counselling services provide a structured process that is concerned with addressing and resolving specific problems, making decisions, working through feelings and inner conflicts, or improving relationships with others (BAC 1986). Counselling facilitates personal growth, development, self-understanding and the adoption of constructive life practices.

The counselling process will depend on the individual counsellor, the individual client and the specific issue.

Mental health support, information and referral services are those that provide support for people experiencing mental illness and which offer reliable referrals, information and self-help resources to empower people to take steps towards maintaining mental health and emotional wellbeing (Lifeline 2012).

*Distinguishing features:*

- Primarily delivered on a one-on-one basis
- Primarily delivered via an interactive 'chat' style modality

## Self-help–online

Self-help—online includes structured interactive online programs which take people, who have a lived experience of mental illness, through exercises to help them develop skills to handle life's challenges more effectively. Unlike Counselling, support, information and referral—online, services which fall under Self-help—online never involve interaction with another person, only interaction with the online program's content.

*Distinguishing features:*

- Population-based (rather than individually tailored)
- Conducted online
- Not individually facilitated by another person
- Available 24 hours a day

## Group support activities

Group support activities includes services that aim to improve the quality of life and psychosocial functioning of mental health consumers, through the provision of group-based social, recreational or prevocational activities. In contrast to services in the Mutual support and self-help service type, Group support activities are led by a member of the NGO.

*Distinguishing features:*

- Delivered to groups of consumers simultaneously
- Primarily engage consumers in one or more social, recreational, prevocational or physical activities
- Centre-based or conducted in community environments
- Led by an NGO employee or representative

## Mutual support and self-help

Mutual support and self-help includes services that provide information and peer support to people with a lived experience of mental illness. People meet to discuss shared experiences, coping strategies and to provide information and referrals (Metropolitan Health and Aged Care Services Division 2003). Self-help groups are usually formed by peers who have come together for mutual support and to accomplish a specific purpose (Solomon 2004).

*Distinguishing features:*

- Group-based services
- Comprising individuals with common experience and interest
- Led by one or more volunteer/unpaid consumer peers
- Provided on a face-to-face basis or through interactive online forums. Please note, while this service type can be conducted though interactive online forums, the online activity is not intended to be measured under the MH NGOE NMDS.

## Staffed residential services

Staffed residential services are those that provide overnight accommodation in a domestic-style environment, which is staffed for a minimum of 6 hours a day and at least 50 hours per week. Accommodation may be provided on a short, medium or long term basis.

*Distinguishing features:*

- Deliver services in a setting that provides overnight accommodation to consumers
- Domestic-style environment
- Consumers are encouraged to take responsibility for their daily living activities
- Staff are on-site for a minimum of 6 hours a day and at least 50 hours per week

## Personalised support–linked to housing

Personalised support services are flexible services tailored to a mental health consumer's individual and changing needs. They include a range of one-on-one activities provided by a support worker directly to mental health consumers in their homes or local communities (Department of Communities 2011).

*Personalised support—linked to housing* includes services that provide personalised psychosocial support that is coordinated with provision of social housing or privately negotiated housing at the point of entry into the program (but not necessarily tied to such indefinitely).

*Distinguishing features:*

- Primarily delivered on a one-on-one, face-to-face basis
- Primarily delivered in the consumer's home or own environment
- Provision of personalised support is coordinated with provision of social housing or a privately negotiated housing place at the point of entry into the program (but not necessarily tied to such indefinitely)
- Services are tailored to the needs of the individual consumer
- May be of varying intensity (e.g. high, medium, low)

## Personalised support–other

Personalised support services are flexible services tailored to a mental health consumer's individual and changing needs. They include a range of one-on-one activities provided by a support worker directly to mental health consumers in their homes or local communities (Department of Communities 2011).

Personalised support—other includes services that provide personalised psychosocial support that is independent of housing arrangements (e.g. provision of social housing or privately negotiated housing) at the point of entry into the program.

*Distinguishing features:*

- Primarily delivered on a one-on-one, face-to-face basis
- Primarily delivered in the consumer's home or own environment
- Provision of personalised support is initiated independently of any housing arrangements
- Services are tailored to the needs of the individual consumer
- May be of varying intensity (e.g. high, medium, low)

## Family and carer support

Family and carer support includes services that provide families and carers of people living with a mental illness support, information, education and skill development opportunities to fulfil their caring role, while maintaining their own health and wellbeing (Mission Australia 2012). These services may be provided in the context of early intervention or ongoing support.

*Distinguishing features:*

- Explicitly targeted at carers and families
- Includes all services focused on family and carer support except staffed residential respite services. Therefore, this includes services that, if they were not targeted at families and carers, would be reported in other service types.

## Individual advocacy

Individual advocacy includes services that seek to represent the rights and interests of people with a mental illness, on a one-to-one basis, by addressing instances of discrimination, abuse and neglect. Individual advocates work with people with mental illness on either a short-term or issue-specific basis.

Individual advocates:

- work with people with mental illness requiring one-to-one advocacy support
- develop a plan of action (sometimes called an individual advocacy plan), in partnership with the person with a mental illness, that maps out clearly defined goals
- educate people with mental illness about their rights
- work through the individual advocacy plan in partnership with the person with a mental illness (FaHCSIA 2012).

*Distinguishing features:*

- One-on-one services
- Primary service provided is advocacy
- Development of a plan of action
- Educate people with a mental illness about their rights

## Care coordination

Care coordination services provide a single point of contact (via a Care Facilitator) for people (and their families/carers) with lived experience of mental illness and complex care needs. Care Facilitators will be responsible for ensuring all of the patients' care needs, clinical and non-clinical and as determined by a nationally consistent assessment tool, are being met (Commonwealth of Australia 2012).

*Distinguishing features:*

- The principal service provided is the coordination of access to a range of services required by the individual
- Where other support services are delivered, they are incidental to the principal care coordination role

## Service integration infrastructure

Service integration infrastructure includes services that provide infrastructure integration to establish a 'one stop shop' service platform that brings together an appropriate range of mental health-related services, both existing and new, which aim to improve the mental well-being and social participation of people with mental illness.

*Distinguishing features:*

- Provides the administrative and capital infrastructure to facilitate the co-location of mental health-related services, rather than coordination of care for individual consumers
- The focus is the coordination of services, rather than on direct service provision

## Education, employment and training

Education, employment and training includes services where the principal function is to provide or support people with lived experience of mental illness, in gaining education, employment and/or training.

*Distinguishing features:*

- The principal purpose is to increase a person's ability to access education, employment and training
- Delivered one-on-one or as part of a group
- Education and training takes place through a structured program of tuition
- The education and training program can result in the attainment of a formal qualification or award (e.g. a Certificate, Diploma or Degree), however, this need not happen in every program

## Sector development and representation

Mental health sector development and representation services engage with a wide variety of issues regarding the sustainability and development of the mental health sector. This includes information dissemination, advocacy, policy analysis, program development and sector capacity building (Family and Community Services 2012).

*Distinguishing features:*

- Short, medium and long-term initiatives
- Initiatives are intended to benefit the mental health sector, rather than an individual organisation
- Services are not provided to individual clients but are targeted at developing and/or representing client service delivery organisations operating in the NGO sector.

## Mental health promotion

Mental health promotion includes services that operate on a population level which aim to raise awareness of mental health issues, improve mental health literacy, reduce stigma and discrimination and maximise the population's mental health and well-being. Mental health promotion may include programs targeted to population segments, based on age (e.g. early childhood) or setting (e.g. school or workplace), as well as initiatives to educate the general population.

This category also includes community-wide activities that provide information and education designed to enhance community understanding, increase the likelihood of identifying and addressing mental health problems and promote good mental health. These programs may be targeted towards specific at-risk communities or communities affected by disaster or trauma.

*Distinguishing features:*

- Provision of information and education
- Population-based
- Typically long-term initiatives

## Mental illness prevention

Mental illness prevention includes services that work to prevent the onset of mental disorders, in order to reduce the incidence and prevalence of mental illness in the community. Mental illness prevention activities are directed at reducing known risk factors and/or preventing people that display early signs of mental illness from developing a diagnosable mental illness. These activities can be either population-wide or targeted at vulnerable segments of the community. In contrast to Mental health promotion, which seeks to enhance the population's mental health, Mental illness prevention aims to prevent the development of mental illness.

*Distinguishing features:*

- Population-based
- Vulnerable segments of the community
- Typically long-term activities