Government of **Western Australia**
Mental Health Commission

Annual Report 2012/13

A Western Australia where everyone works together to encourage and support people who experience mental health problems and/or mental illness to stay in the community, out of hospital and live a meaningful life

Mental Health Commission

This Annual Report provides a review of the Mental Health Commission's (hereby refered to as the Commission) operations for the financial year ended 30 June 2013.

A full copy of this and earlier annual reports are available from the Commission's website at www.mentalhealth.wa.gov.au.

To make this annual report as accessible as possible, it is provided in the following three formats:

- an interactive PDF version, which has links to other sections of the annual report as well as external links to content on our website and external sites (excluding Financial statements from pages 58 to 91). All links are indicated by underlined text.
- an online version, which allows for quick and easy viewing of annual report sections. This version also features easy to use download and print functions
- a text version, which is suitable for use with screen reader software applications.

This annual report can also be made available in alternative formats upon request for those with visual impairments, including audio, large print and Braille.

 ISSN 978-0-9870909-6-6

Contact Details

Office address

Level 5, 81 St Georges Terrace
PERTH WA 6000

Postal address

PO Box X2299
Perth Business Centre
PERTH WA 6847

Telephone

(08) 6272 1200

Facsimile

(08) 6272 1299

Email

ContactUs@mentalhealth.wa.gov.au

Website

www.mentalhealth.wa.gov.au

Contents

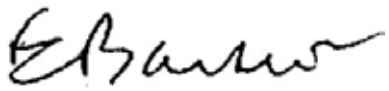
About Us

Hon Helen Morton MLC
MINISTER FOR MENTAL HEALTH

Dear Minister

In accordance with section 61 of the Financial Management Act 2006, I hereby submit for your information and presentation to Parliament, the Annual Report of the Mental Health Commission for the financial year ended 30 June 2013.

The Annual Report has been prepared in accordance with the provisions of the Financial Management Act 2006.



Eddie Bartnik
COMMISSIONER
MENTAL HEALTH COMMISSION

24 SEPTEMBER 2013

Our Mission

To lead mental health reform through the commissioning of accessible, high-quality services and supports and the promotion of mental health, wellbeing and facilitated recovery.

Our Values

The core values of an organisation define its ethos and culture. The Commission's values are as follows.

Hope and Optimism

Aiming high, expecting success but being realistic, knowing that goals can be achieved and recovery is possible.

Leadership

Creating a way for people to contribute to making something extraordinary happen.

Integrity

Acting ethically and taking personal responsibility.

Innovation and excellence

Recognising and rewarding ideas, focusing on quality improvement in all that we do.

Collaboration

Having a strong sense of unity, seeking out the diverse knowledge and experience of people with mental health problems and of those who care for, and work with them.

Transparency

Clearly communicating our contribution in achieving outcomes.

About Us

Our vision

A Western Australia where everyone works together to encourage and support people who experience mental health problems and/or mental illness to stay in the community, out of hospital and live a meaningful life.

Our history

The Mental Health Commission was established in March 2010 as Australia's first Mental Health Commission and represents a key step in implementing mental health reform throughout the State.

The Commission focuses on mental health strategic policy, planning and procurement of services, leads mental health reform across Government, promotes social inclusion, raises public awareness of mental wellbeing and addresses stigma and discrimination surrounding mental illness. We are unique in established mental health commissions nationwide as no other currently has responsibility for purchasing of mental health services. The Commission is not a direct mental health service provider.

Our vision, mission and organisational values have been developed collaboratively and reflect the aspirations of our stakeholders, especially consumers, carers and family members.

Our direction

The Commission's work in 2012/13 has continued to focus on three key strategic directions:

- developing recovery oriented, person centred supports and services for people with mental health problems and/or mental illness
- building connected approaches across Government agencies, and with community, private, and primary care services and the university sector
- planning for a full range of services in a comprehensive and contemporary mental health system, with balanced investment in community supports, early intervention and mental health promotion and prevention as well as acute intervention.

Our functions

- Development and provision of mental health policy and advice to Government.
- Leading the implementation of the Mental Health Strategic Policy.
- Responsibility for identifying key outcomes and determining the range of mental health services required for defined areas and populations across the State.
- Responsibility for specifying activity levels and standards of care.
- Identification of appropriate service providers and benchmarks, and the establishment of associated contracting arrangements with both government and non-government sectors.
- Purchasing of services and supports for the community.
- Ongoing performance monitoring and evaluation of key mental health programs in WA.
- Ensuring effective accountability and governance systems are in place.
- Promoting social inclusion, public awareness and understanding of matters relating to the wellbeing of people with mental health problems and/or mental illness to address stigma and discrimination.

Our people

The Commission has a diverse and dedicated team who work collaboratively with a variety of stakeholders to transform the way in which mental health services are delivered. As at 30 June 2013, the Commission had 90 staff.

The Commission's Wellbeing team continues to ensure staff have a variety of wellbeing opportunities to engage in. This year the team's focus has been activities with a theme of self care and looking after each other. Staff organised 'awareness events' around RU Ok Day, Harmony Day, Loud Shirt Day and Stress Less Day. Physical activities included weekly group training sessions, the Multiple Sclerosis Stair Climb, corporate soccer and Rotary Ramble. Other initiatives included healthy heart checks and sourcing a range of wellbeing resources. This staff-lead team also ensures there is a balance of work and social activities, offering a range of events both internal and external to the workplace, promoting a positive work environment and boosting morale.

Commissioner's Overview

I am pleased to present the fourth Annual Report of the Mental Health Commission.

This report highlights the key reform directions and partnerships that have been put in place to bring about fundamental changes in the mental health sector, with a stronger focus on person and family centred care in the community, partnerships and strategic engagement with state and national level reforms.

Admission and discharge review

The most significant development throughout the year was the joint commissioning by the Commission and the Department of Health (DoH) of the *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*. This independent review of the admission and discharge practices of public mental health services was conducted by Professor Bryant Stokes (Stokes Review). The Stokes Review gave a strong voice to the experiences of consumers, families and carers, staff and the general community with respect to the current operations of the mental health system in WA. The final report and State Government response was published in November 2012 and the Commission, in partnership with DoH, developed a comprehensive Implementation Framework for addressing the recommendations of the Stokes Review, along with an Implementation Partnership Group chaired by Barry MacKinnon AM.

Mental Health Services Plan

The Commission undertook jointly with the DoH to progress the principal recommendation of the Stokes Review to develop a Mental Health Services Plan (Plan) for Western Australia. Preliminary planning activities have been completed in 2012/13 for the development of this Plan, which is expected to be finalised by mid 2014. This plan will outline the optimal mix of services and supports required to meet the needs of the population experiencing mental illness and the resources required for delivery over the next 10 years. The development of this plan will provide an important opportunity for all stakeholders to communicate their aspirations and priorities to the Commission. The Western Australian plan will be informed by the *National Mental Health Services Planning Framework* and will further facilitate alignment between identified State priorities and national priorities. Such an approach is expected to optimise the benefits to WA through national level funding opportunities in the future, including National Health Reforms and the National Disability Insurance Scheme.

Mental Health Bill

New mental health legislation is an integral part of the Commission's mental health reform agenda. Proposed new legislation will provide greater protections and certainties for consumers; recognise and involve families and carers; and promote compliance by mental health services – all promoting recovery from mental illness and safeguarding against breaches of rights. The past year has seen substantial progress, with the *Green Mental Health Bill* tabled in Parliament in November 2012. The Green Bill was tabled for public comment, and the Commission's consultation with stakeholders has been ongoing. We are now preparing for the introduction of the Mental Health Bill 2013 into Parliament.

Delivering Community Services in Partnership (DCSP) Policy

The Commission has initiated a significant program of contracting reforms in line with the DCSP Policy for eligible organisations providing mental health community services. Fifty nine organisations have been re-engaged under a DCSP Policy Preferred Service Provider (PSP) process to provide outcomes based mental health community services on behalf of the Commission at an agreed sustainable price. The full amount of the government's allocation to the Commission of the applicable Component I and Component II funding for 2012/13 has been allocated to these community based organisations as part of their ongoing contractual arrangements.

CoMHWA

The Commission continued with its second year of funding to Consumers of Mental Health WA (CoMHWA). CoMHWA is steadily establishing itself to coordinate, promote and support the consumer voice within mental health services and to the wider community. A budget of $1.375 million over five years has been set aside to establish and support CoMHWA to provide systemic advocacy for and by consumers. A new Executive Director and Project Officer have recently commenced.

Peer work

As the Certificate IV in Mental Health Peer Work is now endorsed as a national qualification, the Commission is working collaboratively with various stakeholders including consumer, family and carer organisations, non-government organisations and public mental health services, including drug and alcohol and training organisations, to develop a strategic approach to strengthen the peer workforce. Supported by the Commission and Mental Health Carers Arafmi WA, a Recognition of Prior Learning tool has been developed by Polytechnic West, with current peer workers being enrolled in semester two, 2013. Further consumer, family and carer leadership investments have included Allies in Change, a community leadership program run in the Goldfields this year. The program allowed 37 consumers, families, carers and service providers to enhance their skills to effectively work in partnership with communities for greater advocacy and improved social inclusion. Participants, including many Aboriginal representatives, came from Kalgoorlie and surrounding areas such as Esperance.

Allies in Change workshop in the Goldfields

National mental health reform

In 2012/13, the Commission strengthened its role as the driver of strategic reform, aiming to achieve consistency across Commonwealth and State goverments. As Mental Health Commissioner, I represent Western Australia on several Council of Australian Governments (COAG) Senior Officials Working Groups and Principal Committees that are leading mental health reform nationally.

In 2012 COAG's *Roadmap for National Mental Health Reform 2012-22* was released having been developed in consultation with senior state level officials and the mental health sector. This Roadmap sets out the shared vision for the future of mental health in Australia and addresses the need for a longer term vision and framework to guide national mental health reform.

The Commission is also developing a strong partnership with the National Mental Health Commission to share information on policy priorities and stakeholder expectations. This important role played by the Commission ensures that issues identified by people with mental illness, their carers and families, and other stakeholders at the State level are appropriately reflected in the national policy directions and funding priorities. WA also participated in the first international meeting of Mental Health Commissions in Sydney in March 2013 and was a signatory to the *Sydney Declaration* which outlined priority areas for collaboration such as seclusion and restraint, Indigenous mental health, international benchmarking and the importance of work for people experiencing mental illness.

Agency collaboration

In 2012/13, the Commission continued to promote a whole-of-government approach in addressing mental health issues and entered into close collaborative networks with other State Government agencies to identify opportunities for joint effort. Particular examples include the Street to Home program's Mobile Clinical Outreach Team which provides mental health and drug and alcohol treatment for people who are sleeping rough in the Perth and Fremantle inner city areas (in conjunction with the Department for Child Protection and Family Support) and the new multi agency court diversion programs in both the Children's and Adult Courts (in conjunction with Departments of Health, Attorney General, Corrective Services, WA Police and non-government partners).

Commission achievements

As the Commissioner for Mental Health, I am pleased to provide information in this report on achievements in the broader work of the Commission. The Commission receives funding through the State's budget appropriation and Commonwealth funding for specific national partnership programs to engage the best possible mix of services to benefit the community.

The Commission invested a total of over $598 million in 2012/13 to support the delivery of mental health services, including public specialised mental health (in-patient and community) and non-government services. Approximately 86 per cent of the Commission's investment was for public specialised mental health services in 2012/13. The Commission continues to work towards achieving an improved balance of services through investment in the non-government sector. The total investment in the non-government in 2012/13 was $85.2 million, an increase from $64.7 million.

The Commission consolidated the gains made by the implementation of new initiatives in the previous reporting periods by continuing to improve the level and quality of services delivered through these programs. While maintaining the effort in ongoing programs such as Individualised Community Living, Mental Health Assertive Community Intervention, Statewide Specialist Aboriginal Mental Health Service, Mobile Clinical Outreach Team, National Perinatal Depression Initiative and the *WA Suicide Prevention Strategy,* the Commission has also continued its investment to increase the supply of step-up and step-down services to ease pressure on hospital emergency departments and provide increased choices for consumers and their families/carers. These programs provide the basis for the Commission's advancement towards its overarching vision of a Western Australia where everyone works together to encourage and support people who experience mental health problems and/or mental illness to stay in the community, out of hospital and live a meaningful life.

Merger with Drug and Alcohol Office

Another important development for mental health reform was the Premier's announcement on 10 April 2013 that the Commission and Drug and Alcohol Office (DAO) will amalgamate under a single Chief Executive. This will ensure better integration of the State's network of services relating to prevention, treatment, professional education and training, and research activities in the drug and alcohol sector and across mental health services. This improved coordination of services will provide better support to people with co-occurring issues and enhance programs for those most at risk.

Acknowledgement and appreciation

The contributions of people with lived experience of mental illness, their families, carers and networks to the wellbeing of our community is greatly appreciated.

The important role played by the staff of the Commission in their dedication towards the achievement of our vision also requires special mention. I would like to acknowledge the quality, professionalism and hard work of our staff, who uphold and fully reflect the Commission's values – hope and optimism, leadership, integrity, innovation, excellence, collaboration and transparency.

The collective effort of the Commission and all its stakeholders in the mental health sector has helped to establish a strong reputation within the broader community for the mission that we have set on. This work would not have been

possible without the enduring support and commitment from our Minister, the Hon Helen Morton MLC, and I take this opportunity to record my gratitude for her commitment, dedication and support.

I would also like to thank Mr Barry MacKinnon AM, Chair and members of the Mental Health Advisory Council, as well as Mr Peter Fitzpatrick AM, Chair and members of the Ministerial Council for Suicide Prevention for their significant contribution throughout the year.

Last, but not the least, I would like to commend the effort of all mental health workers in this State. The Commission's effort in planning and policy development will become meaningless without the exceptional contribution from the State's dedicated mental health workforce. The Commission will continue to focus on developing a State mental health workforce development strategy to meet the challenges posed by a growing population, with significant changes to WA's demography.

I thank you all for your valuable support in our fourth year of operation, and look forward to working closely with you in the coming years.

Eddie Bartnik
COMMISSIONER
MENTAL HEALTH COMMISSION

Operational Structure

Responsible Minister

The Commission is responsible to the Minister for Mental Health, the Hon Helen Morton MLC.

Accountable authority

The Commission was established by the Governor in Executive Council under Section 35 of the *Public Sector Management Act 1994*.

The accountable authority of the Commission is the Commissioner for Mental Health, Mr Eddie Bartnik.

Administered legislation

The Commission does not directly administer any legislation.

Other key legislation

In the performance of its functions, the Commission complies with the following laws:

- *Auditor General Act 2006*
- *Carers Recognition Act 2004*
- *Corruption and Crime Commission Act 2003*
- *Disability Services Act 1993*
- *Equal Opportunity Act 1984*
- *Financial Management Act 2006*
- *Freedom of Information Act 1992*
- *Health and Disability Services (Complaints) Act 1995*
- *Hospital and Health Services Act 1927*
- *Industrial Relations Act 1979*
- *Mental Health Act 1996*
- *Minimum Conditions of Employment Act 1993*
- *Occupational Safety and Health Act 1984*
- *Public Interest Disclosure Act 2003*
- *Public Sector Management Act 1994*
- *Salaries and Allowances Act 1975*
- *State Records Act 2000*
- *State Superannuation Act 2000*
- *State Supply Commission Act 1991*
- *Workers' Compensation and Injury Management Act 1981*

In the financial administration of the agency, management has complied with the requirements of the *Financial Management Act 2006* and all other relevant laws, and exercised controls that provide reasonable assurance that the receipt and expenditure of monies and the acquisition and disposal of public property and incurring of liabilities have been in accordance with legislative provisions.

At the date of signing, management is not aware of any circumstances that would render the particulars included in this statement misleading or inaccurate.

Organisational structure

The Commission comprises five directorates. The organisational structure has remained unchanged in 2012/13. However a Consultant Psychiatrist has been seconded to the Commission from the Department of Health and is a member of the Corporate Executive. The organisational structure as at 30 June 2013 is shown in Figure 1.

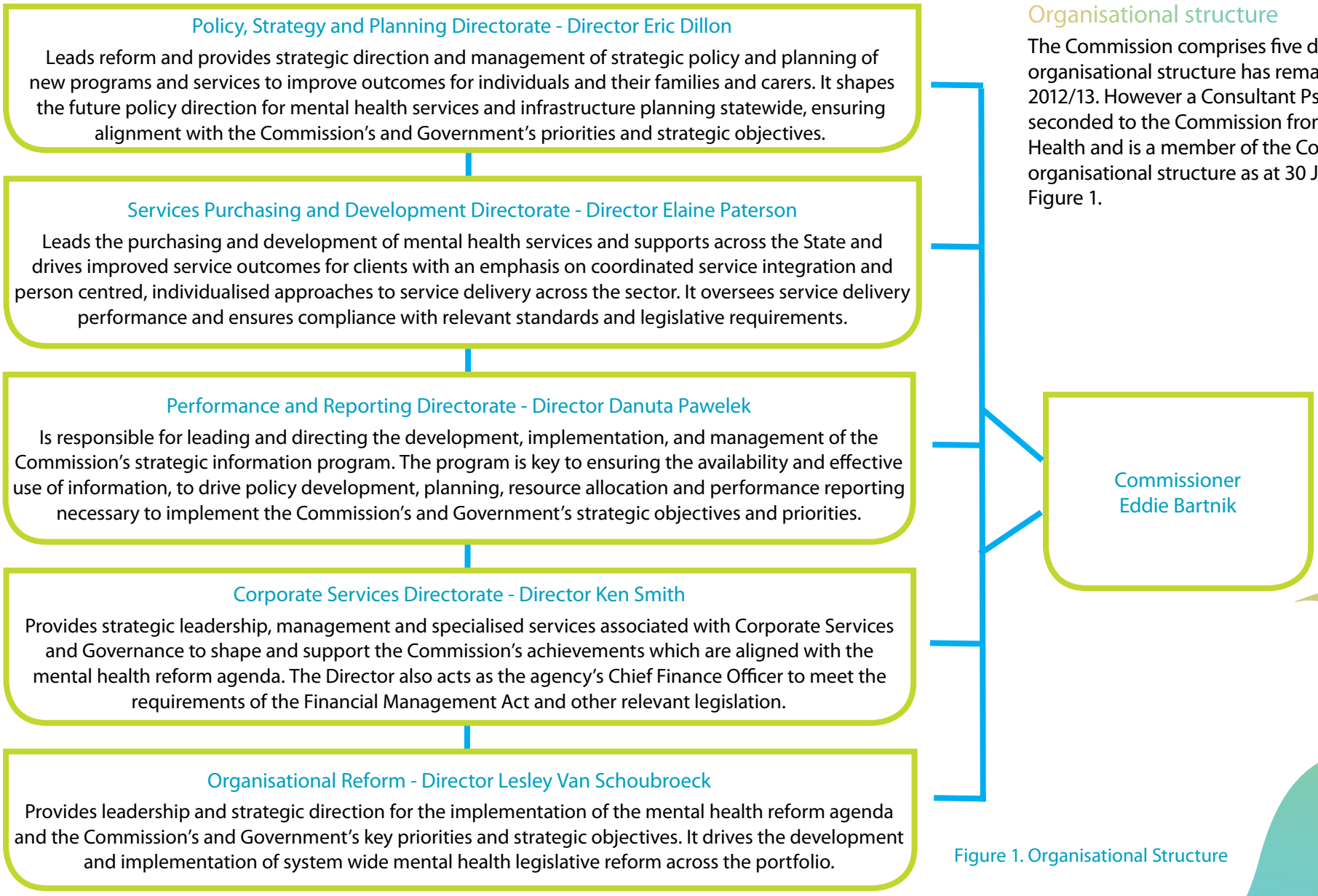


Figure 1. Organisational Structure

Executive Staff

L-R: Ken Smith, Danuta Pawelek, Eric Dillon, Elaine Paterson, Lesley van Schoubroeck and Eddie Bartnik

The Corporate Executive is the Commission's senior management team.

Eddie Bartnik

Mental Health Commissioner

Eddie Bartnik was appointed the State's first Mental Health Commissioner in August 2010. He has worked in the human services sector for many years and has significant national and international experience.

Eddie has held senior positions within the Western Australian public service across various agencies. This includes leadership roles in policy, funding and statewide service delivery with the Disability Services Commission where he championed innovative approaches to individualised funding and personalised support. Eddie was previously the Acting Director General of the Department for Communities from 2009 to 2010.

Eddie's qualifications include a Masters degree in Clinical Psychology, Master of Educational Studies and a Bachelor of Arts (Honours in Psychology). Eddie is a Graduate of the Australian Institute of Company Directors, a Fellow of the Australasian Society of Intellectual Disability and a Fellow of the Australian Institute of Management.

Eric Dillon

Director Policy, Strategy and Planning

Eric Dillon holds a BSc Hons and Masters Degree in Environmental Science and other post graduate qualifications. Eric has significant experience in local government in the United Kingdom and over 25 years of experience in the Western Australian public sector, much of which has been at senior executive level working within the health, mental health and drug and alcohol sectors and in collaboration with non-government organisations.

Danuta Pawelek

Director Performance and Reporting

Danuta Pawelek has 26 years experience working in the Western Australian public sector. Danuta has considerable expertise in policy development and evaluation, strategic development and change management, as well as a thorough understanding of accountability mechanisms in the public sector. Danuta has extensive practical experience in information and systems development and implementation. Danuta holds a Magister (Masters) of Economics Degree from the Lodz University in Poland.

Lesley van Schoubroeck

Director Organisational Reform

Lesley van Schoubroeck has extensive experience in policy and strategy in human services organisations and in central agencies in the Western Australian public sector. Lesley has a PhD from Griffith University in politics and public policy as well as post graduate qualifications in psychometrics and is a former secondary teacher. Lesley is committed to promoting fairness and justice and incorporating the views of the most vulnerable people in the development and implementation of policy and in reviewing the performance of the public sector.

Executive Staff

Ken Smith

Director Corporate Services and Governance

Ken Smith has a wide variety of experience over 37 years from small business, government line agencies and Treasury. In addition to human resources and information technology experience, Ken has a strong financial management, accounting and budgeting background. This includes pioneering whole of government financial reporting and Treasury responsibility for managing the budget allocations of a number of agencies. Ken is a CPA and Chief Finance Officer of the Commission.

Elaine Paterson

Director Services Purchasing and Development

Elaine Paterson has worked in the WA State Government for nine years following 20 years experience working in a number of different government departments in the UK. Elaine joined the Commission in 2011 coming from the Department of Finance where she was working on the implementation of the Delivering Community Services in Partnership Policy. Elaine has a Masters in Business Administration, a Masters in Business Psychology, and a degree in Business Administration and Human Resource Management.

Dr Steve Patchett

Consultant Psychiatrist

Steve Patchett has over 30 years experience as a psychiatrist in public mental health services in New Zealand and WA. He has directed programs in Community Mental Health and Forensic Mental Health and was Executive Director of the Mental Health Division, Department of Health, between 2007 and 2010. Steve has a strong interest in the development and accountability of modern, high quality mental health services throughout WA.

Ministerial Portfolio Support

Hon Helen Morton MLC

MINISTER FOR MENTAL HEALTH

In addition to the Commission, the Ministerial mental health portfolio encompasses a number of statutory and non-statutory entities including:

- the Drug and Alcohol Office (DAO)
- the Council of Official Visitors (CoOV)
- the Mental Health Review Board (MHRB).

As the lead agency supporting the Minister for Mental Health, the Commission plays an important role in supporting and coordinating the operations of these entities.

The CoOV and MHRB are rights protection bodies established under the *Mental Health Act 1996*. Administrative responsibility for the CoOV and MHRB was transferred to the Commission through the 2012/13 State Budget. Specific activities undertaken by the Commission in support of these entities over the past year include:

- relocation of the MHRB to its new premises at 681 Murray Street, West Perth
- management of appointments and reappointments to the MHRB (Mr Michael Hawkins' appointment as President of the MHRB has been extended by the Governor in Executive Council until 31 December 2013)
- facilitation of input from Board members and Official Visitors in respect of proposed legislative reforms contained in the *draft Mental Health Bill*
- development of a new computer-based case management system to support the operation of both entities, which is scheduled to be rolled out in 2013/14
- provision of advice regarding compliance with legislation and policy governing the operation of the public sector
- board approvals
- ensuring members and staff of both entities are included in portfolio wide planning and activities as appropriate.

Ministerial liaison

The Commission's Ministerial Liaison Unit (MLU) coordinates and prepares responses to Ministerial and Parliamentary enquiries. The MLU provides an important liaison function between the Minister for Mental Health, the Minister's office and the Commission, and between agencies where a coordinated response is required.

Regular briefings are provided to the Minister's office on key issues to ensure effective communication between the Commission and the Minister. In 2012/13, the MLU dealt with approximately 622 pieces of correspondence including briefing notes, letters and Parliamentary Questions.

Performance Management Framework

Outcomes, services and performance information

The Commission has the lead responsibility for mental health reform across the State and its work is underpinned by the Government's ten year strategic policy *Mental Health 2020: Making it personal and everybody's business*. The Commission's main contribution to achieving government goals in 2012/13 was in the area of 'Outcome Based Service Delivery'. The links between the government goal, the Commission's desired outcome, services purchased and performance indicators for 2012/13 are outlined in Figure 2.

Changes to Outcome Based Management Framework

The Commission's *Outcome Based Management Framework* was updated in the *2013/14 WA Government Budget Statements* following approval by the Department of Treasury.

Whole of government goal

Outcomes Based Service Delivery: Greater focus on achieving results in key service delivery areas for the benefit of all Western Australians

Our desired outcome

Accessible and high quality mental health services and supports that are recovery focussed and promote mental health and wellbeing

Key effectiveness indicators:

- Readmissions to hospital within 28 days of discharge
- Percent of contacts with community-based public mental health non-admitted services within 7 days post discharge from public mental health inpatient units
- Proportion of service funding directed to publicly funded community mental health services
- Proportion of service funding directed to community organisations (NGOs)

Services we purchase

Service One

Promotion and prevention

Key efficiency indicator

Cost per capita of activities to enhance mental health and wellbeing (illness prevention, promotion and protection activities)

Service Two

Specialised admitted patient services

Key efficiency indicator

Average cost per purchased bed day in specialised mental health units

Service Three

Specialised community services

Key efficiency indicator

Average cost per purchased episode of community care provided by public mental health services

Service Four

Accommodation, support and other services

Key efficiency indicators

- Average cost per hour for community support provided by non-government organisations to people with mental health problems
- Average MHC subsidy per bedday for people with mental illness living in community supported residential accommodation

Figure 2. Outcome Based Management Framework

	2012/13 Budget $'000	2012/13 Actual $'000	Variation $'000
Total cost of services (expense limit)	582,079	598,196	16,117
Net cost of services	458,038	443,803	(14,235)
Total equity	9,931	9,225	(706)
Net increase/(decrease) in cash held	(777)	1,740	2,517
Approved full time equivalent staff level	85	90	5

Table 1. Summary of highlights comparing actual results with budget targets

Summary of Key Performance Indicators

	2011-12 Actual	2012-13 Actual	2012-13 Target[1]	VARIATION 2012-13 Actual and Target
Outcome: Accessible and high quality mental health services and supports that are recovery focused and promote mental health and wellbeing				
Key Effectiveness Indicators				
Readmission to hospital within 28 days of discharge	9.8%	11.9%	<=12%	Within range
Percent of contacts with community-based public mental health non-admitted services within 7 days post discharge from public mental health inpatient units	70%	73.4%	>=70%	Within range
Proportion of service funding directed to publicly funded community mental health services	38.7%	42.2%	>=40%	Within range
Proportion of funding directed to community organisations (NGOs)	11.4%	13.3%	>=15%	(1.7%)
Service 1: Promotion and Prevention				
Key Efficiency Indicator:				
Cost per capita of activities to enhance mental health and wellbeing (illness prevention, promotion and protection activities)	$10	$15	$17	($2)
Service 2: Specialised admitted patient services				
Key Efficiency Indicator:				
Average cost per purchased bedday in specialised mental health units	$1,138	$1,102	$1,117	($15)
Service 3: Specialised community services				
Key Efficiency Indicator:				
Average cost per purchased episode of community care provided by public mental health services	$1,820	$2,142	$1,964	$178
Service 4: Accommodation, support and other services				
Key Efficiency Indicators:				
Average cost per hour for community support provided by non-government organisations to people with mental health problems	$73	$76	$78	($2)
Average MHC subsidy per bedday for people with mental illness living in community supported residential accommodation	$206	$210	$240	($30)

[1] Set as part of the Government Budget process.

Table 2. Summary of key performance indicators

Key Directions

The Commission continues to focus on the implementation of reform strategies that will deliver a person focused, comprehensive and high-quality mental health system in WA.

A key initiative was the development of the Government's ten year strategic policy *Mental Health 2020: Making it personal and everybody's business* that was launched by Premier Colin Barnett in October 2011. The policy provides a whole-of-government and community approach to mental health and sets out three key directions:

1

Person centred supports and services

The unique strengths and needs of the person experiencing mental health problems and/or mental illness are the key focus of individualised planning, supports and services.

2

Connected approaches

Strong connections between public and private mental health services, primary health services, mainstream services, businesses, communities, individuals, families and carers help achieve the best outcomes for Western Australians living with mental health problems and/or mental illness.

3

Balanced investment

A comprehensive and contemporary mental health system provides a full range of support and services, ranging from mental health promotion and prevention activities, through to early intervention, treatment and recovery.

These directions impact upon every aspect of the current mental health system – enhancing high quality and established treatment services, building on fledgling supports and developing innovative recovery and early intervention services.

Reform Direction

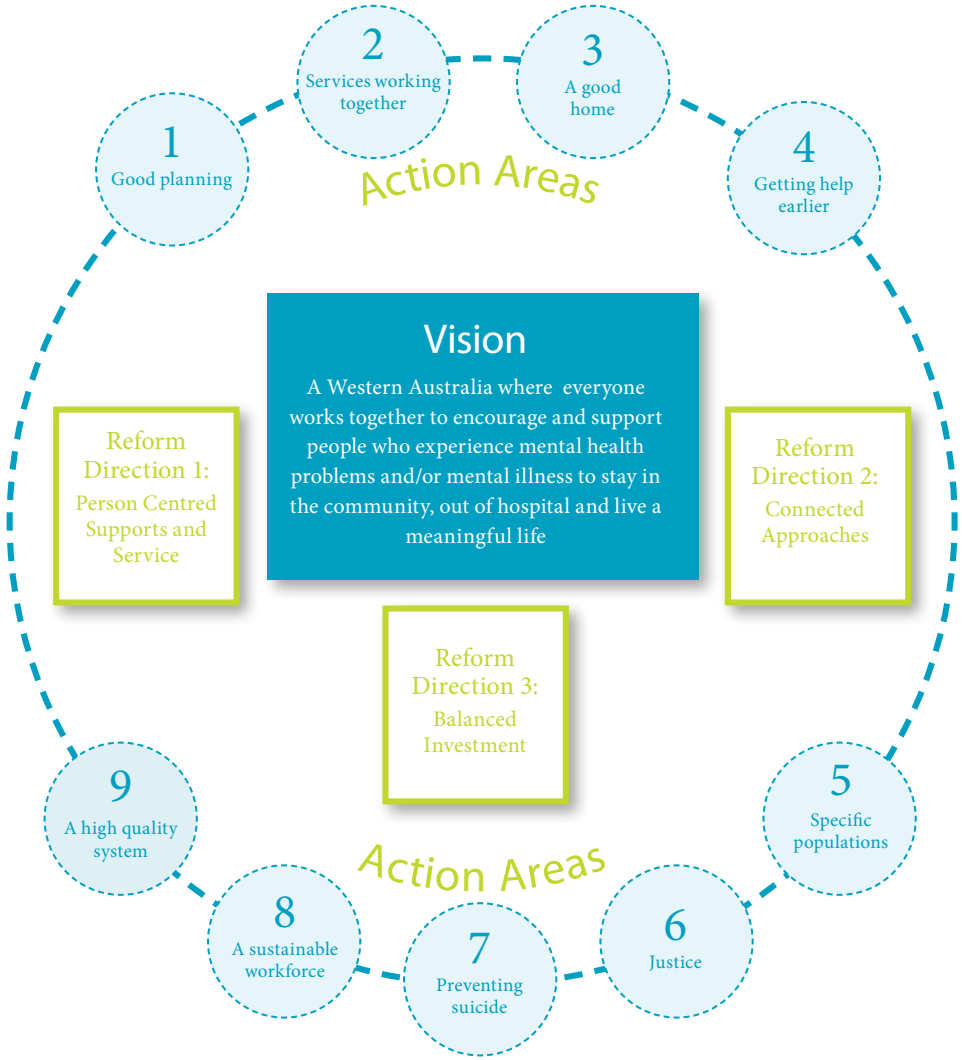


Figure 3. Reform agenda

The Commission is implementing the reform agenda in a staged approach. The Commission developed it first *Action Plan* that identified actions against nine priority areas for 2011/12 to improve mental health services and supports, and implement the strategic policy.

In 2012/13, two systemic reform initiatives commenced. The first was the Government's response to the *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* completed by Professor Bryant Stokes, AM. The Government broadly supported the recommendations and these are being progressively actioned largely by the Commission and Department of Health. The principal recommendation was to develop a comprehensive mental health services plan. Accordingly, the Commission and Department of Health have commenced the development of a comprehensive ten year Mental Health Services Plan that will provide a blueprint for the development of mental health services in WA for the next decade. Further details are provided in the Legislation and Quality Assurance section on page 24.

In addition, in April the State Government announced the amalgamation of the Commission with the Drug and Alcohol Office (DAO). This will ensure better integration of the State's network of mental health and drug and alcohol prevention and treatment services across WA and strengthen the new organisations ability to negotiate and manage contracts for the future. The DAO Board will continue to operate and be supported by the Commission until changes to the *Alcohol and Drug Authority Act 1974* can be enacted to amalgamate the DAO and the Commission.

The Commission, in partnership with government, private, non-government and community organisations, is building a State where everyone is working together to encourage and support people who experience mental health problems and/or mental illness to stay in the community, out of hospital and live a meaningful life.

Understanding Mental Health Problems and Illnesses

Prior to the 1990s, limited information was available about the extent and impact of mental illness in Australia. In 1995, a program of study under a common theme of understanding mental health and wellbeing in the population of Australia was initiated to address this gap. As part of the program, three surveys known collectively as the *National Survey of Mental Health and Wellbeing* (the National Survey) commenced in 1997.

The first survey was designed to investigate the prevalence and impact of common mental disorders[1] in adults, the second[2] focused on the less common mental illnesses, in particular psychotic disorders[3] and the third[4] captured information about the mental health of children and adolescents. The first two surveys were repeated in 2007[5] and 2010[6] respectively and a new survey of children and adolescents is being conducted during 2013.

Mental illness comprises a wide spectrum of disorders with varying degrees of severity. Examples include anxiety, depression, bipolar disorders and schizophrenia. The effect of mental illness can be severe on the individuals and families concerned, and its influence is far-reaching for society as a whole. Social problems commonly associated with mental illness include poverty, unemployment or reduced productivity, violence and crime. People with mental illness often experience human rights problems such as isolation, discrimination and being stigmatised [7].

1 Depression, Anxiety and Substance Abuse.
2 People living with psychotic illness: An Australian Study 1997- 98. Commonwealth of Australian 1999.
3 Schizophrenia, bipolar affective disorders and depression with psychotic symptoms and persistent delusional disorders
4 Sawyer et al. The mental health of young people in Australia: Key findings from the child and adolescent component of the national survey of mental health and well-being. Australian and New Zealand Journal of Psychiatry 2001;35:806-14.
5 National Survey of Mental Health and Wellbeing 2007
6 People living with psychotic illness 2010. Report on the second Australian Survey. Commonwealth of Aust 2011.
7 Australian Institute of Health and Welfare, Australia's Health 2012. Australia's Health Series, No 13, Canberra, 2012

Together with prevalence data, information on burden of disease and severity of mental illness contribute to our understanding of the impact of mental health problems.

Burden of disease

Mental disorders are the leading cause of non-fatal burden of disease (24 per cent) in Australia, meaning that, of the total years of healthy life lost through illness or disease, 24 per cent are lost through the effects of mental illness[8]. The disability-adjusted life year is a measure of overall disease burden expressed as the number of years lost due to not only ill health and disability, but also early death. Worldwide, major depression is predicted to be the second leading cause of disability adjusted life years in 2020[9].

The peak onset for mental illness is in youth and mental illness in childhood and adolescence creates a significant clinical and social burden on the individual, their family and society. For older teens (15-19 years) mental illness accounted for the majority (51 per cent) of total burden from all diseases and injury. For young teens (10-14 years) mental illness accounted for almost half of their total ill health (47 per cent in both sexes)[10].

8 Begg et all (2007), The burden of disease and injury in Australia 2003, AIHW PHE 82, April Canberra.
9 Murray C and Lopez D (1997) "Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study. The Lancet, Vol 349, Issue 9064
10 Access Economics Pty Ltd (2009). The economic impact of youth mental illness and the cost effectiveness of early intervention.

Prevalence

Based on the 2007 National Survey[11] of common mental disorders, it is estimated that in WA approximately one in five (20 per cent or 380,000)[12] adults (16-85 years) experience a mental disorder during any given year and that one in two (45 per cent or 860,000)[13] adults will experience a mental disorder at some time in their lives[14].

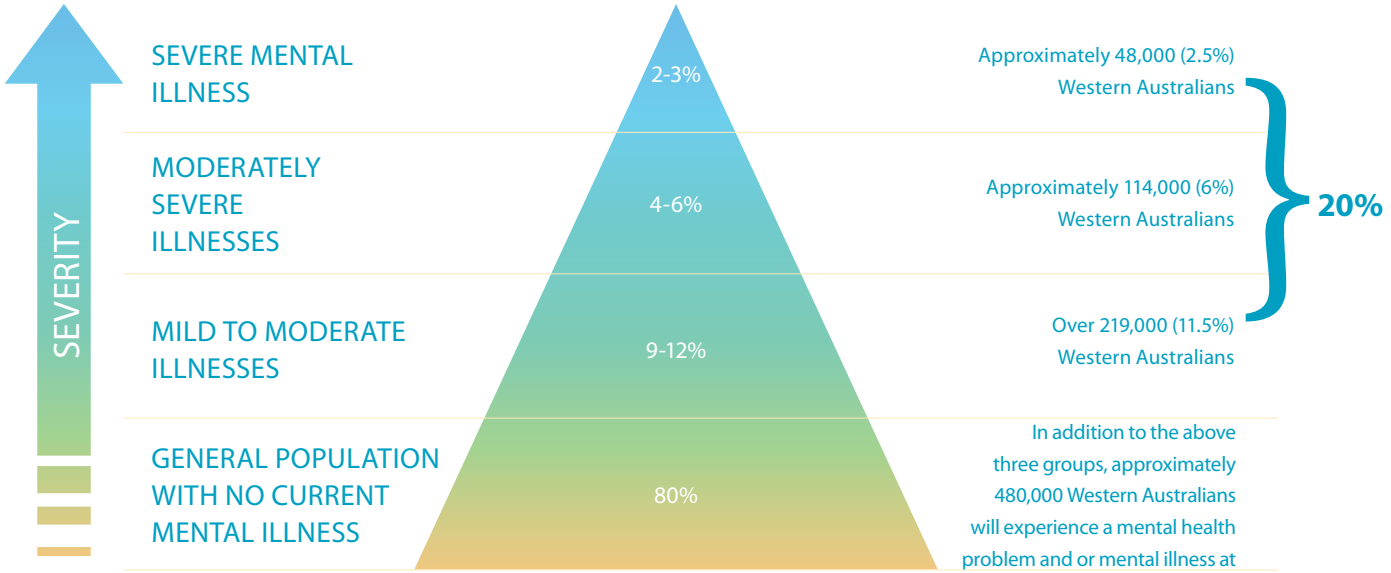
Based on the 1997 child and adolescent component of the National Survey[15], it is estimated that 14 per cent or approximately 60,000 young Western Australians aged between 4-17 years were affected by a clinically significant mental health problem.[16]

The 2010 *Survey of High Impact Psychosis*[17], investigated the prevalence and impact of psychotic disorders. It is estimated that approximately 7,100 Western Australians (aged 18 to 64 years) have a psychotic illness that has a high impact in terms of disability.[18] The onset of these illnesses is usually in late adolescence or early adulthood with a consequent negative impact on education, employment and social relationships.

Severity of illness

The measure of severity used in the 2007 National Survey summarises all the mental disorders experienced in a 12 month period and their effect on a person's daily life and categorises this impact as severe, moderate or mild. Figure 4 illustrates the estimated number of Western Australians by the severity of common mental disorders experienced in a 12 month period. [19]

Figure 4. Prevalence and severity of mental disorders in Western Australia in one year



Extrapolated to the June 2012 Western Australian estimated residential population (ERP) of persons aged 16 to 85 years (1,904,426)

11 National Survey of Mental Health and Wellbeing 2007
12 Extrapolated to projected WA population June 2012.
13 Extrapolated to projected WA population June 2012.
14 Extrapolated to projected WA population June 2012.
15 National Survey of Mental Health and Wellbeing 2007
16 Extrapolated to projected WA population June 2012.
17 Commonwealth of Australia (2011). People living with psychotic illness 2010. Report on the second Australian national survey.
18 Extrapolated to projected WA population June 2012.
19 Council of Australian Governments. National Action Plan for Mental Health 2006-2011. Fourth Progress Report – covering implementation to 2009-10

Suicide statistics in Western Australia

Suicide is a major public health concern and preventing suicide and suicidal behaviour requires a comprehensive whole-of-government and whole-of-community approach. The Western Australian Suicide Prevention Strategy 2009-2013 was developed to provide a framework for the State Government to coordinate and invest in suicide prevention strategies at all levels in the community.

Suicide and suicidal behaviour involves a complex interaction and interplay between genetic, biological, social, environmental and demographic factors, family characteristics and childhood experiences, personality and beliefs, mental disorders and alcohol and drug use. Often a combination of these factors can increase the risk of suicidal behaviour.

The Australian Bureau of Statistics (ABS) is the statutory agency responsible for analysis and reporting of mortality data in Australia, including suicide. Data on suicide in Australia has been published by the ABS since 1983, with suicide statistics available from 1881.

ABS data on suicide deaths are sourced from the state and territory Registrars of Births, Deaths and Marriages and supplemented by information from the National Coroners Information System. The management of death registration systems is the responsibility of the eight individual state and territory Registrars. Published data on suicide are always retrospective with up to an 18 month lag due to the length of time required for coronial processes to be finalised. Care needs to be taken in interpreting figures relating to suicide due to limitations of data.

The ABS primarily publishes data on deaths due to suicide in its annual Causes of Death (cat.no.3303.0) publication. Further detail on suicide statistics, using ABS data unpublished in Causes of Death, are published in various formats in national documents including the Report on Government Services (RoGS).

Table 3 below presents statistics on suicide for the period 2002 to 2010, as reported in the 2013 RoGS, as well as preliminary data for 2011 from the ABS' Causes of Death (CoD).

RoGS	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number of deaths	242	227	194	203	245	266	300	278	310
Standardised death rate (per 100,000 pop[n])	12.6	11.6	9.8	10.1	12.1	12.6	14.2	12.7	13.8

CoD-ABS	2011
Number of deaths	306
Standardised death rate 2007-2011	13.1

Table 3: Deaths due to suicide registered in Western Australia - 2002 to 2010

Note

ICD-10 codes X60-X84.9 and Y87.0 were used to define suicide for all years.

Numbers based on the year the death was registered.

Include deaths of persons usually resident overseas, that occur in WA

Data for 2009, 2010 and 2011 are preliminary and subject to revision as cases may be added when coronial investigations for deaths occurring in these years are finalised.

Sources: Report on Government Services, 2013 - Table 12A.59.

Australian Bureau of Statistics, Causes of Death, 2011 (cat. no. 3303.0)

Table 4 presents statistics on suicide deaths of Western Australian residents, registered in WA for the period 2002 to 2011, compiled by the Department of Health's Epidemiology Branch. A similar table was presented in the Commission's 2011-12 Annual Report; however, the figures for 2008 to 2010 have been updated.

These statistics are also sourced from the ABS but differ from the data provided in Table 3.

Key differences include:

- year of registration of death (Table 3), compared with year of death (Table 4)
- all deaths occurring in WA (Table 3), compared with death of WA residents only (Table 4)
- single year data used to calculate standardised rates (Table 3), compared with three year moving averages used to calculate age standardised rates (Table 4).

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Number of deaths	244	214	196	206	250	258	295	271	299	286
Age standardised rate (per 100,000 pop[n])	12.5	11.2	10.3	10.7	11.5	12.6	12.5	12.8	12.3	12.5

Table 4: Deaths due to suicide of Western Australian residents, registered in WA-2002 to 2011

Notes
ICD-10 codes X60-X84.9 and Y87.0 were used to define suicide for all years.
Numbers based on the year of death.
Include deaths registered in WA for WA residents only.
Age Standardised death rates are calculated using three year moving averages in order to show trend data.
Data for 2009 to 2011 are preliminary and subject to change as cases may be added when coronial investigations for deaths occurring in these years are finalised.
In future Annual Reports data published nationally will be reproduced.
Source: Epidemiology Branch, WA Department of Health

Legislation and Quality Assurance

Protecting the rights of people with mental health problems or mental illness, their families and carers is a key function of the Commission. Ensuring choice and greater control over the supports and services they access is also central to the Commission's role. In 2012/13 a range of key initiatives were advanced to contribute to this reform agenda as follows.

Draft Mental Health Bill

New mental health legislation is an essential part of the Commission's mental health reform agenda.

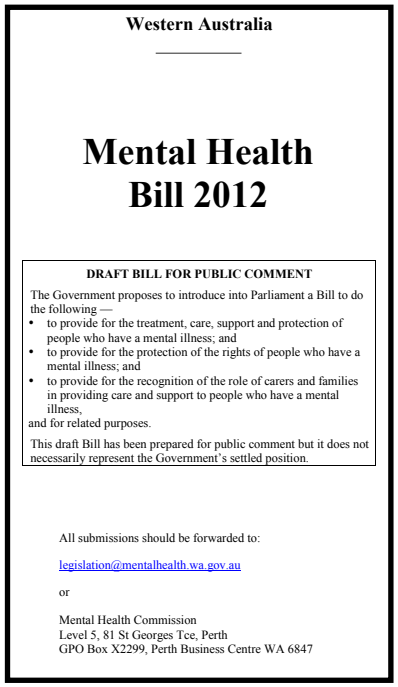
2012/13 has seen significant progress in the drafting of a new Mental Health Bill, which will provide for the treatment, care, support and protection of people experiencing mental illness.

In 2012, the *Draft Mental Health Bill* underwent a community consultation. Over 1,200 submissions were received reflecting many competing views. As a result, many changes were made and it was decided that a further round of consultation would be beneficial.

The Hon Helen Morton, Minister for Mental Health, tabled the *Green Mental Health Bill 2012* in Parliament on 8 November 2012. Explanatory materials were published to generate discussion and debate. The Commission invited submissions on the Green Bill until 28 February 2013 and received over 100. This further consultation was extremely valuable, and drafting of amendments to the Green Bill is underway.

To facilitate the considerable amount of work required to ensure successful transition to the new legislation, the Commission has:

- made progress in bringing together people experiencing mental illness, families and carers, clinicians and policy makers to provide input on processes and practicalities with respect to implementation of the Bill
- conducted nearly 37 forums and interviews to obtain input as to how the Mental Health Advocacy Service (currently the Council of Official Visitors) should operate under the Bill
- worked with the President of the Mental Health Review Board (MHRB) to arrange presentations by interstate Tribunal members to MHRB members and psychiatrists, to facilitate the transition from the MHRB to a Mental Health Tribunal
- worked in collaboration with the *Health and Disability Services Complaints Office* and 14 key stakeholders to draft a plain English document mapping complaints processes in the mental health sector and outcomes that can be achieved
- drafted specifications, and tendered for, a new computer-based case management system to support the operations of the MHRB and the Council of Official Visitors, that will be modified to support the Mental Health Tribunal and the Mental Health Advocacy Service once they are established



Western Australia

Mental Health Bill 2012

DRAFT BILL FOR PUBLIC COMMENT

The Government proposes to introduce into Parliament a Bill to do the following —

- to provide for the treatment, care, support and protection of people who have a mental illness; and
- to provide for the protection of the rights of people who have a mental illness; and
- to provide for the recognition of the role of carers and families in providing care and support to people who have a mental illness,

and for related purposes.

This draft Bill has been prepared for public comment but it does not necessarily represent the Government's settled position.

All submissions should be forwarded to:

legislation@mentalhealth.wa.gov.au

or

Mental Health Commission
Level 5, 81 St Georges Tce, Perth
GPO Box X2299, Perth Business Centre WA 6847

- met with many stakeholders and presented at a range of meetings and forums to provide information and answer questions about the new Mental Health Bill
- participated in forums conducted by Gregor Henderson, international mental health consultant, relating to quality assurance in the mental health sector.

In addition to progressing new mental health legislation, the Commission drafted an extensive submission to the Department of the Attorney General in relation to forensic mental health legislation, the *Criminal Law (Mentally Impaired Accused) Act 1996*, and contributed to the development of legislation by other departments.

Quality Assurance Framework

The Commission has a responsibility to lead mental health reform through commissioning accessible, high quality services that promote and support good mental health, wellbeing and recovery for people with mental illness or mental health problems, their families and carers. In 2011, the Commission contracted international consultant Gregor Henderson to provide advice to inform the development of a new Quality Assurance Framework for mental health services in WA. The *Developing a Quality Assurance Framework for Mental Health in Western Australia* (the Report) presents a framework for the future that builds on the already substantial work that has taken place on quality assurance in mental health in WA and on the views of the many stakeholders and agencies involved. In 2012/13, the Commission continued to progress the implementation of the Report's recommendations.

Following the initial visit and Report by Gregor Henderson, the Commission has progressed the recommendations regarding rights and protections through the Green Mental Health Bill; and the quality management recommendations via the development of the six *Outcome Statements* and the initial self assessment process conducted in the community managed sector. Gregor Henderson was again engaged in March 2013 to consult with key stakeholders to further outline the key elements of the quality assurance system as it operates in WA, with a particular focus on the quality management aspects.

The *Green Mental Health Bill 2012*, has included recommendations within the report that relate to the rights and protection of people experiencing mental illness, their families and carers. These include:

- a new Charter of Mental Health Care Principles setting out what consumers can rightfully expect from mental health services
- establishment of an independent Mental Health Tribunal to replace the Mental Health Review Board and to provide more regular and comprehensive reviews of involuntary patient status
- a statutory Mental Health Advocacy Service to replace the Council of Official Visitors, under the direction of a Chief Mental Health Advocate and with an expanded remit to support vulnerable patients
- new requirements to include families and carers in decision making and discharge planning
- new safeguards in relation to regulated treatments such as electroconvulsive therapy
- mandatory reporting of suspected physical and sexual assault of patients.

The recommendations relating to quality management included in the report have been progressed through:

- the development of six *Outcome Statements* in partnership with key groups in the community, including people with mental health problems and/or mental illness, and their families and carers
- the majority of Commission funded service providers undergoing a preferred provider process in line with the 'pre-qualification' process highlighted in the report. This will ensure equity across mental health services through demonstrating the same service standards
- the development of a quality management framework that includes:
    - an annual self assessment completed by non-government organisations including the development of a 12 month continuous improvement plan
    - improved reporting, tracking, management and investigation (as and when required) of Notifiable Incidents
    - evaluations that will be conducted by a panel of independent evaluators (including carers and people with a lived experience of mental illness) who will assess service quality by seeking evidence of the quality of the mental health service through direct feedback, observations and documentation. Services will need to demonstrate that they actively support individuals, and/or their families and carers, to achieve their personal goals (as they relate to the Mental Health Outcomes), and address the intent of each National Standard in practice. This independent evaluation process is under development and will be trialled in early 2014
    - establishing strengthened partnerships to progress the recommendations in the report.

Mental Health Outcomes Statements

Health, wellbeing and recovery

People enjoy good physical, social, mental, emotional and spiritual health and wellbeing and are optimistic and hopeful about their recovery.

A home and financial security

People have a safe home and a stable and adequate source of income.

Relationships

People have enriching relationships with others that are important to them such as family, friends and peers.

Recovery, learning and growth

People develop life skills and abilities, and learn ways to recover that builds their confidence, self esteem and resilience for the future.

Rights, respect, choice and control

People are treated with dignity and respect across all aspects of their life and their rights and choices are acknowledged and respected. They have control over their lives and direct their services and supports.

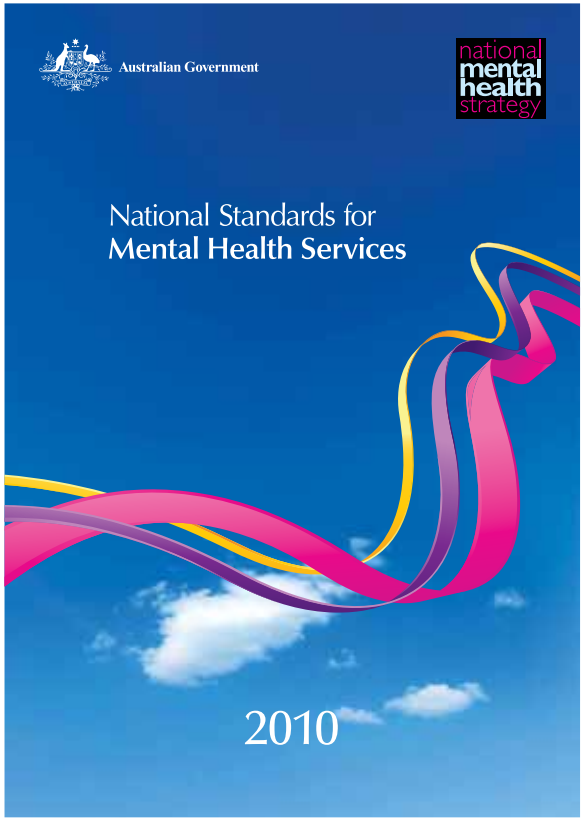
Community belonging

People are welcomed and have the opportunity to participate and contribute to community life.

National Standards for Mental Health Services 2010 (National Standards)

In 2012/13, the Commission continued to support the implementation of the *National Standards* in consultation with key stakeholders across the mental health sector. This included continued funding to the Western Australian Association for Mental Health (WAAMH) to deliver training to the sector on the National Standards.

All Commission funded services undertook a self assessment against the National Standards in late 2012 which included the development of a 12 month continuous improvement plan. This assessment process will occur annually and will complement the independent evaluation process that will occur approximately every three years for funded services.

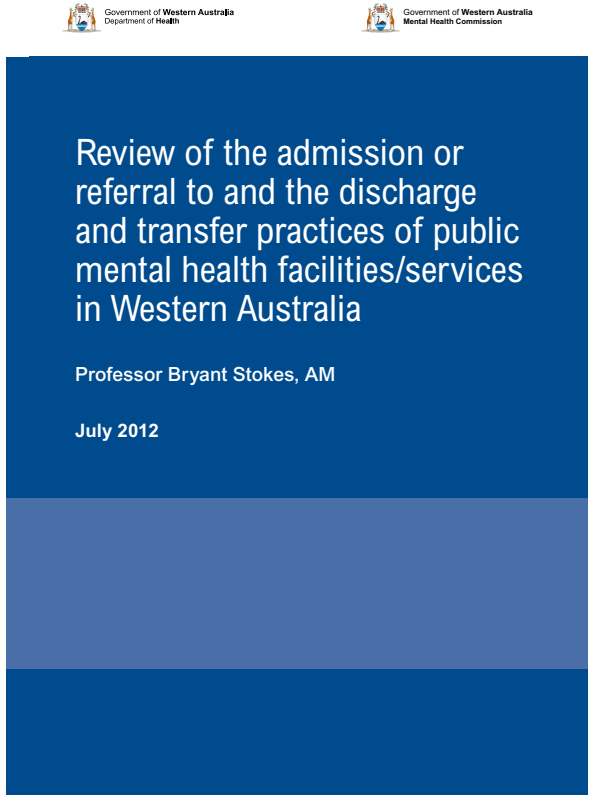


Review of admission and discharge planning

An independent review, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities in Western Australia* (the Stokes Review) was led by Professor Bryant Stokes, AM with the report released in November 2012. The Stokes Review was undertaken to provide an analysis of the compliance with recommended practices, and to provide recommendations to ensure the policies and practices are effective. The resulting report provides significant guidance and assists with quality improvement in public mental health services.

The Stokes Review included findings from public hospital emergency departments and specialised inpatient and community public mental health services. The final report contained 117 recommendations, and presented information arising from submissions and interviews with individuals with mental illness, families, carers, clinicians and service providers.

Comprehensive work has begun to implement the recommendations and further details are provided in Significant Issues Impacting the Commission section on page 54.



Funded services

The Commission is responsible for a range of public investment in mental health and purchases services which best meet the needs of individuals, families and carers. Since its establishment in 2010, the Commission has been progressively working to achieve balanced investment across the mental health system. This involves ensuring that critical resources required to support people with mental illness are in place and that investment in specialised mental health services is complemented by investment in a range of formal and informal supports and services which focus on prevention, early intervention and recovery. This will take time to achieve but significant progress has been made during the year.

The total expenditure on mental health services in 2012/13 was over $598 million, including public specialised mental health (inpatient and community) and non-government services. With approximately 86 per cent of the Commission's service investment in public specialised mental health services. The Commission's aim is to achieve an improved balance of services through future investment. The below table provides an overview of funding allocation to public mental health services and non-government organisations over the previous two years. The Commission intends to develop a comprehensive and contemporary mental health system that provides a full range of support and services, and to build the role of the non-government sector and its connection to people in the community.

	2010-11 $'000	% of total	2011-12 $'000	% of total	2012-13 $'000	% of total
Public mental health*	$441,587	90%	$470,794	88%	$513,006	86%
Non-government organisations	$49,107	10%	$64,735	12%	$85,190	14%
Total	$490,693	100%	$535,529	100%	$598,196	100%

Table 5: Commission's investment in public and non-government services in 2010-2013

*Includes a publicly funded, privately operated hospital.

A cornerstone of this investment is improving the range of services in a strong and sustainable non-government sector. In 2012/13 more than $85 million was invested by the Commission in 86 non-government organisations for mental health services and supports including prevention and promotion, community support and supported accommodation. A list of community sector organisations funded by the Commission is included in Appendix One.

Preventing suicide

The *WA Suicide Prevention Strategy 2009-2013* (Strategy) continues to be implemented across the State. The Strategy is overseen by the Ministerial Council for Suicide Prevention (MCSP) with initiatives implemented by Centrecare as the lead non-government organisation. Significant community engagement has been achieved with 45 Community Action Plans (CAPs) developed and owned by local communities in 255 individual locations. There are seven statewide plans and targeted CAPs for at-risk groups including Aboriginal and regional communities, young homeless people, sex and gender diverse people and people in prison. Over 220 organisations have taken an Agency Pledge to implement suicide prevention activities and training for their workforce and stakeholders. The Agency Pledges are a highly successful and sustainable element of the Strategy, as the increased suicide prevention awareness within organisations also creates flow-on benefits to their families and community networks.

Alongside the Strategy, the Commission invested over $1.6 million across a range of suicide prevention initiatives such as counselling and early intervention services, crisis lines and the national depression and anxiety initiative beyondblue. In 2012/13, Lifeline WA received $520,000 towards their telephone crisis counselling services. Youth Focus received $465,000 for additional staff to help young people overcome issues associated with self-harm, depression and suicide.

Suicide response in the Kimberley

There continues to be a significant number of suicides in the Kimberley requiring a coordinated response. Under the Strategy, approximately $2.7 million in funding has been allocated to CAPs in the Kimberley region. The CAPs are delivering a range of community awareness raising events and mental health and suicide prevention training programs. Local leadership is being fostered to help people in need access supports, and services are strengthening networks to enhance safety and reduce risks.

Coordinated response for at-risk young people

In response to an increase in emergency presentations to hospitals by young people for suicide attempts and self-harm, a new program was funded in 2012. The program connects school-aged children with mental health services such as the Child and Adolescent Mental Health Service (CAMHS) and headspace to reduce the risk of self-harm or suicide. The Commission and the Ministerial Council for Suicide Prevention provided joint funding of $474,000 for six additional mental health staff at CAMHS and $200,000 to the Department of Education for a school psychologist who will work with the Catholic Education Office, Association for Independent Schools in WA and the public school system and will collaborate with Child and Adolescent Mental Health services (CAMHS) to bring about a more integrated approach in relation to suicide prevention. These initiatives will complement the rollout of the CAMHS Acute Response Team (ART). ART is a 24-hour, seven-day-a-week program at Princess Margaret Hospital to assess and assist children and young people experiencing mental health issues in the community.

The Commission provided an additional $200,000 to Youth Focus for a coordinated mental health crisis response strategy in WA metropolitan high schools. Students impacted by a mental health crisis are better supported with a specialist psychologist delivering immediate counselling and psychological support. A school liaison officer is establishing improved communication pathways with school staff, stakeholders and local services/supports; and mental health training is being delivered to school communities.

Individualised Community Living

The Commission has continued to implement the key reform directions of its strategic policy, *Mental Health 2020: Making it personal and everybody's business*, through promoting and establishing person centred approaches for people with mental illness, their families and carers.

A flagship initiative for achieving this has been through the *Individualised Community Living (ICL) strategy*, established in 2011/12, and designed to assist individuals and their families in working towards a good life and increased control and choice over the supports and services they receive.

The ICL strategy involves three components of reform including:

- commissioning of services in an outcomes based procurement environment for community managed organisations and development of policies, frameworks and systems by the Commission with emphasis on individual choice of housing, locations and living arrangements
- clinical assessment procedures, transition planning and provision of complementary specialist clinical services
- development of comprehensive support plans for each individual including active involvement in decision making and self direction by the person with mental illness, their family and carers.

Since the commencement of the strategy, 100 people have received a personalised support package to live in their own home in the community with access to a range of community based activities, supports and clinical services. Each person has been actively involved in choosing and furnishing their home, with 85 people having moved in and the remainder of the people in the process of transitioning to their new home.

In 2012/13 additional capital funding of $11,485,000 over four years was committed for the purchase of 22 community based homes and $14,430,000 for 48 packages of support. This will support an additional 22 people to move into their new home and an additional 26 people to receive support while continuing to live in their current home.

In support of the implementation of the ICL strategy the Commission has:

- developed a suite of policies, frameworks and guidelines that support the strategy, including *Creating a Great Life with You, Accountability and Safeguards Frameworks*, *Individualised Funding policy* and guidelines and the *Individualised Support and Funding Policy* as well as operational guidelines
- established the ICL Independent Panel that reviews all individual plans for newly eligible people and recommends them for funding
- continued to build on partnerships with key stakeholders and developed a Memorandum of Understanding (MOU) with the Department of Housing and the Department of Health
- sponsored a range of training and development opportunities attended by individuals with a lived experience, family members and mental health sector organisations.

People who have received assistance through ICL report that:

- being involved in the purchasing of their new home has great meaning to them, people feel valued and that they have been heard
- having their own home has created stability to re-engage with their community. People have been able to revisit and engage in activities they used to enjoy, including returning to study, volunteering, enjoying social activities, creative expression and enjoying time with family and friends
- personalised packages have enabled tailoring of supports and services specific to individual needs. This has ensured parents with mental illness have successfully kept their family together and in some instances people are able to share their home with a flatmate who helps out.

Community alternatives to hospitalisation

The Commission has progressed a range of initiatives to support the implementation of community alternatives to hospitalisation. Mental health subacute services are one such initiative and the first model of care of its kind for WA.

Also known as step-up, step-down services, subacute services provide appropriately balanced clinical and non-clinical care and support to individuals who are at risk of becoming unwell and for people leaving hospital who may require more intensive support before returning home.

During the year, the development of the 22 bed Joondalup subacute service culminated in the establishment of a modern and person centred service which commenced service provision in May 2013.

Planning for the Rockingham and Broome subacute services has continued, with appropriate land options being sourced and negotiations underway to enable the development of future subacute services in these locations. It is anticipated that these services will become operational by 2015-16.

Additionally, the planning and development for the six bed subacute service in the Goldfields region is underway with funding of $2.52 million allocated for its operation. This new subacute service will ensure that people living with mental illness in the Goldfields region will have access to mental health services closer to where they live.

The Government has also announced an intention to develop a 10 bed subacute service in Bunbury and a six bed service in Karratha. When completed this will deliver a total of 72 subacute beds, of which 28 will be in country regions.

Joondalup subacute service opened by the Minister for Mental Health, the Hon Helen Morton MLC and Premier Colin Barnett MLA.

Supported accommodation

In 2012/13, the Commission continued to fund a variety of supported accommodation options with a total of 1696 beds available, excluding the *Individualised Community Living Strategy*.

The supported accommodation program is delivered in partnership with the Department of Health and Department of Housing and a number of non-government organisations.

The program provides supported housing for people with a severe and persistent mental illness, people who are homeless, at risk of homelessness, people in unsuitable accommodation or residing for long periods in inpatient units. This group of people experience an increased risk of extended inpatient admission, frequent inpatient readmission, and high usage of community mental health and other services, due to the limited supported accommodation options previously available in the community to adequately meet their needs.

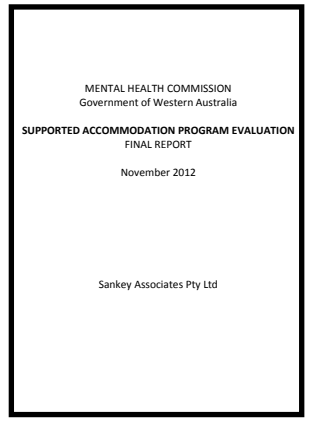
The Supported Accommodation Program offers crisis and respite care, transitional care, independent living, licensed psychiatric hostels, long term accommodation, community supported residential units and community options for young people and adults, as well as specialist residential services for older people.

The Commission engaged Sankey Associates, an independent consultant, to complete an evaluation of 20 services in the supported accommodation program.

The evaluation process included in-person consultation with service providers, interviews with residents and their families, as well as two paper-based surveys. A reference group comprised of key stakeholders, including the Commission, service providers, consumers and carers supported the evaluation process.

The *Supported Accommodation Program Evaluation Final Report* demonstrated that the Supported Accommodation Program is achieving significant positive outcomes for residents, and in doing so, is supporting and reassuring their families and carers as well.

"This is a valuable program delivering tangible benefits to people experiencing severe and persistent mental illness. As well as being provided with a good home, residents receive good clinical and non-clinical care and feel comfortable, safe and well supported. Many residents are pleased with the changes they have made in their lives and are optimistic about things continuing to go well for them. The Program is achieving good outcomes even in circumstances where families had previously held few expectations of improvement in the lives of their partners, adult children or siblings. Families are grateful and relieved that their family member is safe, well and happy. There are indications that the Program reduces preventable re-admissions to hospital."[1]


MENTAL HEALTH COMMISSION
Government of Western Australia

SUPPORTED ACCOMMODATION PROGRAM EVALUATION
FINAL REPORT

November 2012

Sankey Associates Pty Ltd

While the findings from the evaluation indicate positive outcomes for residents, the Commission is working at a number of levels to address the various issues highlighted in the report. The final report together with a commentary document prepared by the Commission can be downloaded from the Commission's website.

1 Sankey Associates Pty Ltd, Supported Accommodation Program Evaluation, Final Report November 2012

Specialised mental health services

The Commission provides funding to various organisations (public, private and non-government) to deliver a range of specialised mental health services. These services include mental health promotion and mental illness prevention, assessment, clinical interventions, support and recovery programs in a variety of settings including hospitals, community clinics, residential accommodation as well as support provided in the person's home.

Appendix Two provides a high level overview of services funded by the Commission categorised into four services:

- prevention and promotion
- specialised mental health admitted
- specialised community mental health
- accommodation, support and other services.

Prevention and promotion services focus on protecting, supporting, sustaining and maximising mental health among populations and individuals. Activities include early intervention, advocacy, carer/family support, education and information.

Specialised mental health admitted services provide admitted patient care to people with mental disorders. These services are provided in authorised public hospitals including Graylands/Selby, King Edward Memorial, Swan, Bentley, Armadale, Fremantle, Rockingham, Albany, Bunbury, and Kalgoorlie, as well as two publicly funded private hospitals, Joondalup and Mercy. These services are also provided in designated mental health inpatient units located in Royal Perth, Sir Charles Gairdner, Osborne Park, Broome and Princess Margaret hospitals. In early 2013, an expanded mental health inpatient unit was opened on the new site of the Albany Hospital, initially providing three additional inpatient beds. A further four beds will be opened in 2013 which will bring the total available specialised mental health inpatient beds in Albany to 16.

WA Health provides **specialised community mental health** services focussing on clinical interventions and specialist mental health support. The Commission has continued the process of increasing investment in these services with the allocation of $6.3 million commencing in 2012-13 to develop assertive community intervention services for children and their families experiencing a mental health crisis to reduce unnecessary emergency department presentations and prevent avoidable inpatient admissions. This funding is being provided as part of the Commonwealth *National Partnership Agreement Supporting National Mental Health Reform.*

Accommodation, support and other services are provided by a range of non-government organisations and include psychosocial support, rehabilitation, day programs, respite care, housing support and accommodation services.

Better services for Aboriginal people

As part of the *WA Implementation Plan for Closing the Gap in Indigenous Health Outcomes*, the State Government in 2010/11 committed a total of $22.47 million over four years to establish a Statewide Specialist Aboriginal Mental Health Service (SSAMHS), to provide specialist clinical interventions to Aboriginal people with severe and persistent mental illnesses across WA.

The SSAMHS model is a highly innovative arrangement which delivers whole-of-life mental health care. In addition to specialist clinical interventions, this model involves the family and engages traditional healers identified by people with mental illness and their families through community networks.

SSAMHS is focused on delivering improved access to responsive mental health services for Aboriginal people along with a career structure that will encourage recruitment and retention of Aboriginal staff. The key objectives of SSAMHS are:

- improving access to culturally appropriate mental health services for Aboriginal people and their families
- building the capacity of the Aboriginal mental health workforce
- developing and maintaining interagency partnerships aimed at the development of a more holistic approach to Aboriginal mental health care
- improving the cultural understanding and functioning of mental health service providers.

Agreements have been in place for SSAMHS to provide services in all metropolitan and country regions, except the Kimberley, since January 2011. The agreement for the Kimberley region was finalised in December 2011, and service delivery

commenced in May 2012. The Kimberley model involves an innovative regional partnership between WA Country Health Services and Aboriginal Controlled Community Health Services.

Guided by an interim evaluation conducted in early 2012, the SSAMHS program was further developed and consolidated during 2012/13. SSAMHS workers are progressively being co-located within mainstream mental health services, and at June 30 2013, over 80 per cent of 61.5 COAG funded SSAMHS positions were filled.

Further funding for SSAMHS was approved by the Department of Treasury in June 2013 which will enable the program to continue through to June 2014. The Commission will closely work with the new State Government Aboriginal Affairs Cabinet Subcommittee to improve coordination of Closing the Gap services and funding.

Acting Executive Director for North Metro Health Service Mental Health Patrick Marwick, Minister for Mental Health Helen Morton and Michael Mitchell, Program Manager, Specialist Aboriginal Mental Health Service Metropolitan unveil the plaque for the new service

Other Aboriginal-specific programs funded by the Commission include the Looking Forward project in the metropolitan south-east corridor, which aims to develop a model for mental health and drug and alcohol services to effectively engage with the Aboriginal community. Funding was also provided to deliver Aboriginal perinatal mental health training to Aboriginal health workers and other health providers in two metropolitan and two rural areas.

Reducing stigma and mental illness prevention

Reducing stigma and preventing mental illness is a key priority for the Commission which is constantly researching new and improved ways of engaging the community in this critical area. To gain further insight TNS Social Research was engaged to undertake research on stigma associated with mental illness, and identify key elements to inform social marketing campaigns and strategies to create positive behavioural and attitudinal change.

Over 1500 Western Australians were surveyed, including 590 people who self-identified as consumers. This research provides a baseline for measuring the effectiveness of stigma reduction strategies and changes in community attitudes over time in WA.

Key findings show that:

- Generally, the majority of the community do think that mental illness is a real medical illness (72 per cent), do not believe that mental illness is a sign of personal weakness (71 per cent) and do not believe that people can just snap out of the problem (69 per cent).
- A significant minority view people with mental illness as unpredictable (42 per cent), or a danger to others (20 per cent). Many people kept more social distance from people with schizophrenia.
- Over half of consumers have self-stigmatised, with three in 10 not disclosing illness in the workplace and three in 10 avoiding social events.
- Those with an experience of suicidal thoughts, self-harm, anxiety or an eating disorder are significantly more likely to report higher levels of self-stigma, including in their dealings with health professionals.
- Demographically, significantly more stigmatising attitudes are reported among

people who do not know anyone with a mental illness, men and people aged 18 to 44.

- Schools, workplaces and the media are important settings for stigma reduction education.
- General practitioners are critical to reducing stigma as they are often the first point of contact when someone is experiencing mental illness.

While there is a reasonable level of awareness around mental illness in WA, more needs to be done to engage young people and middle-aged men, and to break down stereotypes and prejudice around specific mental illnesses. A multi-pronged approach to address stigma should involve consumers and carers in educating the wider community about mental illness; strengthen peer-based programs; and utilise multi-media and innovative strategies to increase community support and awareness.

The Commission is using the research to improve existing stigma reduction activities such as Mental Health Week and the Music Feedback youth mental health campaign. New activities have been funded to address stigma, focusing on consumer empowerment and systemic change. This includes community awareness forums, public speaking workshops for consumers, and capacity building for self-help groups.

New initiatives included the Commission funding Connect Groups, the peak body for self-help and support groups in WA. The Connect Groups Pay it Forward grants involved the provision of brokerage funds to its member groups as part of a strategy to prevent the onset of mental health issues and support the recovery process of individuals. Over 50 support groups working in the community benefited from the grants and used the funds to buy minor equipment, build membership and strengthen capacity.

The Commission also provided a one off grant to Connect Groups to pilot five units of competency in self help and support group facilitation, which contributes toward a Certificate IV in Community Services. Twenty community members benefited from scholarships and the course has allowed an increase in the number of support group facilitators as well as strengthening a vital alternative community- based workforce.

New investment was provided to the Mental Illness Fellowship of WA to develop mental health multimedia resources for fly-in, fly-out workers and their families, with a focus on building resilience and early intervention.

The Commission has also continued throughout the year to support partnerships which promote mental wellbeing and prevent mental illness through universal campaigns and local activities. This includes significant funding for the national depression and anxiety initiative beyondblue, the Act Belong Commit statewide mental health campaign, the Music Feedback youth mental health campaign and school programs such as Aussie Optimism. A range of community arts and skill development programs are funded to foster social inclusion and improve mental health outcomes for at-risk groups.

Assisting People with Exceptionally Complex Needs

The People with Exceptionally Complex Needs (PECN) program is a multi-agency initiative that supports adults with co-occurring mental illness, acquired brain injury, intellectual disability and/or significant substance use problems. Individuals selected for the program receive intensive and coordinated support to meet a range of needs including access to housing, education and training, employment, health services and appropriate support.

During 2012, additional funding from the Commission enabled the capacity of the PECN program to be increased, with 19 individuals currently being supported. All 19 individuals now have access to individualised funding through the Commission or the Disability Services Commission. Support plans are being developed or are in place, and housing has been approved or provided for 11 individuals to date. There is clear evidence the PECN program is making a positive difference to the lives of these individuals and their families.

Following the success of the PECN program, the Young People with Exceptionally Complex Needs (YPECN) project was initiated in early 2012 to coordinate services for young people with exceptionally complex, co-occurring needs. A coordinator for the program was appointed in March 2012, with funding and leadership being provided jointly by the Commission, Department for Child Protection and Family Support and Disability Services Commission. The YPECN project provides coordination for 11 young people and has achieved significant outcomes

for individuals such as re-engagement with family, return to school and education, and the provision of support to maintain placements with family or a service provider.

Disruptive Behaviour Management Strategy

The State Government introduced a *Disruptive Behaviour Management Strategy* to address public concern about disruptive behaviour in public housing.

The Commission and the Department of Housing developed a Memorandum of Understanding (MOU) which strengthens relationships and information sharing between the two agencies, and focuses on improving housing outcomes for people with mental health problems who are facing tenancy eviction. From this MOU, an Interagency Executive Committee was formed with membership consisting of senior representatives from the Commission, the Department of Health and the Department of Housing.

In addition, the Commission provided $20,000 to the Department of Housing for their key front line staff to undertake a two-day Mental Health First Aid Training course. This training has assisted staff to improve their knowledge and understanding of the signs and symptoms of mental health problems and/or mental illness.

The Commission and the Department of Housing will continue to work closely together to action the MOU, whereby mental health service providers will be notified of any 'strikes' or warnings under the *Disruptive Behaviour Management Strategy* that have the potential to impact on people with mental illness. This will provide an opportunity to review the support provided to people at risk.

Services for older people

In 2012/13, the Commission continued planning work to ensure that an appropriate mix of services and supports is available for the rapidly growing number of older people in WA. Developing the capacity of health and aged care providers to better manage mental health related issues and providing appropriate alternatives to reduce demand for acute inpatient care remain key priorities.

In late 2012 the Department for Communities launched *An Age-friendly WA: The Seniors Strategic Planning Framework 2012-2017*, (the Framework) which seeks to achieve a vision where all Western Australians age well in communities where they matter, belong and contribute. The Commission provided input into the development of the Framework in regard to approaches relating to mental health and wellbeing and will use the Framework to guide future planning initiatives for this age group.

Three key projects enhancing mental health services for older people became fully operational in 2012/13. Australian Government funding provided as part of the *National Partnership Agreement on Improving Public Hospitals* enabled the establishment and expansion of community mental health teams for older adults in Peel and the South West. The 10 bed older adult inpatient unit at Rockingham Hospital also became fully operational during the period, providing older people living in Rockingham, Kwinana and the Peel region with greater access to specialist mental health services closer to home.

Supporting people from culturally and linguistically diverse backgrounds

In 2012 the independent review *Transcultural Mental Health Services in Western Australia* was undertaken by Mr Rajiv Ramanathan, Director, Practical Visionaries, to examine current transcultural mental health services and consider national and international best practice standards.

More than 30 stakeholders including consumers and carers provided feedback to the review which will inform the future development and planning of WA transcultural mental health services. The review was also based on information gained through previous submissions to the *Mental Health 2020* consultation, and reviews and evaluations including those conducted by the Department of Health, South Metropolitan Health Service, Office of Multicultural Interests and Multicultural Mental Health Australia.

A final report detailing all findings and, where possible, costed recommendations, is currently being reviewed by the Transcultural Mental Health Review Reference Group with representation from the Commission, non-government agencies and consumers and carers.

Some of the key issues that have emerged from the Review include:

- difficulties in navigating the transcultural mental health system and accessing the range of services available
- the need for better coordination of existing services between general health, community, and mental health services and a clearer understanding of pathways to various services
- development of a culturally and linguistically diverse (CaLD) community capacity building strategy to ensure consistent information provision is delivered to individuals and communities
- current lack of evidence and information on access rates to mental health services in WA and the lack of availability of high quality transcultural mental health data
- the need for the development of a CaLD focused stigma reduction initiative that is in alignment with approaches recommended by the recent research (2012) conducted by TNS consultants on behalf of the Commission
- identification of the need to develop and enhance the cultural competency of Western Australian mental health services, including general practitioners, and ensure alignment with national initiatives.

Recommendations arising from the review will be considered in relation to the recommendations of the Stokes Review and when drafting the ten year Mental Health Services Plan.

Mental Health Court Diversion and Support Program

The State Government has invested $6.7 million in a new dedicated mental health court diversion and support service for adults and children. This joint pilot program funded through the Commission and the Department of the Attorney General will provide opportunities for individuals with mental health problems and/or mental illness who intersect with the criminal justice system to access community mental health services, to improve their mental health and address their offending.

The adult program began in the Perth Magistrates Court on 18 March 2013 and involves a specialist court, known as the *Specialist Treatment and Referral Team (START Court)*, offering mental health support services for people with a mental illness. A specialist clinical team which includes mental health nurses, a social worker and a consultant psychiatrist undertake assessments, provide advice to the court and develop individualised care plans. The adult program is an investment of $4.5 million. Up to the end of June 2013, 138 individuals appeared in *START Court*, and of these 104 had been assessed by the clinical team for suitability for inclusion in the *START Court* program. As at 30 June 2013, 50 individuals were being supported by the clinical team which is comprised of a psychiatrist, social worker, and mental health nurses.

The children's program commenced services on 8 April 2013 and will see an investment of $2.2 million to place specialised mental health expertise within the Perth Children's Court. This specialist support within the court, known as *Links*, has an emphasis on early intervention and the team provides assessments and reports to the court, in addition to developing effective personal support plans for children and their families/carers to coordinate agency and community support. The *Links* team, which includes a forensic psychologist and mental health nurses, will work collaboratively with the multi-disciplinary services already in place for children. As of 30 June 2013 the *Links* Team had assessed 30 children for *Links* suitability.

Both the adult and the children's programs are supported by the non-government sector in providing

The Links team at the Perth Children's Court.

non-clinical services. Community based services which address psychosocial needs such as education for children and skills development for adults are vital in diverting individuals from the criminal justice system and assisting in improving mental health. The Mental Health Court Diversion and Support Project will be evaluated to contribute to the development of the service into the future.

Services for infants, children and youth

There has been a growth in demand in recent years for assistance from children and their families with mental health problems. 75 per cent of all severe mental illness begins before the age of 24 years with peak onset between 18-24 years. Close to one third (31 per cent) of young people in WA experience a mental health problem/ mental illness each year.

Significant work has been undertaken to progress major reforms and innovations in mental health support and services for infants, children and young people. The Commission invests over $3.5 million of recurrent funding in the community managed sector to provide mental health services for children and young people.

Children and Young People

The Commission has commenced planning a comprehensive youth mental health service as part of a 10 year Mental Health Services Plan. Strategic planning and investment over the next 10 years aims to develop a statewide youth mental health service stream, integrating specialist and community mental health supports and services for young people aged 16 to 24 years and their families. In the meantime there have been a number of significant developments in the support provided to young people and their families and carers.

In January 2013, the Bentley Adolescent Unit, a 12 bed mental health inpatient facility for young people, completed extensive renovations with funding from the Commission and the Commonwealth Government. Renovations included more youth friendly and safe accommodation, greater outdoor and indoor recreational space, youth friendly furnishings and other changes to improve the therapeutic environment.

The Commission has worked in partnership with the Commonwealth Government to secure funding of $13.4 million over four years for a community based response known as Assertive Community Intervention (ACI) for children and their families experiencing a mental health crisis. The model provides a clinical service operated by the Child and Community Health Service (CAMHS) and family support offered through the non government sector.

Further, in response to an increase in emergency presentations by young people, an innovative new program is connecting school-aged children with mental health services such as CAMHS and headspace to reduce the risk of self-harm or suicide. The Commission and the Ministerial Council for Suicide Prevention provided joint funding of $473,700 for six additional mental health staff at CAMHS and $200,000 to the Department of Education for a school psychologist. These initiatives will complement the rollout of the CAMHS Acute Response Team (ART) which is a 24-hour, seven-day-a-week program to assess and assist children and young people experiencing mental health issues in the community with the aim of averting unnecessary hospitalisation. Based at Princess Margaret Hospital for Children, ART works alongside the ACI initiative.

Through the *State Suicide Prevention Strategy,* the Youth Affairs Council of WA (YACWA) received $300,000 to implement Stage 1 and Stage 2 Community Action Plans (CAPs) targeting young homeless people and their support workers. The CAPs encompass life skills training and peer support projects to empower homeless young people. YACWA will deliver suicide prevention training and develop strategic resources for support workers. Additional CAPs are reaching out to young people at-risk in the Town of Vincent, Peel, Wheatbelt, and the Kimberley region.

In late 2012, the State Government announced funding for a youth early psychosis service in the Perth Metropolitan area. In addition, the Commonwealth Government has announced its intention to fund an Early Psychosis Prevention and Intervention Centre (EPPIC) auspiced by headspace, as part of the Commonwealth Government's national mental health reform plan.

The State Government has sustained investment and provided a greater focus on mental health promotion, prevention, social inclusion and stigma reduction. mental health education programs for school communities aim to build resilience, promote positive mental health behaviours, and dispel the stereotypes and misunderstandings around mental illness. Key initiatives developed in WA include Aussie Optimism, an evidence-based mental health promotion program for children

in primary and lower secondary schools coordinated through Curtin University; Changing Minds School Education Program delivered by Mental Health Carers Arafmi and people with lived experience of mental illness; and Music Feedback youth mental health campaign led by YACWA. The Commission also supports the implementation of the national Kids Matter and Mind Matters mental health frameworks in WA schools through the State steering committee.

The Commission has provided funding to the Integrated Service Centres (ISC) at Koondoola and Parkwood primary schools to effectively engage children and their families from refugee and culturally and linguistically diverse backgrounds. The ISCs enhance access to culturally responsive services and supports; improve mental health, wellbeing and education outcomes; and build local community connections.

Further initiatives have been progressed in 2012/13 for children and young people that are included elsewhere in this report.

- Young People with Exceptionally Complex Needs (YPECN) (see page 35)
- Court diversion including specialised mental health expertise within the Perth Children's Court (see page 37)

Perinatal and Infant Mental Health Services

The Commission facilitates a monthly Infant Mental Health Planning Group (IMHPG) with representatives from government agencies and the Australian Association for Infant Mental Health Inc (AAIMHI). The IMHPG provides expert advice and enhances linkages around early childhood, parenting, family support and infant and child mental health. It also identifies gaps in policy and practice in relation to infant and child mental health within WA, fosters collaborative partnerships, and develops effective strategies to address areas of need within infant and child mental health.

The Commission provided $198,000 to continue a successful scholarship scheme to develop workforce expertise in infant mental health. This funding is administered by the AAIMHI to enable clinicians to undertake postgraduate university studies and approved training courses. AAIMHI is currently identifying frameworks for workforce competencies and training for a sustainable perinatal and infant mental health workforce. In addition, the Commission contributed funding of $49,300 to St John of God Outreach Services towards perinatal and infant mental health training in Armadale, Cockburn, Kalgoorlie and Albany.

The Commission has partnered with St John of God Outreach Services in the City of Swan and the WA Council of Social Services in the City of Cockburn to trial new models for integrated, community-based perinatal and infant mental health services. Women's health centres in Fremantle, Gosnells, Midland, Rockingham and Northbridge are also funded to deliver holistic perinatal mental health services.

For further information on perinatal mental health investment and programs see the National Partnerships section on page 50.

Stakeholder Engagement and Interagency Partnerships

Throughout the year the Commission has progressed opportunities to establish and strengthen a collaborative approach to mental health reform. The Commission maintained partnerships across a broad range of sectors with State Government departments and agencies, the community managed sector, private providers, universities and other research institutions.

Advisory bodies

Mental Health Advisory Council - chaired by Barry MacKinnon AM

The Commission has a strong partnership with the Mental Health Advisory Council (MHAC) which has been appointed by Cabinet to provide high level, independent advice to the Mental Health Commissioner on major issues affecting mental health care reform.

This was the MHAC's second year of operation and minutes of all meetings are available on the Commission's website.

Members of the Mental Health Advisory Council.

In the last year, the MHAC focused on seven priority areas:

- Mental Health Bill
- communication strategies
- drugs, alcohol and mental health
- *Mental Health 2020: Making it personal and everybody's business*
- the *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* by Professor Bryant Stokes, AM
- implementation of values
- workforce issues – education, peer, ageing.

The August 2012 meeting was held in Narrogin and the June 2013 meeting was held in Kalgoorlie as part of a program of planned country meetings to allow for better engagement and understanding of the issues impacting people within regional WA areas.

There has been a change to membership of the Council with two new members, Ms Victoria Hovane and Ms Pietra Liedel, replacing Mr Geoff Diver and Ms Katherine Hams from 1 July 2013. A list of members is provided in Appendix Three.

The Commission values the advice of the Council with the Commissioner and the Chair meeting regularly to address the major issues to be considered in the reform agenda. Statements of advice are now presented in writing to the Commission.

Ministerial Council for Suicide Prevention - chaired by Peter Fitzpatrick

In September 2009 the Government launched the $13 million W*estern Australian Suicide Prevention Strategy 2009-13* (Strategy) and a revised Ministerial Council for Suicide Prevention (MCSP).

The Council provides highly focused, practical advice to the Minister for Mental Health on suicide prevention initiatives and services throughout WA to be delivered through the contracted non-government organisation, Centrecare. Executive support and governance frameworks are provided by the Commission.

The WA Strategy is aligned with the *National Suicide Prevention Strategy: Living is for Everyone (LIFE)* and contains six action areas:

- Action Area 1: Improving the evidence base and understanding of suicide prevention
- Action Area 2: Building individual resilience and the capacity for self-help
- Action Area 3: Improving community strength, resilience and capacity in suicide prevention
- Action Area 4: Taking a coordinated approach to suicide prevention
- Action Area 5: Providing targeted suicide prevention activities
- Action Area 6: Implementing standards and quality in suicide prevention

The MCSP continues to meet on a monthly basis to oversee the implementation of Community Action Plans (CAPs), One Life Suicide Prevention Agency Pledge Partnerships and other initiatives to support suicide prevention including workplace and stakeholder activities. As part of the MCSP's commitment to engage with regional communities, the February 2013 meeting was held in Bunbury. A number of presentations were delivered by local suicide prevention Community Coordinators to provide an overview of their CAPs, key outcomes and issues in their district.

In 2013 there was a change to the MCSP membership with five new members appointed: Mr Stuart Smith, Professor Cobie Rudd, Mr James Gibson, Dr Neale Fong and Ms Donna Cole. A list of members is provided in Appendix Three.

The independent evaluation of CAPs and Strategy initiatives is being undertaken by Edith Cowan University (ECU) to demonstrate outcomes achieved so far and to build the evidence base for future suicide prevention activities in WA. The ECU evaluation report is due in March 2014 along with an overall Strategy evaluation to be overseen by the MCSP and these reports will provide critical data to inform the direction of the next Strategy. The MCSP will also hold its annual planning day on 19 September 2013.

Members of the Ministerial Council for Suicide Prevention

Partnerships

Western Australia Association for Mental Health (WAAMH)

The Commission continues to work closely with WAAMH, the peak body for community-managed mental health services in WA, to deliver a variety of education, prevention and promotion initiatives to the community and other stakeholders.

WAAMH and the Commission are key partners in implementing the *Delivering Community Services in Partnership policy* (DCSP) and progressing the Commission's reforms related to person centred, recovery orientated supports and services. The President of WAAMH is also a member of the Partnership Forum which oversees the implementation of the DCSP reforms. WAAMH and the Commission have also facilitated sector forums regarding both the DCSP and Commission reforms.

WAAMH collaborated in 2012 with the Commission to coordinate and promote various events and activities to recognise Mental Health Week. Mental Health Week promotes social and emotional wellbeing in the community, encourages people to maximise their health potential, enhances the coping capacity of communities, individuals, families and carers, and boosts mental health recovery. Events ranged from art exhibitions to seminars, poetry competitions, a quiz night and a basketball competition.

During 2012/13, WAAMH undertook the following additional projects:

- development of a sector strategic framework that outlines the key principles and processes that support better lives for people with mental illness, their families and carers and introduce a framework by which the non-government sector can effectively engage with the reform agenda
- engagement with the sector to map mental health services across WA and to establish a service directory that will be available through WAAMH's website. It is expected that this will be completed in July 2013
- establishment of an Outcome Measurement Taskforce following a successful Fostering Partnerships Grant from the Department of Finance. The taskforce is to develop a set of indicators and evidence against the Mental Health Outcomes that will assist in measuring how service providers are supporting individuals and families in meeting their individual needs
- provision of support to public and community managed mental health services to improve access to employment for people with mental health issues through the provision of technical assistance, training, fidelity assessment, consultation and support which has been built on the evidence-based Individual Placement Support (IPS) model of employment support. This support through WAAMH for IPS will continue in 2013/14
- provision of ongoing training to the sector including Certificate IV in Mental Health, Mental Health First Aid, Social Inclusion and Working with Aboriginal People.

Western Australian Collaboration for Substance Use and Mental Health

The Commission has maintained its ongoing partnership with the Drug and Alcohol Office (DAO) during 2012/13 to drive and support the WA Collaboration for Substance Use and Mental Health (WACSUMH). WACSUMH brings together government, non-government and community partners across the mental health, drug and alcohol, health and primary care sectors to progress initiatives towards creating an accessible, integrated and comprehensive service response for people who experience both substance use and mental health problems.

WACSUMH has supported the development of an accredited co-morbidity training program for general practitioners and other primary health care professionals. The roll out of this training in 2012/13 has been facilitated by Primary Care WA, with joint funding from the Commission and DAO. Training workshops have been held in the Perth metropolitan area and in Geraldton and Bunbury, with strong attendance by

general practitioners and allied health professionals who are interested in learning how to manage and treat people with both substance use and mental health issues.

The Commission and DAO's Workforce Development branch, in partnership with the Department of Corrective Services, provided funding to secure the services of Professor Steven Rollnick to provide a Motivational Interviewing workshop to clinicians, practitioners and workers from each sector. The Commission through WACSUMH also provided funding to WA Networks of Alcohol and Other Drug Agencies (WANADA) for the production and updating of a joint services directory handbook for workers across the mental health and alcohol and other drug sectors including GPs.

WACSUMH continued to drive work on integrated pathways, prevention, promotion and early intervention to support people with a mental health problem and/or mental illness and drug and alcohol problems by developing the *Collaborative Care Framework*. The Framework is currently being drafted for the consideration of the WACSUMH before a sector consultation phase is pursued. This will be followed by an implementation strategy to assist uptake within the sector.

WACSUMH has also taken carriage of developing strategies to address a number of the recommendations in the Stokes Review that relate to people who have co-occurring mental health and alcohol and other drug problems.

Dual disability

The term dual disability is used to describe individuals who have two or more conditions and may require assistance from a number of services. This can include: people with intellectual disability and mental health difficulties; people with mental health and complex physical health issues; and/or people with acquired brain injury and mental health difficulties.

People with intellectual disability are significantly more likely to experience mental health problems than people without intellectual disability. Despite their increased risk of mental illness, people with intellectual disability can experience difficulties receiving appropriate treatment.

Considerable focus on this area has been achieved in the last year, commencing with the Commission and the Disability Service Commission (DSC) establishing a Dual Disability Working Group. This interagency partnership includes a specialist psychiatrist from the Department of Health and carer advocate, and aims to develop strategies to improve access to appropriate mental health supports for people with disabilities. As a result of the work of this group, the Commission provided $145,000 to the WA Council for Social Services to develop a dual disability competency framework and accredited mental health awareness training package for staff working with people with disability, and carer support information. Development of these training resources and information will be guided by the Dual Disability Working Group and relevant stakeholders.

Further, through the Dual Disability Working Group the Commission and DSC invested in a series of symposia by international experts on improving mental and physical health outcomes for people with disability. These seminars were targeted at Department of Health staff, GPs and practice nurses.

The Commission has contributed expertise and resources to the *WA Study on the Health of People with Intellectual Disability* which has a secondary study aimed at capturing people's experience across health and mental health services. This groundbreaking research is led by the Centre for Research into Disability and Society at Curtin University and has strong cross-sector support.

The Commission is also represented on the Expert Advisory Group for the Disability Health Network which was established in January 2013. This network is led by the Department of Health and aims to explore ways to improve the health of people with disability and promote multiagency work to address identified priorities. Workforce training and education issues are being examined to improve disability and mental health awareness across services.

Commissioner for Children and Young People

The Commission has maintained an important partnership with the Commissioner for Children and Young People (CCYP) including hosting cross-sector forums to highlight mental health issues for young people.

In August 2012 the Commission and CCYP hosted a seminar featuring Professor Michael Chandler from the University of British Columbia who is renowned for his research into youth suicide among Canada's First Nations communities. Professor Chandler provided an overview of his research on addressing the

complexities of youth suicide and the vital role of cultural continuity to build resilience and strengthen communities. Professor Chandler also met with the Ministerial Council for Suicide Prevention and the School of Indigenous Studies at the University of Western Australia, and coordinated public forums in Perth and the Kimberley.

Eddie Bartnik, Commissioner for Mental Health, Professor Michael Chandler and Michelle Scott, Commissioner for Children and Young People.

Funding has been provided to the CCYP to enable the Perth visit by Dr Michael Ungar, Professor of Social Work at Dalhousie University and Scientific director of the Resilience Research Centre in Novia Scotia, Canada. Dr Ungar specialises in the topic of resilience and its application to clinical and community workers with a particular focus on children and families with complex needs. Dr Ungar will deliver the Children's Week keynote address in October 2013.

Supporting Consumer, Family and Carer Engagement Policy and Guidelines

Engagement is central to the Commission's strategic policy *Mental Health 2020: Making it Personal and Everybody's Business*.

To ensure a high quality, effective mental health system that is responsive, people with mental health problems and mental illness, their families and carers need to be engaged as genuine partners in mental health reform at the individual, service, system and community levels.

The Commission directly engages with consumers, families and carers seeking their advice on policy and planning for mental health reform. The Commission funds organisations to encourage engagement and provide a systemic voice in programs, systems planning and implementation.

In 2013, the Commission finalised its *Supporting Consumer, Family and Carer Engagement Policy and Guidelines* and developed an engagement framework (see Figure 4). The policy affirms the Commission's commitment to working with consumers, families and carers and outlines the circumstances when payments will be made to them for participation in Commission activities. The policy is based on the *International Association for Public Participation* and reflects the valuable contribution these important stakeholders make to the Commission's work.

Allies in Change

The Goldfields was the 2012 venue for the second *Allies in Change*, a community leadership program funded by the Commission. Allies in Change supported 37 consumers, families, carers and service providers to develop their skills to work in partnership with communities for improved social inclusion. Participants came from Kalgoorlie and surrounding areas and included Aboriginal representatives.

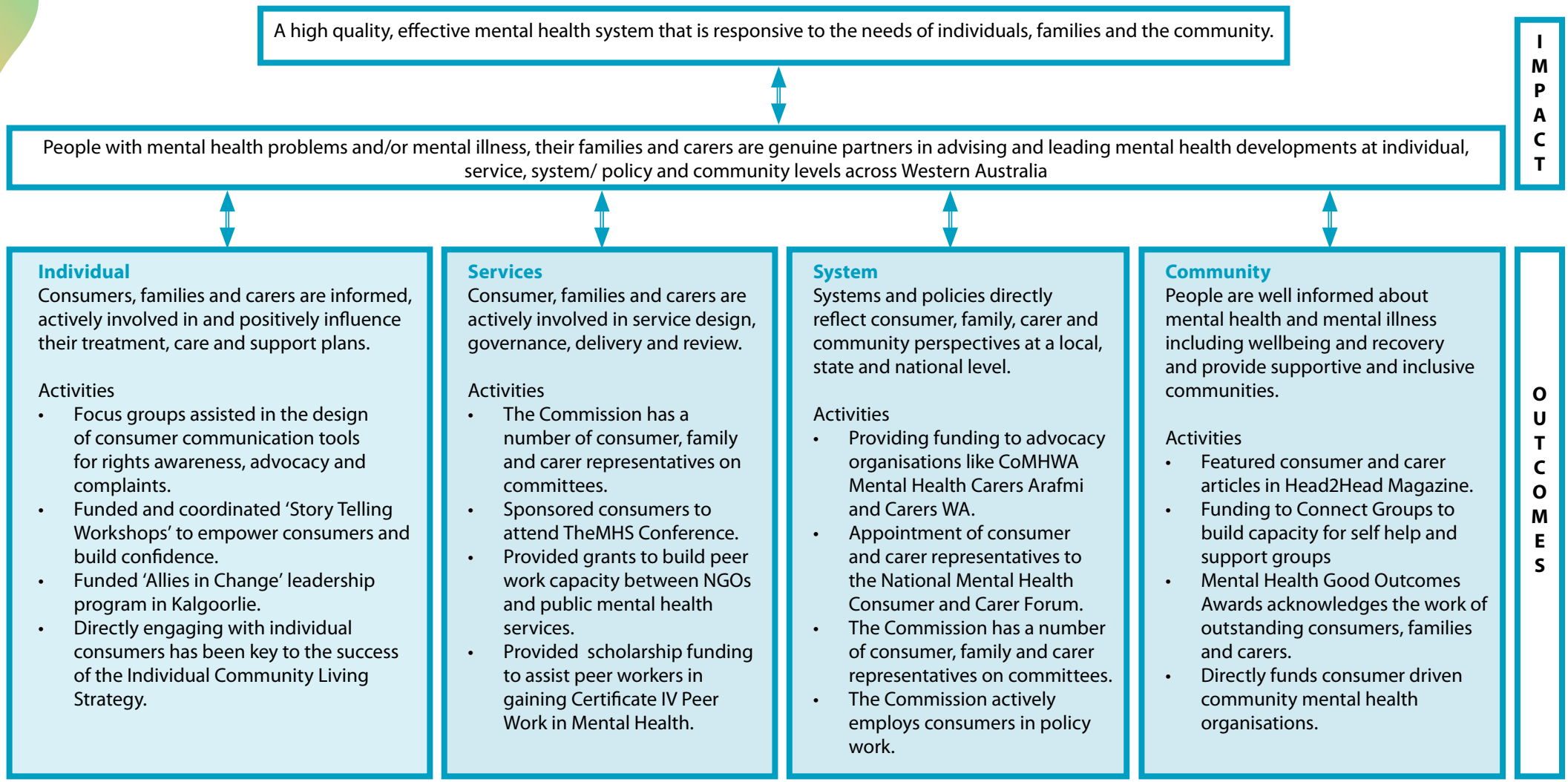
Consumers of Mental Health WA (CoMHWA)

The Commission provided its second year of funding to Consumers of Mental Health (CoMHWA). CoMHWA is steadily progressing in establishing itself to coordinate, promote and support the consumer voice within mental health services and the wider community. A budget of $1.375 million over five years has been set aside to establish and support CoMHWA, to provide systemic advocacy. CoMHWA is run for and by consumers.

Mental Health Carers Arafmi and Children of Parents with Mental Illness

The Commission has been working with Mental Health Carers Arafmi to provide additional support to coordinate and facilitate the statewide Children of Parents with a Mental Illness (COPMI) committee. This will ensure a strategic and consistent family inclusive approach to developing and delivering COPMI education and awareness raising activities across WA while meeting the particular needs of specific communities. This collaboration will support and resource links with existing COPMI networks to share knowledge, skills, innovations and resources; and showcase current research and evidence based approaches.

Figure 5: Engagement Framework



Community education and communication

The Commission continued to invest in mental health promotion and illness prevention initiatives that support the development of resilience, increase mental health literacy in the community and address the stigma related to mental illness.

During the year, the Commission's Communications and Community Education branch managed communication opportunities for the Commission, both internally and externally. It also coordinated stakeholder engagement, events and awards, sponsorship opportunities and developed comprehensive communication strategies.

The team worked closely with the Commission's Executive, providing communication advice and producing publications that contributed to an increase in community awareness, education and understanding of mental health issues.

In addition to this, the team managed the many sponsorships and grants administered by the Commission. In 2012/13 the Commission supported organisations to hold conferences, events and workshops throughout the State. Some of the initiatives that received funding included: WA celebrations for National Youth Week; training workshops with a renowned United Kingdom psychologist through the Richmond Fellowship; the 2013 National Suicide Prevention Australia Conference; Music to Open Your Mind and training workshops run by the Drug and Alcohol Office.

During Mental Health Week the Commission partnered with the WA Association of Mental Health to produce a *mental health liftout* in The West Australian.

Mental Health Good Outcomes Awards

The Commission hosted its annual Awards cermony on 9 October 2012 during Mental Health Week. The Awards raise community awareness, breaking down stigma and promote innovation and excellence across the mental health sector.

In 2012 the Awards, in their tenth year, honoured and recognised the exceptional achievements of our State's mental health sector and celebrated inspiring role models whose activities and contributions have impacted positively on their community.

In 2012, there was a 35 per cent increase in nominations, highlighting the extraordinary amount of activity the sector is engaged in. The Awards were expanded to 12 categories with 30 judges from across government and the community sector. Each winner received a cash prize of $1,000, a framed certificate and an art trophy (see images on next page) made by consumers at Disability in the Arts, Disadvantage in the Arts, Australia. Appendix Four contains the list of winners.

The Commission extends it's appreciation to the Award sponsors including the McCusker Foundation.




Workforce development

The Commission commenced drafting a *Workforce Development Strategy 2013-15* which aligns with the *National Mental Health Workforce Strategy* and maps objectives and activities against the three key reform directions outlined in the State Government's ten year strategic policy *Mental Health 2020: Making it personal and everybody's business*. The Workforce Development Strategy will align with the ten year Mental Health Services Plan to ensure that services have the workforce capacity and skills to develop in accordance with identified need and investment.

In 2012/13 the Commission provided funding of approximately $2.7 million to develop the mental health workforce. Among the initiatives funded this year were:

- scholarships for mental health professionals from government and non-government organisations to undertake further studies in mental health
- additional training posts for specialist training in child and adolescent psychiatry
- support for the rollout of the Mental Health Professional Online Development across public mental health services in WA
- workforce development in Independent Community Living to support person-centred care and recovery
- training for the mental health and community services sector in co-occurring mental health and drug and alcohol issues
- undergraduate preparation for mental health clinical placements
- mental health nurse incentive payments to encourage retention of nurses in the mental health sector
- development of a competency framework for workers in dual disability
- engagement of an international speaker on trauma informed care and practice
- assistance with developing accredited training for Certificate IV in Mental Health Peer Work
- specific workforce development assistance to staff employed within the Statewide Specialist Aboriginal Mental Health Service.

A full list of workforce development initiatives that received funding in 2012/13 is listed in Appendix Five.

Research and evaluation

Research and evaluation are critical activities to build the capacity of the Commission to develop evidence based policies and programs that are responsive to community needs. The Commission contracted the following specific research and evaluation projects in 2012/13.

Evaluation of Supported Accommodation Program

The *Supported Accommodation Program* (the SAP) aims to provide supported housing for people with a severe and persistent mental illness; people who are homeless, at risk of homelessness, people in unsuitable accommodation or residing for long periods in inpatient units.

The Commission contracted independent consultants, Sankey Associates, to conduct a program evaluation to assess whether the SAP was meeting residents' needs and aspirations, whether it increased residents' independence, participation, quality of life and wellbeing, and to what extent partnerships between service providers and clinical services were effective in delivering coordinated services.

The evaluation process included face to face consultation with service providers, interviews with a selection of residents and their families, as well as two paper-based surveys.

The *Supported Accommodation Program Evaluation Final Report* demonstrated that the SAP is achieving significant positive outcomes for residents. As well as being provided with a good home, residents reported receiving good clinical and non-clinical care and felt comfortable, safe and well supported. Of the 127 residents surveyed during the evaluation, 94 per cent rated the SAP as having had a 'good' to 'excellent' effect on their overall wellbeing, and 90 per cent reported an improved ability to socialise, be more independent and to lead a good life.

The report also highlighted the challenges around partnerships and the integration of clinical and non-clinical care to deliver coordinated services, as well as a potential need to clarify and improve referral processes. The final report together with a commentary document prepared by the Commission can be downloaded from the Commission's website.

Interim evaluation – Statewide Specialist Aboriginal Mental Health Service

As part of the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*, the WA Government committed $22.47 million over four years to develop the Statewide Specialist Aboriginal Mental Health Service (SSAMHS). This has involved the establishment of multi-disciplinary specialist teams located within mainstream mental health services. SSAMHS supports Aboriginal people to access mainstream mental health services and increases the capacity of mental health services to better meet the needs of Aboriginal people.

The WA Centre for Mental Health Policy Research undertook an interim evaluation of the process and outcomes of the SSAMHS to inform future service development and funding. The evaluation process involved interviews and focus groups with service providers, Aboriginal mental health workers, external agencies, as well as an analysis of contract report data and literature reviews.

Despite the relatively short period of operation there was strong agreement among all stakeholders about the value of the program and universal support for its continuation. The following observations were highlighted:

- The SSAMHS mental health workers have been able to engage with and get the trust of Aboriginal communities in a way that 'opens doors' into the communities for mental health services.
- One of the key objectives of the program is to increase the number of Aboriginal people working in the mental health sector and the program is achieving this goal. Despite the pressure and complexity of implementating

of the program, the SSAMHS services have been successful in building up and retaining their Aboriginal workforce with 85 per cent of positions occupied. Furthermore, 35 per cent of Aboriginal mental health workers were currently enrolled in the Bachelor of Health Science (Mental Health) being provided through Charles Sturt University.

- There were encouraging trends with respect to increased service provision to Aboriginal consumers. Analysis of preliminary data indicates that the number of individuals using community mental health services increased by 17 per cent between 1 July 2010 and 31 December 2012.

It is anticipated that the second and final phase of the SSAMHS Evaluation will involve a comprehensive and intensive engagement process with local Aboriginal people to assess the impact of SSAMHS for Aboriginal people with mental illness, their families and communities.

North Metropolitan Survey of High Impact Psychosis

In 2011 the Commission and North Metropolitan Health Service Mental Health funded the Neuropsychiatric Epidemiology Research Unit within the School of Psychiatry and Clinical Neurosciences at the University of Western Australia to undertake an extension of the national Survey of High Impact Psychosis in the North Metropolitan area of Perth (North Metro). The aims of this survey were to:

- estimate the prevalence of psychosis in North Metropolitan Health Service (NMHS) catchment area population
- describe the social and economic circumstances of people living with psychosis within North Metro, as well as their mental and physical health profiles and their use of services
- develop a local evidence base to help inform mental health policy development and planning for mental health service providers in North Metro
- develop services to meet specific local needs to benefit people living with psychosis, their friends, family, carers and services supporting them.

Screening for psychosis took place within inpatient and community mental health services, and community managed sector agencies (non government organisations) supporting people with mental illness in designated catchments (Perth city, Stirling and southern Joondalup) in March 2012. The number of people who were screened as positive for psychosis was 1302. A randomly selected sample of 250 people who screened positive for psychosis were interviewed and assessed between April 2012 and April 2013.

The survey collected data on psychopathology, utilisation of mental health and other services, treatments, perceived need, cognition, education, employment and income, living circumstances, activities of daily living, family responsibilities, social and other functioning, support networks, physical health, and drug and alcohol use. GPs also completed questionnaires on participants who were their patients, and described issues in managing patients with psychosis in general practice.

Data collection has been completed and the survey is in the analysis and report writing phase. The results and final report from the project are expected to be completed by the end of 2013.

National and International Partnerships

The Commission has continued to strengthen partnerships with key Commonwealth Government departments and with senior mental health representatives from other states and territories.

Agreements with the Commonwealth Government

Commonwealth-State National Partnership Agreements

Under the funding reform implemented since 2007, all Commonwealth Government funding to the State is provided through Intergovernmental Agreements negotiated via the Council of Australian Governments (COAG) to encourage the achievement of higher level performance outcomes. Funding for the health sector, including mental health, is provided through the *National Healthcare Agreement* and its related National Partnership Agreements (NPAs). The Commission has a key role in providing policy advice to COAG and its related operational committees in relation to mental health reform, which informs the Commonwealth Government's funding decisions.

There was significant activity in 2012/13 to negotiate potential longer term partnership agreements with the Commonwealth Government, and to implement other ongoing agreements. As part of these negotiations, the Commission held extensive consultations with the Department of Health, the Department of the Premier and Cabinet, the Department of Treasury and other relevant agencies to ensure a coordinated approach and the most effective investment of Commonwealth funding of mental health services in WA.

The following COAG Agreements that relate to the mental health sector were in place during the 2012/13 financial year.

National Partnership Agreement Supporting National Mental Health Reform

This NPA provides a total funding of $26.08 million to WA between 2011/12 and 2015/16 financial years. The contribution from the Commonwealth for the 2012/13 financial year was $4.07 million.

The outcomes sought by this NPA are:

- more people with severe and persistent mental illness and complex care needs, including those experiencing or at risk of homelessness, will be able to access stable accommodation
- fewer people with a mental illness will frequently present ('cycle through') at emergency departments, major hospitals and related support services.

WA supports the achievement of these NPA outcomes through the implementation of two unique initiatives, the *Individualised Community Living* (ICL) and the *Assertive Community Intervention* (ACI).

National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

The State Government committed a total funding of $117.43 million towards the implementation of this NPA between 2009/10 and 2012/13 financial years. The total Commonwealth Government commitment across all jurisdictions to support this NPA initiative was $805.46 million.

The Commission continued in 2012/13 to support the achievement of the objectives of this NPA through the implementation of the Statewide Specialist Aboriginal Mental Health Service (SSAMHS).

Although this NPA expired on 30 June 2013, the State Government is supporting the continued operation of SSAMHS to June 2014 while negotiations are under way in relation to a replacement agreement. The Commission is closely working with the Aboriginal Affairs Cabinet Subcommittee to improve coorodination and efficiency of programs supporting this NPA objective.

National Partnership Agreement on Improving Public Hospital Services

This NPA commits a total funding of $351.6 million between 2010/11 and 2016/17 financial years for WA. This funding is provided to facilitate improved access to public hospital services, including elective surgery and emergency department services, and subacute care.

While the Department of Health has the lead responsibility for the implementation of this NPA, the Commission has the responsibility for the implementation of some elements, in particular, increasing the supply of subacute mental health services. Total funding of $31 million has been committed for initiatives relating to the mental health sector.

The Commission has commenced the provision of 22 subacute beds through the Joondalup subacute services in 2012/13 in relation to this NPA initiative and is progressing the development of a six bed subacute service in Broome.

National Partnership Agreement on Health Services – Perinatal Depression Initiative

The *National Perinatal Depression Initiative* (NPDI), implemented from 2008/2009 to 2012/2013, provided Commonwealth funding for the states and territories to improve prevention and early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers experiencing depression. Total funding of $3.696 million was committed by the Commonwealth to WA for the NPDI. This funding complemented the state funding provided by the public mental health and community sectors.

The NPDI provided funding in 2012-13 financial year for clinical services in the north and south metropolitan areas and in identified priority areas in regional WA. A number of community based organisations were also funded to deliver support services across regional and metropolitan areas.

The Commission was also engaged in negotiations with the Commonwealth to develop a new NPDI Project Agreement for future years.

National Partnership Agreement on Homelessness

This NPA was established by COAG in 2008 with the aim of substantially reducing and preventing homelessness through a range of innovative programs. The Department for Child Protection and Family Support is the lead agency in WA for this NPA. The Commission has continued to support implementation of this NPA through the Mobile Clinical Outreach Team (MCOT) initiative.

The MCOT initiative provides mental health and drug and alcohol services for rough sleepers in inner city Perth and Fremantle, within the Street to Home program. The MCOT is delivered by the North Metropolitan Mental Health Service. Mental health nurses, social workers, and a part-time consultant psychiatrist provide assertive outreach mental health and drug and alcohol treatment, as well as consultation and liaison services.

The NPA finished on 30 June 2013. A one year time limited NPA has been negotiated for the 2013/14 financial year while a longer term strategy to address homelessness and related support services is being developed.

Collaboration with other national and international programs and initiatives

International Initiative for Mental Health Leadership (IIMHL)

The IIMHL provides an international infrastructure to identify and exchange information about effective leadership, management and operational practices in the delivery of mental health services. Seven countries currently make up the IIMHL collaboration: Australia, Canada, England, the Republic of Ireland, New Zealand, Scotland and the United States of America. All jurisdictions contribute towards Australia's membership on the IIMHL. The Western Australian Mental Health Commissioner is an Australian representative on the Sponsoring Countries group in the IIMHL.

The 2013 IIMHL Exchange and Network Meeting was held in Auckland, New Zealand. The Commissioner participated in this Exchange and Network Meeting and delivered an invited keynote presentation on leading mental health reform initiatives in the Australian context. An evaluation of the 2013 IIMHL found that leaders connected and networked; learned about service models, management and operational practices, and developments in the host country; increased their awareness about innovation and best practice; and shared ideas and experiences.

The 2014 IIMHL Exchange and Network Meeting will be held in England.

National Mental Health Commission

The launch of *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention* in December 2012, (the Report Card) was a key step in the establishment of the National Mental Health Commission as a driver of mental health reform in Australia. The Report Card included a commitment by the National Mental Health Commission (NMHC) to undertake a regular and independent qualitative survey of people with a mental health problem and their families and carers. The NMHC continues to work on the development of this survey through the National Contributing Life Project, with WA represented in this project by the Commission's consumer advisor.

In March 2013 the NMHC hosted a two day meeting of representatives from leading mental health organisations and Commissions from Australia, Canada, Ireland, Scotland, New Zealand and the United States. The Western Australian Mental Health Commissioner and the Chair of the Mental Health Advisory Council attended on

behalf of WA, and joined other participants in discussing ways to bring about change for the benefit of people living with and recovering from mental health difficulties, their families and supporters and the wider community. The *Sydney Declaration*, released following the meeting, sets out the shared commitment and dedication of participants to purse actions on five key areas: Indigenous mental health; seclusion and restraint; work and mental health; knowledge exchange; and international benchmarking. This commitment will be strengthen by continuing collaboration and partnership, and by creating opportunities for further dialogue and learning.

The Commission and the NMHC jointly hosted a meeting in Perth on 17 July 2013 bringing together key mental health organisations and Commissions from across Australia and New Zealand.

Participation on national mental health committees and policy advisory bodies

The Commission is represented on a number of national mental health committees and policy advisory bodies as follows:

- The WA Mental Health Commissioner continued to represent WA on the Mental Health Standing Committee (MHSC), until its conclusion of business at the end of 2012. The MHSC played a key role in overseeing the implementation of the *Fourth National Mental Health Plan 2009–2014* and facilitating cross jurisdictional communication and information exchange to improve both consistency and outcomes for national mental health reforms. The MHSC held its last meeting in October 2012 and responsibility for its work program was transferred to the Mental Health, Drug and Alcohol Principal Committee (MHDAPC).
- The MHDAPC was established in 2012 following a review by the Australian Health Ministers' Advisory Council (AHMAC) of its committee structure. WA is represented on the group by the Mental Health Commissioner and the Executive Director, Drug and Alcohol Office. The role of the MHDAPC is to advise AHMAC on national mental health, alcohol, tobacco, and other drug issues. This is undertaken in a complex environment which includes overseeing the *Fourth National Mental Health Plan, the National Drug Strategy,* mental health and drug and alcohol aspects of the Closing the Gap initiative and implementation of designated COAG Mental Health reform initiatives. The establishment of the MHDAPC provides an opportunity to better integrate and progress the work of the mental health and drug and alcohol sectors as well as enabling development and implementation of specific and related national initiatives and projects.
- The MHDAPC is supported by the Mental Health Information Strategy Subcommitee, the Safety and Quality Partnership Subcommittee and the Inter-Governmental Committee on Drugs. These groups facilitate the provision of expert and technical advice, provide recommendations on national policy issues and play a key role in the implementation of a number of actions arising from the Fourth National Mental Health Plan 2009-2014.
- Throughout 2012 the Commission continued to support the development of the *Roadmap for National Mental Health Reform 2012-22* (the Roadmap) through ongoing participation on the Senior Officials Mental Health Working Group, which was established by COAG in 2011. Following an initial WA consultation in January 2012, a second consultation was facilitated in September 2012 to enable organisations to provide further feedback on the revised draft. The Roadmap was launched by COAG in December 2012.
- The Roadmap is intended to set out the shared vision for Australia's future, where good mental health is valued, promoted and understood as a whole of community responsibility, and people with mental illness and their families and carers are supported to live full and rewarding lives. The Roadmap is consistent with and complementary to the Commission's strategic policy *Mental Health 2020: Making it personal and everybody's business*.
- When launching the Roadmap COAG announced the establishment of the COAG Working Group on Mental Health Reform (WGMHR). WA is represented on the WGMHR by the Commissioner and a representative from the Department of the Premier and Cabinet. The group commenced meetings in February 2013 and will oversee the development of indicators and targets for national mental health reform and the development of a successor to the *Fourth National Mental Health Plan*. The group is supported by an Expert Reference Group, on which the Commission is also represented.

Fourth National Mental Health Plan 2009–2014

The Commission maintained its support for the implementation of the F*ourth National Mental Health Plan 2009-2014*. Work continues to focus on the Social Inclusion and Children and Youth flagship initiatives, which incorporates a number of actions that are common in theme. A number of other actions are being driven by committees or working groups reporting to the newly established MHDAPC.

Key achievements in 2012/13 include:

- A revised *Mental Health Statement of Rights and Responsibilities* endorsed by health ministers in November 2012, and launched in February 2013.
- States and Territories participated in a national stock take of initiatives that enhance participation in education, training and employment by people with a mental illness. This will inform future initiatives.
- A national recovery forum was held on 21-22 June 2012 as part of progress towards the development of a National Recovery Framework. It is anticipated that the framework will be endorsed during the first half of 2013 and launched at TheMHS Conference to be held in Perth in August 2013.
- Significant progress was made towards the development of a National Mental Health Service Planning Framework (NMHSPF). It is expected that work on developing the framework will continue until late 2013.
- Further progress was achieved towards the development of a renewed Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework. A discussion paper, developed by a consultant in partnership with the project working group, will be subject to consultation from February 2013.
- A *Draft Accreditation Workbook for Mental Health Services,* that incorporates the *National Standards for Mental Health Services*, was developed and released for trialling and consultation purposes in December 2012.

National Disability Insurance Scheme

During 2012/2013, the Australian Government announced the establishment of the National Disability Insurance Scheme (NDIS) now called *Disability Care*, and a number of NDIS trial sites across Australia. On 5 August 2013 the Commonwealth and State Governments signed an agreement on an NDIS launch in WA commencing 1 July 2014. The agreement is to launch two approaches in WA, allowing genuine comparison and learning along the way. The State government's My Way model will be fully implemented in the lower south west region from 1 July 2014 and Cockburn Kwinana area from 1 July 2015. In addition, the national DisabilityCare Australia model will be implemented in the Perth hills area from 1 July 2014. Additional funding from the Commonwealth will flow from 1July 2014. The DisabilityCare Australia model includes people with a psychiatric disability.

My Way will be run by the Disability Services Commission (DSC) in collaboration with the Commission via an experienced team based in the lower south west and will also include people with a psychiatric disability. Local, community-based teams of coordinators and specialist staff will support people with disability to access the services they need from a wide range of service providers. My Way offers individualised/personalised services, genuine consumer choice and control, a strong focus on individualised planning, local decision making, minimal bureaucracy and a strong partnership approach between the DSC, the Commission and a range of not-for-profit service providers .

Partners in Recovery

Partners in Recovery (PIR) is a Commonwealth Government service initiative funded in 2012/13 by the Department of Health and Ageing. PIR is intended to better support people experiencing severe and persistent mental illness with complex needs. This is achieved through supporting the multiple sectors, services and supports people may come into contact with and could benefit from, to work in a more collaborative, coordinated, and integrated way. The Commission is working in collaboration with Medicare Locals and PIR to ensure better service outcomes for people with severe and persistent mental illness.

Significant Issues Impacting the Commission

The State's 10 year strategic policy *Mental Health 2020: Making it personal and everybody's business* continues to guide the Commission's core business to foster person centred supports and services; connected approaches; and balanced investment.

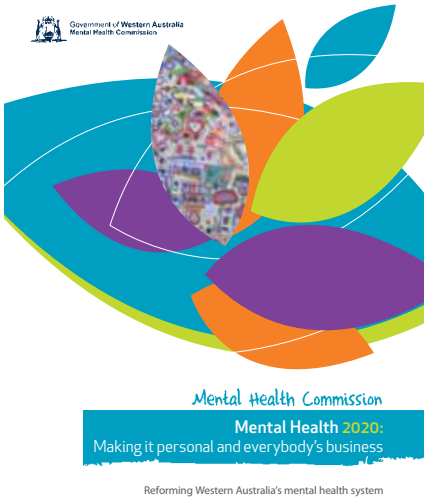
The Commission has continued to advance mental health system reforms through a range of mechanisms in a rapidly changing environment. Important developments have and will continue to impact the mental health sector, both nationally and within the State. The Commission has the leading role in driving positive reform, managing the challenges and harnessing the opportunities that arise from these changes.

Reform has continued with a broad range of initiatives including, but not confined to development of the Council of Australian Governments' (COAG) mental health reforms, creation of the National Mental Health Commission (NMHC), further implementation of activity based funding, commencement of DisabilityCare, rollout of Medicare Locals, further implementation of National Partnership Agreements and deployment of specific initiatives funded by the Australian Government such as Partners in Recovery. The Commission has actively engaged with these initiatives as appropriate with a view to optimising outcomes for the people of WA. Many of these initiatives are complex, not directly within the control of the Commission and have a significant interface and influence on the delivery of mental health services and supports in the State.

There are many synergies between the NMHC's *Contributing Life* and the WA's *A good life in the community* framework that are effectively engaging consumers, carers, service providers and stakeholders within and beyond the clinical health system. The Commission has been active in liaising with the NMHC about the nature of reforms required and the development of a supportive and inclusive culture.

The Commission was also closely engaged in policy development through the COAG, which developed the *Roadmap for National Mental Health Reform 2012-22* and is represented on the Working Group and Expert Reference Group to oversee implementation of the Roadmap and the development of a successor to the *4th National Mental Health Plan*.

A major initiative for the year ahead is participation in the implementation of the agreed framework for WA's implementation of DisabilityCare. This is a highly significant development that has great potential to improve the level of services and supports for people with a long term disability related to mental illness. Importantly, the trial arrangements for WA offer a unique opportunity to test alternative methods of implementation, maximise benefits and reduce bureaucracy. The Commission will be involved over the next two years in the implementation of the three trial sites, particularly the two MyWay sites in the lower south west and Cockburn-Kwinana. These two sites will adopt the State's preferred approach whilst a third site in the Perth hills will apply the Commonwealth's preferred DisabilityCare model.



Implementation of activity based funding within the public mental health services is continuing in close collaboration with the Department of Health. This is a national initiative which will require careful application to mental health services with a view to ensuring that the State and the community is appropriately funded for the services provided.

Both the Commonwealth and State have a strong focus on:

- improving mental health outcomes and reducing disadvantage among Aboriginal Australians
- improving the physical health of people with a mental illness and creating a more holistic, integrated approach to physical, emotional and mental health
- strengthening social inclusion and creating opportunities for people to make a meaningful contribution
- engaging family and carers in planning and decision-making
- building more timely, effective support and treatment systems, with a shift

in focus towards recovery and addressing problems before the require hospitalisation

- ensuring services are of a high quality and are accessible to culturally and geographically diverse communities
- addressing homelessness and providing more accessible housing with appropriate community-based support
- preventing suicide through whole-of-community approaches.

While there are common goals to improve mental health for all Australians, there are also silos to break down. People want better coordinated, accessible and timely services. Governments need to work together to address duplication and eliminate the waste of resources and confusion this creates for people on the ground.

From an intergovernmental perspective, ensuring the continuity of Commonwealth Government funding for public mental health services and related supports, including those provided by community organisations, has been a challenge. A number of National Partnership Agreements that provide funding to WA have either expired or are due to expire in the near future. The Commission, in consultation with the Department of Health, is negotiating with the Commonwealth to achieve successful outcomes for Western Australians and this work will continue into the future. In addition, the Commission will work with organisations such as headspace and Medicare Locals to ensure that the rollout of complementary programs is properly coordinated so that the mental health system functions as seamlessly as possible for people with mental illness, their families and carers.

Underpinning reform of mental health within WA are several key initiatives that are underway, including implementation of new legislation, amalgamation of the Commission with the Drug and Alcohol Office (DAO), implementation of the recommendations of the Stokes *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, and development of a ten year Mental Health Services Plan to guide future service development and reform.

Legislative reform remains a priority and the Minister for Mental Health tabled the *Green Mental Health Bill 2012* in Parliament on 8 November 2012. Explanatory materials were published to generate discussion and debate. The Commission invited submissions on the Green Bill until 28 February 2013 and received over 100. This further consultation was extremely valuable and resulted in refinements which are currently being drafted. Final stakeholder engagement is underway and the Government's intention is to introduce the *Mental Health Bill 2013* in Parliament by October 2013. The proposed legislation provides a vital contemporary platform for the improvement of the mental health system.

Another key development for mental health reform was the Premier's announcement on 10 April 2013 that the Commission and DAO will amalgamate under the control of a single Chief Executive. This will ensure better integration of the State's network of services relating to prevention, treatment, professional education and training, and research activities in the drug and alcohol sector and across mental health services. This improved coordination of services will provide more streamlined support to people with co-occurring issues and enhance programs for those most at-risk and is an important step in delivering connected approaches.

The *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, conducted by Professor Bryant Stokes (Stokes Review) was published in November 2012. The Stokes Review contains 117 recommendations encompassing the need for comprehensive service across the State; better support for carers and families; acute issues and suicide prevention; and the judicial and criminal justice system.

During the review period, a total of 891 people were interviewed; patient records were examined; and data was analysed in relation to 255 individuals who suicided during 2009. In addition, a total of 29 submissions were received by the review team.

The Stokes Review Implementation Partnership Group has been established and is independently chaired by Barry MacKinnon AM to provide governance oversight and monitoring of the implementation of all the recommendations.

Progress is being made with a number of initiatives including

commencement of or commitment to new services such as child and adolescent mental health services, subacute services and development of strategies to better support people with complex and co-occurring needs. The Department of Health has also commenced significant work in addressing governance, policy and workforce development issues.

The principal recommendation from the Stokes Review was the need for a comprehensive mental health services plan. The Commission and Department of Health are working collaboratively to develop a comprehensive ten year Mental Health Services Plan to be completed by December 2013. This is a major sector-wide initiative that will be informed by the *National Mental Health Services Planning Framework* and the State's Clinical Services Framework. The ten year plan will provide Government with a blueprint for future service development across the State.

In addition to progressing the latest developments, the Commission is continuing to address the many complex issues and areas requiring reform to achieve better mental health outcomes for our most disadvantaged groups. New partnerships and programs are progressively being implemented for people in the justice system, with dual disability and co-morbidity to help people access suitable support and achieve a good life.

New governance and advocacy systems have been put in place to maintain the momentum of statewide mental health reforms, enable greater dialogue across sectors, strengthen the voice of consumers and carers, and guide the implementation of major initiatives.

The establishment and funding of a new consumer association, *Consumers of Mental Health WA*, has proceeded within a co-design framework. Strategic advice and practical assistance was provided to the small existing consumer group by an established peak body to support their transition to an effective systemic advocacy organisation. While this has been an evolving process, the agenda has at all times been led by consumers with the Commission playing a technical support role.

The *Mental Health Advisory Council* (MHAC) appointed by Cabinet brings a wide range of experience and expertise to the reform process. The MHAC is chaired by Barry MacKinnon AM and provides independent advice to the Mental Health Commissioner on key topics such as the new Mental Health Bill and implementation of *Mental Health 2020: Making it personal and everybody's business*. The MHAC also holds meetings in regional areas and was recently in Kalgoorlie and Narrogin. Members of the MHAC are actively involved in the processes supporting the implementation of the recommendations from the Stokes Review and the development of the ten year Mental Health Services Plan.

The Ministerial Council for Suicide Prevention (MCSP), chaired by Peter Fitzpatrick AM, plays a key role in guiding the implementation of the *WA Suicide Prevention Strategy 2009-2013* (Strategy) which is delivered by Centrecare as the lead non-government organisation. Suicide is a major tragedy for the individuals, families and all community members who are impacted by the loss of life. Tackling suicide requires a whole-of-community response and the statewide Strategy has maintained a strong focus on community capacity building and increasing awareness about ways to recognise, support and prevent suicide among people at risk. It has a particular focus on addressing the needs of young people, young men, Aboriginal people and people who live in rural and regional WA.

The Commission has supported the important work of the MCSP and Strategy through improved governance arrangements. The Commission also funds a range of early intervention, crisis counselling and postvention programs. When suicide crisis has hit communities hard, the Commission has had an integral role in coordinating Commonwealth, State and local agencies and leaders to deliver an effective and immediate response. In 2012/13, suicides and self-harm incidents among school aged young people and people in the Kimberley were of serious concern. Urgent responses were put into place through interagency service provision and joint investment from the MCSP, the Commission and Commonwealth Department of Health and Ageing.

The Strategy has achieved considerable community engagement as outlined earlier in this report. An independent evaluation of Community Action Plans and Strategy initiatives by Edith Cowan University is due in March 2014. The MCSP and the Commission are also working on a broader evaluation to capture the outcomes at many levels, identify areas for improvement and build the evidence base for future suicide prevention activities in WA.

The Mental Health Court Diversion project is a significant joint initiative between

the Commission and the Department of the Attorney General which will require focused support in the year ahead. The State Government has invested funding for a 20 month pilot in the metropolitan area. It provides opportunities for people with a mental illness in the criminal justice system to access community mental health services, to improve their mental health and address their offending. Most jurisdictions in Australia and many internationally have similar programs, and evaluations show improvements in mental health, recidivism and cost savings. The Court Diversion initiative will be evaluated by the end of 2013.

Central to person centred service is the Commission's work to enable people to be better supported to live a good life in the community. *Individualised Community Living Strategy* (ICLS) represents a major shift in the way services and supports are provided to people with mental illness and their families and carers and this service will continue to grow in 2013/14. ICLS was expanded in the 2012/13 State Government Budget through an allocation of $4.6 million for 18 packages of support over four years. An additional $8.7 million was allocated to the Department of Housing for the provision of 16 houses over four years. The Commonwealth Government committed $12.6 million over four years to provide six houses and 30 packages of support. As at June 30, 106 of the 109 houses to be purchased between 2011 and 2013 were secured or are in progress. To date, 85 people have moved into their new home and the remainder are in the process of transitioning into their new accommodation.

The Commission's program of developing subacute services is continuing following the opening of the Joondalup service in May 2013. The Commission will actively progress the next services at Broome, Rockingham and the Goldfields and commence planning for further services at Karratha and Bunbury.

The Commission will further develop a strong relationship with area health services in the year ahead through local dialogue and contract negotiations, with a view to collaborating on opportunities to deliver reform and efficiency, and increase the focus on providing enhanced support to people closer to home and in community settings. There are major service developments underway at Midland, the New Children's Hospital and Fiona Stanley Hospital that will require careful implementation.

Also central to the Commission's reform agenda is a strong and sustainable non-government sector. The Commission is progressively implementing new contracts with non government services in accordance with the Government's *Delivering Community Services in Partnership* policy. The Commission has worked closely with the WA Association of Mental Health and the not-for-profit sector to identify ways of improving services and supports for people with mental health and to implement components one and two of the State Government's sustainability funding. The Commission will deploy an additional $21.3 million over four years, and the Drug and Alcohol Office (DAO) $27.2 million over four years, which will mean:

- organisations contracted to the DAO and the Commission through this process have increased levels and security of funding
- the not-for-profit sector will be able to sustain its services into the future
- a stronger focus on service delivery outcomes and standards.

The Commission will also be progressively implementing a new quality framework to ensure that services meet national standards and deliver high quality outcome focused services. This work has commenced and will be implemented in collaboration with the sector and with active input from people with mental illness, their families and carers.

Achieving better outcomes for people will require increased collaboration between governments and service providers. A challenge for the future is for the Commission to progressively develop improved collaborative mechanisms for co-commissioning, partnerships and information sharing. A range of mechanisms are already in place to achieve this but there is scope for considerable improvement in this area and the Commission will be continuing to explore opportunities to achieve effective outcomes.

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

MENTAL HEALTH COMMISSION

Report on the Financial Statements
I have audited the accounts and financial statements of the Mental Health Commission.

The financial statements comprise the Statement of Financial Position as at 30 June 2013, the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows, Schedule of Income and Expenses by Service, Schedule of Assets and Liabilities by Service, and Summary of Consolidated Account Appropriations and Income Estimates for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information, including Administered transactions and balances.

Commissioner's Responsibility for the Financial Statements
The Commissioner is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards and the Treasurer's Instructions, and for such internal control as the Commissioner determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the financial statements based on my audit. The audit was conducted in accordance with Australian Auditing Standards. Those Standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Commission's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Commissioner, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion
In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the financial position of the Mental Health Commission at 30 June 2013 and its financial performance and cash flows for the year then ended. They are in accordance with Australian Accounting Standards and the Treasurer's Instructions.

Report on Controls
I have audited the controls exercised by the Mental Health Commission during the year ended 30 June 2013.

Controls exercised by the Mental Health Commission are those policies and procedures established by the Commissioner to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions.

Commissioner's Responsibility for Controls
The Commissioner is responsible for maintaining an adequate system of internal control to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of public and other property, and the incurring of liabilities are in accordance with the Financial Management Act 2006 and the Treasurer's Instructions, and other relevant written law.

Auditor's Responsibility
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the controls exercised by the Mental Health Commission based on my audit conducted in accordance with Australian Auditing and Assurance Standards.

An audit involves performing procedures to obtain audit evidence about the adequacy of controls to ensure that the Commission complies with the legislative provisions. The procedures selected depend on the auditor's judgement and include an evaluation of the design and implementation of relevant controls.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion
In my opinion, the controls exercised by the Mental Health Commission are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2013.

Report on the Key Performance Indicators
I have audited the key performance indicators of the Mental Health Commission for the year ended 30 June 2013.

The key performance indicators are the key effectiveness indicators and the key efficiency indicators that provide information on outcome achievement and service provision.

Commissioner's Responsibility for the Key Performance Indicators
The Commissioner is responsible for the preparation and fair presentation of the key performance indicators in accordance with the Financial Management Act 2006 and the Treasurer's Instructions and for such controls as the Commissioner determines necessary to ensure that the key performance indicators fairly represent indicated performance.

Auditor's Responsibility
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the key performance indicators based on my audit conducted in accordance with Australian Auditing and Assurance Standards.

An audit involves performing procedures to obtain audit evidence about the key performance indicators. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments the auditor considers internal control relevant to the Commissioner's preparation and fair presentation of the key performance indicators in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the relevance and appropriateness of the key performance indicators for measuring the extent of outcome achievement and service provision.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion
In my opinion, the key performance indicators of the Mental Health Commission are relevant and appropriate to assist users to assess the Commission's performance and fairly represent indicated performance for the year ended 30 June 2013.

Independence
In conducting this audit, I have complied with the independence requirements of the Auditor General Act 2006 and Australian Auditing and Assurance Standards, and other relevant ethical requirements.

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators
This auditor's report relates to the financial statements and key performance indicators of the Mental Health Commission for the year ended 30 June 2013 included on the Commission's website. The Commission's management is responsible for the integrity of the Commission's website. This audit does not provide assurance on the integrity of the Commission's website. The auditor's report refers only to the financial statements and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial statements and key performance indicators to confirm the information contained in this website version of the financial statements and key performance indicators.

GLEN CLARKE
DEPUTY AUDITOR GENERAL
Delegate of the Auditor General for Western Australia
Perth, Western Australia
18 September 2013

Certification of Financial Statements

MENTAL HEALTH COMMISSION
CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2013

The accompanying financial statements of the Mental Health Commission have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the financial year ended 30 June 2013 and the financial position as at 30 June 2013.

At the date of signing we are not aware of any circumstances which would render the particulars included in the financial statements misleading or inaccurate.

Ken Smith
Chief Finance Officer
Mental Health Commission

18 September 2013

Eddie Bartnik
Accountable Authority
Mental Health Commission

18 September 2013

Statement of Comprehensive Income

For the year ended 30 June 2013

	Note	2013	2012
		$	$
COST OF SERVICES			
Expenses			
Employee benefits expense	6	11,269,404	7,274,546
Contracts for services	7	575,922,864	521,338,591
Supplies and services	8	1,968,821	1,528,533
Grants and subsidies	9	8,215,476	4,859,441
Depreciation expense	10	54,288	-
Other expenses	11	765,190	527,702
Total cost of services		**598,196,043**	**535,528,813**
Income			
Revenue			
Commonwealth grants and contributions	12	153,519,850	6,891,266
Other grants and contributions	13	760,255	2,748,592
Other revenue		112,992	79,987
Total revenue		**154,393,097**	**9,719,845**
Total income other than income from State Government		**154,393,097**	**9,719,845**
NET COST OF SERVICES		**443,802,946**	**525,808,968**
Income from State Government			
Service appropriation	14	409,946,000	532,106,000
Services received free of charge	14	33,151,228	3,313,789
Total income from State Government		**443,097,228**	**535,419,789**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(705,718)**	**9,610,821**
OTHER COMPREHENSIVE INCOME		-	-
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(705,718)**	**9,610,821**

See also the 'Schedule of Income and Expenses by Service'.

The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

Statement of Financial Position

As at 30 June 2013

	Note	2013 $	2012 $
ASSETS			
Current Assets			
Cash and cash equivalents	21	11,986,579	12,500,118
Restricted cash and cash equivalents	15, 21	2,200,000	-
Receivables	16	266,480	1,473,824
Total Current Assets		**14,453,059**	**13,973,942**
Non-Current Assets			
Restricted cash and cash equivalents	15, 21	298,320	244,320
Plant and equipment	17	135,939	156,279
Total Non-Current Assets		**434,259**	**400,599**
TOTAL ASSETS		**14,887,318**	**14,374,541**
LIABILITIES			
Current Liabilities			
Payables	18	3,281,429	2,885,472
Provisions	19	2,004,724	1,334,540
Total Current Liabilities		**5,286,153**	**4,220,012**
Non-Current Liabilities			
Provisions	19	376,007	223,653
Total Non-Current Liabilities		**376,007**	**223,653**
TOTAL LIABILITIES		**5,662,160**	**4,443,665**
NET ASSETS		**9,225,158**	**9,930,876**
EQUITY			
Contributed equity	20	945,900	945,900
Accumulated surplus/(deficit)	20	8,279,258	8,984,976
TOTAL EQUITY		**9,225,158**	**9,930,876**

See also the 'Schedule of Assets and Liabilities by Service'.

The Statement of Financial Position should be read in conjunction with the accompanying notes.

Statement of Changes in Equity

For the year ended 30 June 2013

	Note	2013 $	2012 $
CONTRIBUTED EQUITY	20		
Balance at start of period		945,900	945,900
Transactions with owners in their capacity as owners:			
Contributions by owners		-	-
Distributions to owners		-	-
Balance at end of period		945,900	945,900
ACCUMULATED SURPLUS/(DEFICIT)	20		
Balance at start of period		8,984,976	(625,845)
Surplus/(Deficit) for the period		(705,718)	9,610,821
Balance at end of period		8,279,258	8,984,976
TOTAL EQUITY			
Balance at start of period		9,930,876	320,055
Total comprehensive income/(loss) for the period		(705,718)	9,610,821
Balance at end of period		**9,225,158**	**9,930,876**

The Statement of Changes in Equity should be read in conjunction with the accompanying notes.

Statement of Cash Flows

For the year ended 30 June 2013

	Note	2013	2012
		$ Inflows (Outflows)	$ Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation	14	409,946,000	532,106,000
Net cash provided by State Government		**409,946,000**	**532,106,000**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(10,247,493)	(6,945,834)
Contracts for services		(541,154,408)	(519,426,800)
Supplies and services		(1,976,416)	(1,340,259)
Grants and subsidies		(8,346,043)	(4,108,536)
Other payments		(647,869)	(518,726)
Receipts			
Commonwealth grants and contributions		153,519,850	6,891,266
Other grants and contributions		567,796	2,993,612
Other receipts		100,992	79,987
Net cash used in operating activities	21	**(408,183,591)**	**(522,375,290)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payment for purchase of non-current physical assets		(21,948)	(156,279)
Net cash used in investing activities		**(21,948)**	**(156,279)**
Net increase in cash and cash equivalents		1,740,461	9,574,431
Cash and cash equivalents at the beginning of the period		12,744,438	3,170,007
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	21	**14,484,899**	**12,744,438**

The Statement of Cash Flows should be read in conjunction with the accompanying notes.

Schedule of Income and Expenses by Service

For the year ended 30 June 2013

	Specialised Admitted Patient Services		Specialised Community & Other Services (a)		TOTAL	
	2013	2012	2013	2012	2013	2012
	$	$	$	$	$	$
COST OF SERVICES						
Expenses						
Employee benefits expense	5,020,519	3,710,018	6,248,885	3,564,528	11,269,404	7,274,546
Contracts for services	256,573,636	265,882,682	319,349,228	255,455,909	575,922,864	521,338,591
Supplies and services	877,110	779,552	1,091,711	748,981	1,968,821	1,528,533
Grants and subsidies	3,659,995	2,478,315	4,555,481	2,381,126	8,215,476	4,859,441
Depreciation expense	24,185	-	30,103	-	54,288	-
Other expenses	340,892	269,128	424,298	258,574	765,190	527,702
Total cost of services	266,496,337	273,119,695	331,699,706	262,409,118	598,196,043	535,528,813
Income						
Commonwealth grants and contributions	68,393,093	3,514,546	85,126,757	3,376,720	153,519,850	6,891,266
Other grants and contributions	338,694	1,401,782	421,561	1,346,810	760,255	2,748,592
Other revenue	50,338	40,793	62,654	39,194	112,992	79,987
Total income other than income from State Government	68,782,125	4,957,121	85,610,972	4,762,724	154,393,097	9,719,845
NET COST OF SERVICES	197,714,212	268,162,574	246,088,734	257,646,394	443,802,946	525,808,968
Income from State Government						
Service appropriation	182,630,943	271,374,060	227,315,057	260,731,940	409,946,000	532,106,000
Services received free of charge	14,768,872	1,690,032	18,382,356	1,623,757	33,151,228	3,313,789
Total income from State Government	197,399,815	273,064,092	245,697,413	262,355,697	443,097,228	535,419,789
SURPLUS/(DEFICIT) FOR THE PERIOD	(314,397)	4,901,518	(391,321)	4,709,303	(705,718)	9,610,821

The Schedule of Income and Expenses by Service should be read in conjunction with the accompanying notes.

(a) The former 'Specialised Community Mental Health' service category has been expanded into three services in 2013. Table A shows the 2013 figures for these new service categories.

Table A

Specialised Community and Other Services

For the year ended 30 June 2013

	Promotion and Prevention 2013 $	Specialised Community Services 2013 $	Accommodation and Support Services 2013 $	Total 2013 $
COST OF SERVICES				
Expenses				
Employee benefits expense	742,654	4,711,738	794,493	6,248,885
Contracts for services	37,953,317	240,793,349	40,602,562	319,349,228
Supplies and services	129,745	823,164	138,802	1,091,711
Grants and subsidies	541,400	3,434,890	579,191	4,555,481
Depreciation expense	3,578	22,698	3,827	30,103
Other expenses	50,426	319,926	53,946	424,298
Total cost of services	39,421,120	250,105,765	42,172,821	331,699,706
Income				
Commonwealth grants and contributions	10,116,958	64,186,650	10,823,149	85,126,757
Other grants and contributions	50,101	317,862	53,598	421,561
Other revenue	7,446	47,242	7,966	62,654
Total income other than income from State Government	10,174,505	64,551,754	10,884,713	85,610,972
NET COST OF SERVICES	29,246,615	185,554,011	31,288,108	246,088,734
Income from State Government				
Service appropriation	27,015,441	171,398,423	28,901,193	227,315,057
Services received free of charge	2,184,666	13,860,528	2,337,162	18,382,356
Total income from State Government	29,200,107	185,258,951	31,238,355	245,697,413
DEFICIT FOR THE PERIOD	(46,507)	(295,060)	(49,753)	(391,321)

Schedule of Assets and Liabilities by Service

As at 30 June 2013

	Specialised Admitted Patient Services		Specialised Community and Other Services (a)		TOTAL	
	2013	2012	2013	2012	2013	2012
	$	$	$	$	$	$
ASSETS						
Current assets	6,438,838	7,126,710	8,014,221	6,847,232	14,453,059	13,973,942
Non-current assets	193,462	204,305	240,797	196,294	434,259	400,599
Total Assets	6,632,300	7,331,015	8,255,018	7,043,526	14,887,318	14,374,541
LIABILITIES						
Current liabilities	2,354,981	2,152,206	2,931,172	2,067,806	5,286,153	4,220,012
Non-current liabilities	167,511	114,063	208,496	109,590	376,007	223,653
Total Liabilities	2,522,492	2,266,269	3,139,668	2,177,396	5,662,160	4,443,665
NET ASSETS	4,109,808	5,064,746	5,115,350	4,866,130	9,225,158	9,930,876

The Schedule of Assets and Liabilities by Service should be read in conjunction with the accompanying notes.

(a) The former 'Specialised Community Mental Health' service category has been expanded into three services in 2013. Table B shows the 2013 figures for these new service categories.

Table B

Specialised Community and Other Services

For the year ended 30 June 2013

	Promotion and Prevention 2013 $	Specialised Community Services 2013 $	Accommodation and Support Services 2013 $	TOTAL 2013 $
ASSETS				
Current assets	952,456	6,042,824	1,018,941	8,014,221
Non-current assets	28,618	181,564	30,615	240,797
Total Assets	981,074	6,224,388	1,049,556	8,255,018
LIABILITIES				
Current liabilities	348,357	2,210,141	372,674	2,931,172
Non-current liabilities	24,779	157,209	26,508	208,496
Total Liabilities	373,136	2,367,350	399,182	3,139,668
NET ASSETS	607,938	3,857,038	650,374	5,115,350

Summary of Consolidated Account Appropriations and Income Estimates

For the year ended 30 June 2013

	2013 Estimate $	2013 Actual $	Variance $	2013 Actual $	2012 Actual $	Variance $
Delivery of Services						
Item 107 Net amount appropriated to deliver services	398,371,000	408,051,000	9,680,000	408,051,000	531,838,000	(123,787,000)
Section 25 transfer of service appropriation	-	1,428,000	1,428,000	1,428,000	-	1,428,000
Amount Authorised by Other Statutes						
- *Salaries and Allowances Act 1975*	467,000	467,000	-	467,000	268,000	199,000
Total appropriations provided to deliver services	398,838,000	409,946,000	11,108,000	409,946,000	532,106,000	(122,160,000)
Administered Transactions						
Section 25 Administered grants, subsidies and other transfer payments	70,334,000	68,905,000	(1,429,000)	68,905,000	27,951,000	40,954,000
Section 25 Administered capital appropriations	2,300,000	2,956,000	656,000	2,956,000	150,000	2,806,000
Total administered transactions	72,634,000	71,861,000	(773,000)	71,861,000	28,101,000	43,760,000
GRAND TOTAL	471,472,000	481,807,000	10,335,000	481,807,000	560,207,000	(78,400,000)
Details of Expenses by Service						
Promotion and Prevention	40,884,000	39,421,120	(1,462,880)	39,421,120		
Specialised Community Services	221,315,000	250,105,765	28,790,765	250,105,765		
Accommodation and Support Services	43,420,000	42,172,821	(1,247,179)	42,172,821		
	305,619,000	331,699,706	26,080,706	331,699,706	262,409,118	69,290,588
Specialised Admitted Patient Services	276,460,000	266,496,337	(9,963,663)	266,496,337	273,119,695	(6,623,358)
Total Cost of Services	582,079,000	598,196,043	16,117,043	598,196,043	535,528,813	62,667,230
Less Total income	(124,038,000)	(154,393,097)	(30,355,097)	(154,393,097)	(9,719,845)	(144,673,252)
Net Cost of Services	458,041,000	443,802,946	(14,238,054)	443,802,946	525,808,968	(82,006,022)
Adjustments (a)	(59,203,000)	(33,856,946)	25,346,054	(33,856,946)	6,297,032	(40,153,978)
Total appropriations provided to deliver services	398,838,000	409,946,000	11,108,000	409,946,000	532,106,000	(122,160,000)
Details of Income Estimates						
Income disclosed as Administered Income	72,634,000	71,861,000	(773,000)	71,861,000	28,101,000	43,760,000
	72,634,000	71,861,000	(773,000)	71,861,000	28,101,000	43,760,000

(a) Adjustments comprise movements in cash balances and other accrual items such as receivables and payables.

Note 30 'Explanatory statement' provides details of any significant variations between estimates and actual results for 2013 and between actual results for 2013 and 2012.

Notes to the Financial Statements

For the year ended 30 June 2013

Note 1 Australian Accounting Standards

General

The Commission's financial statements for the year ended 30 June 2013 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' includes Standards and Interpretations issued by the Australian Accounting Standards Board (AASB).

The Commission has adopted any applicable new and revised Australian Accounting Standards from their operative dates.

Early adoption of standards

The Commission cannot early adopt an Australian Accounting Standard unless specifically permitted by Treasurer's Instruction 1101 *'Application of Australian Accounting Standards and Other Pronouncements'*. There has been no early adoption of Australian Accounting Standards that have been issued or amended (but not operative) by the Commission for the annual reporting period ended 30 June 2013.

Note 2 Summary of significant accounting policies

(a) General statement

The Commission is a not-for-profit reporting entity that prepares general purpose financial statements in accordance with Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board as applied by the Treasurer's Instructions. Several of these are modified by the Treasurer's Instructions to vary application, disclosure, format and wording.

The *Financial Management Act* and the Treasurer's Instructions impose legislative provisions that govern the preparation of financial statements and take precedence over the Australian Accounting Standards, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board.

Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

(b) Basis of preparation

The financial statements have been prepared on the accrual basis of accounting using the historical cost convention.

The accounting policies adopted in the preparation of the financial statements have been consistently applied throughout all periods presented unless otherwise stated.

The financial statements are presented in Australian dollars and all values are rounded to the nearest dollar ($).

Note 3 'Judgements made by management in applying accounting policies' discloses judgements that have been made in the process of applying the Commission's accounting policies resulting in the most significant effect on amounts recognised in the financial statements.

Note 4 'Key sources of estimation uncertainty' discloses key assumptions made concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

(c) Reporting entity

The reporting entity comprises the Commission only.

Mission

To lead mental health reform through the commissioning of accessible, high quality services and supports and the promotion of mental health, wellbeing and facilitated recovery.

The Commission is predominantly funded by Parliamentary appropriations.

Services

The Commission is responsible for purchasing mental health services from a range of providers including public health systems, other government agencies, private sector providers and non-government organisations.

The Commission provides the following services. Income, expenses, assets and liabilities attributable to these services are set out in the 'Schedule of Income and Expenses by Service' and the 'Schedule of Assets and Liabilities by Service'.

Promotion and Prevention

Promotion and prevention services focus on protecting, supporting, sustaining and maximising mental health among populations and individuals; and increasing protective factors and decreasing risk factors to reduce the incidence and prevalence of mental health problems and illness.

Note 2 Summary of significant accounting policies (continued)

Specialised Admitted Patient Services

Specialised mental health admitted patient services are defined as publicly funded services with a primary function to provide admitted patient care to people with mental disorders in authorised hospitals and designated mental health inpatient units located within general hospitals.

Specialised Community Services

Specialised community services includes assessment, treatment and continuing care of non-admitted patients provided from a hospital or community mental health centre by public sector providers.

Accommodation and Support Services

Accommodation and support services for mental health comprise services provided by community sector organisations including advocacy, psychosocial support, rehabilitation, day programs, respite care, housing support and accommodation services.

(d) Contributed equity

AASB Interpretation 1038 *'Contributions by Owners Made to Wholly-Owned Public Sector Entities'* requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated by the Government (the owner) as contributions by owners (at the time of, or prior to transfer) before such transfers can be recognised as equity contributions. Capital appropriations have been designated as contributions by owners by Treasurer's Instruction 955 *'Contributions by Owners made to Wholly Owned Public Sector Entities'* and have been credited directly to Contributed equity.

The transfer of net assets to/from other agencies, other than as a result of a restructure of administrative arrangements, are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal. Refer also to note 20 'Equity'.

(e) Income

Revenue recognition

Revenue is recognised and measured at the fair value of consideration received or receivable as follows:

Service appropriations

Service Appropriations are recognised as revenues at fair value in the period in which the Commission gains control of the appropriated funds. The Commission gains control of appropriated funds at the time those funds are deposited to the bank account. Refer to note 14 'Income from State Government' for further information.

Net appropriation determination

The Treasurer may make a determination providing for prescribed receipts to be retained for services under the control of the Commission. In accordance with the determination specified in the 2012-2013 Budget Statements, the Commission retained $154,393,097 in 2013 ($9,719,845 in 2012) from the following:

- Specific purpose grants and contributions; and
- other departmental revenue.

Grants, donations, gifts and other non-reciprocal contributions

Revenue is recognised at fair value when the Commission obtains control over the assets comprising the contributions, usually when cash is received.

Other non-reciprocal contributions that are not contributions by owners are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

Gains

Realised or unrealised gains are usually recognised on a net basis. These include gains arising on the disposal of non-current assets.

Note 2 Summary of significant accounting policies (continued)

(f) Plant and equipment

Capitalisation/expensing of assets

Items of plant and equipment costing $5,000 or more are recognised as assets and the cost of utilising assets is expensed (depreciated) over their useful lives. Items of plant and equipment costing less than $5,000 are immediately expensed direct to the Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

Initial recognition and measurement
Plant and equipment are initially recognised at cost.

For items of plant and equipment acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

Subsequent measurement
All items of plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Depreciation
All non-current assets having a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits.

In order to apply this policy, the diminishing value with a straight line switch method is utilised for plant and equipment. Under this depreciation method, the cost amounts of the assets are allocated on average on a diminishing value basis over the first half of their useful lives and a straight line basis for the second half of their useful lives.

The assets' useful lives are reviewed annually. Expected useful lives for each class of depreciable asset are:

Leasehold Improvements	3 years
Furniture and fittings	15 years
Office Equipment	10 years

Artworks controlled by the Commission are classified as plant and equipment. These are anticipated to have indefinite useful lives. Their service potential has not, in any material sense, been consumed during the reporting period and consequently no depreciation has been recognised.

(g) Impairment of Assets

Plant and equipment are tested for any indication of impairment at the end of each reporting period. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised. Where an asset measured at cost is written down to recoverable amount, an impairment loss is recognised in profit or loss. Where a previously revalued asset is written down to recoverable amount, the loss is recognised as a revaluation decrement in other comprehensive income. As the Commission is a not-for-profit entity, unless an asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

The risk of impairment is generally limited to circumstances where an asset's depreciation is materially understated, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation/amortisation reflects the level of consumption or expiration of asset's future economic benefits and to evaluate any impairment risk from falling replacement costs.

The recoverable amount of assets identified as surplus assets is the higher of fair value less costs to sell and the present value of future cash flows expected to be derived from the asset. Surplus assets carried at fair value have no risk of material impairment where fair value is determined by reference to market-based evidence. Where fair value is determined by reference to depreciated replacement cost, surplus assets are at risk of impairment and the recoverable amount is measured. Surplus assets at cost are tested for indications of impairment at the end of each reporting period.

Refer also to note 2(i) 'Receivables' and note 16 'Receivables' for impairment of receivables.

(h) Leases

Finance lease rights and obligations are initially recognised, at the commencement of the lease term, as assets and liabilities equal in amount to the fair value of the leased item or, if lower, the present value of the minimum lease payments, determined at the inception of the lease. The assets are disclosed as plant and equipment under lease, and are depreciated over the period during which the Commission is expected to benefit from their use. Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding lease liability, according to the interest rate implicit in the lease.

Operating leases are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased properties.

Note 2 Summary of significant accounting policies (continued)

(i) Financial Instruments

In addition to cash, the Commission has two categories of financial instrument:

- Loans and receivables; and
- Financial liabilities measured at amortised cost.

Financial instruments have been disaggregated into the following classes:

Financial Assets
- Cash and cash equivalents
- Restricted cash and cash equivalents
- Receivables

Financial Liabilities
- Payables

Initial recognition and measurement of financial instruments is at fair value which normally equates to the transaction cost or the face value. Subsequent measurement is at amortised cost using the effective interest method.

The fair value of short-term receivables and payables is the transaction cost or the face value because there is no interest rate applicable and subsequent measurement is not required as the effect of discounting is not material.

(j) Cash and cash equivalents

For the purpose of the Statement of Cash Flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise cash on hand and short-term deposits with original maturities of three months or less that are readily convertible to a known amount of cash and which are subject to insignificant risk of changes in value.

(k) Accrued salaries

Accrued salaries (see note 18 'Payables') represent the amount due to employees but unpaid at the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Commission considers the carrying amount of accrued salaries to be equivalent to its fair value.

The accrued salaries suspense account (see note 15 'Restricted cash and cash equivalents') consists of amounts paid annually into a suspense account over a period of 10 financial years to largely meet the additional cash outflow in each eleventh year when 27 pay days occur instead of the normal 26. No interest is received on this account.

(l) Receivables

Receivables are recognised at original invoice amount less an allowance for uncollectible amounts (i.e. impairment). The collectability of receivables is reviewed on an ongoing basis and any receivables identified as uncollectible are written off against the allowance account. The allowance for uncollectible amounts (doubtful debts) is raised when there is objective evidence that the Commission will not be able to collect the debts. The carrying amount is equivalent to fair value as it is due for settlement within 30 days.

Refer to note 2(i) 'Financial Instruments' and note 16 'Receivables'.

Accounting procedure for Goods and Services Tax

Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for GST have been assigned to the 'Department of Health'. This accounting procedure was a result of application of the grouping provisions of "A New Tax System (Goods and Services Tax) Act 1999" whereby the Department of Health became the Nominated Group Representative (NGR) for the GST Group as from 1 July 2012. The 'Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals' (Metropolitan Health Services) was the NGR in the previous six financial years. The entities in the GST group include the Department of Health, Mental Health Commission, Metropolitan Health Services, Peel Health Service, WA Country Health Service, WA Alcohol and Drug Authority, QE II Medical Centre Trust, and Health and Disability Services Complaints Office.

GST receivables from and payables to ATO for the GST group are recorded in the accounts of the Department of Health. GST payables are recognised upon the receipt of tax invoices for purchases of goods and services. Accordingly, accrued expense amounts are generally exclusive of GST.

(m) Payables

Payables are recognised at the amounts payable when the Commission becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value, as they are generally settled within 30 days.

Refer to note 2(i) 'Financial Instruments' and note 18 'Payables'.

Note 2 Summary of significant accounting policies (continued)

(n) Provisions

Provisions are liabilities of uncertain timing or amount and are recognised where there is a present legal or constructive obligation as a result of a past event and when the outflow of resources embodying economic benefits is probable and a reliable estimate can be made of the amount of obligation. Provisions are reviewed at end of each reporting period.

Refer to note 19 'Provisions'.

Provisions - employee benefits

All annual leave and long service leave provisions are in respect of employees' services up to the end of the reporting period.

Annual leave

The liability for annual leave that is expected to be settled within 12 months after the end of the reporting period is recognised and measured at the undiscounted amounts expected to be paid when the liability is settled.

Annual leave that is not expected to be settled within 12 months after the end of the reporting period is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

When assessing expected future payments, consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions, as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

The provision for annual leave is classified as a current liability as the Commission does not have an unconditional right to defer settlement of the liability for at least 12 months after the end of the reporting period.

Long service leave

The liability for long service leave expected to be settled within 12 months after the end of the reporting period is recognised and measured at the undiscounted amounts expected to be paid when the liability is settled.

Long service leave that is not expected to be settled within 12 months after the end of the reporting period is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

When assessing expected future payments, consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions, as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Unconditional long service leave provisions are classified as current liabilities as the Commission does not have an unconditional right to defer settlement of the liability for at least 12 months after the end of the reporting period. Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Commission has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

Sick Leave

Liabilities for sick leave are recognised when it is probable that sick leave paid in the future will be greater than the entitlement that will accrue in the future.

Past history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised in the Statement of Comprehensive Income for this leave as it is taken.

Deferred Leave Scheme

The provision for deferred leave relates to the Commission's employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. The provision recognises the value of salary set aside for employees to be used in the fifth year. The liability has been calculated on current remuneration rates in respect of services provided by the employees up to the end of the reporting period and includes related on-costs. Deferred leave is reported as a current provision as employees can leave the scheme at their discretion at any time.

Note 2 Summary of significant accounting policies (continued)

Superannuation

The Government Employees Superannuation Board (GESB) and other fund providers administer public sector superannuation arrangements in Western Australia in accordance with legislative requirements. Eligibility criteria for membership in particular schemes for public sector employees vary according to commencement and implementation dates.

Eligible employees contribute to the Pension Scheme, a defined benefit pension scheme closed to new members since 1987, or the Gold State Superannuation Scheme (GSS), a defined benefit lump sum scheme closed to new members since 1995.

Employees commencing employment prior to 16 April 2007 who were not members of either the Pension Scheme or the GSS became non-contributory members of the West State Superannuation Scheme (WSS). Employees commencing employment on or after 16 April 2007 became members of the GESB Super Scheme (GESBS). From 30 March 2012, existing members of the WSS or GESBS and new employees have been able to choose their preferred superannuation fund provider. The Commission makes contributions to GESB or other fund providers on behalf of employees in compliance with the *Commonwealth Government's Superannuation Guarantee (Administration) Act 1992*. Contributions to these accumulation schemes extinguish the Commission's liability for superannuation charges in respect of employees who are not members of the Pension Scheme or GSS.

The GSS is a defined benefit scheme for the purposes of employees and whole-of-government reporting. However, it is a defined contribution plan for agency purposes because the concurrent contributions (defined contributions) made by the Commission to GESB extinguishes the Commission's obligations to the related superannuation liability.

The Commission has no liabilities under the Pension Scheme or the GSS. The liabilities for the unfunded Pension Scheme and the unfunded GSS transfer benefits attributable to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS obligations are funded by concurrent contributions made by the Commission to the GESB.

The GESB makes all benefit payments in respect of the Pension Scheme and GSS transfer benefits and recoups the employer's share from the Treasurer.

Refer to note 2(o) 'Superannuation Expense'.

Provisions - other

Employment on-costs

Employment on-costs, including workers' compensation insurance, are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment on-costs are included as part of 'Other expenses' and not included as part of the Commission's 'Employee benefits expense'. The related liability is included in 'Employment on-costs provision'.

Refer to note 11 'Other expenses' and note 19 'Provisions'.

(o) Superannuation expense

The superannuation expense in the Statement of Comprehensive Income comprises of employer contributions paid to the GSS (concurrent contributions), the West State Superannuation Scheme (WSS), the GESB Super Scheme (GESBS) and other superannuation funds. The employer contribution paid to the GESB in respect of the GSS is paid back into the Consolidated Account by the GESB.

(p) Services received free of charge or for nominal cost

Services received free of charge or for nominal cost are recognised as income at the fair value of those services that can be reliably measured and the Commission would otherwise pay for. A corresponding expense is recognised for services received.

Services received from other State Government agencies are separately disclosed under Income from State Government in the Statement of Comprehensive Income.

(q) Assets Transferred between Government Agencies

Discretionary transfers of assets between State Government agencies free of charge, are reported under Income from State Government at the fair value of those assets that the Commission would otherwise pay for. Transfers of assets and liabilities in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under AASB 1004 in respect of the net assets transferred.

(r) Comparative figures

Comparative figures are, where appropriate, reclassified to be comparable with the figures presented in the current financial year.

Note 3 Judgements made by management in applying accounting policies

The preparation of financial statements requires management to make judgements about the application of accounting policies that have a significant effect on the amounts recognised in the financial statements. The Commission evaluates these judgements regularly.

Employee benefits provision

An average turnover rate for employees has been used to calculate the non-current long service leave provision. This turnover rate is representative of the Health public authorities in general.

Operating lease commitments

The Commission has entered into a number of leases for buildings for branch office accommodation. It has been determined that the lessor retains substantially all the risks and rewards incidental to ownership. Accordingly, these leases have been classified as operating leases.

Note 4 Key sources of estimation uncertainty

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Long Service Leave

Several estimations and assumptions used in calculating the Commission's long service leave provision include expected future salary rates, discount rates, employee retention rates and expected future payments. Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Commission has applied the following Australian Accounting Standards effective for annual reporting periods beginning on or after 1 July 2012 that impacted on the Commission.

Title		
AASB 2011-9	*Amendments to Australian Accounting Standards – Presentation of Items of Other Comprehensive Income [AASB 1, 5, 7, 101, 112, 120, 121, 132, 133, 134, 1039 & 1049]* This Standard requires to group items presented in other comprehensive income on the basis of whether they are potentially reclassifiable to profit or loss subsequently (reclassification adjustments). There is no financial impact.	

Future impact of Australian Accounting Standards not yet operative

The Commission cannot early adopt an Australian Accounting Standard unless specifically permitted by Treasurer's Instruction 1101 *'Application of Australian Accounting Standards and Other Pronouncements'*. Consequently, the Commission has not applied early any of the following Australian Accounting Standards that may impact the Commission. Where applicable, the Commission plans to apply these Australian Accounting Standards from their application date.

Title		Operative for reporting periods beginning on/after
AASB 9	*Financial Instruments* This Standard supersedes AASB 139 *'Financial Instruments: Recognition and Measurement'*, introducing a number of changes to accounting treatments. *AASB 2012-6 Amendments to Australian Accounting Standards - Mandatory Effective Date of AASB 9 and Transition Disclosures* amended the mandatory application date of this Standard to 1 January 2015. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2015

Note 5 Disclosure of changes in accounting policy and estimates (continued)

Title		Operative for reporting periods beginning on/after
AASB 10	*Consolidated Financial Statements* This Standard supersedes AASB 127 *'Consolidated and Separate Financial Statements'* and Int 112 *'Consolidation – Special Purpose Entities'*, introducing a number of changes to accounting treatments. Mandatory application of this Standard was deferred by one year for not-for-profit entities by AASB 2012-10 *Amendments to Australian Accounting Standards - Transition Guidance and other Amendments*. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2014
AASB 11	*Joint Arrangements* This Standard supersedes AASB 131 *'Interests in Joint Ventures'*, introducing a number of changes to accounting treatments. Mandatory application of this Standard was deferred by one year for not-for-profit entities by AASB 2012-10. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2014
AASB 12	*Disclosure of Interests in Other Entities* This Standard supersedes disclosure requirements under AASB 127 *'Consolidated and Separate Financial Statements'* and AASB 131 *'Interests in Joint Ventures'*. Mandatory application of this Standard was deferred by one year for not-for-profit entities by AASB 2012-10. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2014
AASB 13	*Fair Value Measurement* This Standard defines fair value, sets out a framework for measuring fair value and requires additional disclosures about fair value measurements. There is no financial impact.	1 Jan 2013
AASB 119	*Employee Benefits* This Standard supersedes AASB 119 (October 2010), making changes to the recognition, presentation and disclosure requirements. The Commission does not have any defined benefit plans, and therefore the financial impact will be limited to the effect of discounting annual leave and long service leave liabilities that were previously measured at the undiscounted amounts.	1 Jan 2013
AASB 127	*Separate Financial Statements* This Standard supersedes AASB 127 *'Consolidated and Separate Financial Statements'*, introducing a number of changes to accounting treatments. Mandatory application of this Standard was deferred by one year for not-for-profit entities by AASB 2012-10. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2014
AASB 128	*Investments in Associates and Joint Ventures* This Standard supersedes AASB 128 *'Investments in Associates'*, introducing a number of changes to accounting treatments. Mandatory application of this Standard was deferred by one year for not-for-profit entities by AASB 2012-10. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2014

Note 5 Disclosure of changes in accounting policy and estimates (continued)

Title		Operative for reporting periods beginning on/after
AASB 1053	*Application of Tiers of Australian Accounting Standards* This Standard establishes a differential financial reporting framework consisting of two tiers of reporting requirements for preparing general purpose financial statements. There is no financial impact.	1 Jul 2013
AASB 1055	*Budgetary Reporting* This Standard specifies the nature of budgetary disclosures, the circumstances in which they are to be included in the general purpose financial statements of not-for-profit entities within the GGS. The Commission will be required to disclose additional budgetary information and explanations of major variances between actual and budgeted amounts, though there is no financial impact.	1 Jul 2014
AASB 2010-2	*Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements [AASB 1, 2, 3, 5, 7, 8, 101, 102, 107, 108, 110, 111, 112, 116, 117, 119, 121, 123, 124, 127, 128, 131, 133, 134, 136, 137, 138, 140, 141, 1050 & 1052 and Int 2, 4, 5, 15, 17, 127, 129 & 1052]* This Standard makes amendments to Australian Accounting Standards and Interpretations to introduce reduced disclosure requirements for certain types of entities. There is no financial impact.	1 Jul 2013
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. AASB 2012-6 amended the mandatory application date of this Standard to 1 January 2015. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2015
AASB 2011-2	*Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project – Reduced Disclosure Requirements [AASB 101 & 1054]* This Standard removes disclosure requirements from other Standards and incorporates them in a single Standard to achieve convergence between Australian and New Zealand Accounting Standards for reduced disclosure reporting. There is no financial impact.	1 Jul 2013
AASB 2011-6	*Amendments to Australian Accounting Standards – Extending Relief from Consolidation, the Equity Method and Proportionate Consolidation – Reduced Disclosure Requirements [AASB 127, 128 & 131]* This Standard extends the relief from consolidation, the equity method and proportionate consolidation by removing the requirement for the consolidated financial statements prepared by the ultimate or any intermediate parent entity to be IFRS compliant, provided that the parent entity, investor or venturer and the ultimate or intermediate parent entity comply with Australian Accounting Standards or Australian Accounting Standards – Reduced Disclosure Requirements. There is no financial impact.	1 Jul 2013
AASB 2011-7	*Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 139, 1023 & 1039 and Int 5, 9, 16 & 17]* This Standard gives effect to consequential changes arising from the issuance of AASB 10, AASB 11, AASB 127 '*Separate Financial Statements*' and AASB 128 '*Investments in Associates and Joint Ventures*'. For not-for-profit entities it applies to annual reporting periods beginning on or after 1 January 2014. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2013

Note 5 Disclosure of changes in accounting policy and estimates (continued)

		Operative for reporting period beginning on/afi
AASB 2011-8	*Amendments to Australian Accounting Standards arising from AASB 13 [AASB 1, 2, 3, 4, 5, 7, 101, 102, 108, 110, 116, 117, 118, 119, 120, 121, 128, 131, 132, 133, 134, 136, 138, 139, 140, 141, 1004, 1023 & 1038 and Int 2, 4, 12, 13, 14, 17, 19, 131 & 132]* This Standard replaces the existing definition and fair value guidance in other Australian Accounting Standards and Interpretations as the result of issuing AASB 13 in September 2011. There is no financial impact.	1 Jan 2013
AASB 2011-10	*Amendments to Australian Accounting Standards arising from AASB 119 (September 2011) [AASB 1, 8, 101, 124, 134, 1049 & 2011-8 and Int 14]* This Standard makes amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 119 in September 2011. There is limited financial impact.	1 Jan 2013
AASB 2011-11	*Amendments to AASB 119 (September 2011) arising from Reduced Disclosure Requirements* This Standard gives effect to Australian Accounting Standards – Reduced Disclosure Requirements for AASB 119 (September 2011). There is no financial impact.	1 Jul 2013
AASB 2012-1	*Amendments to Australian Accounting Standards - Fair Value Measurement - Reduced Disclosure Requirements [AASB 3, 7, 13, 140 & 141]* This Standard establishes and amends reduced disclosure requirements for additional and amended disclosures arising from AASB 13 and the consequential amendments implemented through AASB 2011-8. There is no financial impact.	1 Jul 2013
AASB 2012-2	*Amendments to Australian Accounting Standards - Disclosures - Offsetting Financial Assets and Financial Liabilities [AASB 7 & 132]* This Standard amends the required disclosures in AASB 7 to include information that will enable users of an entity's financial statements to evaluate the effect or potential effect of netting arrangements, including rights of set-off associated with the entity's recognised financial assets and recognised financial liabilities, on the entity's financial position. There is no financial impact.	1 Jan 2013
AASB 2012-3	*Amendments to Australian Accounting Standards - Offsetting Financial Assets and Financial Liabilities [AASB 132]* This Standard adds application guidance to AASB 132 to address inconsistencies identified in applying some of the offsetting criteria, including clarifying the meaning of "currently has a legally enforceable right of set-off" and that some gross settlement systems may be considered equivalent to net settlement. There is no financial impact.	1 Jan 2014
AASB 2012-5	*Amendments to Australian Accounting Standards arising from Annual Improvements 2009-11 Cycle [AASB 1, 101, 116, 132 & 134 and Int 2]* This Standard makes amendments to the Australian Accounting Standards and Interpretations as a consequence of the annual improvements process. There is no financial impact.	1 Jan 2013
AASB 2012-6	*Amendments to Australian Accounting Standards - Mandatory Effective Date of AASB 9 and Transition Disclosures [AASB 9, 2009-11, 2010-7, 2011-7 & 2011-8]* This Standard amends the mandatory effective date of AASB 9 Financial Instruments to 1 January 2015. Further amendments are also made to consequential amendments arising from AASB 9 that will now apply from 1 January 2015 and to consequential amendments arising out of the Standards that will still apply from 1 January 2013. There is no financial impact.	1 Jan 2013
AASB 2012-7	*Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements [AASB 7, 12, 101 & 127]* This Standard adds to or amends the Australian Accounting Standards to provide further information regarding the differential reporting framework and the two tiers of reporting requirements for preparing general financial statements. There is no financial impact.	1 Jul 2013

Note 5 Disclosure of changes in accounting policy and estimates (continued)

Title		Operative for reporting periods beginning on/after
AASB 2012-10	*Amendments to Australian Accounting Standards - Transition Guidance and Other Amendments (AASB 1, 5, 7, 8, 10, 11, 12, 13, 101, 102, 108, 112, 118, 119, 127, 128, 132, 133, 134, 137, 1023, 1038, 1039, 1049 & 2011-7 and Int 12)* This Standard makes amendments to AASB 10 and related Standards to revise the transition guidance relevant to the initial application of those Standards, and to clarify the circumstances in which adjustments to an entity's previous accounting for its involvement with other entities are required and the timing of such adjustments. The Standard was issued in December 2012. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2013
AASB 2012-11	*Amendments to Australian Accounting Standards - Reduced Disclosure Requirements and Other Amendments (AASB 1, 2, 8, 10, 107, 128, 133, 134 & 2011-4)* This Standard makes various editorial corrections to Australian Accounting Standards - Reduced Disclosure Requirements (Tier 2). These corrections ensure that the Standards reflect decisions of the AASB regarding the Tier 2 requirements. The Standard also extends the relief from consolidation and the equity method (in the new Consolidation and Joint Arrangement Standards) to entities complying with Australian Accounting Standards - Reduced Disclosure Requirements. There is no financial impact.	1 Jul 2013

Note 6 Employee benefits expense

	2013 $	2012 $
Salaries and wages (a)	10,392,173	6,747,739
Superannuation - defined contribution plans (b)	877,231	526,807
	11,269,404	7,274,546

(a) Includes the value of the fringe benefit to the employees plus the fringe benefits tax component and the value of superannuation contribution component for leave entitlements.

(b) Defined contribution plans include West State, Gold State and GESB and other eligible funds.

Employment on-costs (workers' compensation insurance) are included at note 11 'Other expenses'.

Employment on-costs liability is included at note 19 'Provisions'.

Note 7 Contracts for services

Purchase of Public Mental Health	504,688,776	460,852,174
Non-Government and Other Services	71,234,088	60,486,417
	575,922,864	521,338,591

Public hospitals, private hospitals, non-government organisations and other organisations are contracted to provide specialised mental health services to the public patients and the community.

	2013 $	2012 $
Note 8 Supplies and services		
Advertising	38,694	46,171
Communication	97,255	51,606
Computer related services	67,091	17,200
Consulting fees	611,935	534,494
Consumables	245,858	194,286
Operating lease expenses	665,990	477,402
Shared services charges	107,727	103,584
Other	134,271	103,790
	1,968,821	1,528,533
Note 9 Grants and subsidies		
Recurrent		
National Partnership Agreement - Improving public hospitals	2,790,000	-
Other Grants	5,119,956	4,371,073
Scholarships	305,520	488,368
	8,215,476	4,859,441
Note 10 Depreciation expense		
Leasehold Improvements	52,093	-
Furniture and fittings	627	-
Office Equipment	1,568	-
	54,288	-
Note 11 Other expenses		
Workers' compensation insurance (a)	34,436	21,200
Other employee related expenses	272,185	224,767
Repairs and maintenance	76,498	21,135
Travel related expenses	46,472	8,206
Audit fees	97,351	53,400
Legal fees	27,096	25,852
Other	211,152	173,142
	765,190	527,702

(a) The employment on-costs include workers' compensation insurance only. The on-costs liability associated with the recognition of annual and long service leave liability is included at note 19 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Note 12 Commonwealth grants and contributions

National Partnership on Improving Public Hospital Services	11,453,626	3,722,266
National Partnership on Supporting National Mental Health	4,071,000	-
National Health Reform Agreement (a)	137,995,224	-
Public Hospital NHR Access to Emergency Departments	-	3,169,000
	153,519,850	6,891,266

(a) As from 1 July 2012, activity based funding and block grant funding have been received from the Commonwealth Government under the National Health Reform Agreement for services, health teaching, training and research provided by local hospital networks. The new funding arrangement established under the Agreement requires the Commonwealth Government to make funding payments to the State Pool Account from which distributions to the local hospital networks are made by the Department of Health and Mental Health Commission. In previous financial years, the equivalent Commonwealth funding was received in the form of Service Appropriations from the State Treasurer.

13 Other grants and contributions

Disability Services Commission	-	1,871,371
Department of Child Protection	634,800	584,800
Other	125,455	192,421
	760,255	2,748,592

	2013 $	2012 $
Note 14 Income from State Government		
Service appropriation received during the period:		
Amount appropriated to deliver services	409,479,000	531,838,000
Amount authorised by other statutes:		
Salaries and Allowances Act 1975	467,000	268,000
	409,946,000	532,106,000

As from 1 July 2012, activity based funding and block grant funding have been received from the Commonwealth Government under the National Health Reform Agreement for services, health teaching, training and research provided by local hospital networks. The new funding arrangement established under the Agreement requires the Commonwealth Government to make funding payments to the State Pool Account from which distributions to the local hospital networks are made by the Department of Health and Mental Health Commission. In previous financial years, the equivalent Commonwealth funding was received in the form of Service Appropriations from the State Treasurer.

Services received free of charge from other State government agencies during the period:		
State Solicitor's Office - legal advisory services	9,828	25,852
Department of Health - corporate services	19,512	57,937
Department of Health - services for Series B population growth	-	3,230,000
Department of Finance - office accommodation leasing services	13,112	-
Metropolitan Health Services - contracted mental health services	30,488,776	-
WA Country Health Service - contracted mental health services	2,620,000	-
	33,151,228	3,313,789
Note 15 Restricted cash and cash equivalents		
Current		
Capital grant from the Commonwealth Government (a)	2,200,000	-
Non-current		
Accrued salaries suspense account (b)	296,320	244,320

(a) The unspent fund from the Commonwealth Government is committed to the construction of the Broome sub-acute facility.

(b) Funds held in the suspense account used only for the purpose of meeting the 27th pay in a financial year that occurs every 11 years.

Note 16 Receivables		
Current		
Receivables	266,480	74,021
Other debtors (a)	-	1,399,803
	266,480	1,473,824

(a) Comprises of a refund due from WA Country Health Service for overpayment of an invoice to Specialised Statewide Aboriginal Health Service.

Refer to note 2(l) 'Receivables' and note 32 'Financial Instruments'.

	2013 $	2012 $
Note 17 Plant and equipment		
Leasehold improvements		
At cost	156,279	156,279
Accumulated depreciation	(52,093)	-
	104,186	156,279
Furniture & Fittings		
At cost	6,273	-
Accumulated depreciation	(627)	-
	5,646	-
Office Equipment		
At cost	15,675	-
Accumulated depreciation	(1,568)	-
	14,107	-
Artworks		
At cost	12,000	-
Total plant and equipment	135,939	156,279

Reconciliations

Reconciliations of the carrying amounts of plant and equipment at the beginning and end of the reporting period are set out below.

Leasehold improvements		
Carrying amount at the start of year	156,279	-
Additions	-	156,279
Depreciation	(52,093)	-
Carrying amount at the end of year	104,186	156,279
Furniture & Fittings		
Carrying amount at the start of year	-	-
Additions	6,273	-
Depreciation	(627)	-
Carrying amount at the end of year	5,646	-
Office Equipment		
Carrying amount at the start of year	-	-
Additions	15,675	
Depreciation	(1,568)	-
Carrying amount at the end of year	14,107	-
Artworks		
Carrying amount at the start of year	-	-
Additions	12,000	-
Carrying amount at the end of year	12,000	-
Total plant and equipment		
Carrying amount at the start of year	156,279	-
Additions	33,948	156,279
Depreciation	(54,288)	-
Carrying amount at the end of year	135,939	156,279

There were no indications of impairment to plant and equipment at 30 June 2013.

Note 18 Payables		
Current		
Trade creditors	919,917	854,098
Accrued salaries	325,991	186,741
Accrued expenses	2,035,521	1,844,633
	3,281,429	2,885,472

Refer to note 2(n) 'Payables' and note 32 'Financial Instruments'.

	2013 $	2012 $
Note 19 Provisions		
Current		
Employee benefits provision		
Annual leave (a)	897,886	587,050
Long service leave (b)	1,024,230	618,032
Deferred salary scheme (c)	82,608	129,458
	2,004,724	1,334,540
Non-current		
Employee benefits provision		
Long service leave (b)	376,007	223,653
	2,380,731	1,558,193
(a) Annual leave liabilities have been classified as current as there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:		
Within 12 months of the end of the reporting period	631,116	413,355
More than 12 months after the end of the reporting period	266,770	173,695
	897,886	587,050
(b) Long service leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities will occur as follows:		
Within 12 months of the end of the reporting period	205,758	155,393
More than 12 months after the end of the reporting period	1,194,479	686,292
	1,400,237	841,685
(c) Deferred salary scheme liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities will occur as follows:		
Within 12 months of the end of the reporting period	82,608	129,458
More than 12 months after the end of the reporting period	-	-
	82,608	129,458
Note 20 Equity		
The Government holds the equity interest in the Commission on behalf of the community. Equity represents the residual interest in the net assets of the Commission.		
Contributed equity		
Balance at start of period	945,900	945,900
Contributions by owners	-	-
Distributions to owner	-	-
Balance at end of period	945,900	945,900
Accumulated surplus / (deficit)		
Balance at start of period	8,964,976	(525,845)
Result for the period	(705,718)	9,610,821
Balance at end of period	8,279,258	8,964,976
Total Equity at end of period	9,225,158	9,930,876

	2013 $	2012 $
Note 21 Notes to the Statement of Cash Flows		
Reconciliation of cash		
Cash at the end of the financial year as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:		
Cash and cash equivalents	11,986,579	12,500,116
Restricted cash and cash equivalents (refer to note 15)	2,498,320	244,320
	14,484,899	12,744,436
Reconciliation of net cost of services to net cash flows used in operating activities		
Net cost of services (Statement of Comprehensive Income)	(443,602,946)	(525,808,968)
Non-cash items:		
Services received free of charge (refer to note 14)	33,151,228	3,313,789
Donation of non-current assets	(12,000)	-
Depreciation expense (refer to note 10)	54,288	-
(Increase)/decrease in assets:		
Current receivables (a)	1,207,344	(1,154,782)
Increase/(decrease) in liabilities:		
Current payables (a)	395,957	886,813
Current provisions	670,184	248,483
Non-current provisions	152,354	39,375
Net cash used in operating activities (Statement of Cash Flows)	(408,183,591)	(522,375,290)
(a) Note that the Australian Taxation Office (ATO) receivable/payable in respect of GST and the receivable/payable in respect of the sale/purchase of non-current assets are not included in these items as they do not form part of the reconciling items.		
Note 22 Commitments		
The commitments below are inclusive of GST where relevant.		
Non-cancellable operating lease commitments		
Commitments for minimum lease payments are payable as follows:		
Within 1 year	372,438	7,920
Later than 1 year and not later than 5 years	704,602	-
	1,077,040	7,920
The leases are non-cancellable, with rent payable monthly in advance. Operating leases relating to buildings and office equipment do not have contingent rental obligations. There are no restrictions imposed by these leasing arrangements on other financing		
Contracts for the provision of mental health services		
Expenditure commitments in relation to private hospitals and non government organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:		
Within 1 year	67,330,553	62,552,575
Later than 1 year and not later than 5 years	165,884,442	25,488,488
Later than 5 years	18,351,067	18,110,115
	251,566,062	106,151,178
Other expenditure commitments		
Other expenditure commitments contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:		
Within 1 year	2,200,000	-

Note 23 Remuneration of senior officers

The number of senior officers, whose total fees, salaries, superannuation, non-monetary benefits and other benefits for the financial year fall within the following bands are:

	2013	2012
$ 70,001 - $ 80,000	-	3
$100,001 - $110,000	-	1
$150,001 - $160,000	1	-
$160,001 - $170,000	1	-
$170,001 - $180,000	1	1
$200,001 - $210,000	-	1
$210,001 - $220,000	2	-
$240,001 - $250,000	-	1
$250,001 - $260,000	1	-
$320,001 - $330,000	1	-
$350,001 - $360,000	-	1
	7	8

	$	$
Base remuneration and superannuation	1,360,072	1,143,741
Annual leave and long service leave accruals	85,908	116,061
Other benefits	47,370	49,245
Total remuneration of senior officers:	1,493,350	1,309,047

The total remuneration includes the superannuation expense incurred by the Commission in respect of senior officers.

Note 24 Remuneration of auditor

Remuneration payable to the Auditor General in respect of the audit for the current financial year is as follows:

Auditing the accounts, financial statements and key performance indicators	69,000	72,000

Note 25 Contingent liabilities and contingent assets

The Commission is not aware of any contingent liabilities or contingent assets .

Note 26 Events occurring after the end of the reporting period

The Government has announced the amalgamation of the Mental Health Commission and the WA Alcohol and Drug Authority. No date has been set for the formal transition, but is expected to occur during the 2013-14 financial year.

Note 27 Related bodies

A related body is a body which receives more than half its funding and resources from the Commission and is subject to operational control by the Commission.

The Commission had no related bodies during the financial year.

Note 28 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from the Commission and is not subject to operational control by the Commission.

The Commission had the following affiliated bodies during the financial year:

Albany Halfway House Association Incorporated	1,200,490	-
Bunbury Pathways Incorporated	577,095	-
Consumers of Mental Health WA	260,625	-
Even Keel Bipolar Support Association Incorporated	108,312	104,607
G.R.O.W.	-	673,100
Home Health Pty Ltd (trading as Tender Care)	920,385	889,805
June O'Conner Centre Incorporated	1,414,050	-
Mental Health Carers ARAFMI (WA) Inc	2,148,431	1,994,050
Mental Illness Fellowship of WA Incorporated	1,663,331	-
Samaritan of Albany Befrienders Incorporated	10,698	-
Schizophrenia Fellowship Albany and Districts Incorporated	201,895	-
Support in Site Incorporated	76,321	-
The Richmond Fellowship of WA	7,796,395	7,229,577
Western Australian Association for Mental Health	906,045	-
	17,283,873	10,891,139

	2013 $	2012 $
Note 29 Special Purpose Accounts		
State Managed Fund (Mental Health) Account		
The purpose of the special purpose account is to hold money received by the Mental Health Commission, for the purposes of health funding under the National Health Reform Agreement that is required to be undertaken in the State through a State Managed Fund.		
Balance at the start of period	-	-
Receipts:		
Service appropriations (State Government)	202,894,000	-
Commonwealth grants and contributions	92,733,781	-
	295,627,781	-
Payments:		
Block grant funding to local hospital networks	(295,627,781)	-
Balance at the end of period	-	-

Note 30 Explanatory statement

Significant variations between estimates and actual results for income and expense as presented in the financial statement titled 'Summary of Consolidated Account Appropriations and Income Estimates' are shown below: Significant variations are considered to be those greater than 10% or that are 4% or more of the current year's Total Cost of Services.

Significant variances between estimates and actual results for 2013

	2013 Estimate $	2013 Actual $	Variance $
(a) Total appropriations provided to deliver services	398,838,000	409,946,000	11,108,000
The increase in Appropriation is due to a Government decision to fund $12,300,000 of mental health activity within the Department of Health (DoH) above the budget settings plus the $1,428,000 section 25 transfer of the Council of Official Visitors (COOV). These were offset by savings from Government decisions in relation to Full Time Equivalent ceiling and temporary procurement freeze.			
(b) Total Cost of Services			
Promotion and Prevention	40,884,000	39,421,120	(1,462,880)
Specialised Community Services	221,315,000	250,105,765	28,790,765
Accommodation and Support Services	43,420,000	42,172,821	(1,247,179)
Specialised Admitted Patient Services	276,460,000	266,496,337	(9,963,663)
	582,079,000	598,196,043	16,117,043
The Total Cost of Services exceeded budget in total due to $12,300,000 additional expenditure on DoH mental health activity, $1,415,495 expenditure on the COOV and $5,357,000 spent on Commonwealth funded National Partnership Agreement (NPA) Mental Health Reform projects approved subsequent to the 2012-13 budget process. The movement between Specialised Community Services and Specialised Admitted Patient Services is due to revised modelling and improvements in classification of types of service.			
(c) Total Income	124,038,000	154,393,097	30,355,097
Total Income was higher than budget due to $26,091,224 higher National Health Reform Agreement (NHRA) revenue and $4,071,000 NPA Mental Health Reform revenue approved subsequent to the 2012-13 budget process. The NHRA revenue attributable to Activity Based Funding was classified as Services received free of charge for Estimate purposes.			

Note 30 Explanatory statement (continued)

Significant variances between actual results for 2012 and 2013

	2013 Actual $	2012 Actual $	Variance $
(a) Total appropriations provided to deliver services	409,946,000	532,106,000	(122,160,000)
The decrease in Appropriation is due to the introduction of new funding arrangements which increased revenue as part of the Commonwealth National Health Reform Agreement.			
(b) Total Cost of Services			
Promotion and Prevention	39,421,120		
Specialised Community Services	250,105,765		
Accommodation and Support Services	42,172,821		
	331,699,706	262,409,118	69,290,587
Specialised Admitted Patient Services	266,496,337	273,119,695	(6,623,357)
	598,196,043	535,528,813	62,667,230
Total Cost of Services increase is largely due to: i) $43,836,602 - to recognise increased activity identified within the Department of Health's Clinical Services Framework (CSF), plus approved above - CSF activity; ii) $3,256,506 - growth in the Individualised Community Living Strategy (ICLS) payment; iii) $1,673,191 - Joondalup Sub-acute facility commenced in 2012-13; iv) $4,188,000 - higher Suicide Prevention Strategy payment; v) $2,790,000 - grant to the Department of Housing for ICLS housing; vi) $3,994,858 - employee benefits including staff transferred with the Mental Health Review Board, Council of Official Visitors and growth in number of employees to implement initiatives approved in the			
(c) Total Income	154,393,097	9,719,845	144,673,252
Total Income increase is largely due to: i) $137,995,223 increase from the National Health Reform Agreement funding arrangements introduced in 2012-13; ii) $4,562,360 increase in revenue from the National Partnership Agreement for Improving Public Hospitals.			
(d) Total Administered transactions			
Administered income - section 25 transfer	71,861,000	28,101,000	43,760,000
Administered expenses - transfer to WA Alcohol and Drug Authority	71,861,000	28,101,000	43,760,000

Note 31 Disclosure of administered income and expenses by service

	Drug and Alcohol 2013 $	Drug and Alcohol 2012 $
Expenses		
Appropriations transferred to WA Alchohol and Drug Authority	71,861,000	28,101,000
Total administered expenses	71,861,000	28,101,000
Income		
Appropriations from Government for transfer	71,861,000	28,101,000
Total administered income	71,861,000	28,101,000

The Western Australian Alcohol and Drug Authority (WAADA) separated from the Health ministerial portfolio and united with the Mental Health Commission in the Mental Health ministerial portfolio from 1 January 2012. Appropriations have been administered by the Commission on behalf of WAADA from 1 January 2012 in accordance with the Minister for Mental Health's direction.

Note 32 Financial instruments

a) **Financial risk management objectives and policies**

Financial instruments held by the Commission are cash and cash equivalents, restricted cash and cash equivalents, receivables and payables. The Commission has limited exposure to financial risks. The Commission's overall risk management program focuses on managing the risks identified below.

Credit risk
Credit risk arises when there is the possibility of the Commission's receivables defaulting on their contractual obligations resulting in financial loss to the Commission.

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment, as shown in the table at Note 32(c) 'Financial Instruments Disclosure' and Note 16 'Receivables'.

Credit risk associated with the Commission's financial assets is minimal because the debtors are predominately government bodies.

Liquidity risk
Liquidity risk arises when the Commission is unable to meet its financial obligations as they fall due. The Commission is exposed to liquidity risk through its trading in the normal course of business.

The Commission has appropriate procedures to manage cash flows including drawdowns of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

Market risk
Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Commission's income or the value of its holdings of financial instruments. The Commission does not trade in foreign currency and is not materially exposed to other price risks.

The Commission is not exposed to interest rate risk, because all cash and cash equivalents are non-interest bearing.

b) **Categories of financial instruments**

The carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are:

	2013 $	2012 $
Financial Assets		
Cash and cash equivalents	11,986,579	12,500,118
Restricted cash and cash equivalents	2,498,320	244,320
Loans and receivables	266,480	1,473,824
Financial Liabilities		
Financial liabilities measured at amortised cost	3,281,429	2,885,472

c) **Financial instrument disclosures**

Credit risk

The following table details the Commission's maximum exposure to credit risk, and the ageing analysis of financial assets. The Commission's maximum exposure to credit risk at the end of the reporting period is the carrying amount of financial assets as shown below. The table discloses the ageing of financial assets that are past due but not impaired and impaired financial assets. The table is based on information provided to senior management of the Commission.

The Commission does not hold any collateral as security or other credit enhancements relating to the financial assets it holds.

Aged analysis of financial assets

			Past due but not impaired					
	Carrying amount	Not past due and not impaired	up to 1 month	1 - 3 months	3 months to 1 year	1 - 5 years	More than 5 years	Impaired financial assets
	$	$	$	$	$		$	$
2013								
Cash and cash equivalents	11,986,579	11,986,579	-	-	-		-	-
Restricted cash and cash equivalents	2,498,320	2,498,320	-	-	-		-	-
Receivables	266,480	216,902	-	-	49,578	-	-	-
	14,751,379	14,701,801	-	-	49,578	-	-	-
2012								
Cash and cash equivalents	12,500,118	12,500,118						
Restricted cash and cash equivalents	244,320	244,320						
Receivables	1,473,824	1,405,824	62,000	-	6,000	-	-	-
	14,218,262	14,150,262	62,000	-	6,000	-	-	-

Liquidity risk and interest rate exposure

The following table details the Commission's interest rate exposure and the contractual maturity analysis of financial assets and financial liabilities. The maturity analysis section includes interest and principal cash flows. The interest rate exposure section analyses only the carrying amount of each item.

Interest rate exposures and maturity analysis of financial assets and financial liabilities

			Interest rate exposure				Maturity Dates		
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 1 month	1 - 3 months	3 months to 1 year
	%	$	$	$	$	$		$	$
2013									
Financial Assets									
Cash and cash equivalents	-	11,986,579	-	-	11,986,579	11,986,579	11,986,579	-	-
Restricted cash and cash equivalents	-	2,498,320	-	-	2,498,320	2,498,320	2,498,320	-	-
Receivables	-	266,480	-	-	266,480	266,480	266,480	-	-
		14,751,379	-	-	14,751,379	14,751,379	14,751,379	-	-
Financial Liabilities									
Payables	-	3,281,429	-	-	3,281,429	3,281,429	3,281,429	-	-
		3,281,429	-	-	3,281,429	3,281,429	3,281,429	-	-
2012									
Financial Assets									
Cash and cash equivalents	-	12,500,118	-	-	12,500,118	12,500,118	12,500,118	-	-
Restricted cash and cash equivalents	-	244,320	-	-	244,320	244,320	244,320	-	-
Receivables	-	1,473,824	-	-	1,473,824	1,473,824	1,473,824	-	-
		14,218,262	-	-	14,218,262	14,218,262	14,218,262	-	-
Financial Liabilities									
Payables	-	2,885,472	-	-	2,885,472	2,885,472	2,885,472	-	-
		2,885,472	-	-	2,885,472	2,885,472	2,885,472	-	-

Fair values

All financial assets and liabilities recognised in the Statement of Financial Position, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

Certification of Key Performance Indicators

MENTAL HEALTH COMMISSION
CERTIFICATION OF KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2013

I hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the Mental Health Commission and fairly represent the performance of the Mental Health Commission for the financial year ended 30 June 2013.

Eddie Bartnik
Commissioner, Mental Health Commission
Accountable Authority

18 September 2013

Outcome Based Management Framework

Whole of Government Goal	Our Desired Outcome	Services we purchase
Outcomes Based Service Delivery: Greater focus on achieving results in key service delivery areas for the benefits of all Western Australians	Accessible and high quality mental health services and supports that are recovery focussed and promote mental health and wellbeing **Key Effectiveness Indicators** • Readmissions to hospital within 28 days of discharge • Percent of contacts with community-based public mental health non-admitted services within 7 days post discharge from public mental health inpatient units • Proportion of service funding directed to publicly funded community mental health services • Proportion of service funding directed to community organisations (NGOs)	*Service 1*: Promotion and prevention *Service 2*: Specialised admitted patient services *Service 3*: Specialised community services *Service 4*: Accommodation, support and other services

Key Efficiency Indicators

Service one Promotion and prevention	Service two Specialised admitted patient services	Service three Specialised community services	Service four Accommodation, support and other services
Cost per capita of activities to enhance mental health and wellbeing (illness prevention, promotion and protection activities)	Average cost per purchased bedday in specialised mental health units	Average cost per purchased episode of community care provided by public mental health services	• Average cost per hour for community support provided by non-government organisations to people with mental health problems • Average MHC subsidy per bedday for people with mental illness living in community supported residential accommodation.

Readmissions to hospital within 28 days of discharge

Mental health inpatient services aim to provide treatment that enables individuals to return to the community as soon as possible. Readmissions to an acute specialised mental health inpatient unit following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital. In this sense, they potentially point to deficiencies in the functioning of the overall care system.

International literature identifies the concept of one month as an appropriate defined time period for the measurement of readmissions following discharge from an acute mental health inpatient service.

This indicator reports on planned as well as unplanned readmissions as current health systems cannot accurately identify unplanned readmissions.

Percent of readmissions to acute mental health inpatient facilities within 28 days of discharge

2012/13	Target[1]
11.9%	<=12%

Results

- In 2012/13, the readmission rate to acute mental health inpatient mental health facilities was 11.9%.
- This result is within the target range.

Notes
This is a new KPI approved for 2012/13, therefore comparative figures are not provided.
[1]The target was set as part of the Government Budget process.

Data Source
Hospital Morbidity Data Collection, Department of Health.

Percent of contacts with community-based public mental health non-admitted services within 7 days post discharge from public mental health inpatient units

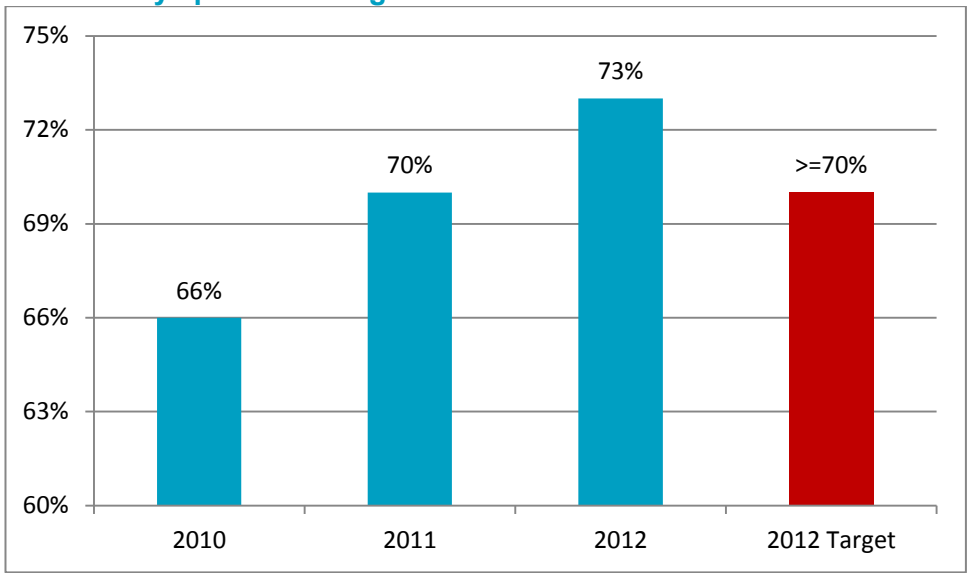
A large proportion of people with a mental health problem have a chronic or recurrent illness that results in only partial recovery between acute episodes and deterioration in functioning that can lead to problems in living an independent life. As a result, hospitalisation may be required on more than one occasion each year with the need for ongoing community-based support.

A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with public community based services and supports, are less likely to need inappropriate readmission.

These community services provide ongoing clinical treatment and access to a range of programs that maximise an individual's independent functioning and quality of life.

The time period of seven days was recommended nationally as an indicative measure for contact with community based non-admitted services following discharge from hospital.

Percent of patients that had contact with a community-based service within 7 days post discharge



Results

- In 2012, 73% of patients had contact with a community-based public mental health service within seven days post discharge from a public mental health inpatient unit.
- This result is higher than the 2011 figure, trending in the right direction and within the target range.

Notes

Data is for the calendar year of 2012.
The target was set as part of the Government Budget process.

Data Sources

Mental Health Information System, Department of Health.
Hospital Morbidity Data Collection, Department of Health.

Proportion of service funding directed to publicly funded community mental health services

Currently a large proportion of funding is directed to acute inpatient care. State Government as well as national mental health policy articulate a shift from the reliance on acute care provided in inpatient services to services and supports provided in the community as a key reform initiative.

One of the State Government's three key reform directions articulated in the Mental Health Commission's strategic policy document *Mental Health 2020: Making it personal and everyone's business* is 'balanced investment' i.e., working towards a contemporary mental health system that provides a full range of support and services.

Publicly funded community mental health services (specialised public mental health services) provide clinical services including assessment, treatment and continuing care of non-admitted patients provided from a hospital or community mental health centre by public sector providers.

This indicator is a proxy measure of accessibility and appropriateness of services.

Proportion of funding to publicly funded community mental health services

2012/13	Target[1]
42.2%	>=40%

Results

- In 2012/13, the proportion of funding directed to public community mental health services was 42.2%.
- This result is within the target range.

Notes

This is a new KPI approved for 2012/13, therefore comparative figures are not provided.
[1]The target was set as part of the Government Budget process.

Data Source

Mental Health Commission financial systems.

Proportion of service funding directed to community organisations (Non Government Organisations)

Currently a large proportion of funding is directed to acute inpatient care. State Government as well as national mental health policy articulate a shift from the reliance on acute care provided in inpatient services to services and supports provided in the community as a key reform initiative.

One of the State Government's three key reform directions articulated in the Mental Health Commission's strategic policy document *Mental Health 2020: Making it personal and everyone's business* is 'balanced investment' i.e. working towards a contemporary mental health system that provides a full range of support and services.

Community organisations (NGOs) provide a range of support services including advocacy, psychosocial support, rehabilitation, day programs, respite care, housing and accommodation support, individualised living support and sub acute services.

This indicator is a proxy measure of accessibility and appropriateness.

Proportion of funding directed to community organisations

2012/13	Target[1]
13.3%	>=15%

Results

- In 2012/13, the proportion of funding directed to community organisations was 13.3%.
- This result is lower than the aspirational target set.

Notes

This is a new KPI approved for 2012/13, therefore comparative figures are not provided.
[1]The target was set as part of the Government Budget process.

Data Source

Mental Health Commission financial systems.

Cost per capita of activities to enhance mental health and wellbeing (illness prevention, promotion and protection activities)

Prevention, promotion and protection activities focus on groups rather than individuals. The activities aim to eliminate or reduce modifiable risk factors associated with individual, social and environmental health determinants to enhance mental health and wellbeing and prevent mental disorders before they develop.

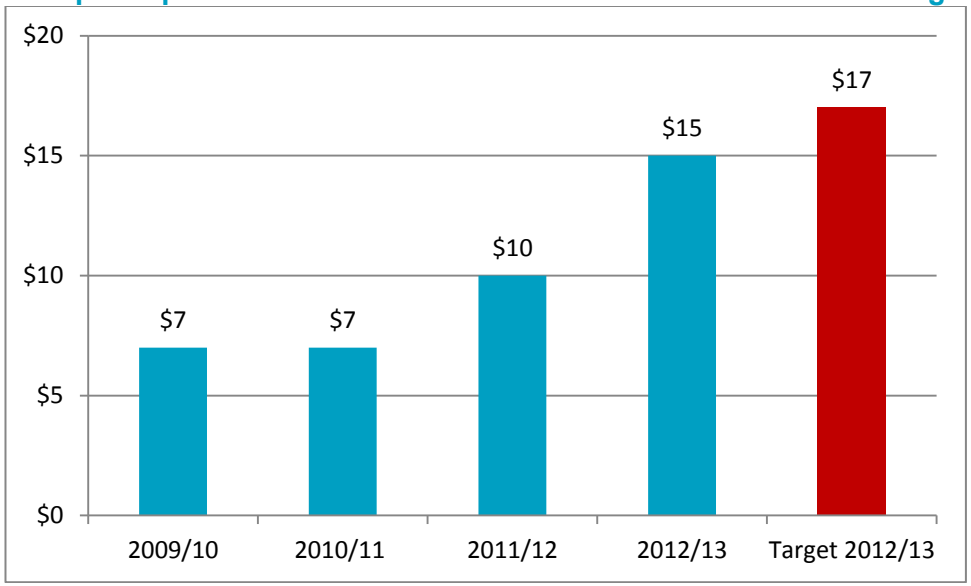
Mental health promotion is defined as activities designed to lead to improvement of the mental health and functioning of persons through prevention, education and intervention activities and services. It involves the population as a whole in the context of their everyday lives. Such measures encourage lifestyle and behavioural choices, attitudes and beliefs that protect and promote mental health and reduce mental disorders.

This indicator measures the cost of mental health promotion, illness prevention, protection and related activities.

Results

- In 2012/13, the cost per capita to provide prevention, promotion, protection and related activities to enhance mental health and wellbeing was $15.
- This result is higher than the 2011/12 figure due to the inclusion of funding for the Individualised Community Living Strategy (ICLS).
- This result is below the target following finalisation of budget allocation across services.

Cost per capita of activities to enhance mental health and wellbeing



Notes
Includes the Mental Health Commission's corporate services and other indirect costs.
The target was set as part of the Government Budget process.

Data Sources
Mental Health Commission financial systems.
Australian Bureau of Statistics December 2012 population for Western Australia (2,472,717).

Average cost per purchased bedday in specialised mental health units

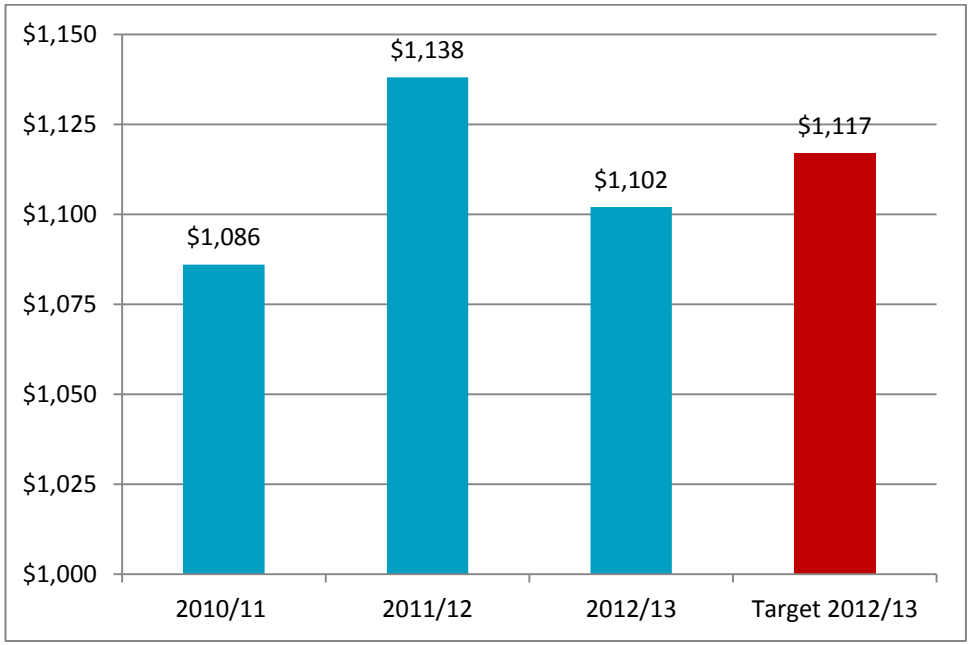
Specialised mental health inpatient units provide admitted patient care in publicly funded authorised facilities and designated mental health units located within general hospitals.

In order to ensure quality care and cost effectiveness, it is important to monitor the unit cost of admitted patient care in specialised mental health inpatient units. The efficient use of hospital resources can help minimise the overall costs of providing mental health care and enable the reallocation of funds to appropriate alternative non admitted care.

Results

- In 2012/13 the average cost per bedday in a specialised mental health inpatient unit was $1,102.
- This result is lower than the 2011/12 figure and the target largely due to realignment of funding between the Department of Health inpatient and community mental health services. This realignment was a consequence of a review of the modelling and improvements in classification of types of service.

Average cost per purchased bedday in specialised mental health units



Notes

This indicator is reported at a statewide level based on funding provided to the Department of Health.
The unit cost reflects a 'purchased' bedday cost and includes a proportion of Mental Health Commission's corporate services and other indirect costs.
This indicator measures the average cost per purchased bedday in authorised (capacity to provide care to patients under the Mental Health Act 1996) and designated facilities (no capacity to provide care to patients under the Mental Health Act 1996) in Western Australia.
The target was set as part of the Government Budget process.

Data Sources

Mental Health Commission financial systems.
BedState and HCare Data Warehouse (for Bunbury, Broome and Kalgoorlie Hospitals) provided by the Department of Health.

Average cost per purchased episode of community care provided by public mental health services

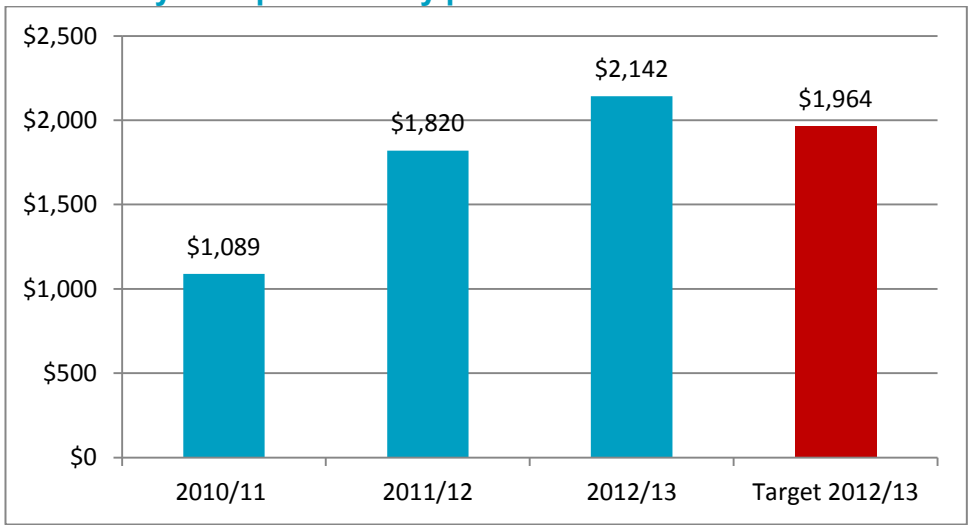
Services provided by public community-based mental health services include assessment, treatment and continuing care.

The efficient use of public community-based resources can help minimise the overall costs of providing mental health care. It is therefore important to monitor the unit cost of community based patient care in specialised public mental health community services.

Results

- In 2012/13, the average cost per three month episode of community care provided by public mental health services was $2,142.
- This result is higher than the 2011/12 figure and the target, largely due to the realignment of funding between the Department of Health inpatient and community mental health services. This realignment was a consequence of a review of the modelling and improvements in classification of types of service.

Average cost per purchased three month episode of community care provided by public mental health services



Notes

This indicator is reported at a statewide level based on funding provided to the Department of Health.
The unit cost reflects a 'purchased' cost per three month episode of community care and includes a proportion of Mental Health Commission's corporate services and other indirect costs.
An episode of community care is defined as each three month period of care with one or more service contacts for an individual.
The target was set as part of the Government Budget process.

Data Sources

Mental Health Commission financial systems.
Mental Health Information System, Department of Health.

Average cost per hour for community support provided by non-government organisations to people with mental health problems

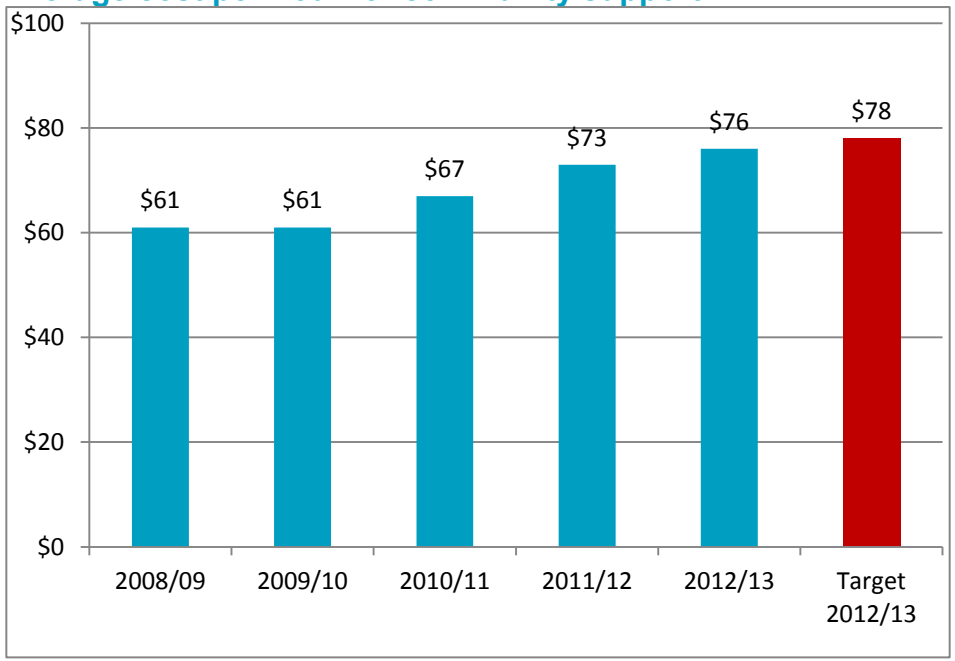
Community based support programs support people with mental health problems to develop/maintain skills required for daily living, improve personal and social interaction, and increase participation in community life and activities. They also aim to decrease the burden of care for carers.

These services primarily are provided in the person's home or in the local community. The range of services provided is dependent on the needs and goals of the individual.

Results

- In 2012/13 the average cost per hour for providing community support to people with mental health problems was $76.
- This result is higher than the 2011/12 figure but lower than the target.

Average cost per hour for community support



Notes
Includes the Mental Health Commission's corporate services and other indirect costs.
The target was set as part of the Government Budget process.

Data Sources
Non-government mental health service activity 6 monthly reports extrapolated for the full 12 months.
Mental Health Commission financial systems.

Average MHC subsidy per bedday for people with mental illness living in community supported residential accommodation

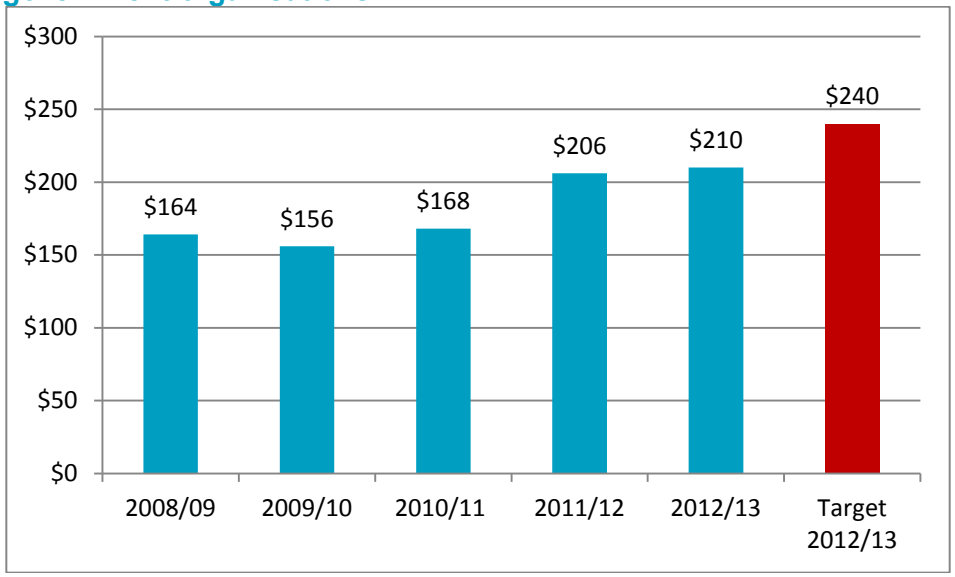
Non-government organisations provide accommodation in residential units for people affected by mental illness who require support to live in the community. Residential care facilities provide support with self-management of personal care and daily living activities as well as initiate appropriate treatment and rehabilitation to improve the quality of life.

This accommodation support is available to people with a mental illness, including older persons with complex mental health issues and significant behavioural problems. They are unable to live independently in the community without the aid of government subsidies to provide appropriate care.

Results

- In 2012/13 the average subsidy per bedday was $210.
- This result is lower than the target due to variable occupancy rates across the services.

Average MHC subsidy per bedday to support people living in community residential accommodation provided by non-government organisations



Notes

Includes the Mental Health Commission's corporate services and other indirect costs.
The target was set as part of the Government Budget process.

Data Sources

Non-government mental health service activity 6 monthly reports extrapolated for the full 12 months.
Mental Health Commission financial systems.

Other Disclosures

Ministerial directives

Treasurer's Instruction 903 (12) requires the Commission to disclose information on any Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financial activities. No such directives were issued by the Ministers with portfolio responsibility for the Commission during 2012/13.

Contracts with senior officers

At the date of reporting other than normal contracts of employment of service, no senior officers or entities in which senior officers have any substantial interests had any interests in existing or proposed contracts with the Commission.

Other Legal Requirements

Compliance with Public Sector Standards and Ethical Codes

In accordance with section 31 (1) of the *Public Sector Management Act 1994*, the Mental Health Commission fully complied with the public sector standards, the *Western Australian Code of Ethics* and the Commission's *Code of Conduct*.

No breaches of standard were lodged during the period of this report.

During the year the Commission undertook a range of activities to promote compliance with public sector standards and ethical codes including monitoring of the Commission's Code of Conduct and the transition to online structured training for staff on Ethical and Accountable Decision Making.

The Commission *Corporate Governance Charter* was launched in October 2010. The charter, based on the former Office of the *Public Sector Standards Good Governance Guide*, assists the Commission and staff to comply with the standards as well as general governance, administration and management reporting requirements. It provides a framework for the proper management of the activities of the Commission and helps the Commission meet its accountability requirements.

The Charter specifically addresses the following public sector good governance principles:

- Government and public sector relationship
- Management and oversight
- Organisational structure
- Operations
- Ethics and integrity
- People
- Finance
- Communication
- Risk management.

Disability Access and Inclusion Plan

The *Disability Service Act 1993* was introduced to ensure that people with disabilities have the same opportunities as other Western Australians. The Commission is committed to ensuring that people with disabilities have the same access to our services, information and facilities as other people.

During the year, the Commission's *Disability Access and Inclusion Plan* 2011-2016 was endorsed by the Disability Services Commission. The Commission is committed to ensuring that the initiatives developed will be successful in addressing statutory requirements and achieving the following desired six outcomes:

1. People with disabilities have the same opportunities as other people to access the services of, and any events organised by the Commission.
2. People with disabilities have the same opportunities as other people to access the buildings and other facilities of the Commission.
3. People with disabilities receive information from the Commission in a format that will enable them to access the information as readily as other people are able to access it.
4. People with disabilities receive the same level and quality of service from the staff of the Commission.

5. People with disabilities have the same opportunity as other people to make complaints to the Commission.

6. People with disabilities have the same access as other people to participate in any public consultation by the Commission.

Compliance with the Electoral Act 1907 section 175ZE (advertising)

In accordance with section 175ZE of the *Electoral Act 1907,* the Commission incurred the following expenditure on advertising agencies, market research, polling, direct mail and media advertising during the reporting period:

Advertising agencies	$
AdCorp Australia Limited	25,378
Media Planet	10,000
Medical Forum Magazine	1,665
TOTAL	37,043

Table 6: Total advertising expenditure 2012-2013

Compliance with Public Sector Standards and Ethical Codes

In accordance with section 31 (1) of the *Public Sector Management Act 1994*, the Commission fully complied with the public sector standards, the *Western Australian Code of Ethics* and the agency's *Code of Conduct*.

No breaches of standard were lodged during the period of this report.

During the year the Commission continued to promote compliance with public sector standards and ethical codes with new and existing staff, including the dissemination of the *Code of Conduct* and ongoing structured training for staff on ethical and accountable decision making.

The introduction by the Public Sector Commission of the new *Commissioner's Instructions on Filling a Public Sector Vacancy* and the new *Employment Standard* have seen improvements in the Commission's capacity to recruit staff in a timely manner.

The appointment of two new public interest disclosure officers in the Commission also highlights the focus placed upon staff to ensure that all decisions are undertaken with integrity, ethics and are compliant with all legislative and regulatory provisions.

Recordkeeping plans

The *State Records Act 2000* (the Act) was established to mandate standardised statutory record keeping practices for every Government agency including records creation policy, record security and the responsibilities of all staff. Government agency practice is subject to the provisions of the Act and the standards and policies of the *State Records Commission*. The Commission has continued to operate under an addendum to the *Department of Health's Record Keeping Plan* (RKP) due for review and renewal in 2012. The Commission is currently undertaking a drafting of its own RKP in accordance with the requirements of the *State Records Act 2000* for submission to the State Records Office in 2013.

Ongoing online and face to face training in the use of the Commission's current record management system and recordkeeping obligations is provided to staff as part of induction processes and is also available to individual staff when required or requested.

During 2013/14 the Commission will continue to review the efficiency and effectiveness of record keeping training and awareness for all staff and look to improve record keeping standards across the agency.

Government Policy Requirements

Occupational safety, health and injury management

The Commission is committed to providing and maintaining a safe and healthy work environment and promoting the health and wellbeing of all employees. The Commission acknowledges its responsibilities under the *Occupational Safety and Health Act 1984* and the *Workers Compensation and Injury Management Act 1981.* For 2012/13 the Mental Health Commission continued to operate under the umbrella of the Department of Health's occupational safety and health policies and procedures, until such time as internal policies and procedures are implemented.

The Commission supports a consultative environment where employees are included in matters affecting their safety, health and wellbeing at work. Employees are encouraged to be proactive in identifying potential hazards and to provide suggestions and comments on how to improve upon our workplace safety efforts. The Commission takes all employee suggestions, complaints and notifications of hazards seriously, and is committed to take proper action immediately.

During the year the Commission progressed the following initiatives:

- continued the roll out of structured training for managers and supervisors in occupational safety, health and injury management responsibilities
- called for expressions of interest for safety representatives and provision of required training
- quarterly reporting on incidents/accidents within the workplace
- developed and implemented occupational safety, health and injury management requirements as part of the Commission's induction manual for all new employees
- provided ergonomic assessments for employees on request
- continued to provide access to an employee assistance program
- provided employees with the option of annual flu injections
- continued to support the Commission's Wellbeing Team in their efforts to promote the health and wellbeing of employees
- purchased a portable defibrillator and conducted training of staff in its use as well as recognising the symptoms of a heart attack
- appointed and trained a first aid officer within the Commission.

Table 7 details our 2012/13 key performance indicators against the following targets:

Indicator	Actual 2011/12	Target 2011/12
Number of fatalities	Zero	Zero
Lost time injury/disease incidence rate	Zero	Zero
Lost time injury severity rate	Zero	Zero
% of injured workers returned to work within 28 weeks	N/A	N/A
% managers trained in occupational safety, health and injury management responsibilities	63%	Greater than or equal to 50%

Table 7: 2012/13 key performance indicators

To continue to achieve our high standards the Commission will be undertaking a review of occupational safety and health management systems during 2013/14. The Commission will also incorporate internal mechanisms that will continue to:

- promote a culture that emphasises safety as a core value in all aspects of work
- train and develop employees in their duty of care through the induction process and ongoing training and development sessions
- empower employees through communication media on the importance of personal safety for themselves and others within the workplace
- conduct monthly workplace inspections to identify hazards, assess risks and implement controls as soon as is practicable
- promote hazard identification as a positive initiative and empower employees and management to report as the hazard is recognised
- investigate all incidents/accidents and implement initiatives to prevent reoccurrence
- affirm compliance with injury management requirements of the *Workers' Compensation and Injury Management Act 1981*, including the development of Return to Work Plans
- maintain a commitment to undertaking an assessment of the OSH management system.

Substantive Equality

As the Commission was only established in 2010, it is not included as a separate agency under the *Policy Framework for Substantive Equality*. However, the Commission is aware of the intent and substance of the Substantive Equality Policy Framework and is committed to ensuring that the Framework is considered in shaping new and existing policies and initiatives in future years. In doing so, the Commission is committed to addressing systemic discrimination and responding to the different needs of client groups within the community.

Appendix One

Community sector organisations funded by the Commission at at 30 June 2013

Service Provider	Service Type
55 Central Incorporated	Independent living skills support
55 Central Incorporated	Psychosocial support
Access Housing Australia Ltd	Supportive landlord services
Access Housing Australia Ltd	Individual Community Living
Aftercare	Individual Community Living
Albany Halfway House Association Incorporated	Community supported residential units
Albany Halfway House Association Incorporated	Independent living skills support
Albany Halfway House Association Incorporated	Intermediate care accommodation
Albany Halfway House Association Incorporated	Psychosocial support
Albany Halfway House Association Incorporated	Recreation
Amana Living	Specialist residential services
Association for Services to Torture and Trauma Survivors Incorporated	Early intervention - general
Baptistcare	Crisis/respite accommodation
Baptistcare	Individual Community Living
Baptistcare	Psychosocial support
Baptistcare	Supportive landlord services
Bay of Isles Community Outreach Incorporated	Independent living skills support
Bay of Isles Community Outreach Incorporated	Psychosocial support
Beyondblue	Mental illness prevention
BP Luxury Care	Psychosocial support
Bunbury Pathways '92 Incorporated	Carer/family support - admitted respite
Bunbury Pathways '92 Incorporated	Carer/family support - education/information and skill development
Bunbury Pathways '92 Incorporated	Independent living skills support
Bunbury Pathways '92 Incorporated	Psychosocial support
Bunbury Pathways '92 Incorporated	Supportive landlord services
Burswood Nursing Care Pty Ltd.	Personal care support
Cam' Can & Associates	Individual Community Living

Carers Association of Western Australia Incorporated	Systemic advocacy
Casson House	Personal care support
Centrecare Incorporated	Carer/family support - education/information and skill development
Centrecare Incorporated	Early intervention - general
Centrecare Incorporated	Independent living skills support
Centrecare Incorporated	Mental illness prevention
Centrecare Incorporated	Psychosocial support
Centrecare Incorporated	Supportive landlord services
Collie Family Centre Incorporated	Early intervention - general
Community First International Limited	Individual Community Living
Consumers of Mental Health WA (CoMHWA)	Systemic advocacy
Country Arts (WA) INC	Mental illness prevention
Curtin University of Technology	Mental health promotion
Curtin University of Technology	Mental illness prevention
Devenish Lodge	Personal care support
Disability in the Arts, Disadvantage in the Arts (WA) Incorporated	Recreation
Enable Southwest	Individual Community Living
Even Keel (Bipolar Disorder Support Association) Incorporated	Psychosocial support
Foundation Housing Association Incorporated	Supportive landlord services
Franciscan House	Personal care support
Fremantle Medicare Local Ltd	Early intervention - general
Fremantle Multicultural Centre	Individual advocacy
Fremantle Women's Health Centre Incorporated	Perinatal mental health service
Fusion (Aust) Ltd	Community supported residential units
Gosnells Women's Health Service Incorporated	Perinatal mental health service
Great Southern Community Housing Association Incorporated	Supportive landlord services
GROW (WA)	Psychosocial support
Hills Community Support Group	Individual advocacy

Hills Community Support Group	Individual Community Living
Hills Community Support Group	Psychosocial support
Hills Community Support Group	Supportive landlord services
Home Health Pty Ltd (trading as Tender Care)	Carer/family support - non admitted respite
Home Health Pty Ltd (trading as Tender Care)	Independent living skills support
Home Health Pty Ltd (trading as Tender Care)	Psychosocial support
Home Health Pty Ltd (trading as Tender Care)	Recreation
Honeybrook Lodge	Personal care support
ISHAR Multicultural Centre for Women's Health	Carer/family support - education/information and skill development
Jennie Bertram & Associates	Individual advocacy
June O'Connor Centre Incorporated	Recreation
Kimberley Aboriginal Medical Services Council (Inc) (KAMSC)	Mental illness prevention
LAMP Incorporated	Carer/family support - education/information and skill development
LAMP Incorporated	Independent living skills support
LAMP Incorporated	Psychosocial support
LAMP Incorporated	Recreation
Life Without Barriers	Individual Community Living
Life Without Barriers	Psychosocial support
Life Without Barriers	Supported accommodation for homeless youth
Lifeline WA (The Living Stone Foundation Inc)	Early intervention - telephone services
Mental Health Carers ARAFMI (WA) Inc	Carer/family support - education/information and skill development
Mental Health Carers ARAFMI (WA) Inc	Individual advocacy
Mental Health Carers ARAFMI (WA) Inc	Mental health promotion
Mental Health Carers ARAFMI (WA) Inc	Recreation
Mental Health Law Centre	Individual advocacy
Mental Illness Fellowship of Western Australia Incorporated	Carer/family support - education/information and skill development
Mental Illness Fellowship of Western Australia Incorporated	Independent living skills support
Mental Illness Fellowship of Western Australia Incorporated	Individual Community Living

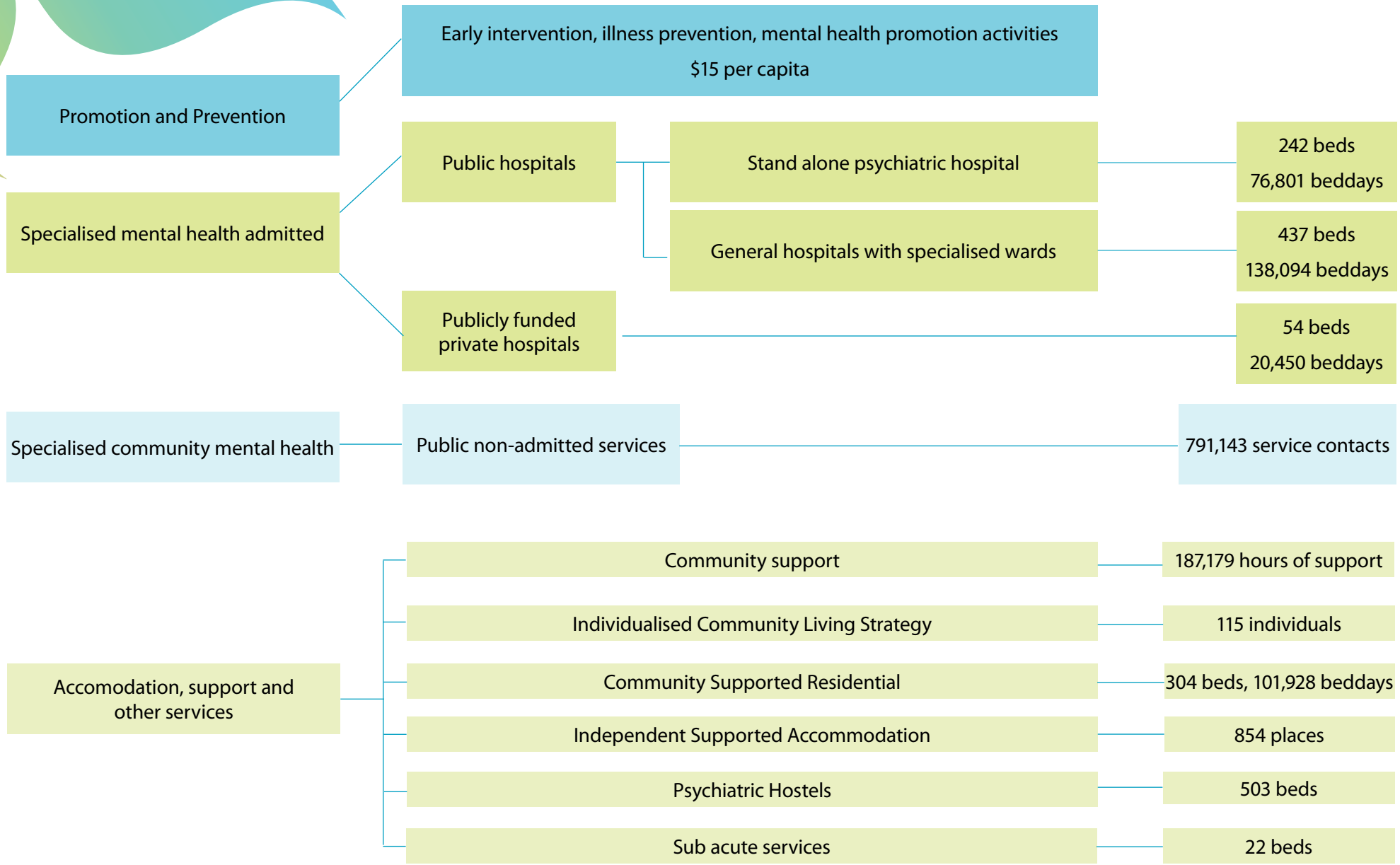
Mental Illness Fellowship of Western Australia Incorporated	Mental health promotion
Mental Illness Fellowship of Western Australia Incorporated	Psychosocial support
Mental Illness Fellowship of Western Australia Incorporated	Recreation
Mercy Hospital	Clinical treatment and care - admitted
Midland Women's Health Care Place Incorporated	Perinatal mental health service
Midwest Community Living Association Incorporated	Recreation
Mission Australia	Individual Community Living
NEAMI Ltd	Individual Community Living
NEAMI Ltd	Sub-Acute
PDLE	Pre-vocational training
Perth Home Care Services Incorporated	Carer/family support - non admitted respite
Perth Home Care Services Incorporated	Individual Community Living
Perth Home Care Services Incorporated	Psychosocial support
Perth Inner City Youth Service	Psychosocial support
Perth Central & East Metro Medicare Local	Clinical treatment and care - non admitted
Pilbara & Kimberley Care Incorporated	Carer/family support - non admitted respite
Pilbara & Kimberley Care Incorporated	Independent living skills support
Pilbara & Kimberley Care Incorporated	Psychosocial support
Pilbara & Kimberley Care Incorporated	Recreation
Richmond Fellowship of WA	Community options
Richmond Fellowship of WA	Community supported residential units
Richmond Fellowship of WA	Crisis/respite accommodation
Richmond Fellowship of WA	Independent living skills support
Richmond Fellowship of WA	Individual Community Living
Richmond Fellowship of WA	Intermediate care accommodation
Richmond Fellowship of WA	Long-term supported accommodation
Richmond Fellowship of WA	Psychosocial support
Richmond Fellowship of WA	Supported accommodation for homeless adults

Romily House	Personal care support
Ruah Community Services	Carer/family support-education/information and skill development
Ruah Community Services	Individual Community Living
Ruah Community Services	Psychosocial support
Ruah Community Services	Research and evaluation
Salisbury Home	Personal care support
Samaritan Befrienders of Albany Incorporated	Early intervention - telephone services
Schizophrenia Fellowship Albany and Districts Incorporated	Independent living skills support
Schizophrenia Fellowship Albany and Districts Incorporated	Psychosocial support
Schizophrenia Fellowship Albany and Districts Incorporated	Recreation
Share and Care Community Services Group	Carer/family support - non admitted respite
Share and Care Community Services Group	Independent living skills support
Share and Care Community Services Group	Psychosocial support
Share and Care Community Services Group	Recreation
Silver Chain Nursing Association Incorporated	Carer/family support - education/information and skill development
Silver Chain Nursing Association Incorporated	Workforce development
South Coastal Women's Health Services Association Incorporated	Perinatal mental health service
Southern Cross Care (WA) Incorporated	Carer/family support - non admitted respite
Southern Cross Care (WA) Incorporated	Community options
Southern Cross Care (WA) Incorporated	Independent living skills support
Southern Cross Care (WA) Incorporated	Individual Community Living
Southern Cross Care (WA) Incorporated	Psychosocial support
Southern Cross Care (WA) Incorporated	Specialist residential services
Spirit of the Streets Choir (Inc)	Mental illness prevention
St Bartholomew's House Incorporated	Community supported residential units
St Bartholomew's House Incorporated	Crisis/respite accommodation
St Bartholomew's House Incorporated	Supportive landlord services
St Jude's Hostel (Pu-Fam Pty Ltd)	Personal care support

St Patrick's Community Support Centre	Mental illness prevention
Support In-Site Incorporated	Recreation
The Salvation Army (Western Australia) Property Trust	Independent living skills support
The Salvation Army (Western Australia) Property Trust	Psychosocial support
The Samaritans Incorporated	Early intervention - general
The Samaritans Incorporated	Early intervention - telephone services
UnitingCare West	Supportive landlord services
University of Western Australia (School of Psychiatry and Neuroclinical Sciences)	Mental health promotion
University of Western Australia (School of Psychiatry and Neuroclinical Sciences)	Research and evaluation
University of Western Australia (School of Psychiatry and Neuroclinical Sciences)	Workforce development
University of Western Australia (School of Psychology)	Research and evaluation
University of Western Australia (School of Psychology)	Workforce development
Vincentcare	Personal care support
Vincentcare	Psychosocial support
WA AIDS Council Incorporated	Early intervention - general
WA Association for Mental Health Incorporated (WAAMH)	Mental health promotion
WA Association for Mental Health Incorporated (WAAMH)	Systemic advocacy
WA Association for Mental Health Incorporated (WAAMH)	Workforce development
WA Music Industry Association	Mental health promotion
Wanslea Family Services Incorporated	Carer/family support - education/information and skill development
Women's Health Care Association Incorporated	Clinical treatment and care - non admitted
Women's Health Care Association Incorporated	Perinatal mental health service
Women's Health Care Association Incorporated	Psychosocial support
Women's Healthworks	Psychosocial support
Woodville House	Personal care support
Youth Affairs Council of WA Inc	Mental health promotion
Youth Focus Inc	Early intervention - general

Appendix Two

Summary of the specialised mental health services and activity contracted by the Commission in 2012/13



Appendix Three

Mental Health Advisory Council and Ministerial Council for Suicide Prevention membership

Mental Health Advisory Council membership

As at 30 June 2013

Barry MacKinnon AM - Chairperson

Dr Judy Edwards - Deputy Chair

Joe Calleja

Margaret Doherty

Dr John Edwards

Pamela Gardner

John Hesketh

Geoff Diver

Katherine Hams

Janelle Ridgway

Lindsay Smoker

Dr Alexandra Welborn

Dr Bernadette Wright

Professor Dianne Wynaden

Victoria Hovane and Pietra Liedel, have been appointed from 1 July 2013 replacing Geoff Diver and Katherine Hams.

Ministerial Council for Suicide Prevention membership

As at 30 June 2013

Peter Fitzpatrick - Chairperson

Eddie Bartnik

Jenny Allen

Brian Mayfield

Joshua Cunniffe

Chris Gostelow

Adele Cox

Estelle Dragun

James Gibson

Professor Cobie Rudd

Stuart Smith

Dr Neale Fong and Donna Cole have been appointed from 1 July 2013, replacing Sam Walsh and Robyn Coleman.

Darryl Kickett served on the Council until August 2012.

Ministerial Council for Suicide Prevention member profiles are available at www.mcsp.org.au/one-life-strategy/mcsp.

Appendix Four

2012 Good Outcomes Award winners

Thirteen West Australian individuals or mental health services that have made an outstanding contribution in the community were announced as Good Outcomes Award winners during Mental Health Week by Mental Health Minister Hon Helen Morton MLC.

The Awards help to break down stigma surrounding mental health while highlighting the positive contribution that people with mental health illness make in our community.

Award Categories	Winner
West Australian Newspapers Limited Award for consumer involvement and engagement	Andrew Markovs
SonShine FM Award for family and carers involvement and engagement	Tony Fowke OAM
Edith Cowan University Award for prevention, promotion and/or early intervention service or program	McCusker Nurse Service - Amana Living
John Da Silva Award for improved outcomes in Aboriginal social and emotional wellbeing	Community Arts Network WA
GESB Award for improved outcomes in seniors mental health	Project Picasso - Amana Living
Dr Mark Rooney Award for Improved Outcomes in Child and Youth Mental Health sponsored by the Commissioner for Children and Young People	Carers Association of WA
University of Western Australia Award for excellence in rural and remote mental health	Boab Health Services
St John of God Health Care Employee of the Year Award	Joint winners: Julie Potts and Ruth Sims
Curtin Health Innovation Research Institute Award for recovery focused service or program	Perth Home Care Services
WA Equal Opportunity Commissioner Award for human rights, equity and diversity in mental health	Freedom Centre
Hollywood Private Hospital Award for improved mental health outcomes delivered in partnership with drug and alcohol services	Drug and Alcohol Youth Service
McCusker Charitable Foundation Award for Excellence	Tony Fowke OAM

Appendix Five

Workforce development initiatives 2012/13

Initiative Overview	Key Outputs and Achievements
Mental Health Workforce Development Strategy and Plan Consultation and planning work to inform the development of a plan to guide workforce development activities targeting the mental health workforce.	During 2012/13 the Commission continued to work on a draft Workforce Development Strategy 2013-15 which aligns with the *National Mental Health Workforce Strategy* and maps objectives and activities against the three key reform directions outlined in the State Government's ten year strategic policy *Mental Health 2020: Making it personal and everybody's business*. The workforce plan will align with the ten year Mental Health Services Plan that will be developed in 2013/14 to ensure that services have the workforce capacity and skills to develop in accordance with identified need and investment.
Independent Community Living Strategy Training and workforce development to support the development of capacity of mental health services to support people with a person centred approach to planning and service provision.	A range of training and workforce development events have been undertaken throughout the year to build the capability of services and staff to provide person centred planning and supports. Training to date has been received enthusiastically by a broad cross section of staff.
Scholarships for Mental Health Professionals Financial support for workers from government and nongovernment organisations to undertake further studies in mental health	In 2012/13, a total of $153,996 was allocated to 64 people who received scholarships of up to $13,000 each to undertake a mental health related course at university or other registered training organisation. Recipients include nurses, allied health professionals and people with a lived experience of mental illness who work in peer and carer peer support roles.
Mental Health Graduate Nurse Incentive Scheme is designed to attract graduate registered nurses to undertake careers in mental health.	This attraction and retention initiative provides payments over the course of three years to graduate nurses who pursue a career in mental health. Over a two year period, the scheme has attracted 45 graduate nurses to work in mental health, of which only four have since left mental health. $156,394.50 was allocated to this initiative in 2012/13.
Dual Disability Competency Framework Dual Disability is a recognised area of shortages in expertise. A joint Disability Services Commission/Mental Health Commission workshop identified an urgent need for workforce capacity building.	The Commission funded WACOSS $120,000 to engage a consultant to work with the Dual Disability working group to scope out a competency framework and training package across the workforce continuum. The competency framework will identify key competencies needed for workers at all levels and across all areas of service delivery for people who have both intellectual disability and mental health difficulties.
Mental Health Professional Online Development (MHPOD) Funding to support the roll out of MHPOD across public mental health services in WA.	The Commission continued to support the further development and roll out of *Mental Health Professional Online Development*. This included $20,824 towards the ongoing operation and development of this nationally led project.

Initiative Overview	Key Outputs and Achievements
Resources to provide more training posts for child and adolescent psychiatrists Funding to address a shortage of child and adolescent psychiatry training posts in Western Australia.	The Commission allocated $1.1m in 2012/13 for advanced child psychiatry training posts and has committed to invest the same amount per annum to support five advanced child psychiatry training posts.
Training events for assisting consumers with co-occurring drug and alcohol and mental health problems. Partnership with the Drug and Alcohol Office (DAO) to provide a range of training events aimed at increasing capability in managing co-occurring issues.	In 2012/13 the Commission provided support to DAO for the development and delivery of a Comorbidity Train the Trainer Program. The aim of the program is to enhance and support the capacity of individual workers, their services and the mental health sector to respond more effectively to individuals who have co-occurring substance use and mental health problems and/or mental illness. An additional $25,000 was committed to extend the training to services in the welfare sector, and to provide drug and alcohol counselling guidelines to the government and non-government mental health sectors.
Marion Centre - Positive Placements Program Training and support to enhance the experience of nursing and allied health students undertaking placements in mental health services.	The Marion Centre was granted $144,500 to continue the Confident Placements program. This program aims to provide undergraduate health professionals with greater knowledge and improved confidence in undertaking their mental health practical placement.
Peer Support Worker Capacity Building Building the capacity of mental health organisations and drug and alcohol agencies to employ peer workers in the area of co-occurring mental health and alcohol and other drug issues.	Palmerston received a grant of $50,000 to work with mental health services to develop a sustainable workforce and organisational support model for AOD and mental health services, integrating peer support.
Gay and Lesbian Community Services of WA Delivery of 'Opening Closets Training' to frontline mental health workers.	$40,000 was provided in 2012/13 for the *Gay and Lesbian Community Services of WA Inc* to extend the Opening Closets training to rural and remote workers. Opening Closets trains frontline mental health workers in both government and community managed organisations and provides policy coaching to mental health services, with the aim of increasing the competency of mainstream mental health service workers in working appropriately with lesbian, gay, bisexual, transgender and intersex clients.
Statewide Specialist Aboriginal Mental Health Service (SSAMHS) A key objective of SSAMHS is to increase the number of trained Aboriginal people in the mental health workforce, and to up skill non-Aboriginal workers in culturally competent mental health care.	Approximately $8 million was invested in SSAMHS, including the recruitment and training of 62 Aboriginal mental health workers. SSAMHS has successfully recruited to 85-90 per cent of positions and has provided cultural competency training to services in metropolitan and rural areas. Workers are enrolled in University and TAFE studies. Since the implementation of SSAMHS, the numbers of Aboriginal consumers with care plans and shared care arrangements have increased, indicating SSAMHS is providing improved mental health care for Aboriginal people.

Mental Health Commission
Level 5, 81 St Georges Terrace
PERTH WA 6000

PO Box X2299
Perth Business Centre, PERTH WA 6847

T: 6272 1200 F: 6272 1299

E: ContactUs@mentalhealth.wa.gov.au
W: www.mentalhealth.wa.gov.au