Government of **Western Australia**
Mental Health Commission

We're working for Western Australia.

Mental Health Commission
Annual Report 2018-19

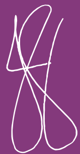
Statement of Compliance

The Hon. Roger Cook MLA
DEPUTY PREMIER;
MINISTER FOR HEALTH;
MENTAL HEALTH

Dear Minister,

In accordance with section 63 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 2019.

The annual report has been prepared in accordance with the provisions of the Financial Management Act 2006.



Jennifer McGrath
ACTING COMMISSIONER
MENTAL HEALTH COMMISSION

17 September 2019

This annual report provides a review of the Mental Health Commission's (hereby referred to as the Commission) operations for the financial year ended 30 June 2019.

The term Aboriginal is used respectfully throughout this report to include both Aboriginal and Torres Strait Islander peoples.

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

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

This publication may be copied in whole or part, with acknowledgement to the Commission.

© Mental Health Commission, Government of Western Australia. *ISSN 2208-4347*

Table of contents

Statement of Compliance 2

Table of Contents 3

Commissioner's Foreword 4

Overview 6

Executive Summary 7

Operational Structure 8

Agency performance 17

Performance Summaries – Report on Operations 18

Key Achievements 22

Significant Issues Impacting the Commission 33

Disclosures and Legal Compliance 36

Certification of Financial Statements 37

Financial Statements 38

Certification of KPIs 86

Auditor General's Opinion of Financial Statements and KPIs 87

Detailed Key Effectiveness Indicators Information 92

Detailed Key Efficiency Indicators Information 106

Ministerial Directives 131

Other Financial Disclosures 131

Governance Disclosures 131

Other Legal Requirements and Government Policy Requirements 131

Board and Committee Remuneration 132

Other Legal Requirements 134

Appendices 138

Acronyms 139

Abbreviations 140

Glossary 141

Service Stream Descriptions 142

Commissioner's Foreword

Jennifer McGrath
Acting Mental Health Commissioner

While my appointment as Acting Commissioner commenced not long before the end of the reporting period, I am pleased to present the 2018-19 Mental Health Commission Annual Report.

I take this opportunity to acknowledge Timothy Marney who was the Mental Health Commissioner from 2014 until 14 June 2019. Mr Marney made a valuable contribution to the State of Western Australia across the mental health, alcohol and other drug (AOD) sector.

The Commission is guided by the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (the Plan) which guides investment and initiatives to enhance the treatment, services and support to people with mental health and/or AOD issues. 2018-19 marked the first major update to the Plan, as the Commission released the *Plan Update 2018* (the Plan Update) which included updated modelling to identify the optimal mix of mental health and AOD services required for the population of Western Australia.

In addition to the Plan Update 2018, the Commission also released the following strategies:

- *Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025*
- *Western Australian Alcohol and Drug Interagency Strategy 2018-2022 (WAADIS)*
- *The Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025* (Prevention Plan)

Development continued on significant strategies, with community consultation held on the draft *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025* and *A Western Australian Strategy to provide safe and stable accommodation and support to people experiencing mental health, alcohol and other drug issues 2019-2025: A Safe Place*.

Additionally, the Commission led the development of the *Full Government Response to the Western Australian Methamphetamine Action Plan (MAP) Taskforce Report* (the Response). The Response adopted an across-government approach in addressing methamphetamine related harms. As part of the Response, the Commission secured $40.5 million in the 2019-20 State Budget for the co-ordinated and integrated approach to address methamphetamine issues in Western Australia.

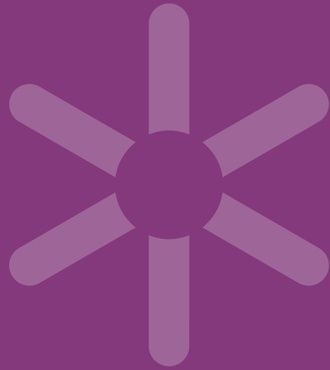
In 2018-19, the Commission purchased $140.9 million of services across the spectrum of care from 116 non-government organisations (NGOs) , and $718 million for the delivery of specialised mental health services in the public health system, through service agreements with Health Service Providers (HSPs). The Commission progressed community mental health step up/step down services with the opening of the Albany service in November 2018. It also commenced building works on the Bunbury facility, and confirmed sites in Geraldton and Kalgoorlie.

Other significant work this year included:

- The launch of the Commission's 2018-2022 Stretch Conciliation Action Plan, which is indicative of our commitment to conciliation in the work that we do, seeking to build understanding and embed actions that properly recognise and respect Aboriginal cultures and people, connection to country, and the impact of history, in order to achieve equity for Aboriginal people;
- The release of the commissioned Impact of FIFO work arrangements on the mental health and wellbeing of FIFO workers report. Undertaken by Curtin University's Centre for Transformative Work Design (CTWD), the report is one of the most comprehensive FIFO research studies in Australia;
- The launch of the Thrive at Work website, resources and tools. This is the culmination of work funded by the Commission in 2017 and conducted by CTWD, following the development of the Western Australian Workplace Mental Health Standards, an initiative of the Suicide Prevention 2020: Together we can save lives strategy; and
- The successful reaccreditation of Next Step Drug and Alcohol Services (Next Step) and the Alcohol and Drug Support Service (ADSS) against national standards for a further three years.

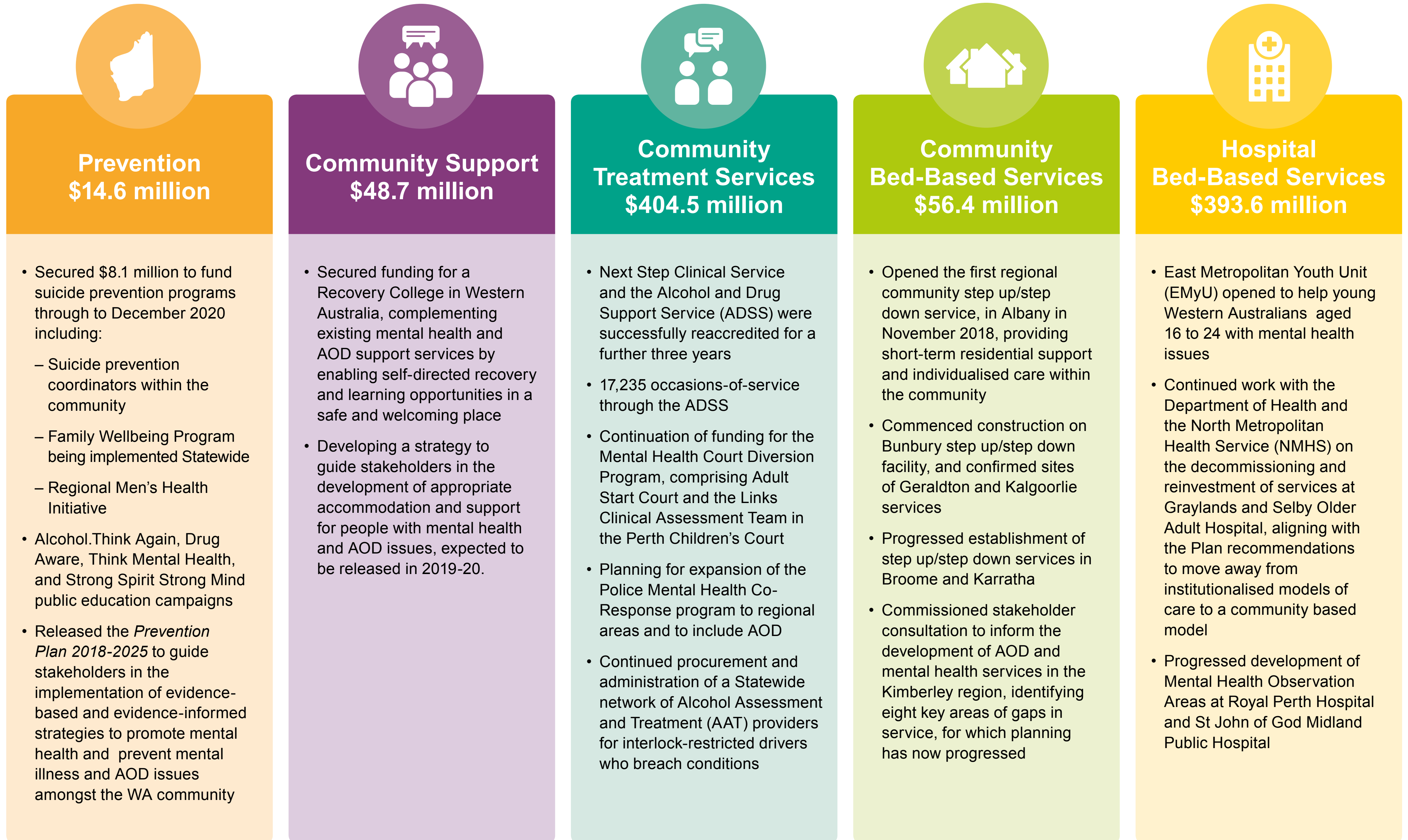
I extend my genuine thanks to every member of the diligent team at the Commission, particularly to former Commissioner Timothy Marney. I look forward to working with the Commission towards achieving our primary goal - a Western Australian community that experiences minimal AOD-related harms and optimal mental health.

Jennifer McGrath
Acting Mental Health Commissioner



Overview

Executive Summary



Prevention
$14.6 million

- Secured $8.1 million to fund suicide prevention programs through to December 2020 including:
  - Suicide prevention coordinators within the community
  - Family Wellbeing Program being implemented Statewide
  - Regional Men's Health Initiative
- Alcohol.Think Again, Drug Aware, Think Mental Health, and Strong Spirit Strong Mind public education campaigns
- Released the *Prevention Plan 2018-2025* to guide stakeholders in the implementation of evidence-based and evidence-informed strategies to promote mental health and prevent mental illness and AOD issues amongst the WA community

Community Support
$48.7 million

- Secured funding for a Recovery College in Western Australia, complementing existing mental health and AOD support services by enabling self-directed recovery and learning opportunities in a safe and welcoming place
- Developing a strategy to guide stakeholders in the development of appropriate accommodation and support for people with mental health and AOD issues, expected to be released in 2019-20.

Community Treatment Services
$404.5 million

- Next Step Clinical Service and the Alcohol and Drug Support Service (ADSS) were successfully reaccredited for a further three years
- 17,235 occasions-of-service through the ADSS
- Continuation of funding for the Mental Health Court Diversion Program, comprising Adult Start Court and the Links Clinical Assessment Team in the Perth Children's Court
- Planning for expansion of the Police Mental Health Co-Response program to regional areas and to include AOD
- Continued procurement and administration of a Statewide network of Alcohol Assessment and Treatment (AAT) providers for interlock-restricted drivers who breach conditions

Community Bed-Based Services
$56.4 million

- Opened the first regional community step up/step down service, in Albany in November 2018, providing short-term residential support and individualised care within the community
- Commenced construction on Bunbury step up/step down facility, and confirmed sites of Geraldton and Kalgoorlie services
- Progressed establishment of step up/step down services in Broome and Karratha
- Commissioned stakeholder consultation to inform the development of AOD and mental health services in the Kimberley region, identifying eight key areas of gaps in service, for which planning has now progressed

Hospital Bed-Based Services
$393.6 million

- East Metropolitan Youth Unit (EMyU) opened to help young Western Australians aged 16 to 24 with mental health issues
- Continued work with the Department of Health and the North Metropolitan Health Service (NMHS) on the decommissioning and reinvestment of services at Graylands and Selby Older Adult Hospital, aligning with the Plan recommendations to move away from institutionalised models of care to a community based model
- Progressed development of Mental Health Observation Areas at Royal Perth Hospital and St John of God Midland Public Hospital

Operational Structure

Deputy Premier and Minister for Health and Mental Health, the Hon. Roger Cook MLA

Enabling legislation

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 Acting Mental Health Commissioner, Ms Jennifer McGrath.

Responsible minister

The Commission is responsible to the Minister for Mental Health, the Hon. Roger Cook MLA, and is the government agency primarily assisting him in the administration of the Mental Health portfolio.

The Hon. Roger Cook MLA is the Deputy Premier of Western Australia and has the portfolios of Health and Mental Health. He has been a member of the Legislative Assembly since 2008, representing the seat of Kwinana. Mr Cook served as Deputy Leader of the Opposition and Shadow Minister for Health from 2008 until March 2017, also having had responsibility for other Shadow Ministry roles in Mental Health, Science and Indigenous Affairs. Mr Cook was sworn in as Deputy Premier, Minister for Health and Mental Health on 17 March 2017.

The Hon. Alanna Clohesy MLC is the Parliamentary Secretary to the Deputy Premier and Minister for Mental Health. She has been a member of the Legislative Council since 2013, representing the East Metropolitan Region.

Organisational structure

Vision and Mission

Our vision is to achieve a Western Australian community that experiences minimal alcohol and other drug-related harms and optimal mental health.

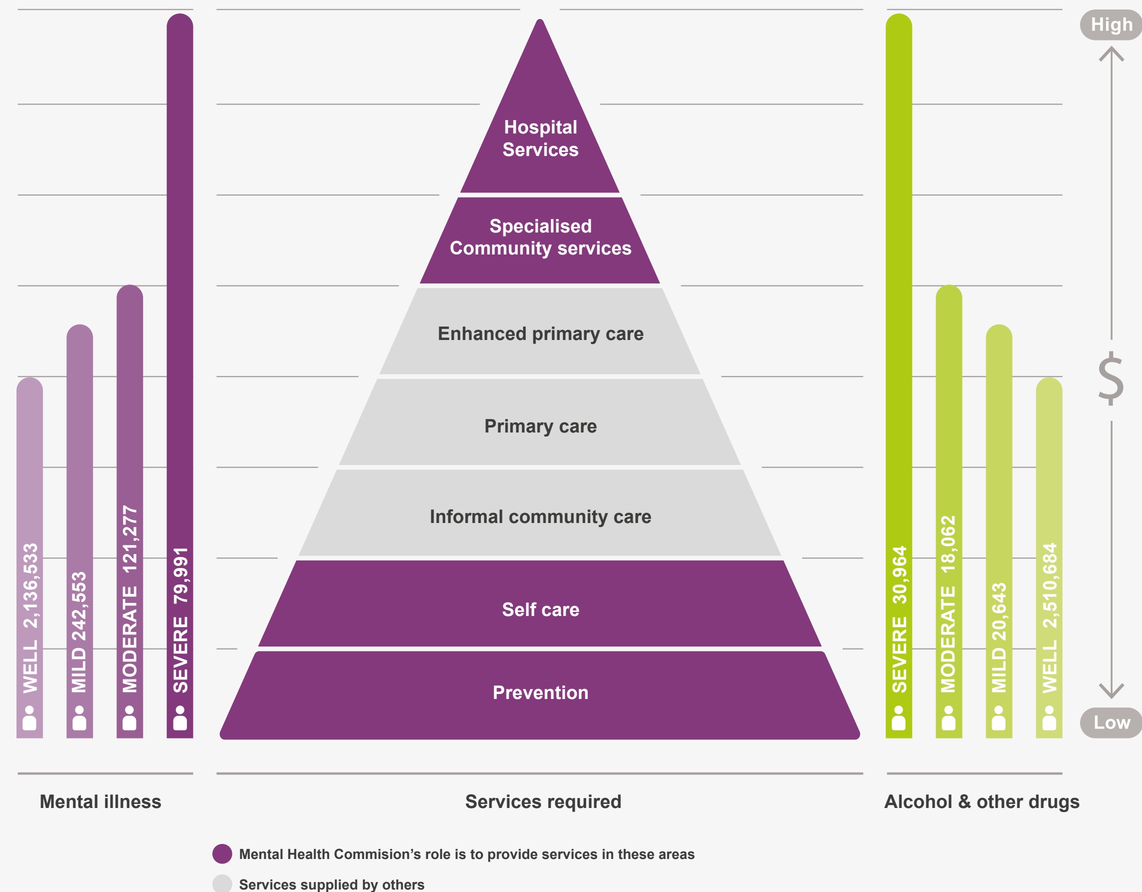
We do this by being an effective leader of alcohol, other drug and mental health commissioning, providing and partnering in the delivery of person-centred and evidence-based:

- Prevention, promotion and early intervention programs;
- Treatment, services and supports; and
- Research, policy and system improvements.

The agency is led by a Commissioner, supported by four divisions:

- Purchasing, Performance and Service Development
- Planning, Policy and Strategy
- Alcohol, Other Drug and Prevention Services
- Corporate Services

The Commission also provides support to three independent bodies, the Mental Health Advocacy Service, the Mental Health Tribunal and the Office of the Chief Psychiatrist. They operate independently but are provided with corporate services support by the Commission.



Source: Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 Update 2018 (Plan Update 2018).

Government of **Western Australia**
Mental Health Commission

Mental Health Commission Organisational Structure

We're working for Western Australia.

Mental Health Commissioner

Internal Audit and Risk Management

- Monitors the activities of the Commision to ensure compliance with organisational, government, legal and best practice requirements.
- Assist Directorates manage risk mitigation and improve organisational performance reporting on key projects and operational deliverables.

Executive Services

- Provides advice, executive and admin support to the Commissioner, liaises with the Minister's Office and external stakeholders on behalf of the Commissioner.

Director — Corporate Services

- Responsible for ensuring an effective corporate governance framework and business practices are in place to support the operations of the Commission.

Chief Finance Officer — **Finance**

Chief Human Resources Officer — **People and Development**

Chief Information Officer — **Information and Technology**

Assistant Director — **Strategic Communications**

Business Manager — **Business Services**

Assistant Commissioner — Alcohol, Other Drug and Prevention Services

Director — Prevention Services

- Responsible for prevention campaigns and programs, liquor licensing support, community programs.
- Workforce development and sector training.
- Alcohol, Drug Support Services including Parent and Family Drug Support.
- Suicide Prevention, current/new MH prevention programs and stigma reduction.
- Culturally secure training (including nationally recognised), resources, consultancy and support.

Manager — **Public Education and Health Promotion Programs**

Manager — **Safe and Healthy Settings**

Manager — **Community Support and Development Programs**

Manager — **Alcohol and Drug Support Services**

Manager — **Strong Spirit Strong Mind Aboriginal Programs**

Manager — **Workforce Development**

Director — Clinical Services

Director of Nursing — **Inpatient and Outpatient Services**

Managers — **Integrated Clinical Service**

- Responsible for assessment and treatment services for people experiencing problems associated with their alcohol and drug use and support for their families.
- Inpatient and outpatient services including withdrawal management, opiate and alcohol pharmacotherapy, clinical psychology, case management and counselling.

Manager — **Community Clinical Programs**

Manager — **Clinical Safety and Quality**

Manager — **Inpatients**

Assistant Commissioner — Planning, Policy and Strategy

Director — Planning, Policy and Strategy

- Leads reform and provides strategic direction including inter-government relations.
- Ongoing implementation and evaluation of the *WA Mental Health Act 2014.*
- Implementation oversight of the WA Mental Health and Alcohol and Other Drug Services Plan and the WA Methamphetamine Action Plan.

Assistant Director — **Service Planning**

Assistant Director — **System Reform**

Assistant Commissioner — Purchasing, Performance and Service Development

Director — Commissioning and Contracting

- Responsible for the coordinated management of the purchasing and contracting of mental health and alcohol and other drug services from both public mental health services and non-government organisations.

Assistant Director — **Health Relationship and Purchasing**

Assistant Director — **NGO Contracts – Metro Country and Diversion**

Assistant Director — **Health Liaison**

Assistant Director — **Strategic Purchasing and Development**

Director — Performance and Programs

- Focus on performance monitoring, reporting and evaluation, which measures the effectiveness of purchasing activities, thus what should continue to fund.
- Management of data collection systems used for contract acquittal and mandatory national data submissions.

Assistant Director — **Programs**

Assistant Director — **Performance**

Senior Officers

Jennifer McGrath

Acting Mental Health Commissioner from 17 June, 2019

Ms McGrath was appointed Acting Commissioner of the Mental Health Commission in June 2019. Ms McGrath most recently held the position of Deputy Director General, Education Business Services at the Department of Education and has worked in the Western Australian public sector for 14 years, holding senior executive positions in the Departments of the Premier and Cabinet and Finance, and the former Department of Child Protection.

Timothy Marney

Mental Health Commissioner to 14 June, 2019

Mr Marney was appointed as Mental Health Commissioner in February 2014. He joined the Western Australian Department of Treasury in 1993, where he held the position of Under Treasurer from 2005 to 2014. In this role, he gained an in-depth understanding of the health system and health reform initiatives, and government procurement policies and practices. As the Mental Health Commissioner, Mr Marney was responsible for planning and commissioning the State's mental health, and AOD services. Mr Marney also has lived experience of mental health issues. Since 2008 Mr Marney has served on the board of beyondblue, the national depression and anxiety initiative, and has been deputy chair of the board since 2010.

Officers

David Axworthy

Assistant Commissioner, Planning, Policy and Strategy

Mr Axworthy has a background in psychology and started working at the Department of Health in 1999. He joined the Office of Mental Health within the Department in 2004. He has filled a variety of roles since then, primarily as a 'purchaser' of mental health services from both the non-government and public mental health sectors. He has been involved in the shift from the purchasing of inputs, through outputs, to the current focus on purchasing person-centred outcomes. He was actively involved in the establishment of the Commission as a stand-alone entity in 2010 and its amalgamation with the Drug and Alcohol Office in 2015.

Sue Jones

Assistant Commissioner, Alcohol, Other Drug and Prevention Services

Ms Jones leads the Prevention Services directorate and the Next Step Drug and Alcohol Services. Ms Jones has previously held the role of Executive Director of Corporate Services at the Department of Treasury and Finance, and worked in the public health system managing the delivery of health services in regional areas in senior executive positions, including Director Operations in Country Health.

Officers

Elaine Paterson

Assistant Commissioner, Purchasing, Performance and Service Development

Ms Paterson is the Assistant Commissioner Purchasing, Performance and Service Development with responsibility for the commissioning and performance of State funded mental health and AOD services. Ms Paterson has worked in the Western Australian State Government for fourteen years following 20 years of experience in a number of different government departments in the United Kingdom. She joined the Commission as the Director for Services Purchasing and Development in 2012, from the Department of Finance, where she gained experience in commissioning and procurement with community managed organisations.

Alex Watt

Director, Corporate Services

Mr Watt is the Commission's Director of Corporate Services. In addition, he is responsible for the provision of corporate service support for the independent bodies – the Mental Health Tribunal, Mental Health Advocacy Service and the Office of the Chief Psychiatrist. He has experience in both the private business sector and State Government. Mr Watt oversaw the commencement and establishment of the Western Australian State Administrative Tribunal and administration of the then Mental Health Review Board.

Administered legislation

The Commission is the agency principally assisting the Minister for Mental Health in the administration of the Mental Health Act 2014 and the Alcohol and Other Drugs Act 1974.

Other key legislation impacting on the Commission's activities

The Commission is required to comply with a range of laws including:

Auditor General Act 2006
Carers Recognition Act 2004
Corruption, Crime and Misconduct 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
Health Services Act 2016
Industrial Relations Act 1979
Minimum Conditions of Employment Act 1993
Occupational Safety and Health Act 1984
Private Hospitals and Health Services Act 1927
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

Performance management framework

Outcome-based management framework

The Commission's outcome-based management framework was developed to assist in monitoring and assessing the agency's performance in achieving the Western Australian Government's desired outcomes. The framework shows the relationship between government goals, agency level government desired outcomes and the Commission's services.

Effectiveness indicators help to determine if the agency's desired outcomes have been achieved through service delivery, while efficiency indicators monitor the relationship between the services delivered and the resources used to produce the service. Collectively, the achievement of the outcomes and services will demonstrate how the Commission contributes to achieving the Western Australian Government goal of Strong Communities.

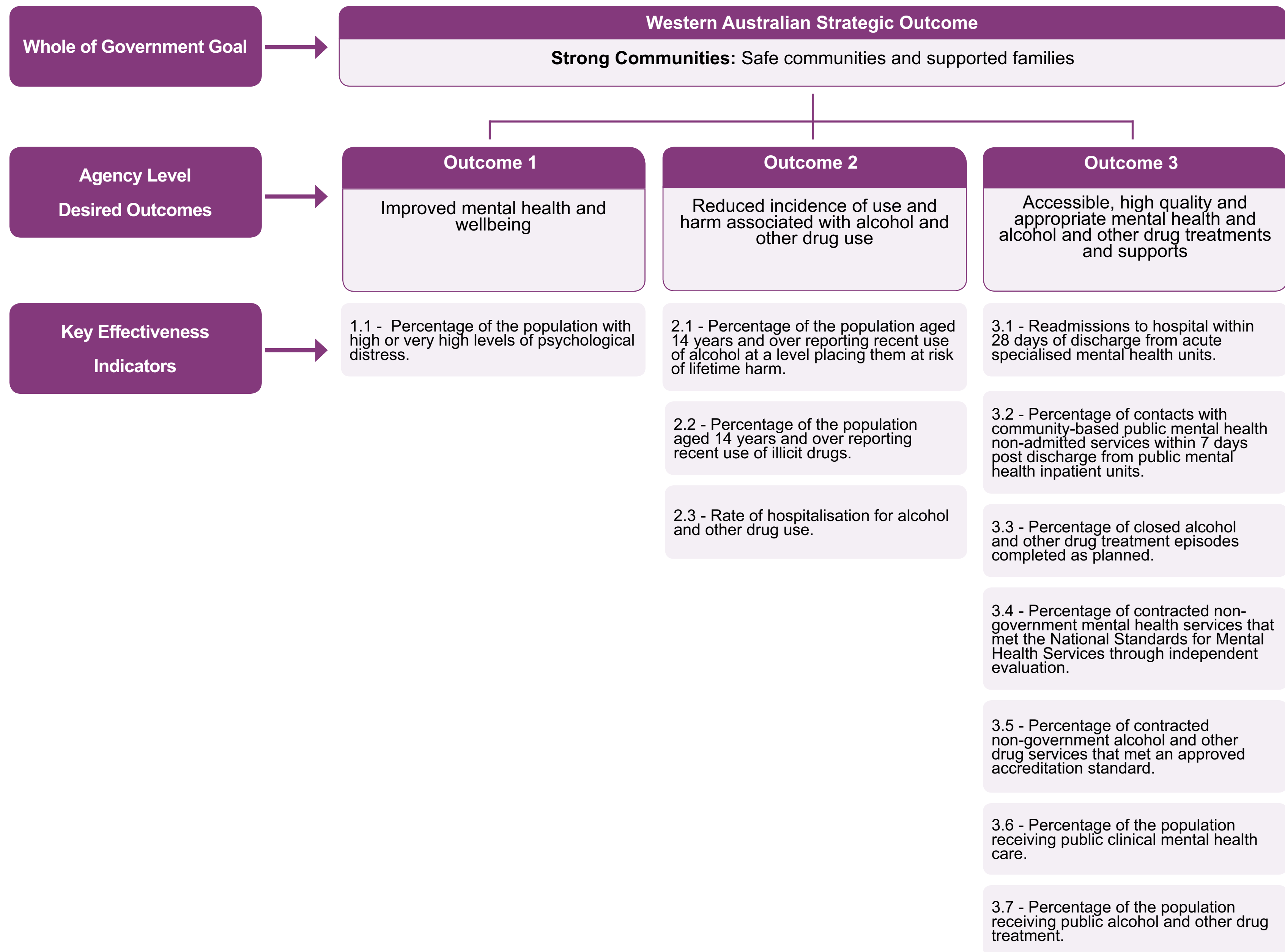
Changes to outcome-based management framework

The Agency's outcome-based management framework did not change during 2018-19 .

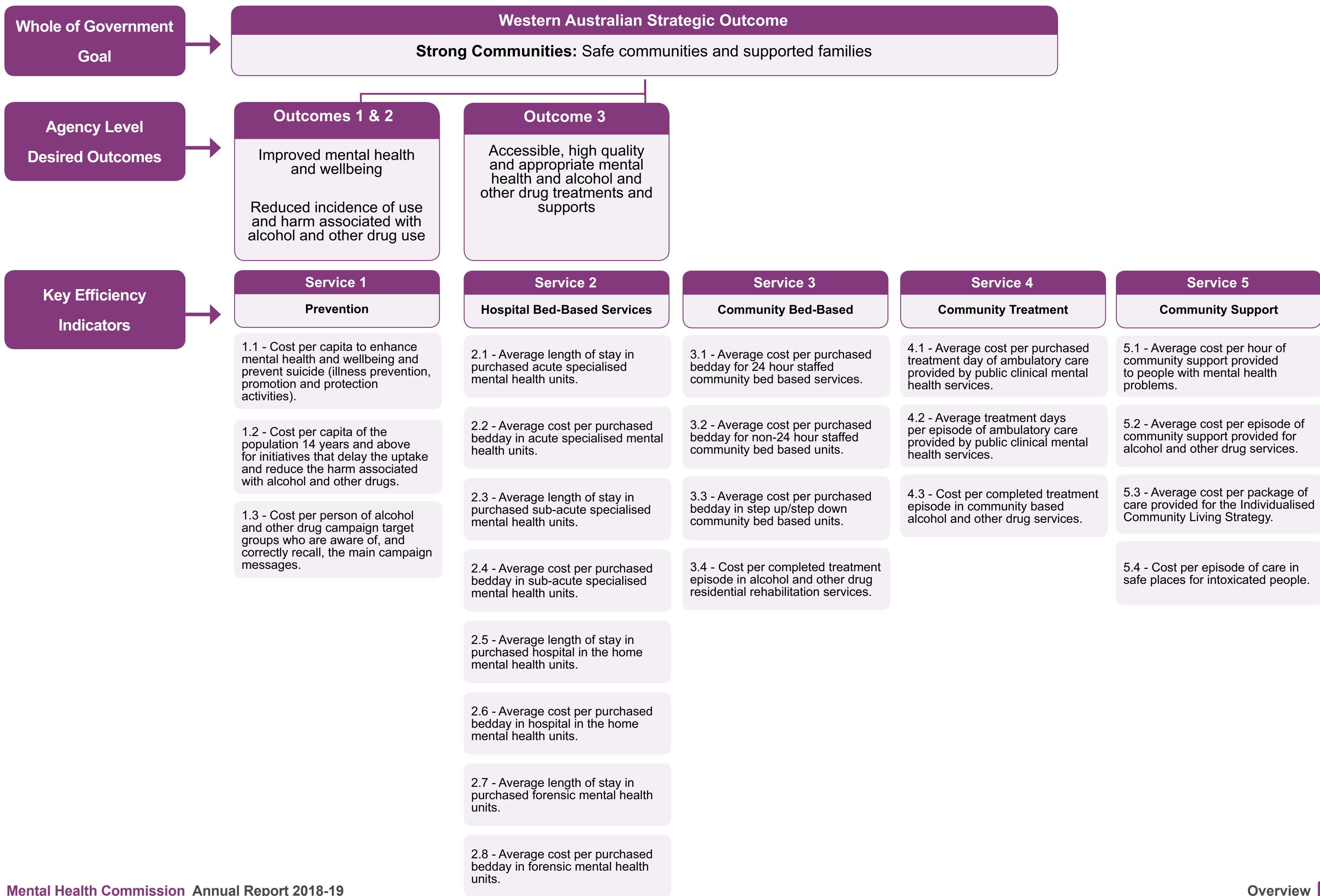
Shared responsibilities with other agencies

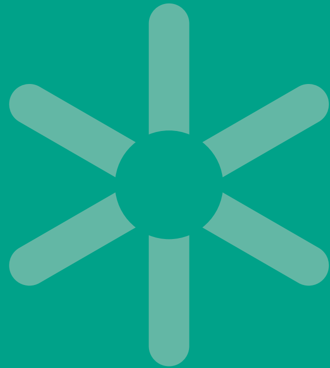
The Agency did not share any responsibilities with other agencies in 2018-19.

Mental Health Commission Performance Management Framework



Operational Structure





Agency Performance

Performance Summaries - Report on Operations

Summary of financial performance

Financial target	2018-19 Budget $'000	2018-19 Actual $'000	Variation $'000
Total cost of service (expense limit)	918,403	917,820	583
Net cost of services	725,424	714,734	10,690
Total equity	45,800	47,270	-1,470
Net increase/(decrease) in cash held	(213)	(10,168)	(9,955)

STAFFING Approved full-time equivalent staff level	2018-19 Budget	2018-19 Actual	Variation
Mental Health Commission	251	261	10
Office of the Chief Psychiatrist	15	15	0
Mental Health Advocacy Service	8	6	-2
Mental Health Tribunal	7	8	1
TOTAL	**281**	**290**	**9**

Working cash targets

	2018-19 Agreed Limit $'000	2018-19 Actual $'000	Variation $'000
Agreed Working Cash Limit (at Budget)	45,691	23,895	21,796
Agreed Working Cash Limit (at Actuals)	46,058	23,895	22,163

The working cash limit represents a cap limit on the Commission's working cash at bank. The working cash at bank excludes restricted cash holdings.

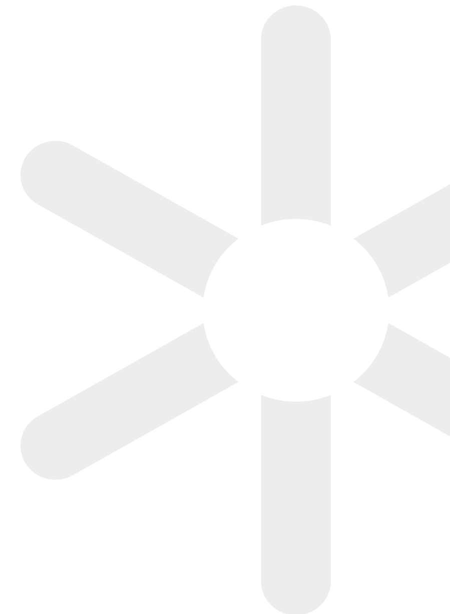
Key Performance Indicator (KPI) results against targets

Indicator		2018-19 Target	2018-19 Actual
Key Effectiveness Indicators			
Outcome 1 – Improved mental health and wellbeing			
1.1	Percentage of the population with high or very high levels of psychological distress	≤9.9%	12.2%
Outcome 2 – Reduced incidence of use and harm associated with alcohol and other drug use			
2.1	Percentage of the population aged 14 years and over reporting recent use of alcohol at a level placing them at risk of lifetime harm	≤18.4%	18.4%
2.2	Percentage of the population aged 14 years and over reporting recent use of illicit drugs	≤16.8%	16.8%
2.3	Rate of hospitalisation for alcohol and other drug use	<988.3	975.2
Outcome 3 – Accessible, high quality and appropriate mental health and alcohol and other drug treatments and supports			
3.1	Readmissions to hospital within 28 days of discharge from acute specialised mental health units (national indicator)	≤12%	17.1%
3.2	Percentage of contacts with community-based public mental health non-admitted services within 7 days post discharge from public mental health inpatient units (national indicator)	≥75%	77.3%
3.3	Percentage of closed alcohol and other drug treatment episodes completed as planned	≥76%	70.1%
3.4	Percentage of contracted non-government mental health services that met the National Standards for Mental Health Services through independent evaluation	100.0%	87.5%
3.5	Percentage of contracted non-government alcohol and other drugs services that met an approved accreditation standard	90.0%	95.5%
3.6	Percentage of the population receiving public clinical mental health care (national indicator)	≥ 2.4%	2.4%
3.7	Percentage of the population receiving public alcohol and other drug treatment	≥ 0.7%	0.7%

Key Efficiency Indicators			
Service 1: Prevention			
1.1	Cost per capita to enhance mental health and wellbeing and prevent suicide (illness prevention, promotion and protection activities)	$4.06	$2.51
1.2	Cost per capita of the population 14 years and above for initiatives that delay the uptake and reduce the harm associated with alcohol and other drugs	$3.41	$3.73
1.3	Cost per person of alcohol and other drug campaign target groups who are aware of, and correctly recall, the main campaign messages	$0.83	$0.80
Service 2: Hospital Bed-Based Services			
2.1	Average length of stay in purchased acute specialised mental health units	<15	15.6
2.2	Average cost per purchased bedday in acute specialised mental health units	$1,515	$1,524
2.3	Average length of stay in purchased sub-acute specialised mental health units	<183	253.9
2.4	Average cost per purchased bedday in sub-acute specialised mental health units	$1,401	$1,356
2.5	Average length of stay in purchased hospital in the home mental health units	< 22	22.0
2.6	Average cost per purchased bedday in hospital in the home mental health units	$1,547	$1,344
2.7	Average length of stay in purchased forensic mental health units	<50	37.7
2.8	Average cost per purchased bedday in forensic mental health units	$1,437	$1,348
Service 3: Community Bed-Based Services			
3.1	Average cost per purchased bedday for 24 hour staffed community bed-based services (national indicator)	$372	$389
3.2	Average cost per purchased bedday for non-24 hour staffed community bed-based units (national indicator)	$180	$188
3.3	Average cost per purchased bedday in step-up/step-down community bed-based units	$541	$511
3.4	Cost per completed treatment episode in alcohol and other drug residential rehabilitation services	$12,781	$11,985

Service 4: Community Treatment			
4.1	Average cost per purchased treatment day of ambulatory care provided by public clinical mental health services (national indicator)	$461	$447
4.2	Average treatment days per episode of ambulatory care provided by public clinical mental health services	<5.00	5.05
4.3	Cost per completed treatment episode in community based alcohol and other drug services	$1,764	$1,725
Service 5: Community Support			
5.1	Average cost per hour of community support provided to people with mental health problems	$133	$120
5.2	Average cost per episode of community support provided for alcohol and other drug services	$10,329	$10,515
5.3	Average cost per package of care provided for the Individualised Community Living Strategy	$52,495	$39,536
5.4	Cost per episode of care in safe places for intoxicated people	$373	$388

For a more in-depth discussion around KPI results, see the sections Detailed Key Effectiveness Indicators Information (page 92) and Detailed Key Efficiency Indicators Information (page 106).



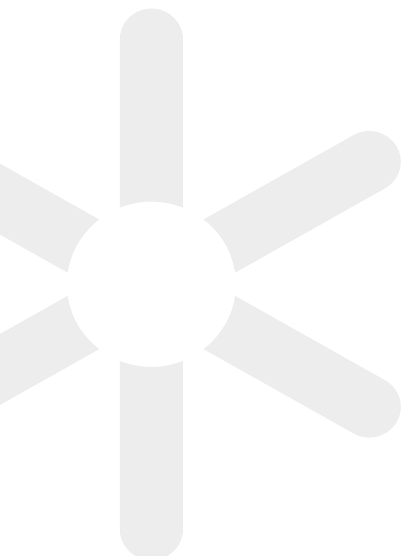
Key Achievements

Introduction

In 2018-19 the Commission's expenditure on mental health and alcohol and other drug (AOD) services grew by 2.6%.

A total of $917.82 million was spent on mental health and AOD services, across the five service streams of Prevention, Community Support Services, Community Treatment Services, Community Bed-Based Services and Hospital-Based Services, to work towards delivering the optimal mix and level of mental health and AOD services to the Western Australian community.

The Commission's key achievements in these areas throughout 2018-19 are outlined on the following pages.



Mental Health Funding

Service	Funding
Prevention	$6.7 million
Community Support Services	$42.3 million
Community Treatment Services	$354.9 million
Community Bed-Based Services	$37.8 million
Hospital Bed-Based Services	$390.0 million
TOTAL	$831.7 million

Alcohol and Other Drug Funding

Service	Funding
Prevention	$7.9 million
Community Support Services	$6.4 million
Community Treatment Services	$49.6 million
Community Bed-Based Services	$18.6 million
Hospital Bed-Based Services	$3.6 million
TOTAL	$86.1 million

Prevention

In 2018-19 the Commission invested $14.59 million in prevention services to help improve mental health, reduce risk of mental illness and suicide, and reduce AOD-related harms.

Suicide prevention

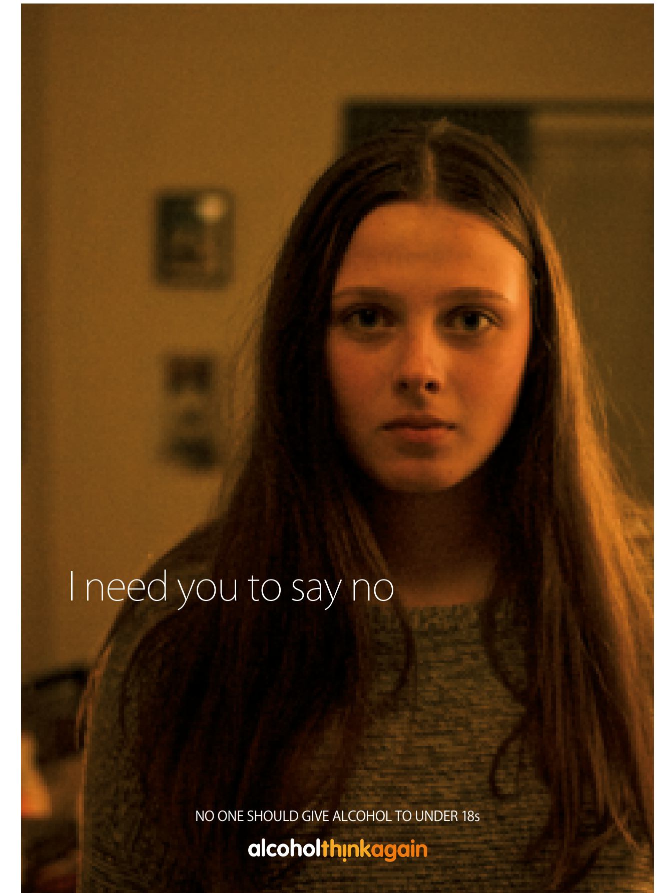
The Commission secured $8.1 million in 2019-20 for the continuation of programs within *Suicide Prevention 2020: Together We Can Save Lives* through to December 2020. Programs include:

- 10 Suicide Prevention Coordinator positions who help build the capacity of communities and relevant service providers to better identify and address local suicide-related issues through evidence based prevention activity.
- The Family Wellbeing program (FWB), which is being implemented Statewide in collaboration with the Aboriginal Health Council of Western Australia (AHCWA) and acknowledges social and emotional wellbeing as a significant contributor to the prevention of Aboriginal suicides. FWB has been identified as a culturally secure training program developed by Aboriginal people for Aboriginal people. The FWB program aims to empower Aboriginal individuals, families, organisations and communities to take greater control over their lives, health and wellbeing.
- The Regional Men's Health Initiative (RMHI), which supports the provision of mental health and wellbeing education for men living in regional, rural and remote farming communities across Western Australia. The RMHI is delivered by Wheatbelt Men's Health Inc., and aims to increase the awareness of issues that impact on the mental health and wellbeing of men by providing educational engagement, promotion of help-seeking, and referral when needed.

Additionally, in partnership with the Federal Government and the local community, the Commission participates in ongoing roundtable discussions and provides support and advice where appropriate regarding suicide prevention activity to address Aboriginal suicide rates in the Kimberley.

Public education campaigns

The Commission's public education campaigns continued to create greater public awareness around mental health, and alcohol and other drugs. Alcohol.Think Again released its new Parents, Young People and Alcohol campaign – 'I need you to say no' in November 2018.



Poster from the Alcohol. Think Again Parents, Young People and Alcohol campaign.

Other campaign highlights throughout 2018-19 included:

- Drug Aware's The Medix campaign increased the safety of patrons with four in five people who recognised the campaign taking action to stay safer while at a music festival or event. These actions included looking out for their friends or having a buddy system, staying appropriately hydrated, taking a break and visiting a chill-out area, avoiding poly-drug use, looking for information on how to help others and seeking first aid when required.
- As part of the Strong Spirit Strong Mind (SSSM) Metro Project, the team delivered a total of six art activation events in youth centres across the Perth metropolitan area. At each of the activations there were two Youth Ambassadors identified from each youth centre, a Drug Alcohol Youth Services (DAYS) Counsellor and an Aboriginal mentor and Artist, Ash Collard. In total there were 18 hours of onsite activation and 260 young people were engaged through art.
- Prompted exposure of the SSSM Metro Project campaign recorded its highest level at 88% since commencement of the campaign, and almost three quarters (74%) of those who saw the campaign saying it made them more aware of where to get help
- Think Mental Health established a sponsorship of the WA Country Football League (implemented via Healthway).
- The Foundation for Alcohol Research and Education (FARE)'s 2019 Annual Alcohol Poll data indicates Western Australians' alcohol-related attitudes, knowledge and behaviour is faring above that of other jurisdictions and the national average. This is indicative of the effectiveness of the Alcohol. Think Again public education program.

Stakeholder engagement

The Commission released the Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 *(Prevention Plan)* which provides a guide for stakeholders in the development and implementation of evidence-based and evidence-informed strategies to promote mental health and prevent mental illness, alcohol and other drug-related issues amongst the Western Australian community.

Development was led by the Commission in partnership with a range of key stakeholders, including academic experts, senior representatives from a range of government departments, key non-government organisations, the general public, and consumers, families, carers and supporters of those with lived experience of mental health and/or AOD-related issues.

Other key achievements relating to prevention services include the launch of the Thrive at Work website, resources and tools. This work was funded by the Commission in 2017 and conducted by the Centre for Transformative Work Design (CTWD), following the development of the Western Australian Workplace Mental Health Standards, an initiative of the Suicide Prevention 2020 strategy;

The Commission also:

- assisted with the development, implementation, review and evaluation of 37 Community Action Plans that seek to address local AOD-related harm across the State;
- monitored liquor licence applications across the State and investigated 204 matters regarding the potential for, and minimisation of, alcohol-related harm and ill-health;
- assisted the Chief Health Officer with 33 interventions regarding liquor licence applications; and
- continued the Commission's partnership with the WA Local Government Association (WALGA) and launched the Managing Alcohol in Our Communities resource to respond to local government requests for evidence-based information about alcohol management.

Community support

The Commission expended $48.7 million on community support services in 2018-19.

A draft model of service for a Recovery College in Western Australia was co-designed by an expert panel which was co-chaired by Mr Joe Calleja and Ms Tandi Kuwana. A Recovery College will complement existing mental health and AOD support services by enabling self-directed recovery and learning opportunities in a safe and welcoming place. Following the co-design of the model of service, the Commission secured $3.6 million as part of the 2019-20 State Budget process to progress the Recovery College establishment.

An important pathway to recovery for people experiencing mental health and/or AOD issues is having safe and stable housing and access to appropriate supports for them to sustain that housing. The Commission and key stakeholders are developing *A Western Australian Strategy to provide safe and stable accommodation and support to people experiencing mental health, alcohol and other drug issues 2019-2025: A Safe Place* to guide stakeholders in the development of appropriate accommodation and support for people with mental health and AOD issues. It is anticipated that the Strategy will be released in 2019-20.

The Commission has contracted the Western Australian Association for Mental Health (WAAMH) on two projects, the first being the Supported Accommodation Services project: framework for referral and transitioning mental health consumers. The co-designed referral framework aims to include a series of pathways appropriate to supporting mental health consumers' transition through the mental health accommodation services purchased by the Commission. It is expected to be completed late in 2019.

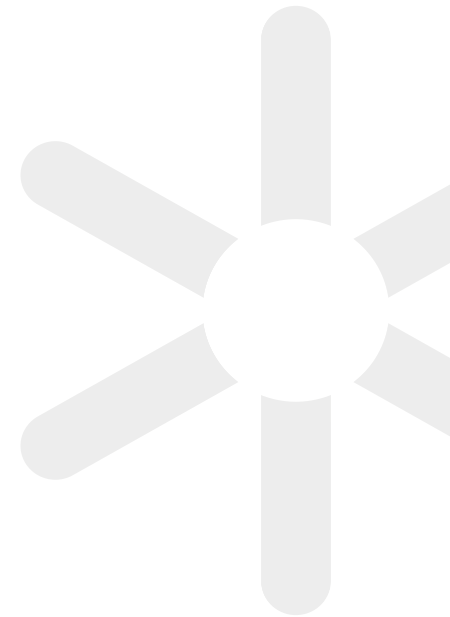
WAAMH has also been contracted to review the Commission's Personalised Support Linked to Housing - Supportive Landlord Services. This review of the Supportive Landlord part of the Independent Living Program model aims to ensure it is meeting individual needs. Findings of the review will also inform future procurement processes and decisions. This is expected to be completed in late 2019.

The Mental Health Inpatient Snapshot Survey 2019 (MHISS 2019) was conducted in April 2019 across publicly funded mental health inpatient facilities in Western Australia.

The MHISS 2019 was coordinated by the Commission with support from HSPs and was designed to capture:

- the proportion of mental health inpatients who could be discharged, if suitable community-based accommodation and mental health support services were available; and
- the types of community-based accommodation and mental health support services required to support hospital discharge for mental health inpatients.

The report findings will provide a critical source of evidence for the future planning and purchasing of community-based accommodation and community support services.



Community treatment

In 2018-19, the Commission invested $404.5 million on community treatment services.

Next Step Drug and Alcohol Services (Next Step) further expanded amphetamine treatment and support across the metropolitan area. A Model of Care and resource kit was developed for amphetamine treatment and support for Next Step and metropolitan Community Alcohol and Drug Service (CADS) clients.

The public Health Service Providers (HSPs) continued to increase the availability and effective coordination of community treatment services. The Commission allocated $326.1 million across the HSPs to provide mental health community treatment services throughout the State in 2018-19.

Training was a particular focus for 2018-19 and included mental health capacity and capability building for clinicians, families and carers. Specific areas included the physical health needs of mental health patients, school nurse and psychologist training, therapeutic crisis intervention for families and infant mental health. All HSPs were funded to provide ‘Project Air’ training to staff. It is a service development and training program that helps health services to diagnose, manage and provide effective treatment for people with personality disorders.

Life-saving naloxone was made widely available with 866 naloxone kits distributed through St Patricks, Hepatitis WA, Wungening Aboriginal Corporation, Peer Based Harm Reduction WA, Next Step and metropolitan CADS. At the end of 2018-19 there were 73 reported opioid overdose reversals using the naloxone kits.

17,235 occasions-of-service were provided to Western Australians through the Alcohol and Drug Support Service (ADSS). Contacts were made via the ADSS free 24/7 telephone counselling, information, referral and support lines, live chat and email. Of these contacts, 25% identified alcohol as the primary drug of concern and 22% identified methamphetamine as the primary drug of concern.

The re-accreditation of Next Step and ADSS was completed in November 2018 against nationally recognised community standards, and was successful for a further three years. Feedback from the surveyors who audited the Commission and both services was very positive, with the final accreditation report serving as a starting point for the development of a new quality plan, with some ambitious targets included. The first update will be submitted to the accrediting agency in July 2019.

The multi-disciplinary Mental Health Court Diversion Program, which comprises the Adult Start Court and the Links Clinical Assessment Team in the Perth Children’s Court, secured a further two years funding with the allocation of $5.9 million in the 2019-20 budget process. This resourcing will be used to commission clinical and non-clinical (psychosocial) mental health services for participants of Start Court and Links.

In 2018, the Commission conducted an evaluation of the Mental Health Court Diversion Program. The evaluation found that the Start Court was effective at improving participants’ mental health outcomes. Out of the 188 cases examined, 173 (82%) demonstrated clinical improvement.

Similarly for Links, the evaluation found that out of the 89 clients case managed by Outcare, 72 (81%) had at least one identified psychosocial need met at program completion.

The Commission continued procurement and administration of a Statewide network of Alcohol Assessment and Treatment (AAT) providers for interlock-restricted drivers who breach the conditions of the WA Alcohol Interlock Scheme and are referred for compulsory AAT. The procured services included an Aboriginal service provider to enhance the provision of culturally secure AAT to Aboriginal people in the Pilbara region. AAT referral numbers to community treatment sessions increased by 212%.

Community bed-based services

In 2018-19 the Commission expended $56.4 million on community bed-based services.

In November 2018, the Commission opened the first regional community step up/step down service in Albany (six beds). This was in addition to the two already operational community mental health step up/step down services in Joondalup (22 beds) and Rockingham (10 beds). Construction commenced on the Bunbury (10 beds) facility, and the Commission confirmed the sites of the Geraldton (10 beds) and Kalgoorlie (10 beds) services, while continuing to progress the planning of the Broome (6 beds) and Karratha (6 beds) services.

Community mental health step up/step down services provide short-term residential support and individualised care for people following discharge from hospital, or for those who are in the community experiencing a change in their mental health, to avoid the need for possible hospitalisation.

The Commission also purchased 44 AOD residential rehabilitation and low medical withdrawal treatment beds in the South West region. Nineteen of the 44 beds opened in January 2019, with the remainder opening mid-2019. Included in the treatment beds are three low medical withdrawal beds, and 41 adult residential rehabilitation beds, of which 12 are Aboriginal specific. The treatment beds will be provided by Palmerston Association at Brunswick Junction and Cyrenian House in Nannup.

The Commission progressed planning regarding gaps in AOD treatment services in the Kimberley through an independent organisation. This included stakeholder consultation in 2018 to inform the development of AOD and co-occurring mental health services in the Kimberley region. The Consultation Summary Report on AOD Services in the Kimberley (the Report) outlined key themes that were raised by stakeholders throughout the consultation. Opportunities to further enhance AOD services in the Kimberley region are presented through the Report, with eight key areas identified as existing gaps in service. As part of the 2019-20 Budget the Commission was allocated $11.6 million over the forward estimates to expand AOD treatment services in the Kimberley region. This includes low medical withdrawal beds for adults, and a youth service addressing the needs of individuals holistically and in a person-centred way, including co-occuring AOD and mental health.

The Hon. Roger Cook MLA and Mr Donald Punch MLA, Member for Bunbury break ground at the site of the Bunbury Step Up/Step Down facility

Hospital bed-based services

In 2018-19 the Commission invested $393.6 million on public mental health inpatient services through contracts with the Child and Adolescent Health Service (CAHS), North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS), East Metropolitan Health Service (EMHS) and WA Country Health Service (WACHS), and AOD services through Next Step.

Supporting young people

The East Metropolitan Youth Unit (EMyU) was opened to provide an additional service to help young Western Australians with mental health issues. The EMyU has 12 beds - three of which offer secure care. It is a dedicated service for young people aged 16 to 24 years who present with complex and acute mental health issues, and provides inpatient care, treatment and assessment. It also offers community care planning to assist young people and their families to access necessary support prior to discharge.

Mental Health Observation Areas

Following the establishment of Mental Health Observation Areas at Sir Charles Gairdner Hospital and Joondalup Health Campus, the Commission also worked toward the establishment of a Mental Health Emergency Centre at Royal Perth Hospital which is expected to open in late 2019. Mental Health Observation Areas provide a calming, low stimulus environment for people who would otherwise remain in emergency departments while awaiting stabilisation, assessment, and referral to other services as necessary.

Ursula Frayne Unit - St John of God, Mt Lawley. BACK: Michael Moltoni (former Director Performance and Programs, Mental Health Commission); Mr Simon Millman MLA (Member for Mt Lawley); Dr George Eskander (Director Medical Services at St John of God Mt Lawley Hospital); FRONT: The Hon. Roger Cook MLA (Deputy Premier and Minister for Mental Health); Vanessa Unwin (Acting CEO, St John of God Mt Lawley). Credit: Sean Middleton

Additionally, planning progressed on a Mental Health Emergency Centre at St John of God Midland Public Hospital. Other key highlights include:

- $15.6 million in 2019-20 for a new 20-bed secure mental health unit at Fremantle Hospital. The secure unit, which will be the second at the hospital, is expected to open in 2022 and will boost the total mental health beds on site to 84.
- The Commission renewed a contract valued at $22.5 million over five years for mental health care to older adults with acute mental health issues, with services located at the Ursula Frayne unit at St John of God Mt Lawley Hospital. This will expand the service with increased admission hours, enhanced access to consultants and stronger links to psychiatry services at St John of God Midland Public Hospital. The unit helps older adults learn how to manage their symptoms with the goal of giving them a better understanding of how lifestyle factors impact mood and mental health, help them address their mental health issues and reduce the risk of relapse.

AOD services at Next Step

At the Commission's Next Step Inpatient Withdrawal Unit, there were 688 admissions in 2018-19, and 513 of admitted clients completed their treatment as planned.

System-wide

Plan Update 2018 and other key strategic documents

The Commission released the Plan Update 2018, which included the first remodelling of the optimal level and mix of services for Western Australian mental health and AOD services, and a summary of progress towards actions outlined in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (The Plan).

The Plan Update 2018 used revised population projections to provide updated modelling of services types, levels and locations for mental health and AOD services required in Western Australia until the end of 2025, including the addition of the East Metropolitan Health Service. Consistent with the original modelling of the Plan, the *Plan Update 2018* identifies the need to rebalance the system by expanding community-based mental health and AOD services and supported accommodation, to reduce pressure on emergency departments and hospital beds.

In addition to the *Plan Update 2018*, the Commission also released the following system-wide strategies:

- Working Together: Mental Health and Alcohol and Other Drug Engagement Framework and Toolkit 2018-2025; and
- Western Australian Alcohol and Drug Interagency Strategy 2018-2022

Development also continued on the draft *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2019-2025* and *A Western Australian Strategy to provide safe and stable accommodation and support to people experiencing mental health, alcohol and other drug issues 2019-2025: A Safe Place.*

Methamphetamine Action Plan

The Commission led the development of the Western Australian Full Government Response to the MAP Taskforce Report (the Response). The Response adopted a cross-government approach in addressing methamphetamine related harms. As part of the Response, $42.5 million was secured in the 2019-20 State Budget for a co-ordinated and integrated approach to address methamphetamine issues in Western Australia. Of this, $40.5 million was allocated to the Commission, and $2 million to the Department of Health (DoH).

This is in addition to the $43.3 million in funding allocated in the 2017-18 State Budget to the Commission to implement the 2017 Methamphetamine Action Plan initiatives.

Key initiatives include:

- establishment of new services in the Kimberley focusing on youth, and low medical withdrawal beds for adults;
- expansion of the Transitional Housing and Support Program;
- continuation of the North West Drug and Alcohol Support Program;
- establishment of a crisis intervention centre in Midland;
- examining options for the establishment of short-term places for critical intervention, including the option for compulsory crisis intervention;
- planning for expansion of the Police Mental Health Co-Response program to include AOD, and into regional areas; and
- planning for a one-stop, 24-hour support service to better support individuals and families in need.

Aboriginal People

In 2018-19, the Commission launched the 2018-2021 Stretch Conciliation Action Plan (CAP). The term 'conciliation' was adopted in place of 'reconciliation' after consultation with the Commission's Noongar Elders in Residence, Charlie and Helen Kickett (known at the Commission as Uncle Charlie and Aunty Helen), who advised that conciliation is a process which involves Aboriginal and non-Aboriginal people walking together for the first time as genuinely equal partners in a shared future.

Launch of the Commission's Conciliation Action Plan. From left: Geri Hayden; John Walley, artist; Timothy Marney, Mental Health Commissioner; Charles T Kickett and Helen Kickett, the Commission's Noongar Elders in Residence.

The CAP is indicative of the Commission's commitment to properly recognise and respect Aboriginal peoples, their culture and connection to country, and the impact history has had on them. We strive for conciliation in the work that we do, seeking to build understanding and embed actions that achieve equity for Aboriginal people.

Perth-based artist John Walley, a descendent of the Whadjuk clan within Noongar Country, created the bespoke artwork that features throughout the CAP. The name of the artwork is Walbrininy, which means spiritual healing, and it features a blue china orchid as its centrepiece. Other elements in the artwork depict people gathering; the past, present and future, and the six Noongar seasons.

The Commission's Strong Spirit Strong Mind (SSSM) Aboriginal Programs team won the WA Small Training Provider of the Year Award at the WA Training Awards 2018 at Crown Perth.

Other key achievements from the SSSM Aboriginal Programs team include:

- Successful re-registration of the Registered Training Organisation (RTO) with the Australian Skills Quality Authority (ASQA) until 2026;
- 22 Aboriginal AOD and Mental Health workers registered for Certificate III in Community Services;
- 14 Aboriginal AOD and Mental Health workers graduated with a full qualification in Certificate III in Community Services;

Artist John Walley with Mental Health Commissioner Timothy Marney, unveiling 'Walbrininy' – the bespoke artwork created for the Commission's Conciliation Action Plan.

- 5 Aboriginal AOD and Mental Health workers graduated with a full qualification in Certificate IV Alcohol and Other Drugs;
- 160 workers completed Ways of Working with Aboriginal people cultural awareness training; and
- updates to the suite of SSSM resources which complement the Commission's culturally secure training packages.

Online Services Directory

The Commission progressed a new online services directory to help Western Australians find relevant mental health and AOD services near them. The online services directory was developed in response to the Plan, which identified the need to deliver tools to improve the ability of consumers to navigate the system and provide access to services online. The directory will be launched in 2019-20.

Mental Health Network

The Mental Health Network (MHN) aims to improve the outcomes for people with mental health issues by facilitating effective collaboration between consumers and support persons, health professionals, hospitals, mental health services, the Commission and the DoH.

A review of the MHN was completed in early 2019 and made recommendations across five key themes: consumer, family and carer engagement; leadership, purpose and governance; communications and processes; resourcing and support; and opportunity to influence and showcase successes. Progress against these recommendations is underway.

Other achievements include provision of a submission to the WA Parliament Select Committee into Elder Abuse, co-development with Dementia Support Australia of the draft *Referral and Collaboration Care Guidelines*, and presentation by the Youth Mental Health Sub Network to the Mental Health Advisory Council (MHAC) on the *Youth Mental Health Report*. The report identified current successes and areas for improvement in the youth mental health space; and provided key recommendations for consideration, including the development of an implementation sub-plan for the dedicated youth stream.

Workforce Development

The Commission developed a draft *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2019-2025* (Workforce Strategic Framework) as a guide for key agencies to support the growth and development of the mental health and AOD workforce. Community consultation took place in July and August 2018, and it is planned that the Workforce Strategic Framework will be finalised and released in 2019-20.

Additionally, the Commission's Workforce Development team provides a range of alcohol and other drug related training and events for professionals and volunteers. Highlights for 2018-19 included:

- the release of the Counselling guidelines: Alcohol and other drug issues. Fourth Edition 2019;
- 156 events totalling 1,200 hours of training delivery to 2,405 workers around the state; and
- 12,507 workforce resources distributed.

Decommissioning and reinvestment of services at Graylands and Selby Older Adult Hospital

The Commission continued to work with the DoH and the NMHS on the decommissioning and reinvestment of mental health services at Graylands and Selby Older Adult Hospital. These are key reform areas in the Plan. The Plan recommends delivering mental health care closer to where people live, moving away from institutionalised models of care to a community based model.

In the 2019-20 State Budget, funding of $3 million was allocated to the DoH, to further progress detailed planning for the divestment of infrastructure and the decommissioning and reinvestment of mental health services at Graylands and Selby Older Adult Hospital. New services may include a combination of inpatient services, community bed-based services, and community support (accommodation options). These services will be established before existing services at Graylands and Selby Hospitals are closed.

Corporate services

Commission employee development and wellness

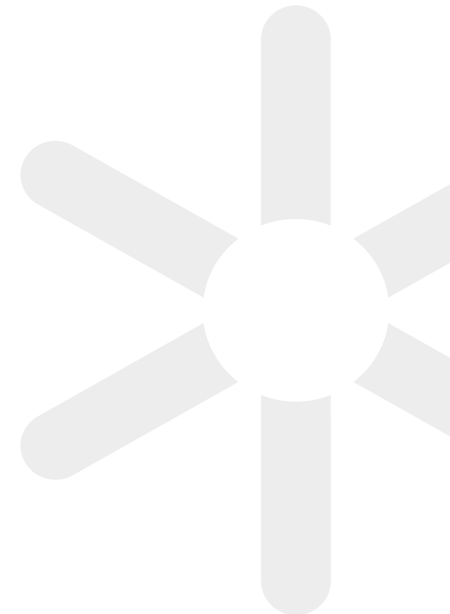
As a pilot organisation of the Thrive at Work project, the Commission took the opportunity to check in with its workforce and explore workplace challenges, key supports and opportunities for improvement. The Commission's employees drove the process through participation in a series of focus groups, facilitated by CTWD. With renewed motivation, employees from across the Commission explored possible solutions to the challenges, which led to the development of the Commission's Thrive at Work Action Plan to drive internal change.

The Action Plan presents solutions to key challenges to be achieved in the short term with some longer term aspirations. So far, the Action Plan has promoted developments such as improved collaboration and communication across teams, streamlined approval processes and the development of a community of practice for managers at the Commission.

Information and Technology

The Commission continued its program of work aligned to the whole of government Digital WA Strategy, with the 2018-19 transition of Government Campus Network (GCN) services to the GovNext platform.

The solution is aimed to increase efficiency and reduce costs of Information and Communications Technology (ICT) infrastructure. It also seeks to improve the security of systems, enhance data protections, provide greater business continuity capability and reduce risks associated with legacy infrastructure.



Significant Issues Impacting the Commission

Addressing methamphetamine use in Western Australia

Methamphetamine use continues to be a significant concern within the Western Australian community. Its effects are far-reaching and the impacts are often devastating for the individuals themselves, their families and communities.

The Methamphetamine Action Plan Taskforce (the Taskforce) was a cross-government initiative to gather further information on the impact of methamphetamine use in Western Australia and provide advice to the government on opportunities to improve service delivery, increase cross-sector collaboration and measure performance. The Methamphetamine Action Plan Taskforce Final Report (the Taskforce Report) was released on 26 November 2018, providing 57 recommendations to government. The complexity of methamphetamine use and the recognition of the Methamphetamine Action Plan Taskforce (the Taskforce) that it must be viewed as a health and community issue have been acknowledged.

The Full Government Response to the Taskforce Report (the Response) released on 7 May 2019, adopts an across government approach in addressing methamphetamine related harms. The Response was developed by the Methamphetamine Action Plan Senior Officer's Working Group agencies, led by the Commission. Development was guided by the ultimate aim of providing more help for individuals and families impacted by methamphetamine use. In addition to the $42.5 million investment as part of the Response, provided in the 2019-20 State Budget, further initiatives are currently being planned to be developed and delivered over the coming years to continue to address methamphetamine issues in Western Australia.

These commitments are in line with the State Government's 'Our Priorities: Sharing Prosperity' program outcome area of Safer Communities, and in particular the priority target to reduce illicit drug use by 15% by 2022.

Suicide prevention

The Statewide suicide prevention strategy, Suicide Prevention 2020: Together We Can Save Lives *(Suicide Prevention 2020)* received funding of $25.9 million over four years, from 2015-16 to 2018-19. The Commission has purchased services from government and non-government organisations that are in line with an evidence-based approach and address the activities outlined in *Suicide Prevention 2020*. A further $8.1 million investment was made as part of the 2019-20 budget process to extend services funded under the strategy until December 2020. The Commission is developing the *Suicide Prevention Action Plan 2021-25*, which will build on the work of *Suicide Prevention 2020*, to provide a guide on activities that can help communities reduce the incidence of suicide.

Emergency department wait times and access to secure beds

In 2018-19 there were 61,527 presentations to emergency departments (EDs) for mental health related issues, with a median wait time of 151 minutes to be admitted to a bed. Mental health accounted for 5.7% of all ED presentations and 7.7% of ED presentations subsequently admitted.

As at 1 January 2019, the current hospital system in Western Australia had capacity for 795 mental health beds, with 344 of these beds being secure. Patient flow reports indicate a small number of mental health consumers wait an extended period of time for a specialised mental health bed when presenting at hospital EDs. Long wait times do not represent the most appropriate clinical care setting for these vulnerable consumers.

A new mental health patient flow model was recently introduced by the State Government which will help people with mental health issues move out of EDs into a more appropriate place, in addition to enabling hospitals to see the live data on the number of consumers waiting for admission and mental health bed capacity at other hospitals. The State Government is also considering other ways to relieve the pressure on EDs and to support those with mental health issues to access treatment, such as Mental Health Observation Areas, increasing the number of acute mental health beds, and identifying accommodation and community services support needs.

The need to rebalance the system

There is a continuing and pressing need to rebalance the system by expanding community based services. Without significant investment in community services, those needing support and treatment for mental health and AOD issues have no alternative but to seek assistance at a hospital. This unnecessarily exacerbates pressure on hospital services and can result in avoidable presentations at EDs by people who have no suitable alternative to help them. Careful planning and investment is needed to develop support options outside of hospitals before the system can be rebalanced.

Divestment of Graylands

Graylands Hospital is one of the last remaining stand-alone adult psychiatric hospitals in Australia, most of which have closed following the first National Mental Health Plan in 1992. The buildings are outdated in terms of infrastructure and the facilities inhibit consumer recovery. The decommissioning of and reinvestment of services from Graylands and Selby Older Adult Hospitals are key reform areas in the Plan and will be progressed across the lifespan of the Plan. The decommissioning and reinvestment will enable increased delivery of services in the community and closer to home; a reduction in unnecessary occupation of costly hospital beds for prolonged periods; a greater focus on rehabilitation and recovery; and a balance of services across the care continuum.

As part of the reinvestment, new services may include a combination of inpatient services; in-home services; community bed-based services; and community support (accommodation options). Funding of $3 million has been allocated to the DoH to undertake detailed planning for the decommissioning and reconfiguration of mental health services, and progression of divestment activities at these sites.

Forensic accommodation

The Commission has identified the establishment of dedicated youth forensic mental health beds as a priority, and is working closely with HSPs, the DoH and the Department of Justice to identify short to medium term options for the establishment of appropriate infrastructure and beds for this service. The additional beds will also be considered as part of the Graylands divestment process. As an interim measure, the Commission is working with HSPs to improve prison in-reach service delivery, noting the prioritisation in forensic mental health services is for youth. Additionally, during the 2019 election, the Federal Government committed $14.8 million in funding for a new, dedicated 10-bed forensic mental health unit for young people in Western Australia.

National Disability Insurance Scheme

The Commission is actively working with State and Commonwealth agencies to assist people with psychosocial disability transition from State funded mental health programs into the National Disability Insurance Scheme (NDIS). This includes contributing as a member on a range of different committees to ensure the rights and interests of people with a mental illness are supported and upheld. As part of this work, the Commission is also mindful that many people with psychosocial disability may not be eligible for the NDIS and is committed to ensuring those individuals are able to access the services they require into the future.

The Bilateral Agreement between the State and Commonwealth Governments identified four Commission programs with ’in-kind’ arrangements. The Commission is continuing to monitor and fund these programs until people have had the opportunity to transition into the NDIS. The Commission is working with the relevant service providers and government agencies to help make the transition as smooth as possible.

Disclosures and Legal Compliance

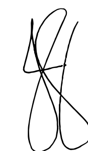
Certification of Financial Statements

The accompanying financial statements of the Mental Health Commission have been prepared in compliance with 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 2019 and the financial position as at 30 June 2019.

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.

Les Bechelli, FCPA
Chief Financial Officer
Mental Health Commission

17 September 2019



Jennifer McGrath
Accountable Authority
Mental Health Commission

17 September 2019

Financial Statements

Mental Health Commission
Statement of Comprehensive Income
For the year ended 30 June 2019

	Notes	2019 $	2018 $
COST OF SERVICES			
Expenses			
Employee benefits expenses	3.1 (a)	34,742,708	37,120,240
Service agreement - WA Health	3.2	718,408,681	702,194,456
Service agreement - non government and other organisations	3.2	140,961,106	137,877,380
Supplies and services	3.4	10,564,372	9,553,414
Grants and subsidies	3.3	8,055,428	2,486,286
Depreciation expense	5.1.1	469,347	493,554
Accommodation expense	3.4	2,441,182	2,467,396
Other expenses	3.4	2,177,626	2,716,637
Total cost of services		**917,820,450**	**894,909,363**
Income			
Revenue			
Commonwealth grants and contributions	4.2	197,811,461	193,249,500
Other grants and contributions	4.2	4,893,361	4,799,349
Other revenue	4.3	381,520	367,564
Total revenue		**203,086,342**	**198,416,413**
Total income other than income from State Government		**203,086,342**	**198,416,413**
NET COST OF SERVICES		**714,734,108**	**696,492,950**
Income from State Government			
Service appropriation	4.1	698,281,000	696,654,964
Services received free of charge	4.1	3,008,527	3,428,198
Royalties for Regions Fund	4.1	3,109,000	6,613,000
Total income from State Government		**704,398,527**	**706,696,162**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(10,335,581)**	**10,203,212**
OTHER COMPREHENSIVE INCOME		-	-
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(10,335,581)**	**10,203,212**

See also the 'Schedule of Income and Expenses by Service'.
The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

Mental Health Commission
Statement of Financial Position
As at 30 June 2019

	Notes	2019 $	2018 $
ASSETS			
Current Assets			
Cash and cash equivalents	7.1.1	23,894,996	32,614,649
Restricted cash and cash equivalents	7.1.1	4,919,808	6,490,296
Receivables	6.1	306,302	603,832
Inventories	6.3	20,098	24,358
Other current assets	6.4	173,369	20,565
Non-current assets classified as held for sale	9.8	4,293,700	-
Total Current Assets		**33,608,273**	**39,753,700**
Non-Current Assets			
Restricted cash and cash equivalents	7.1.1	349,920	228,720
Amounts receivable for services	6.2	6,168,123	5,827,123
Property, plant and equipment	5.1	16,824,366	21,602,391
Total Non-Current Assets		**23,342,409**	**27,658,234**
TOTAL ASSETS		**56,950,682**	**67,411,934**
LIABILITIES			
Current Liabilities			
Payables	6.5	2,136,799	2,464,762
Employee benefits provisions	3.1 (b)	5,600,117	5,126,438
Total Current Liabilities		**7,736,916**	**7,591,200**
Non-Current Liabilities			
Employee benefits provisions	3.1 (b)	1,943,626	2,193,078
Total Non-Current Liabilities		**1,943,626**	**2,193,078**
TOTAL LIABILITIES		**9,680,542**	**9,784,278**
NET ASSETS		**47,270,140**	**57,627,656**
EQUITY			
Contributed equity	9.11	32,135,558	32,135,558
Accumulated surplus	9.11	15,134,582	25,492,098
TOTAL EQUITY		**47,270,140**	**57,627,656**

See also the 'Schedule of Assets and Liabilities by Service'.
The Statement of Financial Position should be read in conjunction with the accompanying notes.

Mental Health Commission
Statement of Changes in Equity
For the year ended 30 June 2019

	Notes	2019 $	2018 $
CONTRIBUTED EQUITY	9.11		
Balance at start of period		32,135,558	32,135,558
Transactions with owners in their capacity as owners		-	-
Balance at end of period		32,135,558	32,135,558
ACCUMULATED SURPLUS	9.11		
Balance at start of period		25,492,098	15,288,886
Changes in accounting policy or correction of prior period errors		(21,935)	-
Restated balance at start of period		25,470,163	15,288,886
Surplus/(deficit) for the period		(10,335,581)	10,203,212
Balance at end of period		15,134,582	25,492,098
TOTAL EQUITY	9.11		
Balance at start of period		57,627,656	47,424,444
Total comprehensive income/(loss) for the period		(10,335,581)	10,203,212
Transactions with owners in their capacity as owners		-	-
Changes in accounting policy or correction of prior period errors		(21,935)	-
Balance at end of period		**47,270,140**	**57,627,656**

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

Mental Health Commission
Statement of Cash Flows
For the year ended 30 June 2019

	Notes	2019 $ Inflows (Outflows)	2018 $ Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		697,940,000	696,313,964
Royalties for Regions Fund - Recurrent		3,109,000	6,613,000
Net cash provided by State Government		**701,049,000**	**702,926,964**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits expenses		(34,807,595)	(36,799,975)
Service agreement - WA Health		(718,416,824)	(702,194,456)
Service agreement - non government and other organisations		(141,293,516)	(138,381,292)
Supplies and services		(7,806,468)	(7,530,375)
Grants and subsidies		(8,111,263)	(2,453,382)
Accommodation expense		(2,429,064)	(2,651,087)
Other payments		(1,805,004)	(2,294,987)
Receipts			
Commonwealth grants and contributions		197,811,461	193,249,500
Other grants and contributions		4,893,361	4,799,349
Other receipts		767,506	59,343
Net cash used in operating activities	7.1.2	**(711,197,406)**	**(694,197,362)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets		(20,535)	(153,000)
Net cash used in investing activities		**(20,535)**	**(153,000)**
Net increase / (decrease) in cash and cash equivalents		(10,168,941)	8,576,602
Cash and cash equivalents at the beginning of the period		39,333,665	30,757,063
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.1.1	**29,164,724**	**39,333,665**

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

Mental Health Commission
Summary of Consolidated Account Appropriations and Income Estimates
For the year ended 30 June 2019

	2019 Estimate $	2019 Actual $	Variance $	2019 Actual $	2018 Actual $	Variance $
Delivery of Services						
Item 50 Net amount appropriated to deliver services	706,647,000	697,472,000	(9,175,000)	697,472,000	695,845,964	1,626,036
Amount Authorised by Other Statutes						
- *Salaries and Allowances Act 1975*	809,000	809,000	-	809,000	809,000	-
Total appropriations provided to deliver services	707,456,000	698,281,000	(9,175,000)	698,281,000	696,654,964	1,626,036
Administered Transactions						
Administered grants, subsidies and other transfer payments	8,287,000	8,475,000	188,000	8,475,000	8,230,000	245,000
Total administered transactions	8,287,000	8,475,000	188,000	8,475,000	8,230,000	245,000
GRAND TOTAL	715,743,000	706,756,000	(8,987,000)	706,756,000	704,884,964	1,871,036
Details of Expenses by Service						
Prevention	17,899,000	14,593,346	(3,305,654)	14,593,346	20,493,423	(5,900,077)
Hospital Bed Based Services	390,076,000	393,653,191	3,577,191	393,653,191	381,410,370	12,242,821
Community Bed Based Services	56,905,000	56,354,175	(550,825)	56,354,175	48,504,089	7,850,086
Community Treatment	405,358,000	404,483,472	(874,528)	404,483,472	399,666,521	4,816,951
Community Support	48,165,000	48,736,266	571,266	48,736,266	44,834,960	3,901,306
Total Cost of Services	918,403,000	917,820,450	(582,550)	917,820,450	894,909,363	22,911,087
Less Total income	(192,979,000)	(203,086,342)	(10,107,342)	(203,086,342)	(198,416,413)	(4,669,929)
Net Cost of Services	725,424,000	714,734,108	(10,689,892)	714,734,108	696,492,950	18,241,158
Adjustments (a)	(17,968,000)	(16,453,108)	1,514,892	(16,453,108)	162,014	(16,615,122)
Total appropriations provided to deliver services	707,456,000	698,281,000	(9,175,000)	698,281,000	696,654,964	1,626,036
Details of Income Estimates						
Income disclosed as Administered Income	9,355,000	9,577,362	222,362	9,577,362	9,415,449	161,913
	9,355,000	9,577,362	222,362	9,577,362	9,415,449	161,913

(a) Adjustments comprise resources received free of charge, Royalities for Regions fund, movements in cash balances and other accrual items such as receivables, payables and superannuation.

Note 9.13 'Explanatory statement' and note 10.3 'Explanatory statement for Administered Items' provide details of any significant variations between estimates and actual results for 2019 and between actual results for 2019 and 2018.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

1. Basis of preparation

The Commission is a WA Government entity and is controlled by the State of Western Australia, which is the ultimate parent. The Commission is a not-for-profit entity (as profit is not its principal objective) and it has no cash generating units.

Statement of compliance

These general purpose financial statements have been prepared in accordance with:
1) The Financial Management Act 2006 **(FMA)**
2) The Treasurer's Instructions **(the Instructions or TI)**
3) Australian Accounting Standards **(AAS)** including applicable interpretations
4) Where appropriate, those **AAS** paragraphs applicable for not for profit entities have been applied.

The Financial Management Act 2006 and the Treasurer's Instructions (the Instructions) take precedence over AAS. Several AAS are modified by the Instructions to vary application, disclosure format and wording. 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.

Basis of preparation

These financial statements are presented in Australian dollars applying the accrual basis of accounting and using the historical cost convention. Certain balances will apply a different measurement basis (such as the fair value basis). Where this is the case the different measurement basis is disclosed in the associated note. All values are rounded to the nearest thousand dollar ($).

Judgements and estimates

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements and estimates made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements and/or estimates are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances.

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 TI 955 Contributions by Owners made to Wholly Owned Public Sector Entities and have been credited directly to Contributed Equity.

The transfers 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.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

2. The Commission outputs

How the Commission operates

This section includes information regarding the nature of funding the Commission receives and how this funding is utilised to achieve the Commission's objectives. This note also provides the distinction between controlled funding and administered funding:

	Note
The Commission objectives	2.1
Schedule of Income and Expenses by Service	2.2
Schedule of Assets and Liabilities by Service	2.3

2.1 The Commission objectives

Mission

To be an effective leader of alcohol, drug and mental health commissioning, providing and partnering in the delivery of person-centred and evidence-based:

* Prevention, promotion and early intervention programs;
* Treatment, services and supports; and
* Research, policy and system improvements.

The Commission is predominantly funded by Parliamentary appropriations and Commonwealth Grants and Contributions.

Services

The Commission is responsible for purchasing mental health services, alcohol and other drug 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.

Prevention

Prevention and promotion in the mental health and alcohol and other drug sectors include activities to promote positive mental health, raise awareness of mental illness, suicide prevention, and the potential harms of alcohol and other drug use in the community.

Hospital Bed Based Services

Hospital bed based services include acute and sub-acute inpatient units, mental health observation areas and hospital in the home.

Community Bed Based Services

Community bed based services are focused on providing recovery-oriented services and residential rehabilitation in a home-like environment.

Community Treatment

Community treatment provides clinical care in the community for individuals with mental health, alcohol and other drug problems. These services generally operate with multidisciplinary teams, and include specialised and forensic community clinical services.

Community Support

Community support services provide individuals with mental health, alcohol and other drug problems access to the help and support they need to participate in their community. These services include peer support, home in-reach, respite, recovery and harm reduction programs.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

2.2 Schedule of Income and Expenses by Service

	Prevention		Hospital Bed Based Services		Community Bed Based Services		Community Treatment		Community Support		Total	
	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018
	$	$	$	$	$	$	$	$	$	$	$	$
COST OF SERVICES												
Expenses												
Employee benefits expenses	552,409	850,054	14,901,148	15,820,646	2,133,202	2,011,917	15,311,111	16,577,899	1,844,838	1,859,724	34,742,708	37,120,240
Service agreement - WA Health	11,422,698	16,080,253	308,125,483	299,275,277	44,110,293	38,058,940	316,602,706	313,600,044	38,147,501	35,179,942	718,408,681	702,194,456
Service agreement - non government and other organisations	2,241,282	3,157,392	60,458,218	58,763,339	8,655,012	7,472,954	62,121,559	61,576,038	7,485,035	6,907,657	140,961,106	137,877,380
Supplies and services	167,974	218,773	4,531,059	4,071,665	648,652	517,795	4,655,719	4,266,555	560,968	478,626	10,564,372	9,553,414
Grants and subsidies	128,081	56,936	3,454,973	1,059,655	494,603	134,757	3,550,027	1,110,375	427,743	124,563	8,055,428	2,486,286
Depreciation expense	7,463	11,302	201,303	210,353	28,818	26,751	206,841	220,421	24,922	24,727	469,347	493,554
Accommodation expense	38,815	56,503	1,047,023	1,051,604	149,889	133,733	1,075,829	1,101,939	129,627	123,617	2,441,182	2,467,396
Other expenses	34,624	62,210	933,984	1,157,831	133,706	147,242	959,680	1,213,250	115,632	136,104	2,177,626	2,716,637
Total cost of services	14,593,346	20,493,423	393,653,191	381,410,370	56,354,175	48,504,089	404,483,472	399,666,521	48,736,266	44,834,960	917,820,450	894,909,363
Income												
Commonwealth grants and contributions	-	181,000	114,840,222	114,705,577	-	-	82,971,239	78,362,923	-	-	197,811,461	193,249,500
Other grants and contributions	2,261,766	2,235,201	128,234	100,000	3,684	-	2,496,491	2,464,148	3,186	-	4,893,361	4,799,349
Other revenue	6,066	8,417	163,634	156,656	23,425	19,922	168,136	164,154	20,259	18,415	381,520	367,564
Total income other than income from State Government	2,267,832	2,424,618	115,132,090	114,962,233	27,109	19,922	85,635,866	80,991,225	23,445	18,415	203,086,342	198,416,413
NET COST OF SERVICES	12,325,514	18,068,805	278,521,101	266,448,137	56,327,066	48,484,167	318,847,606	318,675,296	48,712,821	44,816,545	714,734,108	696,492,950
Income from State Government												
Service appropriation	11,980,343	17,877,531	272,797,813	269,250,408	52,711,737	48,840,533	312,786,858	316,218,539	48,004,249	44,467,953	698,281,000	696,654,964
Services received free of charge	47,836	78,506	1,290,357	1,461,098	184,724	185,808	1,325,857	1,531,033	159,753	171,753	3,008,527	3,428,198
Royalties for Regions Fund	133,000	346,422	-	85,240	2,796,000	10,840	180,000	5,482,478	-	688,020	3,109,000	6,613,000
Total income from State Government	12,161,179	18,302,459	274,088,170	270,796,746	55,692,461	49,037,181	314,292,715	323,232,050	48,164,002	45,327,726	704,398,527	706,696,162
SURPLUS/(DEFICIT) FOR THE PERIOD	(164,335)	233,654	(4,432,931)	4,348,609	(634,605)	553,014	(4,554,891)	4,556,754	(548,819)	511,181	(10,335,581)	10,203,212

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

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

2.3 Schedule of Assets and Liabilities by Service

	Prevention		Hospital Bed Based Services		Community Bed Based Services		Community Treatment		Community Support		Total	
	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018
	$	$	$	$	$	$	$	$	$	$	$	$
ASSETS												
Current assets	534,372	910,360	14,414,588	16,943,027	2,063,548	2,154,651	14,811,166	17,754,002	1,784,599	1,991,660	33,608,273	39,753,700
Non-current assets	371,144	633,374	10,011,559	11,787,939	1,433,224	1,499,076	10,287,000	12,352,167	1,239,482	1,385,678	23,342,409	27,658,234
Total Assets	905,516	1,543,734	24,426,147	28,730,966	3,496,772	3,653,727	25,098,166	30,106,169	3,024,081	3,377,338	56,950,682	67,411,934
LIABILITIES												
Current liabilities	123,017	173,839	3,318,363	3,235,369	475,047	411,443	3,409,659	3,390,230	410,830	380,319	7,736,916	7,591,200
Non-current liabilities	30,904	50,221	833,621	934,690	119,338	118,865	856,556	979,429	103,207	109,873	1,943,626	2,193,078
Total Liabilities	153,921	224,060	4,151,984	4,170,059	594,385	530,308	4,266,215	4,369,659	514,037	490,192	9,680,542	9,784,278
NET ASSETS	751,595	1,319,674	20,274,163	24,560,907	2,902,387	3,123,419	20,831,951	25,736,510	2,510,044	2,887,146	47,270,140	57,627,656

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

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

3. Use of our funding

Expenses incurred in the delivery of services

This section provides additional information about how the Commission's funding is applied and the accounting policies that are relevant for an understanding of the items recognised in the financial statements. The primary expenses incurred by the Commission in achieving its objectives and the relevant notes are:

	Notes	2019 $	2018 $
Employee benefits expenses	3.1(a)	34,742,708	37,120,240
Employee benefits provisions	3.1(b)	7,543,743	7,319,516
Service agreements	3.2	859,369,787	840,071,836
Grants and subsidies	3.3	8,055,428	2,486,286
Other expenses	3.4	15,183,180	14,737,447

3.1(a) Employee benefits expenses

	2019	2018
Wages and salaries	31,660,456	33,099,367
Termination benefits	-	848,943
Superannuation - defined contribution plans (a)	3,082,252	3,171,930
Total employee benefits expenses	**34,742,708**	**37,120,240**

(a) Defined contribution plans include West State, Gold State and GESB Super and other eligible funds. Super contribution paid to GESB for West State, Gold State and GESB Super is $2,681,380 (2017-18 $2,828,978).

Wages and salaries: Employee expenses include all costs related to employment including wages and salaries, fringe benefits tax and leave entitlements.

Termination benefits: Payable when employment is terminated before normal retirement date, or when an employee accepts an offer of benefits in exchange for the termination of employment. Termination benefits are recognised when the Commission is demonstrably committed to terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

Superannuation: The amount recognised in profit or loss of the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, the GESBs, or other superannuation funds. The employer contribution paid to the Government Employees Superannuation Board (GESB) in respect of the GSS is paid back into the Consolidated Account by the GESB.

GSS (concurrent contributions) is a defined benefit scheme for the purposes of employees and whole of government reporting. It is however a defined contribution plan for the Commission 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 does not recognise any defined benefit liabilities because it has no legal or constructive obligation to pay future benefits relating to its employees. 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 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.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

3.1(b) Employee benefits provisions

Provision is made for benefits accruing to employees in respect of wages and salaries, annual leave and long service leave for services rendered up to the reporting date and recorded as an expense during the period the services are delivered.

	2019	2018
Current	**$**	**$**
Employee benefits provision		
Annual leave (a)	2,806,488	2,504,505
Long service leave (b)	2,718,771	2,445,484
Deferred salary scheme (c)	74,858	176,449
Total current employee benefits provisions	**5,600,117**	**5,126,438**
Non-current		
Employee benefits provision		
Long service leave (b)	1,943,626	2,193,078
Total employee benefits provisions	**7,543,743**	**7,319,516**

(a) **Annual leave liabilities:** 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:

	2019	2018
Within 12 months of the end of the reporting period	1,976,317	1,772,717
More than 12 months after the end of the reporting period	830,171	731,788
	2,806,488	2,504,505

The provision for annual leave is calculated at the present value of expected payments to be made in relation to services provided by employees up to the reporting date.

(b) **Long service leave liabilities:** 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. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

	2019	2018
Within 12 months of the end of the reporting period	677,818	613,226
More than 12 months after the end of the reporting period	3,984,579	4,025,336
	4,662,397	4,638,562

The components of the long service leave liabilities are calculated at present value as the Commission does not expect to wholly settle the amounts within 12 months. The present value is measured taking into account the present value of expected future payments to be made in relation to services provided by employees up to the reporting date. These payments are estimated using the remuneration rate expected to apply at the time of settlement, 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.

(c) **Deferred salary scheme liabilities:** Classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Actual settlement of the liabilities is expected to occur as follows:

	2019	2018
Within 12 months of the end of the reporting period	-	78,826
More than 12 months after the end of the reporting period	74,858	97,623
	74,858	176,449

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

3.1(b) Employee benefits provisions (cont.)

Key sources of estimation uncertainty – long service leave

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.

Several estimates and assumptions are used in calculating the Commission's long service leave provision. These 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.

In estimating the non-current long service leave liabilities, employees are assumed to leave the Commission each year on account of resignation or retirement at 7.4%. This assumption was based on an analysis of the historical turnover rates exhibited by employees in the WA health services including the Commission. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

Any gain or loss following revaluation of the present value of long service leave liabilities is recognised as employee benefits expense.

3.2 Service agreements	**2019 $**	**2018 $**
Service agreement - WA Health		
East Metropolitan Health Service	179,086,863	170,698,132
North Metropolitan Health Service	239,227,614	242,582,489
South Metropolitan Health Service	122,908,633	121,661,508
Child and Adolescent Health Service	62,391,473	60,216,879
WA Country Health Service	114,496,802	107,035,448
Department of Health	297,296	-
Total service agreement - WA Health	**718,408,681**	**702,194,456**

Metropolitan Health Service is abolished on 1 July 2016 and established 5 Health Services Providers including Health Support Services due to proclamation of Health Services Act 2016. WA Health comprises the Department of Health, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service, Health Support Services and WA Country Health Service. Under the Commission Service Agreements, public hospitals in WA Health provide specialised mental health services to the public patients and the community.

Service agreement - non government and other organisations		
Non-government and other organisations	140,961,106	137,877,380

Non-government and other organisations are contracted to provide specialised mental health, alcohol and other drug services to the community.

Total service agreements	**859,369,787**	**840,071,836**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

	2019	2018
3.3 Grants and subsidies	**$**	**$**
Recurrent		
Suicide Prevention Strategy	-	997,281
Prevention and Anti-Stigma	100,000	200,000
Crisis Accommodation Support	-	447,807
Ice Breaker Program	180,000	-
Community Living Support	1,200,000	-
Other grants	1,336,295	841,198
Total recurrent grants and subsidies	**2,816,295**	**2,486,286**
Capital		
Bunbury step-up step-down	2,367,000	-
Karratha step-up step-down	1,592,000	-
Kalgoorlie step-up step-down	1,280,133	-
Total capital grants and subsidies	**5,239,133**	**-**
Total grants and subsidies	**8,055,428**	**2,486,286**

Grants and subsidies include payment to Department of Education $0, (2017-18 $327,000) and Department of Communities $6,439,133 (2017-18 $494,802) including capital grants $5,239,133 for the construction of the mental health step-up step down facilities. The Department of Communities will have the ownership of facilities and the Commission will deliver mental health services in partnership with non-government and other organisations via service.

Transactions in which the Commission provides goods, services, assets (or extinguishes a liability) or labour to another party without receiving approximately equal value in return are categorised as ‘Grant expenses’. Grants can either be operating or capital in nature.

Grants can be paid as general purpose grants which refer to grants that are not subject to conditions regarding their use. Alternatively, they may be paid as specific purpose grants which are paid for a particular purpose and/or have conditions attached regarding their use.

Grants and other transfers to third parties (other than contribution to owners) are recognised as an expense in the reporting period in which they are paid or payable. They include transactions such as: grants, subsidies, personal benefit payments made in cash to individuals, other transfer payments made to public sector agencies, local government, non-government schools, and community groups.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

		2019	2018
3.4	**Other expenses**	**$**	**$**
	Supplies and services		
	Specific project expenses - other government organisations (a)	448,928	441,132
	Purchase of outsourced services (b) (c)	4,963,015	3,430,078
	Corporate support services (d)	2,951,365	3,291,064
	Computer related services	129,542	290,444
	Consulting fees (a) (b) (c)	1,020,840	1,059,312
	Consumables	400,641	453,418
	Communications (b)	262,054	283,057
	Printing and Stationery	330,074	265,203
	Other	57,913	39,706
	Total supplies and services	**10,564,372**	**9,553,414**
	Accommodation expense		
	Office accommodation expenses	**2,441,182**	**2,467,396**
	Other expenditures		
	Workers' compensation insurance (a)	141,496	480,467
	Other employee related expenses	356,787	366,354
	Consumable equipment, repairs and maintenance (b) (g)	496,679	414,458
	Loss on revaluation of land	25,700	174,900
	Loss on revaluation of buildings	9,813	155,427
	Travel related expenses (c)	68,047	158,907
	Audit fees (d)	360,540	338,971
	Legal fees (e)	55,649	116,055
	Administration (f)	413,017	162,456
	Advertising	6,868	25,353
	Other insurance (a)	104,282	100,008
	Other (b) (h) (i)	138,748	223,281
	Total other expenditures	**2,177,626**	**2,716,637**
	Total other expenses	**15,183,180**	**14,737,447**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

3.4 Other expenses (cont.)

Supplies and services:
Supplies and services are recognised as an expense in the reporting period in which they are incurred.

(a) Department of Justice $448,928 has been reclassified as specific project expenses (2017-18 $441,132) and $2,386 as consulting fees (2017-18 $0).
(b) Department of Finance $8,266 has been reclassified as communications (2017-18 $1,789 as purchase of outsourced services and $8,895 communications).
(c) Department of Health $0 has been reclassified as consulting fees (2017-18 $21,152) and $37,033 as purchase of outsourced services (2017-18 $5,372).
(d) Health Support Services has provided supply services, IT services, human resource services, finance services to the Commission. Service provided is inclusive free of charge $2,951,365 (2017-18 $3,291,064).

Accommodation expense:
Operating lease payments are recognised on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset. Expenses include Department of Finance $2,295,434 (2017-18 $2,323,471) inclusive of services provided free of charge $12,125 (2017-18 $37,039) and Department of Lands $7,500 (2017-18 $10,000).

Other expenditures:
Other expenditures generally represent the day-to-day running costs incurred in normal operations.

(a) Include expense to Riskcover, $141,946 has been classified as workers' compensation insurance and $102,802 as other insurance (2017-18 $480,467 workers' compensation insurance and $102,222 other insurance).
(b) Include expense to Department of Finance, $188,715 has been classified as consumable equipment, repairs and maintenance (2017-18 $99,656).
(c) Include expense to Statefleet $61,622 (2017-18 $69,488) and State Solicitor's Office $0 (2017-18 $2,853).
(d) Include expense to Office of the Auditor General $205,999 (2017-18 $189,300).
(e) Include expense to Department of Justice - State Solicitor's Office $52,327 (2017-18 $102,475) inclusive of resources received free of charge and Department of Finance $1,390 (2017-18 $1,289).
(f) Include expense to Department of Training and Workforce Development of $0 (2017-18 $5,632).
(g) Include expense to Department of Fire and Emergency $6,622 (2017-18 $6,524).
(h) Include expense to Department of Treasury $0 (2017-18 $94,656).
(i) Include expense to WA Police $89,367 (2017-18 $0).

From 2018-19, **expected credit losses expense** is recognised as the movement in the allowance for expected credit losses. The Commission does not have a expected credit loss expense in 2018-19. The allowance for expected credit losses of trade receivables is measured at the lifetime expected credit losses at each reporting date. The Commission has established a provision matrix that is based on its historical credit loss experience, adjusted for forward-looking factors specific to the debtors and the economic environment. Refer to note 6.1.1 Movement in the allowance for impairment of receivables. Expected credit losses were not required to be measured in 2017-18.

Consumable equipment, repairs and maintenance costs are recognised as expenses as incurred, except where they relate to the replacement of a significant component of an asset. In that case, the costs are capitalised and depreciated.

Loss on revaluation of land and buildings recognised as an expense as no revaluation surplus exist in previous years.

The employment on-costs include **workers' compensation insurance** only. Any on-costs liability associated with the recognition of annual and long service leave liability is included at Note 3.1(b) Employee benefit provision. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

4. Our funding sources

How we obtain our funding

This section provides additional information about how the Commission obtains its funding and the relevant accounting policy notes that govern the recognition and measurement of this funding. The primary income received by the Commission and the relevant notes are:

	Notes	2019 $	2018 $
Income from State Government	4.1	704,398,527	706,696,162
Grants and contribution	4.2	202,704,822	198,048,849
Other revenue	4.3	381,520	367,564

4.1 Income from State Government

	2019	2018
Service appropriation received during the period:		
Amount appropriated to deliver services	697,472,000	695,845,964
Amount authorised by other statutes:		
Salaries and Allowances Act 1975	809,000	809,000
	698,281,000	**696,654,964**
Services received free of charge from other State government agencies during the period:		
State Solicitor's Office - legal advisory services	45,037	100,095
Department of Finance - office accommodation leasing services	12,125	37,039
Health Support Services (a)	2,951,365	3,291,064
Total services received	**3,008,527**	**3,428,198**

(a) Metropolitan Health Service is abolished on 1 July 2016 and established 5 Health Services Providers including Health Support Services. Health Support Services has provided (previously within Metropolitan Health Service) supply services, IT services, human resource services, finance services to the Commission since 2010.

	2019	2018
Royalties for Regions Fund		
Regional Community Services Account	**3,109,000**	**6,613,000**
Total income from State Government	**704,398,527**	**706,696,162**

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 in the bank account or credited to the Amounts receivable for services' (holding account) held at Treasury.

Service appropriations fund the net cost of services delivered (as set out in note 2.2). Appropriation revenue comprises the following:

* Cash component; and
* A receivable (asset).

The receivable (holding account – note 6.2) comprises the following:

* The budgeted depreciation expense for the year; and
* Any agreed increase in leave liabilities during the year.

Regional Community Services Account is sub-fund within the over-arching 'Royalties for Regions Fund'. The recurrent funds are committed to projects and programs in WA regional areas and are recognised as revenue when the Commission gains control on receipt of the funds.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

		2019	2018
4.2	**Grants and contribution**	**$**	**$**
	Commonwealth grants and contributions		
	National Health Reform Agreement (a)	197,607,461	193,068,500
	Indigenous Advancement Strategy	-	181,000
	Specialist Dementia Care Program	204,000	-
	Total commonwealth grants and contributions	**197,811,461**	**193,249,500**

(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 (health services) 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.

	2019	2018
Other grants and contributions		
Department of Health	475,580	492,842
WA Country Health Service	1,129,745	1,129,745
Department for Communities	706,000	706,000
Department of Education	157,884	156,585
WA Police	1,357,000	1,376,000
Healthway	748,522	838,177
Other	318,630	100,000
Total other grants and contributions	**4,893,361**	**4,799,349**
Total grant income	**202,704,822**	**198,048,849**

For **non-reciprocal grants**, the Commission recognises revenue when the grant is receivable at its fair value as and when its fair value can be reliably measured.
Contributions of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

		2019	2018
4.3	**Other revenue**		
	Refund of prior year's payment on contract for services (a)	166,483	99,698
	Interest revenue	101,233	95,932
	Services to external organisations	80,015	131,171
	Other revenue	33,789	40,763
	Total other revenue	**381,520**	**367,564**

(a) Refunds were received from non-government organisations in 2018/19 and 2017/18, as the funds paid in prior year were in excess of the requirement.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

5. Key assets

Assets the Commission utilises for economic benefit or service potential

This section includes information regarding the key assets the Commission utilises to gain economic benefits or provide service potential. The section sets out both the key accounting policies and financial information about the performance of these assets:

	Notes	2019 $	2018 $
Property, plant and equipment	5.1	16,824,366	21,602,391
Depreciation expense	5.1.1	469,347	493,554

5.1 Property, plant and equipment

	2019	2018
Land		
Carrying amount at start of period (fair value)	**8,507,000**	**8,681,900**
Revaluation increments / (decrements)	(25,700)	(174,900)
Classified as held for sale	(3,260,000)	-
Carrying amount at end of period	**5,221,300**	**8,507,000**
Buildings		
Carrying amount at start of period (fair value)	**12,712,423**	**13,288,100**
Revaluation increments / (decrements)	(9,813)	(155,427)
Depreciation	(413,609)	(420,250)
Classified as held for sale	(1,033,700)	-
Carrying amount at end of period	**11,255,301**	**12,712,423**
Computer equipment		
Gross carrying amount	49,886	49,886
Accumulated depreciation	(49,886)	(33,257)
Carrying amount at start of period	**-**	**16,629**
Depreciation	-	(16,629)
Carrying amount at end of period	**-**	**-**
Medical equipment		
Gross carrying amount	167,819	167,819
Accumulated depreciation	(28,618)	(3,293)
Carrying amount at start of period	**139,201**	**164,526**
Depreciation	(23,504)	(25,325)
Carrying amount at end of period	**115,697**	**139,201**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

	2019	2018
5.1 Property, plant and equipment (cont.)	**$**	**$**
Other plant and equipment		
Gross carrying amount	310,623	310,623
Accumulated depreciation	(78,856)	(47,506)
Carrying amount at the start of year	**231,767**	**263,117**
Additions	14,535	-
Depreciation	(32,234)	(31,350)
Carrying amount at the end of year	**214,068**	**231,767**
Artworks		
Gross carrying amount	12,000	12,000
Carrying amount at the start of year	**12,000**	**12,000**
Additions	6,000	-
Carrying amount at the end of year	**18,000**	**12,000**
Total property, plant and equipment		
Gross carrying amount	21,759,751	22,510,328
Accumulated depreciation	(157,360)	(84,056)
Carrying amount at the start of year	**21,602,391**	**22,426,272**
Additions	20,535	-
Revaluation increments/(decrements)	(35,513)	(330,327)
Depreciation	(469,347)	(493,554)
Classified as held for sale	(4,293,700)	-
Carrying amount at the end of year	**16,824,366**	**21,602,391**

Initial recognition

Items of property, plant and equipment, costing $5,000 or more are measured initially at cost. Where an asset is acquired for no or nominal cost, the cost is valued at its fair value at the date of acquisition. Items of property, 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).

The initial cost for a non-financial physical asset under a finance lease is measured at amounts equal to the fair value of the leased asset or, if lower, the present value of the minimum lease payments, each determined at the inception of the lease.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

5.1 Property, plant and equipment (cont.)

Subsequent measurement

Subsequent to initial recognition of an asset, the revaluation model is used for the measurement of land and buildings.

Land and buildings are carried at fair value less accumulated depreciation (buildings) and accumulated impairment losses. All other property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Land and buildings are independently valued annually by the Western Australian Land Information Authority (Valuations and Property Analytics) and recognised annually to ensure that the carrying amount does not differ materially from the asset's fair value at the end of the reporting period.

Land and buildings were revalued as at 1 July 2018 by the Western Australian Land Information Authority (Valuations and Property Analytics).The valuations were performed during the year ended 30 June 2019 and recognised at 30 June 2019. In undertaking the revaluation, fair value was determined by reference to market values for land: $630,000 (2017-18 $639,000) and buildings $1,066,000 (2017-18 $1,091,000). For the remaining balance, fair value of buildings was determined on the basis of depreciated replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

Revaluation model:

(a) Fair Value where market-based evidence is available:

The fair value of land and buildings (non-clinical sites) is determined on the basis of current market values determined by reference to recent market transactions. When buildings are revalued by reference to recent market transactions, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

(b) Fair value in the absence of market-based evidence:

Buildings are specialised or where land is restricted: Fair value of land, buildings (clinical sites) is determined on the basis of existing use.

Existing use buildings: Fair value is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the depreciated replacement cost. When buildings are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

Restricted use land: Fair value is determined by comparison with market evidence for land with similar approximate utility (high restricted use land) or market value of comparable unrestricted land (low restricted use land).

Significant assumptions and judgements: The most significant assumptions and judgements in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated economic life. Professional judgement by the valuer is required where the evidence does not provide a clear distinction between market type assets and existing use assets.

	2019	**2018**
5.1.1 Depreciation expense	**$**	**$**
Buildings	413,609	420,250
Computer equipment	-	16,629
Medical equipment	23,504	25,325
Other plant and equipment	32,234	31,350
Total depreciation expense for the period	**469,347**	**493,554**

As at 30 June 2019 there were no indications of impairment to property, plant and equipment.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

5.1 Property, plant and equipment (cont.)

5.1.1 Depreciation expense (cont.)

Finite useful lives

All property, plant and equipment 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. The exceptions to this rule include assets held for sale, land and investment properties.

Depreciation is calculated on a straight line basis, at rates that allocate the asset's value, less any estimated residual value, over its estimated useful life. Typical estimated useful lives for the different asset classes for current and prior years are below:

Buildings	21 to 50 years
Computer equipment	4 years
Furniture and fittings	10 to 20 years
Medical equipment	10 years
Other plant and equipment	5 to 10 years

The estimated useful lives and residual values are reviewed at the end of each annual reporting period, and adjustments should be made where appropriate.

Land and works of art, which are considered to have an indefinite life, are not depreciated. Depreciation is not recognised in respect of these assets because their service potential has not, in any material sense, been consumed during the reporting period.

Impairment

There were no indications of impairment to property, plant and equipment at 30 June 2019. The Commission held no goodwill during the reporting period.

Non-financial assets, including items of plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired. 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 its recoverable amount, an impairment loss is recognised through profit or loss. Where a previously revalued asset is written down to its recoverable amount, the loss is recognised as a revaluation decrement through other comprehensive income.

As the Commission is a not-for-profit agency, the recoverable amount of regularly revalued specialised assets is anticipated to be materially the same as fair value.

If there is an indication that there has been a reversal in impairment, the carrying amount shall be increased to its recoverable amount. However this reversal should not increase the asset's carrying amount above what would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised in prior years.

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 the asset's future economic benefits and to evaluate any impairment risk from declining replacement costs.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

6. Other assets and liabilities

This section sets out those assets and liabilities that arose from the Commission's controlled operations and includes other assets utilised for economic benefits and liabilities incurred during normal operations:

	Notes	2019 $	2018 $
Receivables	6.1	306,302	603,832
Amounts receivable for services	6.2	6,168,123	5,827,123
Inventories	6.3	20,098	24,358
Other current assets	6.4	173,369	20,565
Payables	6.5	2,136,799	2,464,762

6.1 Receivables

	2019	2018
Current		
Receivables (a)	261,363	520,110
Allowance for impairment of receivables	(21,935)	-
Accrued revenue	25,491	33,413
GST receivables	41,383	50,309
Total receivables	**306,302**	**603,832**

(a) 2017-18 includes $378,400 other grants and contribution to be received from WA Police.

Receivables are recognised at original invoice amount less any allowances for uncollectible amounts (i.e. impairment). The carrying amount of net trade receivables is equivalent to fair value as it is due for settlement within 30 days.

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 entities in the GST group include the Department of Health, Mental Health Commission, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service, Health Support Services, WA Country Health Service, QE II Medical Centre Trust, PathWest Laboratory Medicine WA, Quadriplegic Centre and Health and Disability Services Complaints Office.

Revenues, expenses and assets are recognised net of the amount of associated GST. Payables and receivables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from the ATO is included with Receivables in the Statement of Financial Position.

6.1.1 Movement in the allowance for impairment of receivables

	2019	2018
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	-	-
Remeasurement under AASB 9	21,935	-
Restated balance at start of period	21,935	-
Expected credit losses expense	-	-
Balance at end of period	**21,935**	-

The maximum exposure to credit risk at the end of the reporting period for receivables is the carrying amount of the asset inclusive of any allowance for impairment as shown in the table at Note 8.1(c) ‘Financial instruments disclosures’.

The Commission does not hold any collateral as security or other credit enhancements for receivables.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

		2019	2018
6.2	**Amounts receivable for services**	**$**	**$**
	Non-current amounts receivable for services	6,168,123	5,827,123

Amounts receivable for services represents the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.

Amounts receivable for services are not considered to be impaired (i.e. there is no expected credit loss of the holding accounts).

6.3 Inventories

	2019	2018
Current		
Pharmaceutical stores - at cost	20,098	24,358

Inventories are measured at the lower of cost and net realisable value. Costs are assigned on a weighted average cost basis. Inventories not held for resale are measured at cost unless they are no longer required in which case they are measured at net realisable value.

6.4 Other current assets

	2019	2018
Prepayments	173,369	20,565

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

6.5 Payables

	2019	2018
Current		
Trade creditors (a)	383,004	727,410
Accrued salaries	590,156	657,026
Accrued expenses (a)	1,163,639	1,080,326
Balance at end of period	**2,136,799**	**2,464,762**

(a) Includes expenses not paid yet to Department of Finance $131,128 (2017-18 $72,850), Department of Communities $0 (2017-18 $57,776) and Statefleet $6,473 (2017-18 $0).

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 settlement is generally within 30 days.

Accrued salaries represent the amount due to staff but unpaid at the end of the reporting period. Accrued salaries are settled within a fortnight of the reporting period end. The Commission considers the carrying amount of accrued salaries to be equivalent to its fair value.

The accrued salaries suspense account (See Note 7.1.1 'Restricted cash and cash equivalents') consists of amounts paid annually, from the Commission appropriations for salaries expense, into a Treasury suspense account to meet the additional cash outflow for employee salary payments in reporting periods with 27 pay days instead of the normal 26. No interest is received on this account.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

7. Financing

This section sets out the material balances and disclosures associated with the financing and cashflows of the Commission.

	Notes
Cash and cash equivalents	7.1
Reconciliation of cash	7.1.1
Reconciliation of operating activities	7.1.2
Commitments	7.2
Non-cancellable operating lease commitments	7.2.1
Contracts for the provision of mental health, alcohol and other drug services	7.2.2
Other expenditure commitments	7.2.3

7.1 Cash and cash equivalents

7.1.1 Reconciliation of cash

	2019 $	2018 $
Cash and cash equivalents	23,894,996	32,614,649
Restricted cash and cash equivalents		
- Commonwealth special purpose account (b)	4,919,808	4,814,657
- Royalties for Regions Fund (c)	-	1,675,639
- Accrued salaries suspense account (a)	349,920	228,720
Balance at end of period	**29,164,724**	**39,333,665**

(a) 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. This account is classified as non-current for 10 out of 11 years. The 27th pay was paid in the 2015/16 financial year.

(b) Fund are held for specific purposes for programs relating to drug diversion, development, implementation and administration of initiatives and activities to reduce drug abuse.

(c) Unspent funds are committed to projects and programs in WA regional areas.

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.

7.1.2 Reconciliation of net cost of services to net cash flows provided by/(used in) operating activities

	Notes	2019 $	2018 $
Net cost of services		(714,734,108)	(696,492,950)
Non-cash items:			
Services received free of charge	4.1	3,008,527	3,428,198
Depreciation expense	5.1.1	469,347	493,554
Loss on revaluation of land	3.4	25,700	174,900
Loss on revaluation of buildings	3.4	9,813	155,427

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

7.1.2 Reconciliation of net cost of services to net cash flows provided by/(used in) operating activities (cont.)

	2019 $	2018 $
(Increase)/decrease in assets:		
Current receivables (a)	275,595	(113,386)
Inventories	4,260	(6,114)
Other current assets	(152,804)	7,061
Increase/(decrease) in liabilities:		
Current payables	(327,963)	(1,713,317)
Current provisions	473,679	(225,274)
Non-current provisions	(249,452)	94,539
Net cash provided by/(used in) operating activities	**(711,197,406)**	**(694,197,362)**

(a) This excludes allowance for impairment of receivables as this does not form part of the reconciling item.

7.2 Commitments

The commitments below are inclusive of GST where relevant.

7.2.1 Non-cancellable operating lease commitments

Commitments for minimum lease payments are payable as follows:

	2019	2018
Within 1 year	2,741,260	2,756,742
Later than 1 year and not later than 5 years	10,538,749	10,722,060
Later than 5 years	2,993,012	5,628,046
	16,273,021	**19,106,848**

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. The leases are non-cancellable, with rent payable monthly in advance. Operating lease commitments predominantly consist of contractual agreements for office accommodation. The basis of which contingent operating leases payments are determined is the value for each lease agreement under the contract terms and conditions at current values. Operating leases relating to buildings and office equipment do not have contingent rental obligations.

7.2.2 Contracts for the provision of mental health, alcohol and other drug 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:

	2019	2018
Within 1 year	149,633,149	105,117,715
Later than 1 year and not later than 5 years	150,750,059	101,571,604
Later than 5 years	3,162,568	-
	303,545,776	**206,689,319**

7.2.3 Other expenditure commitments

Other expenditure commitments contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:

	2019	2018
Within 1 year	484,972	40,508

Judgements made by management in applying accounting policies – operating lease commitments
The Commission has entered into a number of leases for office accommodation including variable outgoings. 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.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

8. Risks and Contingencies

This note sets out the key risk management policies and measurement techniques of the Commission.

	Notes
Financial risk management	8.1
Contingent assets and liabilities	8.2
Fair value measurements	8.3

8.1 Financial risk management

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.

(a) Summary of risks and risk management

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.

Credit risk associated with the Commission's financial assets is minimal because the debtors are predominantly government bodies. The main receivable of the Commission is the amounts receivable for services (holding account). For receivables other than government agencies the Commission trades only with recognised, creditworthy third parties. In addition, receivable balances are monitored on an ongoing basis with the result that the Commission's exposure to bad debts is minimised. Debt will be written-off against the allowance account when it is improbable or uneconomical to recover the debt. At the end of the reporting period, there were no significant concentrations of credit risk.

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 normal course of operations.

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.

(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:

	2019	**2018**
	$	**$**
Financial Assets		
Cash and cash equivalents	23,894,996	32,614,649
Restricted cash and cash equivalents	5,269,728	6,719,016
Receivables (a)	286,854	553,523
Amounts receivable for services	6,168,123	5,827,123
Financial Liabilities		
Financial liabilities measured at amortised cost	2,136,799	2,464,762

(a) The amount of receivables excludes GST recoverable from the ATO (statutory receivable.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

8.1 Financial risk management (cont.)

(c) Financial instrument disclosures

Credit risk exposure

The following table details the credit risk exposure on the Commission's trade using a provision matrix.

		Days past due					
	Total	Current	<30 days	31-60 days	61-90 days	90-180 days	>180 days
	$	**$**	**$**	**$**	**$**	**$**	**$**
30 Jun 2019							
Expected credit loss rate		0.00%	0.00%	0.00%	0.00%	0.00%	47.89%
Estimated total gross carrying amount at default	261,363	183,703	20,903	2,448	6,791	1,718	45,800
Expected credit losses	(21,935)	-	-	-	-	-	21,935
1 July 2018 (remeasurement)							
Expected credit loss rate		0.00%	0.00%	0.00%	0.00%	0.00%	35.83%
Estimated total gross carrying amount at default	520,110	74,934	382,390	1,513	-	53	61,220
Expected credit losses	(21,935)	-	-	-	-	-	21,935

(a) The amount of receivables excludes GST recoverable from the ATO (statutory receivable).

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

8.1 Financial risk management (cont.)

(c) Financial instrument disclosures (cont.)

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 exposure 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 $	1 - 5 years $	More than 5 year $
2019											
Financial Assets											
Cash and cash equivalents	-	23,894,996	-	-	23,894,996	23,894,996	23,894,996	-	-	-	-
Restricted cash and cash equivalents	2.1%	5,269,728	-	4,919,808	349,920	5,269,728	5,269,728	-	-	-	-
Receivables (a)	-	286,854	-	-	286,854	286,854	286,854	-	-	-	-
Amounts receivable for services	-	6,168,123	-	-	6,168,123	6,168,123	-	-	-	-	6,168,123
		35,619,701	-	4,919,808	30,699,893	35,619,701	29,451,578	-	-	-	6,168,123
Financial Liabilities											
Payables	-	2,136,799	-	-	2,136,799	2,136,799	2,136,799	-	-	-	-
		2,136,799	-	-	2,136,799	2,136,799	2,136,799	-	-	-	-
2018											
Financial Assets											
Cash and cash equivalents	-	32,614,649	-	-	32,614,649	32,614,649	32,614,649	-	-	-	-
Restricted cash and cash equivalents	2.0%	6,719,016	-	4,814,657	1,904,359	6,719,016	6,719,016	-	-	-	-
Receivables (a)	-	553,523	-	-	553,523	553,523	553,523	-	-	-	-
Amounts receivable for services	-	5,827,123	-	-	5,827,123	5,827,123	-	-	-	-	5,827,123
		45,714,311	-	4,814,657	40,899,654	45,714,311	39,887,188	-	-	-	5,827,123
Financial Liabilities											
Payables	-	2,464,762	-	-	2,464,762	2,464,762	2,464,762	-	-	-	-
		2,464,762	-	-	2,464,762	2,464,762	2,464,762	-	-	-	-

(a) The amount of receivables excludes GST recoverable from the ATO (statutory receivable).

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

8.1 Financial risk management (cont.)

(c) Financial instrument disclosures (cont.)

Interest rate sensitivity analysis

The following table represents a summary of the interest rate sensitivity of the Commission's financial assets and liabilities at the end of the reporting period on the surplus for the period and equity for a 1% change in interest rates. It is assumed that the change in interest rates is held constant throughout the reporting period.

		-100 basis points		+100 basis points	
	Carrying amount	Surplus	Equity	Surplus	Equity
	$	$	$	$	$
2019					
Financial Assets					
Restricted cash and cash equivalents	4,919,808	(49,198)	(49,198)	49,198	49,198
Total Increase/(Decrease)		(49,198)	(49,198)	49,198	49,198

		-100 basis points		+100 basis points	
	Carrying amount	Surplus	Equity	Surplus	Equity
	$	$	$	$	$
2018					
Financial Assets					
Restricted cash and cash equivalents	4,814,657	(48,147)	(48,147)	48,147	48,147
Total Increase/(Decrease)		(48,147)	(48,147)	48,147	48,147

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.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

8.2 Contingent assets and liabilities

Contingent assets and contingent liabilities are not recognised in the statement of financial position but are disclosed and, if quantifiable, are measured at nominal value.

At the reporting date, the Commission is not aware of any contingent assets or contingent liabilities.

The Commission does not have any **pending litigation** that are not recoverable from RiskCover insurance at the reporting date.

Contaminated sites

Under the Contaminated Sites Act 2003, the Commission is required to report known and suspected contaminated sites to the Department of Water and Environmental Regulation (DWER). In accordance with the Act, DWER classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as contaminated – remediation required or possibly contaminated – investigation required, the Commission may have a liability in respect of investigation or remediation expenses.

At the reporting date, the Commission does not have any suspected contaminated sites reported under the Act.

8.3 Fair value measurements

Assets measured at fair value:	Level 1	Level 2	Level 3	Fair Value At end of period
2019	**$**	**$**	**$**	**$**
Non-current assets classified as held for sale (Note 9.8)	-	-	4,293,700	4,293,700
Land (Note 5.1)	-	630,000	4,591,300	5,221,300
Buildings (Note 5.1)	-	1,066,000	10,189,301	11,255,301
	-	**1,696,000**	**19,074,301**	**20,770,301**
2018				
Non-current assets classified as held for sale (Note 9.8)	-	-	-	-
Land (Note 5.1)	-	639,000	7,868,000	8,507,000
Buildings (Note 5.1)	-	1,091,000	11,621,423	12,712,423
	-	**1,730,000**	**19,489,423**	**21,219,423**

There were no transfers between Levels 1, 2, or 3 during the current and previous periods.

Valuation techniques to derive Level 2 fair values

Level 2 fair values of Land and Buildings are derived using the market approach. This approach provides an indication of value by comparing the asset with identical or similar properties for which price information is available. Analysis of comparable sales information and market data provides the basis for fair value measurement.

For properties with buildings and other improvements, the land value is measured by comparison and analysis of open market transactions on the assumption that the land is in a vacant and marketable condition. The amount determined is deducted from the total property value and the residual amount represents the building value.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

8.3 Fair value measurements (cont.)

Fair value measurements using significant unobservable inputs (Level 3)	**Land**	**Buildings**
2019	**$**	**$**
Fair value at start of period	7,868,000	11,621,423
Revaluation increments/(decrements) recognised in Profit or Loss	(16,700)	(6,633)
Depreciation expense	-	(391,789)
Fair value at end of period	**7,851,300**	**11,223,001**
2018		
Fair value at start of period	7,901,900	12,098,100
Revaluation increments/(decrements) recognised in Profit or Loss	(33,900)	(80,227)
Depreciation expense	-	(396,450)
Fair value at end of period	**7,868,000**	**11,621,423**

Valuation processes

Properties of a specialised nature that are rarely sold in an active market or are held to deliver public services are referred to as non-market or current use type assets. These properties do not normally have a feasible alternative use due to restrictions or limitations on their use and disposal. The existing use is their highest and best use. There were no changes in valuation techniques during the period.

Transfers in and out of a fair value level are recognised on the date of the event or change in circumstances that caused the transfer. Transfers are generally limited to assets newly classified as non-current assets held for sale as Treasurer's instructions require valuations of land and buildings to be categorised within Level 3 where the valuations will utilise significant Level 3 inputs on a recurring

Land (Level 3 fair values)

Fair value for restricted use land is based on comparison with market evidence for land with low level utility (high restricted use land). The relevant comparators of land with low level utility is selected by the Western Australian Land Information Authority (Valuation Services) and represents the application of a significant Level 3 input in this valuation methodology. The fair value measurement is sensitive to values of comparator land, with higher values of comparator land correlating with higher estimated fair values of land.

Buildings (Level 3 fair values)

Fair value for existing use specialised buildings is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the depreciated replacement cost. Depreciated replacement cost is the current replacement cost of an asset less accumulated depreciation calculated on the basis of such cost to reflect the already consumed or expired economic benefit, or obsolescence, and optimisation (where applicable) of the asset. Current replacement cost is generally determined by reference to the market-observable replacement cost of a substitute asset of comparable utility and the gross project size specifications.

Valuation using depreciated replacement cost utilises the significant Level 3 input, consumed economic benefit/obsolescence of asset which is estimated by the Western Australian Land Information Authority (Valuation Services). The fair value measurement is sensitive to the estimate of consumption/obsolescence, with higher values of the estimate correlating with lower estimated fair values of buildings.

Basis of Valuation

In the absence of market-based evidence, due to the specialised nature of some non-financial assets, these assets are valued at Level 3 of the fair value hierarchy on an existing use basis. The existing use basis recognises that restrictions or limitations have been placed on their use and disposal when they are not determined to be surplus to requirements. These restrictions are imposed by virtue of the assets being held to deliver a specific community service.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9. Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

	Notes
Events occurring after the end of the reporting period	9.1
Initial application of Australian Accounting Standards	9.2
Future impact of Australian Accounting Standards not yet operative	9.3
Compensation of Key Management Personnel	9.4
Related Party Transactions	9.5
Related bodies	9.6
Affiliated bodies	9.7
Non- current Assets classified as assets held for sale	9.8
Special purpose accounts	9.9
Remuneration of auditor	9.10
Equity	9.11
Services provided free of charge	9.12
Explanatory statement	9.13

9.1 Events occurring after the end of the reporting period

The Commission is not aware of any events occurring after the end of the reporting period that have significant financial effect on the financial statements.

9.2 Initial application of Australian Accounting Standards

AASB 9 Financial instruments

AASB 9 Financial instruments replaces AASB 139 Financial instruments: Recognition and Measurements for annual reporting periods beginning on or after 1 January 2018, bringing together all three aspects of the accounting for financial instruments: classification and measurement; impairment; and hedge accounting.

The Commission applied AASB 9 prospectively, with an initial application date of 1 July 2018. The adoption of AASB 9 has resulted in changes in accounting policies and adjustments to the amounts recognised in the financial statements. In accordance with AASB 9.7.2.15, the Commission has not restated the comparative information which continues to be reported under AASB 139. Differences arising from adoption have been recognised directly in Accumulated surplus/(deficit).

The effect of adopting AASB 9 as at 1 July 2018 was, as follows:

	Adjustments	1 July 2018 $
Assets		
Receivables	(a),(b)	(21,935)
Total Assets		(21,935)
Total adjustments on Equity		
Accumulated surplus/(deficit)	(a),(b)	(21,935)
		(21,935)

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9.2 Initial application of Australian Accounting Standards (cont.)

The nature of these adjustments are described below:

(a) Classification and measurement

Under AASB 9, financial assets are subsequently measured at amortised cost, fair value through other comprehensive income (fair value through OCI) or fair value through profit or loss (fair value through P/L). The classification is based on two criteria: the Commission's business model for managing the assets; and whether the assets' contractual cash flows represent 'solely payments of principal and interest' on the principal amount outstanding.

The assessment of the Commission's business model was made as of the date of initial application, 1 July 2018. The assessment of whether contractual cash flows on financial assets are solely comprised of principal and interest was made based on the facts and circumstances at the time of initial recognition of the assets.

The classification and measurement requirements of AASB 9 did not have a significant impact on the Commission. The following are the changes in the classification of the Commission's financial assets:

• Receivables as at 30 June 2018 are held to collect contractual cash flows and give rise to cash flows representing solely payments of principal. These are classified and measured as Financial assets at amortised cost beginning 1 July 2018.

• The Commission did not designate any financial assets as at fair value through P/L.

In summary, upon the adoption of AASB 9, the Commission had the following reclassifications as at 1 July 2018:

		AASB 9 category		
		Amortised cost	Fair value through OCI	Fair value through P/L
		$	$	$
AASB 139 category	$			
Receivables*	553,523	531,588	-	-
Amounts receivable for	5,827,123	5,827,123	-	-
		6,358,711	**-**	**-**

* The change in carrying amount is a result of additional impairment allowance. See the discussion on impairment below.

(b) Impairment

The adoption of AASB 9 has fundamentally changed the Commission's accounting for impairment losses for financial assets by replacing AASB 139's incurred loss approach with a forward-looking expected credit loss (ECL) approach. AASB 9 requires the Commission to recognise an allowance for ECLs for all financial assets not held at fair value through P/L.

Upon adoption of AASB 9, the Commission recognised an impairment on the Commission's receivables of $21,935 which resulted in a decrease in Accumulated surplus/(deficit) of $21,935 as at 1 July 2018.

Set out below is the reconciliation of the ending impairment allowances in accordance with AASB 139 to the opening loss allowances determined in accordance with AASB 9:

	Impairment under AASB 139 as at 30 June 2018	Remeasurement	ECL under AASB 9 as at 1 July 2018
	$	$	$
Receivables under AASB 139 / Financial assets at amortised cost under AASB	-	21,935	21,935
	-	**21,935**	**21,935**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9.3 Future impact of Australian Accounting Standards not yet operative

The Commission cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 1101 Application of Australian Accounting Standards and Other Pronouncements or by an exemption from TI 1101. By virtue of a limited exemption, the Commission has early adopted AASB 2015-7 Amendments to Australian Accounting Standards - Fair Value Disclosures of Not-for-Profit Public Sector Entities. Where applicable, the Commission plans to apply the following Australian Accounting Standards from their application date.

Title		Operative for reporting periods beginning on/after
AASB 15	*Revenue from Contracts with Customers*	1 Jan 2019
Nature of Change	This Standard establishes the principles that the Commission shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. The mandatory effective date of this Standard is currently 1 January 2019 after being amended by AASB 2016-7.	
Impact	The Commission's income is primarily derived from appropriations which will be measured under AASB 1058, and thus will not be materially affected by this change. Although the recognition of grants and contribution and other revenues will be deferred until the Commission has discharged its performance obligations, these revenues are expected to be fully recognised at year-end and no contract liability will exist. The Commission will adopt the modified retrospective approach on transition to AASB 15. No comparative information will be restated under this approach, and the Commission will recognise the cumulative effect of initially applying the Standard as an adjustment to the opening balance of accumulated surplus/(deficit) at the date of initial application.	
AASB 16	*Leases*	1 Jan 2019
Nature of Change	This Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value.	
Impact	The recognition of additional assets and liabilities, mainly from operating leases, will increase the Commission's total assets by $10,167,655 and total liabilities by $10,167,655. In addition, interest and depreciation expenses will increase, offset by a decrease in rental expense for the year ending 30 June 2020 and beyond. The above assessment is based on the following accounting policy positions : • Option 1/Option 2 of the modified retrospective approach on transition; • the 'low value asset' threshold set at AUD $5,000 (unless GROH, GOA or State Fleet); • For leases classified as 'short term' (12 months or less), these are not recognised under AASB 16 (unless GROH, GOA or State Fleet); • Land, buildings and investment property ROU assets are measured under the fair value model, subsequent to initial recognition; and • Discount rates are sourced from WA Treasury Corporation (WATC). The commission will adopt the modified retrospective approach on transition to AASB 16. No comparative information will be restated under this approach, and the commission will recognise the cumulative effect of initially applying the Standard as an adjustment to the opening balance of accumulated surplus/(deficit) at the date of initial application.	

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9.3 Future impact of Australian Accounting Standards not yet operative (cont.)

Title		Operative for reporting periods beginning on/after
AASB 1058	*Income of Not-for-Profit Entities*	1 Jan 2019
Nature of Change	This Standard clarifies and simplifies the income recognition requirements that apply to not for profit (NFP) entities, more closely reflecting the economic reality of NFP entity transactions that are not contracts with customers. Timing of income recognition is dependent on whether such a transaction gives rise to a liability or other performance obligation (a promise to transfer a good or service), or a contribution by owners, related to an asset (such as cash or another asset) received by the Commission.	
Impact	AASB 1058 will have no impact on appropriations and recurrent grants received by the Commission – they will continue to be recognised as income when funds are deposited in the bank account or credited to the holding account. The Commission will adopt the modified retrospective approach on transition to AASB 1058. No comparative information will be restated under this approach, and the Commission will recognise the cumulative effect of initially applying the Standard as an adjustment to the opening balance of accumulated surplus/(deficit) at the date of initial application.	
AASB 1059	*Service Concession Arrangements: Grantors*	1 Jan 2020
Nature of Change	This Standard addresses the accounting for a service concession arrangement (a type of public private partnership) by a grantor that is a public sector agency by prescribing the accounting for the arrangement from the grantor's perspective. Timing and measurement for the recognition of a specific asset class occurs on commencement of the arrangement and the accounting for associated liabilities is determined by whether the grantee is paid by the grantor or users of the public service provided. The mandatory effective date of this Standard is currently 1 January 2020 after being amended by AASB 2018-5.	
Impact	The Commission does not manage any public private partnership that is within the scope of the Standard.	
AASB 2016-8	*Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not for Profit Entities*	1 Jan 2019
Nature of Change	This Standard inserts Australian requirements and authoritative implementation guidance for not-for-profit entities into AASB 9 and AASB 15. This guidance assists not-for-profit entities in applying those Standards to particular transactions and other events.	
Impact	There is no financial impact.	
AASB 2018-5	*Amendments to Australian Accounting Standards – Deferral of AASB 1059*	1 Jan 2019
Nature of Change	This Standard amends the mandatory effective date of AASB 1059 so that AASB 1059 is required to be applied for annual reporting periods beginning on or after 1 January 2020 instead of 1 January 2019.	
Impact	There is no financial impact.	
AASB 2018-8	*Amendments to Australian Accounting Standards – Right-of-Use Assets of Not-for-Profit Entities*	1 Jan 2019
Nature of Change	This Standard provides a temporary option for not for profit entities to not apply the fair value initial measurement requirements for right-of-use assets arising under leases with significantly below-market terms and conditions principally to enable the entity to further its objectives.	
Impact	The Commissiom will elect to apply the option to measure right-of-use assets under peppercorn leases at cost (which is generally about $1). As a result, the financial impact of this Standard is not material.	

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9.4 Compensation of Key Management Personnel

The Commission has determined that key management personnel include the responsible Minister and senior officers of the Commission. However, the Commission is not obligated for the compensation of the responsible Minister and therefore no disclosure is required. The disclosure in relation to the responsible Minister's compensation may be found in the *Annual Report on State Finances*.

The total fees, salaries, superannuation, non-monetary benefits and other benefits for senior officers of the Commission for the reporting period are presented within the following bands:

Compensation of Senior Officers Band ($)	**2019**	**2018**
470,001 - 480,000	1	-
460,001 - 470,000	1	-
440,001 - 450,000	-	1
290,001 - 300,000	-	1
280,001 - 290,000	-	1
230,001 - 240,000	1	-
220,001 - 230,000	1	1
210,001 - 220,000	1	1
200,001 - 210,000	1	-
190,001 - 200,000	1	1
180,001 - 190,000	1	4
170,001 - 180,000	1	2
130,001 - 140,000	-	1
110,001 - 120,000	-	1
100,001 - 110,000	-	1
90,001 - 100,000	2	-
80,001 - 90,000	-	1
70,001 - 80,000	2	-
60,001 - 70,000	1	-
50,001 - 60,000	-	1
40,001 - 50,000	-	1
10,001 - 20,000	1	1

	$	**$**
Short-term employee benefits	2,229,210	2,671,069
Post-employment benefits	300,453	316,740
Other long-term benefits	247,838	344,939
Total compensation of senior officers	**2,777,501**	**3,332,748**

Total compensation includes the superannuation expense incurred by the Commission in respect of senior officers.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9.5 Related Party Transactions

The Commission is a wholly-owned public sector entity that is controlled by the State of the Western Australia.

Related parties of the Commission include:
- all cabinet ministers and their close family members, and their controlled or jointly controlled entities;
- all senior officers and their close family members, and their controlled or jointly controlled entities;
- all departments and public sector entities, including their related bodies, that are included in the whole of government consolidated financial statements;
- associates and joint ventures, that are included in the whole of Government consolidated financial statements; and
- the Government Employees Superannuation Board (GESB).

Significant transactions with Government-related entities

In conducting its activities, the Commission is required to transact with the State and entities related to the State. These transactions are generally based on the standard terms and conditions that apply to all agencies. Such transactions include:

- service appropriation (Note 4.1);
- services received free of charge from the other state government agencies (Note 4.1);
- grants and contribution received from other government agencies (Note 4.2).
- royalties for regions fund (Note 4.1);
- services agreement WA Health (Note 3.2);
- grants and subsidies payment to other government agencies (Note 3.3);
- specific project expenses and consuting fees and legal fees - Department of Juctice including State Solicitor's Office (Note 3.4);
- corporate support services - Health Support Services (Note 3.4);
- purchase of outsourced services and consulting fees to Department of Health (Note 3.4);
- lease rentals and accommodation including repairs and maintenance, purchase of outsourced services, communications, legal and consulting fees to Department of Finance (Note 3.4);
- lease rentals related payments to Department of Lands (Note 3.4);
- workers' compensation and other insurance payment to Riskcover (Note 3.4);
- vehicle rental payments to Statefleet (Note 3.4);
- audit fees payments to Office of the Audit General (Note 3.4 and Note 9.10);
- annual monitoring related payments to Department of Fire and Emergency (Note 3.4);
- administration related payment to Department of Training and Workforce Development (Note 3.4);
- other payments to Department of Treasury WA (Note 3.4);
- return of unspent revenue to WA Police (Note 3.4);
- services provided free of charge to the other state government agencies (Note 9.12).

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9.5 Related Party Transactions (cont)

Material transactions with related parties

The former Mental Health Commissioner, Mr. Timothy Michael Marney, is the Deputy Chair of the Beyond Blue Ltd, Board of Directors. A not-for-profit organisation, Beyond Blue Ltd, focuses on raising awareness and understanding of anxiety and depression in Australia, and received $342,000 funding from the Commission in 2018/19. This funding, which commenced in 2000, predates the establishment of the Commission and has remained at approximately this level since 2005. The Commission's current contract with Beyond Blue Ltd is for five years contract total value of $1,710,000 from 2015 to 2020. This contract was awarded and approved by the Director, Non-Government Organisations Purchasing and Development in 2015. Funding decisions and contract managment is separted from the Commissioner to ensure there is no capicity to influence decisons.

All other transactions (including general citizen type transactions) between Commission and Ministers/senior officers or their close family members or their controlled (or jointly controlled) entities are not material for disclosure.

Material transactions with other related parties

- Superannuation payments to the Government Employees Superannuation Board (GESB) (Note 3.1(a)).

9.6 Related bodies

A related body is a body that receives more than half of 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.

9.7 Affiliated bodies

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

During the financial year the following affiliated bodies received the funding from the Commission:	2019 $	2018 $
Albany Halfway House Association Incorporated	1,380,097	1,427,306
Consumers of Mental Health WA	501,570	428,986
Even Keel Bipolar Support Association Incorporated	127,971	127,555
Holyoake Australian Institute for Alcohol and Drug Addiction Resolution Inc	(a)	4,274,756
Home Health Pty Ltd (trading as Tender Care)	1,246,501	1,224,369
Local Drug Action Groups Inc.	691,318	673,657
Palmerston Association Inc.	9,694,362	8,590,864
Pathways Southwest Inc.	765,433	759,132
Richmond Wellbeing Incorporated	(a)	10,634,427
St Vincent De Paul Society	(a)	750,092
WA Council on Addictions (trading as Cyrenian House)	9,527,502	9,068,974
Total affiliated bodies	**23,934,754**	**37,960,118**

(a) During 2018/19 financial year, the Commission has provided funding amount $4,528,863 to Holyoake Australian Institute for Alcohol and Drug Addiction Resolution Inc , $11,019,978 to Richmond Wellbeing Incorporated and $826,318 to St Vincent De Paul Society. These organisations received less than half of its funding and resources from the Commission, hence are not affiliated bodies.

In addition, Mental Health Commission has three affiliated bodies as determined by the Treasurer pursuant to Section 60(1)(b) of the Financial Management Act 2006 in 2015/16 financial year.

Mental Health Tribunal is a government administered body that received administrative support from, but is not subject to operational control by the Commission. It is funded by parliamentary appropriation of $2,778,000 for 2018/19 ($2,660,000 for 2017/18).

Mental Health Advocacy Service is a government administered body that received administrative support from, but is not subject to operational control by the Commission. It is funded by parliamentary appropriation of $2,668,000 for 2018/19 ($2,627,000 for 2017/18).

Office of Chief Psychiatrist is a government administered body that received administrative support from, but is not subject to operational control by the Commission. It is funded by parliamentary appropriation of $3,029,000 for 2018/19 ($2,943,000 for 2017/18).

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9.8 Non- current Assets classified as assets held for sale

	2019 $	2018 $
Opening balance	-	-
Add: assets reclassified as held for sale		
Land	3,260,000	-
Buildings	1,033,700	-
Closing balance	**4,293,700**	**-**

Non-current assets held for sale are recognised at the lower of carrying amount and fair value less costs to sell, and are disclosed separately from other assets in the Statement of Financial Position. Assets classified as held for sale are not depreciated or amortised.

Subsequent to the merger of Mental Health Commission and Drug and Alcohol Office in 1 July 2015, the amalgmated Mental Health Commission moved to new premises in April 2016 and services ceased at old site in late 2018. As a result the site has become surplus to requirement and assessed not to be practical from use for mental health and alcohol & other drug services. Management was commited to a plan to sell and developed the decommissioning project of the site. The site has been recently re-zoned to enable the sales proven. Since the approval of the scheme amendments by Minister of Department of Planning, Land and Heritage, the sale is highly probable, within 12 months of classification as held for sale (subject to limited exceptions).

9.9 Special purpose accounts

State Managed Fund (Mental Health) Account (a)

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.

	2019	2018
Balance at the start of period	-	-
Receipts:		
Service appropriations (State Government)	201,279,529	276,444,498
Commonwealth grants and contributions	90,698,271	86,088,705
	291,977,800	**362,533,203**
Payments:		
Block grant funding to local hospital networks in WA Health	(270,895,421)	(341,819,057)
Block grant funding to non-government organisation	(4,895,223)	(3,667,545)
Block grant funding to next step drug and alcohol services	(16,187,156)	(17,046,601)
Balance at the end of period	**-**	**-**

(a) Established under section 16(1)(b) of FMA.

9.10 Remuneration of auditor

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

	2019	2018
Auditing the accounts, controls, financial statements and key performance indicators	**182,172**	**188,678**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9.11 Equity

	2019	2018
	$	$
Contributed equity		
Balance at start of period	32,135,558	32,135,558
Transactions with owners in their capacity as owners	-	-
Balance at end of period	**32,135,558**	**32,135,558**
Accumulated surplus / (deficit)		
Balance at start of period	25,492,098	15,288,886
Result for the period	(10,335,581)	10,203,212
Change in accounting policy	(21,935)	-
Balance at end of period	**15,134,582**	**25,492,098**
Total Equity at end of period	**47,270,140**	**57,627,656**

9.12 Services provided free of charge

Services provided free of charge to other agencies during the period:

	2019	2018
Mental Health Tribunal - corporate services	309,691	314,572
Mental Health Advocacy Service - corporate services	276,383	328,313
Office of the Chief Psychiatrist - corporate services and accommodation	450,289	479,035
Total Services provided free of charge	**1,036,363**	**1,121,920**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9.13 Explanatory statement (Controlled Operations)

All variances between estimates (original budget) and actual results for 2019, and between the actual results for 2019 and 2018 are shown below. Narratives are provided for selected major variances, which are generally greater than:

5% and $17.9 million for the Statements of Comprehensive Income and Cash Flows; and 5% and $1.2 million for the Statements of Financial Position.

9.13.1 Explanatory statement (Statement of Comprehensive Income)

	Variance Note	Estimate 2019 $	Actual 2019 $	Actual 2018 $	Variance between estimate and actual $	Variance between actual results for 2019 and 2018 $
COST OF SERVICES						
Expenses						
Employee benefits expenses		32,707,000	34,742,708	37,120,240	2,035,708	(2,377,532)
Service agreement - WA Health		717,778,000	718,408,681	702,194,456	630,681	16,214,225
Service agreement - non government and other organisations		154,053,000	140,961,106	137,877,380	(13,091,894)	3,083,726
Supplies and services		6,143,000	10,564,372	9,553,414	4,421,372	1,010,958
Grants and subsidies		2,353,000	8,055,428	2,486,286	5,702,428	5,569,142
Depreciation expense		341,000	469,347	493,554	128,347	(24,207)
Accommodation expense		2,509,000	2,441,182	2,467,396	(67,818)	(26,214)
Other expenses		2,519,000	2,177,626	2,716,637	(341,374)	(539,011)
Total cost of services		**918,403,000**	**917,820,450**	**894,909,363**	**(582,550)**	**22,911,087**
Income						
Revenue						
Commonwealth grants and contributions		191,255,000	197,811,461	193,249,500	6,556,461	4,561,961
Other grants and contributions		1,429,000	4,893,361	4,799,349	3,464,361	94,012
Other revenue		295,000	381,520	367,564	86,520	13,956
Total income other than income from State Government		**192,979,000**	**203,086,342**	**198,416,413**	**10,107,342**	**4,669,929**
NET COST OF SERVICES		**725,424,000**	**714,734,108**	**696,492,950**	**(10,689,892)**	**18,241,158**
Income from State Government						
Service appropriation		707,456,000	698,281,000	696,654,964	(9,175,000)	1,626,036
Services received free of charge		4,097,000	3,008,527	3,428,198	(1,088,473)	(419,671)
Royalties for Regions Fund		13,513,000	3,109,000	6,613,000	(10,404,000)	(3,504,000)
Total income from State Government		**725,066,000**	**704,398,527**	**706,696,162**	**(20,667,473)**	**(2,297,635)**
SURPLUS / (DEFICIT) FOR THE PERIOD		**(358,000)**	**(10,335,581)**	**10,203,212**	**(9,977,581)**	**(20,538,793)**
OTHER COMPREHENSIVE INCOME		-	-	-	-	-
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(358,000)**	**(10,335,581)**	**10,203,212**	**(9,977,581)**	**(20,538,793)**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9.13.2 Explanatory statement (Statement of Financial Position)

	Variance Note	Estimate 2019 $	Actual 2019 $	Actual 2018 $	Variance between estimate and actual $	Variance between actual results for 2019 and 2018 $
ASSETS						
Current Assets						
Cash and cash equivalents		23,199,000	23,894,996	32,614,649	695,996	(8,719,653)
Restricted cash and cash equivalents		4,725,000	4,919,808	6,490,296	194,808	(1,570,488)
Receivables		491,000	306,302	603,832	(184,698)	(297,530)
Inventories		18,000	20,098	24,358	2,098	(4,260)
Other current assets		28,000	173,369	20,565	145,369	152,804
Non-current assets classified as held for sale	1, A	-	4,293,700	-	4,293,700	4,293,700
Total Current Assets		**28,461,000**	**33,608,273**	**39,753,700**	**5,147,273**	**(6,145,427)**
Non-Current Assets						
Restricted cash and cash equivalents		414,000	349,920	228,720	(64,080)	121,200
Amounts receivable for services		6,168,000	6,168,123	5,827,123	123	341,000
Property, plant and equipment	1, A	22,720,000	16,824,366	21,602,391	(5,895,634)	(4,778,025)
Total Non-Current Assets		**29,302,000**	**23,342,409**	**27,658,234**	**(5,959,591)**	**(4,315,825)**
TOTAL ASSETS		**57,763,000**	**56,950,682**	**67,411,934**	**(812,318)**	**(10,461,252)**
LIABILITIES						
Current Liabilities						
Payables		4,656,000	2,136,799	2,464,762	(2,519,201)	(327,963)
Employee benefits provisions		5,309,000	5,600,117	5,126,438	291,117	473,679
Total Current Liabilities		**9,965,000**	**7,736,916**	**7,591,200**	**(2,228,084)**	**145,716**
Non-Current Liabilities						
Employee benefits provisions		1,998,000	1,943,626	2,193,078	(54,374)	(249,452)
Total Non-Current Liabilities		**1,998,000**	**1,943,626**	**2,193,078**	**(54,374)**	**(249,452)**
TOTAL LIABILITIES		**11,963,000**	**9,680,542**	**9,784,278**	**(2,282,458)**	**(103,736)**
NET ASSETS		**45,800,000**	**47,270,140**	**57,627,656**	**1,470,140**	**(10,357,516)**
EQUITY						
Contributed equity		26,739,000	32,135,558	32,135,558	5,396,558	-
Reserves		608,000	-	-	(608,000)	-
Accumulated surplus		18,453,000	15,134,582	25,492,098	(3,318,418)	(10,357,516)
TOTAL EQUITY		**45,800,000**	**47,270,140**	**57,627,656**	**1,470,140**	**(10,357,516)**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9.13.3 Explanatory statement (Statement of Cash Flows)

	Variance Note	Estimate 2019 $	Actual 2019 $	Actual 2018 $	Variance between estimate and actual $	Variance between actual results for 2019 and 2018 $
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation		707,115,000	697,940,000	696,313,964	(9,175,000)	1,626,036
Royalties for Regions Fund - Capital		976,000	-	-	(976,000)	-
Royalties for Regions Fund - Recurrent		13,513,000	3,109,000	6,613,000	(10,404,000)	(3,504,000)
Net cash provided by State Government		**721,604,000**	**701,049,000**	**702,926,964**	**-20,555,000**	**-1,877,964**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits expenses		(32,539,000)	(34,807,595)	(36,799,975)	(2,268,595)	1,992,380
Service agreement - WA Health		(717,778,000)	(718,416,824)	(702,194,456)	(638,824)	(16,222,368)
Service agreement - non government and other organisations		(154,053,000)	(141,293,516)	(138,381,292)	12,759,484	(2,912,224)
Supplies and services		(2,173,000)	(7,806,468)	(7,530,375)	(5,633,468)	(276,093)
Grants and subsidies		(2,353,000)	(8,111,263)	(2,453,382)	(5,758,263)	(5,657,881)
Accommodation expense		(2,478,000)	(2,429,064)	(2,651,087)	48,936	222,023
Other payments		(2,446,000)	(1,805,004)	(2,294,987)	640,996	489,983
Receipts						
Commonwealth grants and contributions		191,255,000	197,811,461	193,249,500	6,556,461	4,561,961
Other grants and contributions		1,429,000	4,893,361	4,799,349	3,464,361	94,012
Other receipts		295,000	767,506	59,343	472,506	708,163
Net cash used in operating activities		**(720,841,000)**	**(711,197,406)**	**(694,197,362)**	**9,643,594**	**(17,000,044)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets		(976,000)	(20,535)	(153,000)	955,465	132,465
Net cash used in investing activities		**(976,000)**	**(20,535)**	**(153,000)**	**955,465**	**132,465**
Net increase / (decrease) in cash and cash equivalents	B	(213,000)	(10,168,941)	8,576,602	(9,955,941)	(18,745,543)
Cash and cash equivalents at the beginning of the period		28,551,000	39,333,665	30,757,063	10,782,665	8,576,602
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**28,338,000**	**29,164,724**	**39,333,665**	**826,724**	**(10,168,941)**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

9.13 Explanatory statement (Controlled Operations) (cont.)

Major Estimate and Actual (2019) Variance Narratives for Controlled Operations

1 Variance is directly attributed to reclassification of one asset from non-current property, plants and equipment to current assets in accordance with AASB 5. The sale is highly probable, within 12 months of classification as held for sale (subject to limited exceptions). At the time when the 2018-19 Budget was finalised the probability of the sale was not available hence budget was allocated to non-current property, plants and equipment. Therefore the variance is due to the timing of recognising the actual and establishing a budget for this item.

Major Actual (2019) and Comparative (2018) Variance Narratives for Controlled Operations

A Variance is directly attributed to reclassification of one asset in 2018-19 from non-current property, plants and equipment to current assets in accordance with AASB 5. At the time of 2017-18 actual reporting, the sale of asset was not highly probable within 12 months. The site has subsequently been re-zoned and the sale of the site is highly probable within 12 months of classification as held for sale (subject to limited exceptions).

B The movement of -$18.745 million (-218.6%) is related to 2017-18 net increase of $8.576 million in cash and cash equivalents primarily attributable to the underspend in specific programs in 2017-18 being compounded by a net decrease of $10.169 million in cash and cash equivalents in 2018/19, which is primarily due to $8.0 million non-disbursement by the Department of Primary Industries and Regional Development of the final drawdown for Royalties for Region funded programs, which were receipted in July 2019.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

10. Administered disclosures

This section sets out all of the statutory disclosures regarding the financial performance of the Commission.

	Notes
Disclosure of administered income and expenses by service	10.1
Disclosure of administered assets and liabilities	10.2
Explanatory statement for administered income and expenses	10.3

10.1 Disclosure of administered income and expenses by service

	2019 Hospital Bed Based Services $	2018 Hospital Bed Based Services $
Income		
Appropriations from Government for transfer to :		
Mental Health Tribunal	2,778,000	2,660,000
Mental Health Advocacy Service	2,668,000	2,627,000
Office of Chief Psychiatrist	3,029,000	2,943,000
Service received free of charge (a)	1,093,342	1,182,550
Other revenue	9,020	2,899
Total administered income	**9,577,362**	**9,415,449**
Expenses		
Employee benefits expense	7,725,066	7,670,185
Supplies and services	1,299,371	1,242,619
Accommodation expense	545,966	398,559
Other expenses	198,048	265,007
Total administered expenses	**9,768,451**	**9,576,370**

(a) Service received free of charge in 2018/19 includes $1,036,363 ($1,121,920 in 2017/18) from Mental Health Commission (refer to note 9.12 'Services provided free of charge'), $31,174 ($60,630 in 2017/18) from State Solicitor Office and $28,805 from Department of Finance ($0 in 2017/18).

10.2 Disclosure of administered assets and liabilities

	2019	2018
Current Assets		
Cash and cash equivalents	1,804,224	1,942,409
Receivables	16,042	58,325
Other current assets	1,784	-
Total Administered Current Assets	1,822,050	2,000,734
Total Administered Assets	**1,822,050**	**2,000,734**
Current Liabilities		
Payables	280,539	250,884
Provision	1,045,508	1,119,588
Total Administered Current Liabilities	1,326,047	1,370,472
Non-Current Liabilities		
Provision	256,436	199,604
Total Administered Non-Current Liabilities	256,436	199,604
Total Administered Liabilities	**1,582,483**	**1,570,076**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

10.3 Explanatory statement for administered income and expenses

All variances between estimates (original budget) and actual results for 2019, between the actual results for 2019 and 2018 are below. Narratives are provided for key major variances, which are generally greater than 5% and $188,000.

10.3.1 Explanatory statement for Administered Items (Statement of Comprehensive Income)

	Variance Note	Estimate 2019 $	Actual 2019 $	Actual 2018 $	Variance between estimate and actual $	Variance between actual results for 2019 and 2018 $
Income						
For transfer:						
Administered appropriation						
Mental Health Tribunal	1	2,590,000	2,778,000	2,660,000	188,000	118,000
Mental Health Advocacy Service		2,668,000	2,668,000	2,627,000	-	41,000
Office of Chief Psychiatrist		3,029,000	3,029,000	2,943,000	-	86,000
Service received free of charge		1,068,000	1,093,342	1,182,550	25,342	(89,208)
Other revenue		-	9,020	2,899	9,020	6,121
Total administered income		**9,355,000**	**9,577,362**	**9,415,449**	**222,362**	**161,913**
Expenses						
Employee benefits expense	2	-	7,725,066	7,670,185	7,725,066	54,881
Supplies and services	2	9,355,000	1,299,371	1,242,619	(8,055,629)	56,752
Accommodation expense	2	-	545,966	398,559	545,966	147,407
Other expenses	2		198,048	265,007	198,048	(66,959)
Total administered expenses		**9,355,000**	**9,768,451**	**9,576,370**	**413,451**	**192,081**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

10.3.2 Explanatory statement for Administered Items (Statement of Financial Position)

At the time of budget submission, it was estimated that there will not be any assets and liabilities. All variances between the actual results for 2019 and 2018 are below. Narratives are provided for key major variances, which are generally greater than 5%.

	Variance Note	Estimate 2019 $	Actual 2019 $	Actual 2018 $	Variance between estimate and actual $	Variance between actual results for 2019 and 2018 $
ASSETS						
Current Assets						
Cash and cash equivalents		-	1,804,224	1,942,409	1,804,224	(138,185)
Receivables		-	16,042	58,325	16,042	(42,283)
Other current assets		-	1,784	-	1,784	1,784
Total Administered Current Assets		**-**	**1,822,050**	**2,000,734**	**1,822,050**	**(178,684)**
TOTAL ADMINISTERED ASSETS		**-**	**1,822,050**	**2,000,734**	**1,822,050**	**(178,684)**
LIABILITIES						
Current Liabilities						
Payables		-	280,539	250,884	280,539	29,655
Provisions		-	1,045,508	1,119,588	1,045,508	(74,080)
Total Administered Current Liabilities		**-**	**1,326,047**	**1,370,472**	**1,326,047**	**(44,425)**
Non-Current Liabilities						
Provisions		-	256,436	199,604	256,436	56,832
Total Administered Non-Current Liabilities		**-**	**256,436**	**199,604**	**256,436**	**56,832**
TOTAL ADMINISTERED LIABILITIES		**-**	**1,582,483**	**1,570,076**	**1,582,483**	**12,407**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2019

10.3 Explanatory statement for administered income and expenses (cont.)

Major Estimate and Actual (2019) Variance Narratives

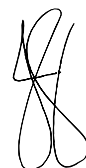
1 Variance of $188,000 for Service Appropriation income is due to the supplementary funding of $155,000 as part of Government Office Accommodation reform, and fit-out costs and $33,000 additional demand funding provided 2018-19.

2 At the time when the 2018-19 Budget was finalised no budget was allocated to each expense line item.

Certification of Key Performance Indicators

For the reporting period ended 30 June 2019

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 2019.



Jennifer McGrath
Acting Commissioner
Mental Health Commission
Accountable Authority

17 September 2019

Auditor General's Opinion of Financial Statements and KPIs

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

MENTAL HEALTH COMMISSION

Report on the Financial Statements

Opinion

I have audited the financial statements of the Mental Health Commission which comprise the Statement of Financial Position as at 30 June 2019, the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows, 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.

In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the Mental Health Commission for the year ended 30 June 2019 and the financial position at the end of that period. They are in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for Opinion

I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Commission in accordance with the *Auditor General Act 2006* and the relevant ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial statements. I have also fulfilled my other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibility of the Commissioner 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, the *Financial Management Act 2006* 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.

In preparing the financial statements, the Commissioner is responsible for assessing the agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Western Australian Government has made policy or funding decisions affecting the continued existence of the Commission.

Auditor's Responsibility for the Audit of the Financial Statements

As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with Australian Auditing Standards, I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the agency's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Commissioner.

- Conclude on the appropriateness of the Commissioner's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the agency's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Commissioner regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report on Controls

Opinion

I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the Mental Health Commission. The controls exercised by the 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 (the overall control objectives).

My opinion has been formed on the basis of the matters outlined in this report.

In my opinion, in all material respects, 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 2019.

The Commissioner's Responsibilities

The Commissioner is responsible for designing, implementing and maintaining controls to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities are in accordance with the *Financial Management Act 2006*, the Treasurer's Instructions and other relevant written law.

Auditor General's Responsibilities

As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the suitability of the design of the controls to achieve the overall control objectives and the implementation of the controls as designed. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3150 *Assurance Engagements on Controls* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements and plan and perform my procedures to obtain reasonable assurance about whether, in all material respects, the controls are suitably designed to achieve the overall control objectives and the controls, necessary to achieve the overall control objectives, were implemented as designed.

An assurance engagement to report on the design and implementation of controls involves performing procedures to obtain evidence about the suitability of the design of controls to achieve the overall control objectives and the implementation of those controls. The procedures selected depend on my judgement, including the assessment of the risks that controls are not suitably designed or implemented as designed. My procedures included testing the implementation of those controls that I consider necessary to achieve the overall control objectives.

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

Limitations of Controls

Because of the inherent limitations of any internal control structure it is possible that, even if the controls are suitably designed and implemented as designed, once the controls are in operation, the overall control objectives may not be achieved so that fraud, error, or noncompliance with laws and regulations may occur and not be detected. Any projection of the outcome of the evaluation of the suitability of the design of controls to future periods is subject to the risk that the controls may become unsuitable because of changes in conditions.

Report on the Key Performance Indicators

Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the Mental Health Commission for the year ended 30 June 2019. The key performance indicators are the key effectiveness indicators and the key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, 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 2019.

The 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 internal control as the Commissioner determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

In preparing the key performance indicators, the Commissioner is responsible for identifying key performance indicators that are relevant and appropriate having regard to their purpose in accordance with Treasurer's Instruction 904 *Key Performance Indicators*.

Auditor General's Responsibility

As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the key performance indicators. The objectives of my engagement are to obtain reasonable assurance about whether the key performance indicators are relevant and appropriate to assist users to assess the agency's performance and whether the key performance indicators are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3000 *Assurance Engagements Other than Audits or Reviews of Historical Financial Information* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements relating to assurance engagements.

indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 904 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

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

My Independence and Quality Control Relating to the Reports on Controls and Key Performance Indicators
I have complied with the independence requirements of the *Auditor General Act 2006* and the relevant ethical requirements relating to assurance engagements. In accordance with ASQC 1 *Quality Control for Firms that Perform Audits and Reviews of Financial Reports and Other Financial Information, and Other Assurance Engagements*, the Office of the Auditor General maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory 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 2019 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.

SANDRA LABUSCHAGNE
DEPUTY AUDITOR GENERAL
Delegate of the Auditor General for Western Australia
Perth, Western Australia
18 September 2019

Detailed Key Effectiveness Indicators Information

Outcome one: Improved mental health and wellbeing

1.1 Percentage of the population with high or very high levels of psychological distress

Description

An indication of the mental health and wellbeing of a population is provided by measuring levels of psychological distress using the 10-item Kessler Psychological Distress Scale (K10). The K10 questionnaire is a widely used and reported measure of global psychosocial distress, and is used in both population based surveys and in clinical settings. High psychological distress has a strong relationship with diagnosable mental disorders and is useful for estimating population need for mental health services.

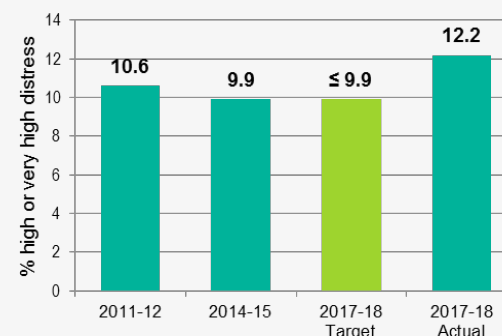
Rationale

Monitoring psychological distress in the Western Australian population will enable the Commission to assess the impact of its services and initiatives on the population to promote mental health and wellbeing.

Results

The proportion of the Western Australian population with high or very high levels of psychological distress is published through the Australian Bureau of Statistics (ABS) National Health Survey which is conducted every three years, and is derived from the K10.

The most recent National Health Survey (2017-18) stated that the proportion of the Western Australian population with high or very high levels of psychological distress (12.2%) was 2.3 percentage points higher than the 2017-18 target and the proportion reported in 2014-15 of 9.9%.



__Note:__ The Kessler Psychological Distress Scale (K10) is scored from 10 to 50, with higher scores indicating a higher level of distress, a score of 22 and above indicates high or very high distress. In the 2017-18 survey, the Western Australian result was 0.8 percentage points below the National figure of 13.0%. The indicator now reflects the financial year in which survey data was collected. Previously, the most recent survey results were presented as the financial year result, which does not accurately reflect prevalence for that year.

__Data source:__ Australian Bureau of Statistics (ABS) – National Health Survey, 2017-18. The 2017-18 survey was conducted in all states and territories and across urban, rural and remote areas of Australia (other than very remote areas), and included around 21,000 people in nearly 16,000 private dwellings.

__Time period:__ The National Health Survey is only conducted every three years. The 2011-12 results were published in 2012-13, the 2014-15 results were published in 2015-16, and the 2017-18 results were published in 2018-19.

Outcome two: Reduced incidence of use and harm associated with alcohol and other drug use

2.1 Percentage of the population aged 14 years and over reporting recent use of alcohol at a level placing them at risk of lifetime harm

Description

Alcohol-related risk of harm is determined using the 2009 National Health and Medical Research Council guidelines. The 2009 guidelines recommend that for healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.

Rationale

Preventing or delaying the onset of risky alcohol consumption contributes to the prevention of long-term health related harm.

This indicator is strategic, measurable and comparable to other jurisdictions. It uses information from the National Drug Strategy Household Survey (NDSHS); a national survey conducted every three years that provides a view of reported illicit drug use and alcohol over time. This indicator reflects the impact of preventative initiatives across a range of government departments, including the Commission, on reducing the incidence of use and harm associated with AOD.

Results

The most recent survey conducted in 2016 stated the proportion of the Western Australian population aged 14 years and over reporting use of alcohol at lifetime risky levels (18.4%) was 3.2 percentage points lower than the proportion reported in the 2013 survey (21.6%). Results of the upcoming 2019 survey are not anticipated to be released until 2020.

Note: *The 2016 survey collected data from 23,772 people aged 12 years and older across Australia and was conducted using a multimode completion methodology. Selected individuals could choose to complete the survey via a paper form, an online form or via a telephone interview. The 2016 survey was the first time an online form was used - the 2013 and 2010 surveys consisted solely of a self-completion drop-and-collect method. Changes to the methodology should be taken into consideration when making comparisons over time.*

In the 2016 survey, the Western Australian result was 1.3 percentage points above the National figure of 17.1%.

The indicator now reflects the calendar year in which survey data was collected. Previously, the most recent survey results were presented as the financial year result, which does not accurately reflect prevalence for that year.

Data source: *Australian Institute of Health and Wellbeing (AIHW) - National Drug Strategy Household Survey (NDSHS), 2016.*

Time period: *The NDSHS is only conducted every three years. The most recent survey was conducted in 2016 with results released in 2017.*

2.2 Percentage of the population aged 14 years and over reporting recent use of illicit drugs

Description

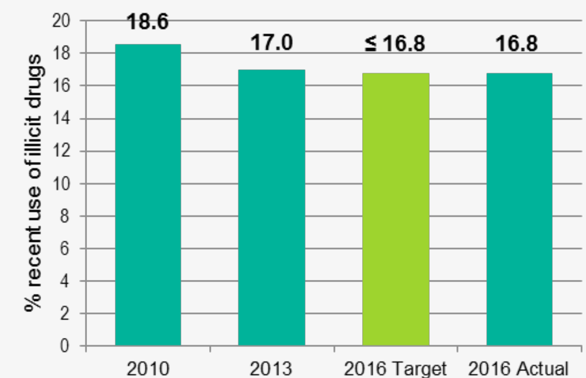
The term 'Illicit drugs', as reported in the NDSHS, covers a wide range of drugs that includes illegal drugs (such as cannabis, ecstasy, heroin and cocaine), and prescription pharmaceuticals (such as tranquillisers, sleeping pills, and opioids) used for illicit purposes, and other substances used inappropriately such as inhalants and naturally occurring hallucinogens. The term 'recent use' refers to the use of drugs or alcohol within 12 months prior to being surveyed for the NDSHS.

Rationale

Preventing illicit drug use reduces the impact of short-term risk and contributes to the prevention of long-term health related harm. This indicator is strategic, measurable and comparable to other jurisdictions. It uses information from the NDSHS, a national survey conducted every three years that provides a view of reported illicit drug use and alcohol over time. This indicator reflects the impact of preventative initiatives of a range of government departments, including the Commission, on reducing the incidence of use and harm associated with AOD.

Results

The most recent survey conducted in 2016 stated the proportion of the Western Australian population aged 14 years and over reporting recent use of illicit drug use (16.8%) was 0.2 percentage points lower than the proportion reported in the 2013 survey (17.0%). Results of the 2019 survey are not anticipated to be released until 2020.



Note: *The 2016 survey collected data from 23,772 people aged 12 years and older across Australia and was conducted using a multimode completion methodology. Selected individuals could choose to complete the survey via a paper form, an online form or via a telephone interview. The 2016 survey was the first time an online form was used - the 2013 and 2010 surveys consisted solely of a self-completion drop-and-collect method. Changes to the methodology should be taken into consideration when making comparisons over time.*

In the 2016 survey, the Western Australian result was 1.2 percentage points above the National figure of 15.6%.

The indicator now reflects the calendar year in which survey data was collected. Previously, the most recent survey results were presented as the financial year result, which does not accurately reflect prevalence for that year.

Data source: *Australian Institute of Health and Wellbeing (AIHW) – National Drug Strategy Household Survey (NDSHS), 2016.*

Time period: *The NDSHS is only conducted every three years. The most recent survey was conducted in 2016 with results released in 2017.*

2.3 Rate of hospitalisation for alcohol and other drug use

Description

This indicator reports the age-standardised rate of hospitalisations attributable to AOD use per 100,000 population. It is common for hospitalisations to result from more than one cause. In order to determine what proportion of hospitalisations are likely due to the effects of AOD, estimates are used. These estimates are called Aetiological Fractions (AFs) and are based on the published literature. Hospitalisation data is a robust measure of harmful health effects attributable to the use of alcohol and other drugs in the community.

Rationale

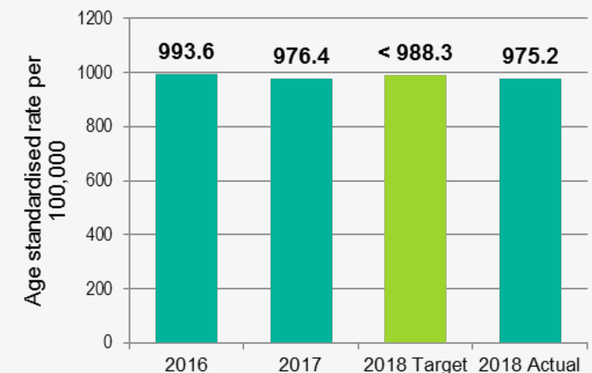
The impact of preventative initiatives to reduce the incidence of harm associated with alcohol and other drugs may be measured indirectly through the rate of hospitalisation for alcohol and other drugs. This indicator may also measure the effectiveness of AOD services which aim to provide high quality and appropriate treatments and supports to reduce the harm associated with AOD use. It can be broadly interpreted as a measure of the impact of AOD use on the health of the general population of Western Australia.

Data source: *Department of Health, Epidemiology Branch.*
Time period: *The data is for the calendar year.*

Results

The latest available data is for the 2018 calendar year and the age-standardised rate of hospitalisations attributable to AOD use is 975.2 per 100,000 population, 1.2 points lower than the rate for the 2017 calendar year (976.4 per 100,000 population), and 13.1 points lower than the 2018 calendar year target (988.3 per 100,000 population).

(results continue over page)



–

Detailed Key Effectiveness Indicators Information

Due to methodology changes that occured in 2018-19 in the underlying estimates used to calculate the rate of hospitalisation, the 2016 result was restated to reflect the updated methodology. The previously audited result presented in the 2017-18 Annual Report for the 2016 calendar year was 988.3 per 100,000 population. As the 2017 calendar year's result was not available at the time, it was not presented in the 2017-18 Annual Report.

Outcome three: Accessible, high quality and appropriate mental health and alcohol and other drug treatments and supports

3.1 Readmissions to hospital within 28 days of discharge from acute specialised mental health units (national indicator)

Description

The proportion of overnight separations from acute specialised mental health inpatient units that are followed by a readmission to the same or another specialised mental health inpatient unit within 28 days of discharge.

Rationale

This indicator measures the appropriateness and quality of care provided by mental health services. The readmission rate is an indicator of the objective to provide effective care and continuity of care in the delivery of mental health services. This indicator is a nationally endorsed and widely reported indicator, considered to be a global performance measure as it potentially points to deficiencies in the functioning of the overall mental health care system. Admissions to a 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 inappropriate or inadequate to maintain the person out of hospital.

This indicator seeks to address the policy question of whether mental health consumers receive effective care in hospital and if on discharge, care is coordinated and continuous in the community setting (and therefore people are more likely to recover). A community support system for people who are discharged from hospital after an acute psychiatric episode is essential to maintain clinical and functional stability and to minimise the need for hospital readmission. This is particularly important in the vulnerable period following discharge from hospital.

Note: *A re-admission for any of the separations identified as 'in scope' is defined as an admission to any acute specialised mental health inpatient unit in Western Australia and includes admissions to specialised mental health inpatient units in publicly funded private hospitals. This indicator is constructed using the national definition and target. Due to a six month lag to enable coding of this indicator; calendar year is a more appropriate reporting period.*

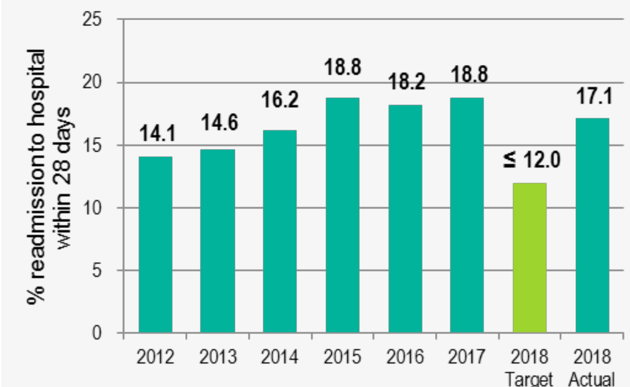
Data source: *Hospital Morbidity Data Collection, Department of Health.*

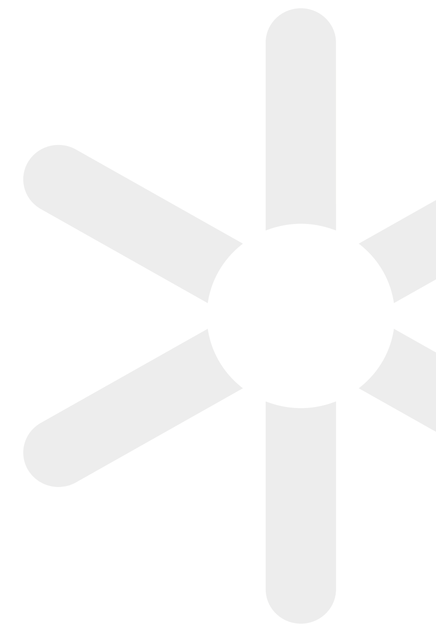
Time period: *The data is for the calendar year.*

Results

In 2018, the readmission rate to acute mental health inpatient facilities within 28 days of discharge was 17.1%. This result is 5.1 percentage points higher than the target of less than 12.0% but 1.7 percentage points below the 2017 result of 18.8%.

(results continue over page)





Since 2014, readmission rates have been impacted by the introduction of new models of care such as hospital in the home. It should be noted that the readmission rate does not differentiate between planned and unplanned readmissions which can affect the overall readmission rates. Planned readmissions may be part of a staged discharge plan or the model of care for the diagnosis.

Due to nationally agreed changes that occurred in 2018-19 to the method for calculating this indicator, results from 2012 to 2017 were restated to reflect the updated methodology. Therefore, the results presented in this annual report are different to those reported in the 2017-18 annual report. The previously audited results presented in the 2017-18 annual report were 13.5% (2012), 14.2% (2013), 15.6% (2014), 17.6% (2015), 17.1% (2016) and 18.1% (2017).

3.2 Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units (national indicator)

Description

The proportion of overnight separations from public mental health inpatient units where a community-based mental health service contact occurred within seven days following discharge. Seven days was recommended nationally as an indicative time period for contact within the community following discharge from hospital.

Rationale

This indicator measures the quality of care provided by mental health services. It is an indicator of the objective to provide continuity of care in the delivery of mental health services. A large proportion of people with a mental health problem have a chronic or recurrent type 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.

Discharge from mental health inpatient units is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have heightened levels of vulnerability and, without adequate follow up, may relapse and/or need to be readmitted. A higher percentage of contact with mental health services within seven days post discharge should lead to a lower proportion of readmissions. These community treatment services provide ongoing clinical treatment and access to a range of programs that maximise an individual's independent functioning and quality of life.

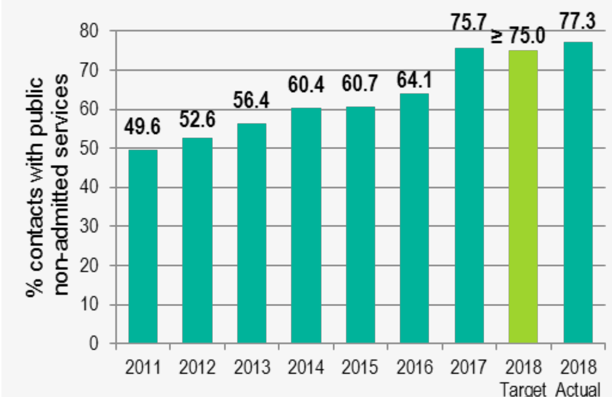
__Note:__ This indicator includes follow up by public mental health non-admitted services only. Follow up by other providers, including private psychiatrists, GPs or community managed (non-government) services are not included. This indicator is constructed using the national definition and target. Due to a six month lag to enable coding of this indicator; calendar year is a more appropriate reporting period.

__Data source:__ Mental Health Information System (MHIS), Department of Health. Hospital Morbidity Data Collection, Department of Health.

__Time period:__ The data is for the calendar year.

Results

In 2018, 77.3% of patients had contact with a community mental health treatment service within seven days post discharge from a public mental health inpatient unit. This result is 1.6 percentage points higher than the 2017 result of 75.7% and 2.3 percentage points higher than the national target of greater than or equal to 75%. As seen over the eight year period, the Commission's focus on regular review and reporting of this indicator is assisting Health Service Providers in achieving the national target.



3.3 Percentage of closed alcohol and other drug treatment episodes completed as planned

Description

This indicator reports the percentage of closed treatment episodes in AOD treatment services that were completed as planned. An episode is the period of care between the start and end of treatment. Treatment episodes are considered to have a planned exit if the reason for cessation is one of the following: ceased at expiation, ceased to participate by mutual agreement, change in the delivery setting, change in the principal drug of concern, change in the main treatment type, transferred to another service provider or treatment completed.

Unplanned exits occur if the reason for cessation is one of the following: ceased to participate against advice, ceased to participate involuntary (non-compliance), ceased to participate without notice, died, sanctioned by drug court or court diversion service back to jail or imprisoned (other than drug court sanctioned).

Rationale

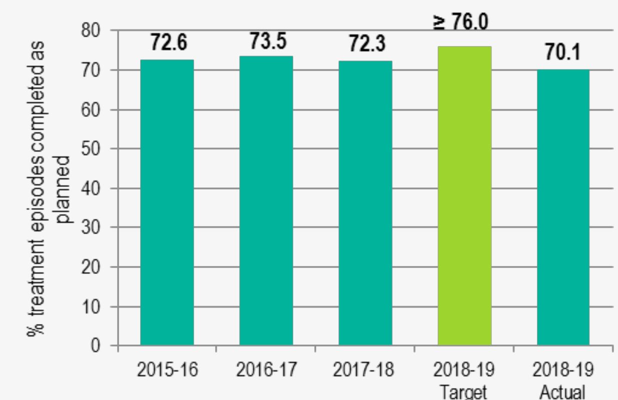
This indicator measures the quality of AOD treatment and supports. International literature identifies that treatment outcomes for people with AOD-related problems are significantly enhanced if they remain in treatment until the program is completed or they leave with the agreement of their clinician. Treatment episodes that are completed as planned are indicative of effective outcomes. A high percentage of closed AOD treatment episodes completed as planned is indicative of high quality and appropriate care in AOD treatment and support.

Data source: *The Commission's De-identified Treatment Agency Database.*

Time period: *Data for the financial year is for the 12-month period from April to March to allow for a three month lag for coding and auditing purposes.*

Results

In 2018-19, the percentage of closed treatment episodes that were completed as planned was 70.1%. This result is 2.2 percentage points lower than the 2017-18 result of 72.3% and 5.9 percentage points lower than the 2018-19 target of greater than or equal to 76.0%. The Commission is continuing to work towards the target to ensure high quality and appropriate care.



3.4 Percentage of contracted non-government mental health services that met the National Standards for Mental Health Services through independent evaluation

Description

Monitoring the non-government organisations (NGOs) contracted by the Commission to provide mental health services and supports against national standards for care will enable appropriate and quality care to individuals in the community.

National Standards for Mental Health Services (NSMHS) provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. These standards can apply to non-government community mental health services as well as specialised public mental health (ie community treatment and hospital-based) services.

This indicator measures the proportion of organisations that have been through Independent Quality Evaluations that achieved at least eight of the ten standards. The intent of independent evaluation is to focus on how an organisation is continuously improving its services, supporting individuals to meet their individual goals (Outcomes) and meeting the Standards. A key component of the Quality Evaluations is identifying the satisfaction people (individuals, families and carers) have experienced accessing the services including their perception and confidence in how the organisation is meeting their needs. Having an independent team of evaluators look at an organisation's services and speak to the people accessing them in a confidential manner can provide the opportunity for continuous improvement activities that otherwise may not be identified.

Rationale

This indicator measures the appropriateness and quality of mental health services provided by NGOs contracted by the Commission against the NSMHS. High quality and appropriate services are associated with better mental health outcomes for consumers.

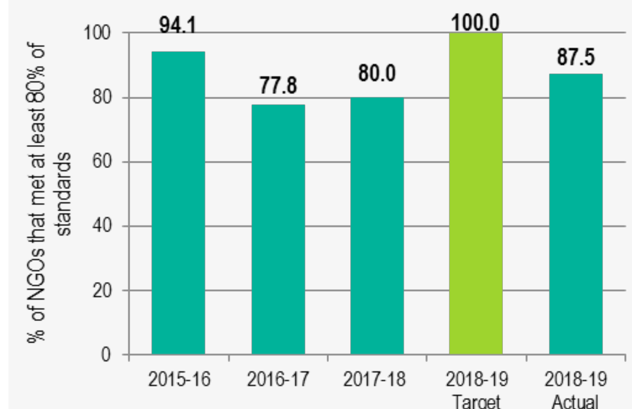
Data source: *Mental Health Commission, Sector and Quality Evaluation Management.*

Time period: *Data is for the financial year. Note, the result for 2018-19 is based only on July-December 2018 due to the move to external accreditation process on 1 January 2019.*

Results

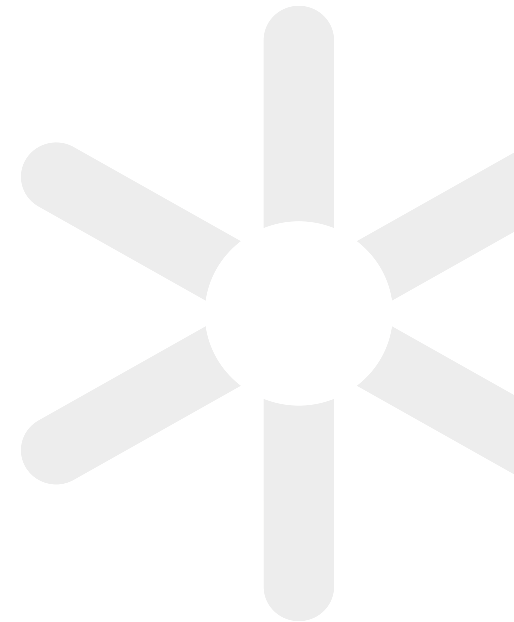
In 2018-19, the percentage of non-government organisations contracted to provide mental health services that met at least eight of the ten NSMHS standards was 87.5%. One of the eight service providers assessed in 2018-19 did not meet at least eight of the standards. This result is 7.5 percentage points higher than the 2017-18 result of 80.0% but 12.5 percentage points lower than the 2018-19 target of 100%.

(results continue over page)



These service providers are required to provide evidence to the Commission that they have completed specified actions within set timeframes in order to bring their services in line with the Standards. The Quality Unit within the Commission works closely with each NGO to ensure any gaps identified against the NSMHS are fully addressed within a specified timeframe.

Note that results are only for the first half of the 2018-19 financial year (July to December 2018) as the Independent Quality Evaluation process was replaced by the external accreditation process in January 2019. The move to external accreditation against a recognised standard for non-government mental health services aligns with the existing requirement for non-government alcohol and other drug services purchased by the Commission.



3.5 Percentage of contracted non-government alcohol and other drug services that met an approved accreditation standard

Description

Monitoring the NGOs contracted by the Commission to provide an AOD treatment service against national standards for care will enable the Commission to be confident that it is investing in services that are providing appropriate and quality care to individuals in the community.

All Commission-funded services delivering alcohol and drug treatment (including AOD community bed-based and community treatment services) are required to achieve and maintain accreditation against an approved accreditation standard. The accreditation process provides an opportunity for continuous improvement activities that otherwise may not be identified.

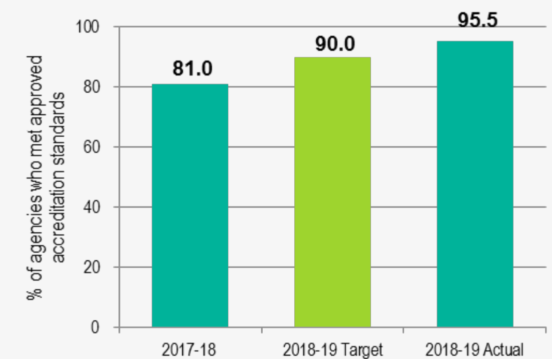
Achieving accreditation provides the Commission with an assurance that clients have access to services that are of quality standard. Having quality assessed against an approved standard ensures that there is equity in how the services are assessed and provides a degree of transparency that will stand up to outside scrutiny.

Rationale

This indicator measures the appropriateness and quality of AOD treatment services provided by NGOs contracted by the Commission against an approved standard. High quality and appropriate services are associated with better outcomes for consumers.

Results

In 2018-19, 95.5% of non-government organisations contracted to provide alcohol and other drugs services met an approved accreditation standard (21 out of 22 organisations). This is 14.5 percentage points higher than the 2017-18 result of 81% and 5.5 percentage points higher than the 2018-19 target of 90%.



Data source: *Mental Health Commission, Quality Unit.*

Providers of AOD treatment services are required to provide an update on their accreditation status as part of the annual activity report to the Commission. These reports are due to the Commission by 31 July of each year. Contract managers within NGO Purchasing and Development are responsible for reviewing and providing feedback on these reports. As part of the review process the Contract Managers will note the information relating to the accreditation status and enter this information into a register maintained by the Quality Unit.

Time period: *Data is for the financial year.*

3.6 Percentage of the population receiving public clinical mental health care (national indicator)

Description

This indicator reports on the proportion of the Western Australian population using a specialised public mental health service. This indicator measures the accessibility of public mental health services. Widespread concern about access to mental health care was a key factor that underpinned the Council of Australian Governments (COAG) National Action Plan on Mental Health endorsed by governments in 2006, and was reinforced in the commitments made under the various National Mental Health Plans. The Third and Fourth National Mental Health Plans in particular have emphasised the need to improve access to primary mental health care, especially for people with common mental illnesses.

The issue of unmet need has become prominent at a national level since the National Survey of Mental Health and Wellbeing indicated that a majority of people affected by a mental disorder do not receive treatment. While not all people affected by a mental disorder require treatment, and while some will only receive treatment from sources other than specialised public mental health services (such as primary care from GPs, treatment in private hospitals or supports from non-government organisations), this indicator enables the Commission to monitor the accessibility of public mental health services, which currently account for more than 78% of the Commission's funding.

Rationale

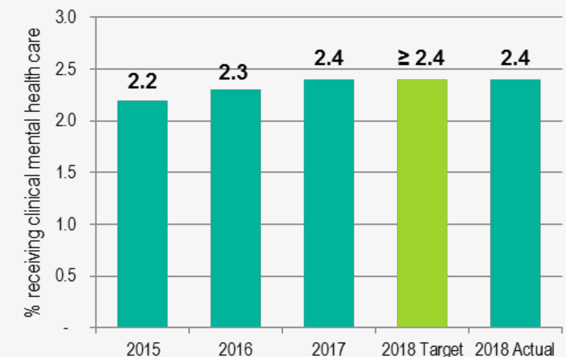
This indicator measures the accessibility of public mental health services. A higher percentage is indicative of greater accessibility to mental health services by those in need.

Data source: *Mental Health Information System (MHIS), Department of Health. Hospital Morbidity Data Collection, Department of Health. Population figures – ABS time series workbook 3101.0 Population by age and sex, Australian States and Territories, Western Australia.*

Time period: *The data for the number of people receiving public clinical mental health care is for the calendar year. The population data for the 2018 calendar year result is based on the ABS June 2018 population estimate released in December 2018 and last updated on 20 June 2019.*

Results

In 2018, the percentage of the Western Australian population receiving public mental health care was 2.4%. This result is equal to the 2017 result (2.4%) and matches the 2018 target (greater than or equal to 2.4%).



3.7 Percentage of the population receiving public alcohol and other drug treatment

Description

This indicator reports on the proportion of the Western Australian population receiving public AOD treatment and measures the accessibility of public AOD services. Data is collated by the Commission from agencies that receive public funding, excluding those solely funded by Commonwealth, then submitted to the Australian Institute of Health and Welfare as part of the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS).

Although the AODTS NMDS collection covers the majority of publicly funded AOD treatment services, including government and non-government organisations, it is difficult to fully quantify the scope of AOD services in Australia. People receive treatment for AOD-related issues in a variety of settings not in scope for the AODTS NMDS. These include: services provided by other not-for-profit organisations and private treatment agencies that do not receive public funding; hospitals, including admitted patient services, outpatient clinics and emergency departments; prisons, correctional facilities and detention centres; primary health-care services, including general practitioner settings, community-based care, Indigenous-specific primary health-care services, and dedicated substance use services; health promotion services (for example, needle and syringe programs); and accommodation services (for example, halfway houses and sobering-up shelters). Therefore, this KPI is likely to be an underestimation of the total percentage of the population receiving AOD treatment.

Rationale

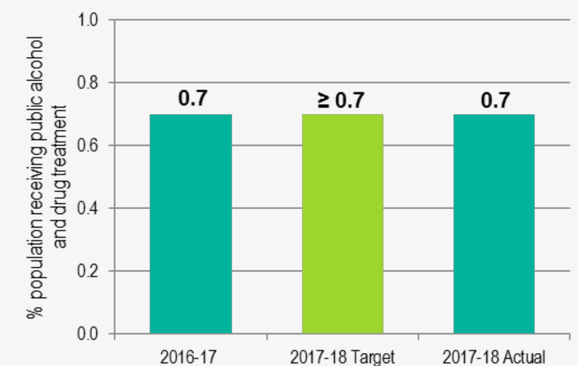
This indicator measures the accessibility of public AOD services. This indicator can be thought of as the AOD equivalent of Key Effectiveness Indicator 3.6, where in general, a higher percentage is indicative of greater accessibility to AOD services by those in need.

Data source: *Australian Institute of Health and Welfare, AOD treatment services in Australia 2017-18. Population figures – ABS time series workbook 3101.0 Population by age and sex, Australian States and Territories, Western Australia.*

Time period: *Due to the timetable for data submissions and jurisdiction sign-off set by the Australian Institute of Health and Welfare, there is a one financial year time lag in the reporting of the results. The population data for the 2017-18 result is based on the ABS June 2017 population estimate, released in December 2018 and last updated on 20 June 2019.*

Results

In 2017-18, the percentage of the Western Australian population receiving public AOD treatment was 0.7%. This result is equal to the 2016-17 result (0.7%) and matches the 2017-18 target (greater than or equal to 0.7%).



Detailed Key Efficiency Indicators Information

Service one: Prevention

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

Description

Mental health prevention, promotion and protection activities focus on groups (populations) 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. Such measures encourage lifestyle and behavioural choices, attitudes and beliefs that protect and promote mental health and reduce mental disorders.

Rationale

This indicator measures the cost per capita of mental health promotion, illness prevention, protection and related activities. It monitors the investment by the Commission in activities that 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 illnesses before they develop.

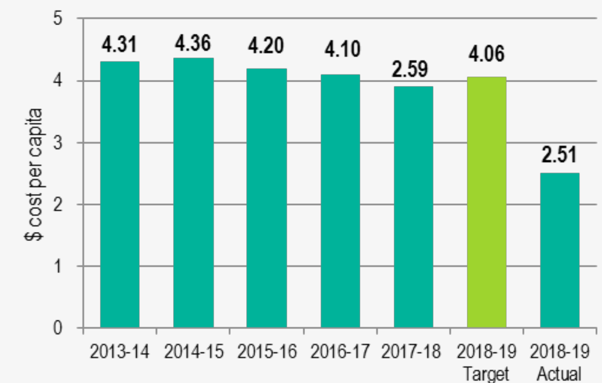
Data source: *The Commission's Financial Systems. Population figures – ABS time series workbook 3101.0. Population by age and sex, Australian States and Territories, Western Australia.*

Time period: *The population data for the 2018-19 result is based on the ABS June 2018 population estimate, released in December 2018 and last updated on 20 June 2019. Cost data is for the financial year.*

Results

In 2018-19, the cost per capita to provide prevention, promotion, protection and related activities to enhance mental health and wellbeing was $2.51. The result is 38.3% lower than the 2018-19 target of $4.06.

(results continue over page)



The substantial change in cost per capita for this indicator is due to a change in how funding has been allocated following a review conducted by the Commission in 2018-19 to further improve reporting transparency and accuracy. While there has been no overall decrease in funding or change in mental health prevention, promotion and protection activities, the 2018-19 result for this indicator differs from the previous financial years' results and the 2018-19 target with the allocation of some funding to other streams such as community treatment and community support.

If funding was allocated the same way in 2017-18, the 2017-18 result ($2.59) would have been similar to the 2018-19 result ($2.51). The previously audited 2017-18 result presented in the 2017-18 annual report, which was based on the previous funding allocation, was $3.90.

Please note it was not possible to restate the results from 2013-14 to 2016-17 and therefore these results are not comparable to the 2017-18 and 2018-19 results presented in this annual report.

1.2 Cost per capita of the population 14 years and above for initiatives that delay the uptake and reduce the harm associated with alcohol and other drugs

Description

The Commission delivers public health campaigns and initiatives to reduce harmful alcohol use and prevent illicit drug use including: the Alcohol.Think Again campaign, which encourages and supports communities to achieve a safer drinking culture in Western Australia; and the Drug Aware program (which includes the Meth Can Take Control program), which focuses on reducing the harm from illicit drugs by encouraging sensible and informed decisions about illicit drug use, through providing credible, factual information and delivering comprehensive strategies to address drug-related issues.

The Commission supports local service providers to prevent AOD use and related problems through activities such as a Statewide network of local drug action groups that deliver preventative activities and education for youth and support for families, and school drug education through the state, Catholic and independent school sectors.

Rationale

This indicator measures the cost per capita of AOD related initiatives that delay uptake and reduce harmful alcohol use as well as preventing illicit drug use. This investment applies to the population as a whole in the context of their everyday lives. The aim is to increase the proportional investment in the prevention service and gain a return in health, economic and social benefits for the Western Australian community.

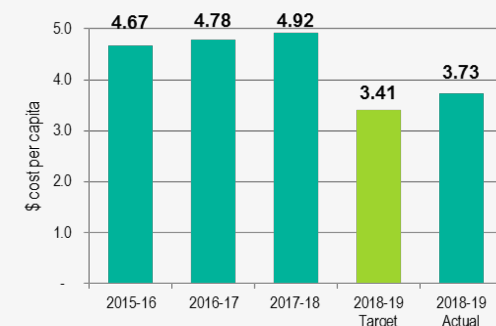
Data source: *The Commission's Financial Systems. Population figures – ABS time series workbook 3101.0. Population by age and sex, Australian States and Territories, Western Australia.*

Time period: *The population data for the 2018-19 result is based on the ABS June 2018 population estimate, released in December 2018 and last updated on 20 June 2019. Cost data is for the financial year.*

Results

In 2018-19, the cost per capita for initiatives that delay the uptake and reduce the harm associated with alcohol and other drugs was $3.73. This result is 9.1% higher than the 2018-19 target of $3.41 but 24.2% lower than the 2017-18 result of $4.92.

The difference between the 2018-19 target and 2018-19 result is because the target was set before external funding sources were able to be finalised. Specific funding sources are those for the Strong Spirit Strong Mind Metro Project and campaign and evaluation funding from Healthway. Note that these were included in the 2017-18 and the 2018-19 results.



1.3 Cost per person of alcohol and other drug campaign target groups who are aware of, and correctly recall, the main campaign messages

Description

The Commission delivers public health campaigns and initiatives to reduce harmful alcohol use and prevent illicit drug use. These include the Alcohol.Think Again and Drug Aware statewide public education campaigns. The campaigns aim to build awareness and understanding of the risks and harms associated with AOD use.

Rationale

This indicator provides a measure of how much it costs to reach each person aware of the campaign and who correctly understood the message(s) presented by the campaign. This provides an indication of how cost efficient the campaign was in delivering the message(s) intended by the campaign to the target population. Costs include direct media scheduling costs, production, evaluation and other campaign associated costs.

Note: *Online post-campaign surveys are conducted with a cohort of individuals representing the age and/or gender of the campaign target group. The surveys collect data on campaign awareness and correct message recall. As advised by TNS Social Research, an adjustment factor of 80% is applied to the correct message recall rate. This figure is then multiplied by the Western Australian population figures for the campaign target group, which is divided by the average cost of a campaign burst in the financial year.*

Data source - Alcohol: *The Commission's Prevention Branch – Total cost of the campaign. OMD WA– forecast percentage of target group they expect to be 'aware' using a 4 + reach. Kantar Public – forecast percentage of target group who 'correctly' identified campaign message from the most recent 'Parents, Young People and Alcohol' post campaign evaluation in 2017. The total sample size was 201 and was weighted by gender within age and by location to approximate the Western Australian population of individuals aged 25 to 54 years. The response rate was 19%. The confidence interval is 95% and the standard error rate is 4.32%. Population figures – ABS time series workbook 3101.0 Population by age and sex, Australian States and Territories, Western Australia.*

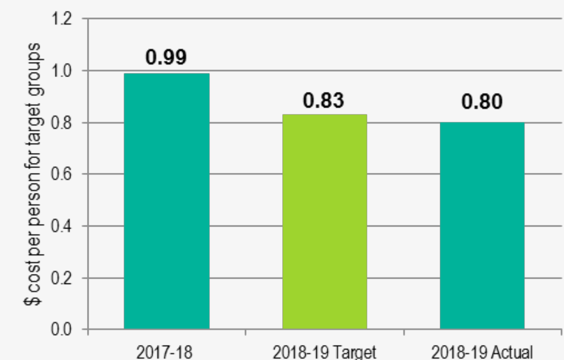
Data Source – Methamphetamine*: The Commission's Prevention Branch – Total cost of the campaign. Kantar Public – percentage of target group who were 'aware' and 'correctly' identified campaign message. The total sample size was 390 and was weighted by gender within age and by location to approximate the Western Australian population of individuals aged 14 to 29 years. The response rate was 35%. The confidence interval is 95% and the standard error rate is 4.96%. Population figures – ABS time series workbook 3101.0 Population by age and sex, Australian States and Territories, Western Australia.*

Time period: *Cost data is for the financial year.*

Results

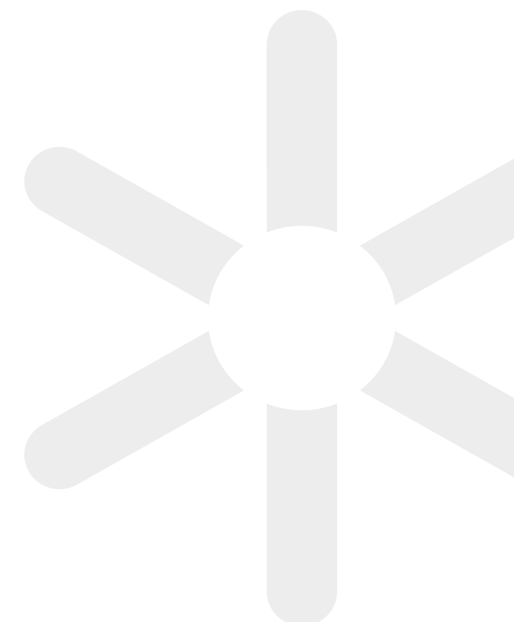
The methodology of this indicator is calculated using combined post campaign evaluation figures of two alcohol and other drug public education campaigns. In 2018-19 the campaigns were Alcohol.Think Again 'Parents, Young People and Alcohol' and the Drug Aware 'Meth can take control'.

(results continue over page)



The 'Parents, Young People and Alcohol' campaign is in market until September 2019 with its post campaign evaluation being conducted immediately upon its completion (results likely October 2019). Therefore forecasted awareness and correct recall figures for the 'Parents, Young People and Alcohol' campaign were used to calculate this KPI indicator.

In 2018-19 the cost per person of AOD campaign target groups who are aware of, and correctly recall, the main campaign messages was $0.80. This is 3.8% lower than the 2018-19 target of $0.83 and 19.2% lower than the 2017-18 result ($0.99).



Service two: Hospital Bed-Based Services

2.1 Average length of stay in purchased acute specialised mental health units

Description

Acute hospital beds provide inpatient assessment and treatment services for people experiencing severe episodes of mental illness who cannot be adequately treated in a less restrictive environment. Average length of stay is defined as the number of inpatient patient days divided by the number of separations. This indicator also includes data from the Next Step inpatient withdrawal units (for AOD use).

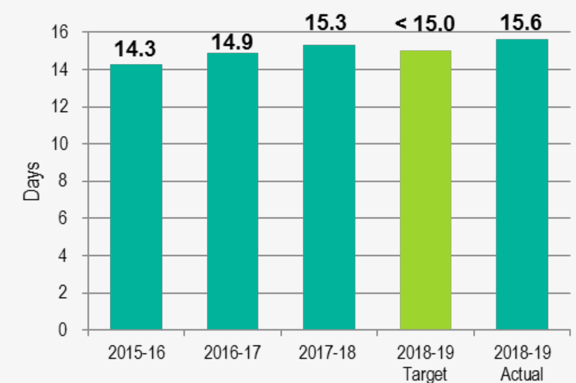
Average length of stay is included to present a more meaningful picture of the efficiency of each bed type. In national reports, such as the Report on Government Services, average length of stay is commonly reported together with cost per inpatient bedday to provide an overall picture of the cost of inpatient care.

Rationale

The purpose of this indicator is to better understand underlying factors which cause variation in acute specialised mental health care costs. It may also demonstrate the degrees of accessibility to acute specialised mental health units. The length of stay indicates the relative volume of care provided to people in acute units and is the main driver of variation in costs.

Results

In 2018-19, the average length of stay for patients with a separation (eg discharged) in acute mental health hospital beds was 15.6 days. This result is 4.1% higher than the 2018-19 target of less than 15.0 days and is 2.3% higher than the 2017-18 result of 15.3 days.



Note: *This indicator also includes a small amount of activity from the Next Step inpatient withdrawal units (for alcohol and other drug use).*

Data source: *Hospital Morbidity Data Collection, Department of Health. Next Step data extracted from the Commission's De-identified Treatment Agency Database.*

Time period: *Data for the financial year is for the 12-month period from April to March to allow for a three month lag for coding and auditing purposes.*

2.2 Average cost per purchased bedday in acute specialised mental health units

Description

As outlined in the Plan, acute hospital beds provide hospital-based inpatient assessment and treatment services for people experiencing severe episodes of mental illness who cannot be adequately treated in a less restrictive environment. Cost per inpatient bedday is defined as expenditure on inpatient services divided by the number of inpatient beddays. This indicator also includes data from the Next Step inpatient withdrawal units (for AOD use).

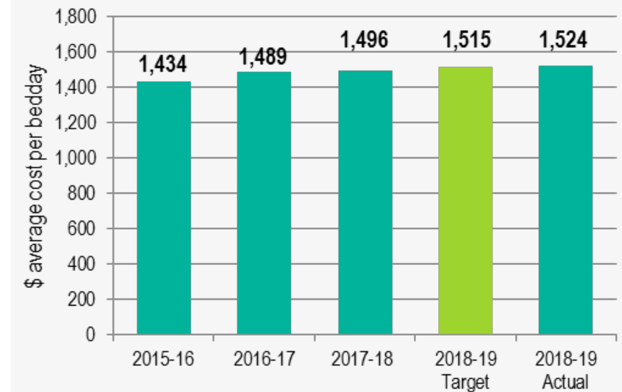
A key objective of the Plan is the realignment of bed-based services to ensure that beds of the right type are in the right places, in the right quantity, and delivered at an efficient price. This indicator will enable greater transparency of services in the context of the developing Activity Based Funding environment, and over time will enable monitoring of progress towards the targets and goals identified in the Plan.

Rationale

The unit cost of admitted patient care in acute specialised mental health units is closely monitored in order to ensure cost effectiveness.

Results

In 2018-19, the average cost per bedday in acute mental health hospital beds was $1,524. This result is 0.6% higher than the 2018-19 target of $1,515 and is 1.9% higher than the 2017-18 result of $1,496.



Data source: *The Commission's Financial Systems. BedState, Department of Health. Next Step data extracted from the Commission's De-identified Treatment Agency Database.*

Time period: *Data is for the financial year.*

2.3 Average length of stay in purchased sub-acute specialised mental health units

Description

Sub-acute specialised mental health units provide hospital-based treatment and support in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their receiving treatment in a less restrictive environment. This service provides for adults, older adults and a selected number of young people with special needs when appropriate. Average length of stay is defined as the number of inpatient patient days divided by the number of separations.

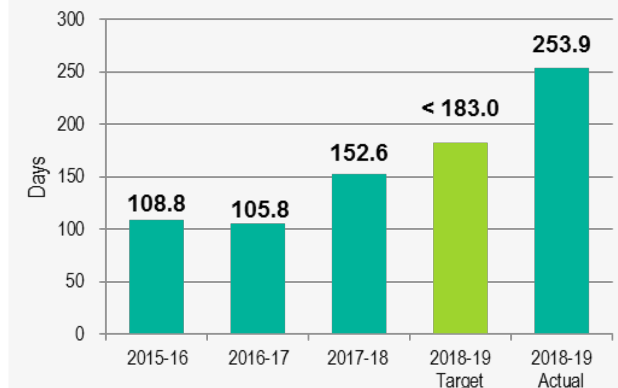
Average length of stay is included to present a more meaningful picture of the efficiency of each bed type. In national reports, such as the Report on Government Services, average length of stay is commonly reported together with cost per inpatient bedday to provide an overall picture of the cost of inpatient care.

Rationale

The purpose of this indicator is to better understand underlying factors which cause variation in sub-acute specialised mental health care costs. It may also demonstrate the degrees of accessibility to sub-acute specialised mental health units. The length of stay indicates the relative volume of care provided to people in sub-acute units and is the main driver of variation in costs.

Results

In 2018-19, the average length of stay for patients with a separation (eg discharged) in sub-acute mental health hospital beds was 253.9 days. This result is 38.7% higher than the 2018-19 target of less than 183 days and is 66.4% higher than 2017-18 result of 152.6 days. In 2018-19, a number of exceptionally long stay patients were able to be appropriately discharged following a review by a Health Service Provider. The longer length of stay for these patients contributed to an overall increase in average length of stay.



Data source: *Hospital Morbidity Data Collection, Department of Health.*

Time period: *Data for the financial year is for the 12-month period from April to March to allow for a three month lag for coding and auditing purposes.*

2.4 Average cost per purchased bedday in sub-acute specialised mental health units

Description

Sub-acute hospital short stay provides hospital-based treatment and support in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their receiving treatment in a less restrictive environment. This service provides for adults, older adults and a selected number of young people with special needs when appropriate. Cost per inpatient bedday is defined as expenditure on inpatient services divided by the number of inpatient beddays.

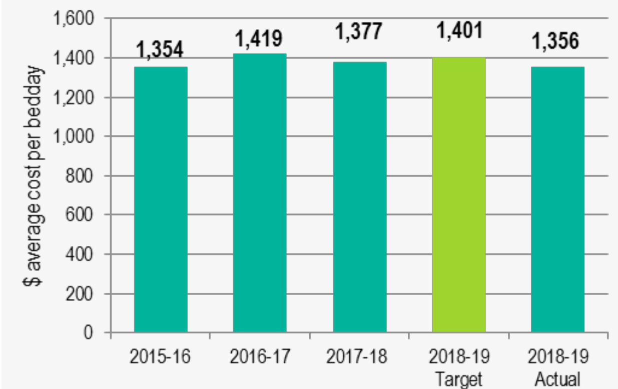
A key objective of the Plan is the realignment of bed-based services to ensure that beds of the right type are in the right places, in the right quantity, and delivered at an efficient price. This indicator will enable greater transparency of services in the context of the developing Activity Based Funding environment, and over time will enable monitoring of progress towards the targets and goals identified in the Plan.

Rationale

The unit cost of admitted patient care in sub-acute specialised mental health units is closely monitored in order to ensure cost effectiveness.

Results

In 2018-19, the average cost per bedday in sub-acute mental health hospital beds was $1,356. This result is 3.2% lower than the 2018-19 target of $1,401 and is 1.5% lower than the 2017-18 result of $1,377.



Data source: *The Commission's Financial Systems. BedState, Department of Health.*
Time period: *Data is for the financial year.*

2.5 Average length of stay in purchased hospital in the home mental health units

Description

The mental health Hospital in the Home (HITH) program offers individuals the opportunity to receive hospital level treatment delivered in their home, where clinically appropriate. HITH is consistent with the approach of providing care in the community, closer to where individuals live. HITH is delivered by multidisciplinary teams including medical and nursing staff. People admitted into this program remain under the care of a treating hospital doctor. HITH is delivered in the community, but measured and funded via 'beds', and therefore falls under the hospital beds stream for funding purposes. Average length of stay is defined as the number of inpatient patient days divided by the number of separations.

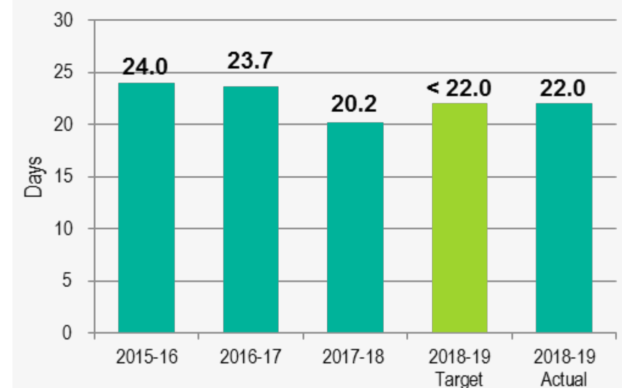
Average length of stay is included to present a more meaningful picture of the efficiency of each bed type. In national reports, such as the Report on Government Services, average length of stay is commonly reported together with cost per inpatient bedday to provide an overall picture of the cost of inpatient care.

Rationale

The purpose of this indicator is to better understand underlying factors which cause variation in HITH mental health care costs. It may also demonstrate the degrees of accessibility to HITH mental health units. The length of stay indicates the relative volume of care provided to people in HITH units and is the main driver of variation in costs.

Results

In 2018-19, the average length of stay for patients with a separation (eg discharged) in purchased hospital in the home mental health beds was 22.0 days. This result is equal to the 2018-19 target of less than 22.0 days and is 9.0% higher than the 2017-18 result of 20.2 days.



Data source: *Hospital Morbidity Data Collection, Department of Health.*
Time period: *Data for the financial year is for the 12-month period from April to March to allow for a three month lag for coding and auditing purposes.*

2.6 Average cost per purchased bedday in hospital in the home mental health units

Description

The HITH program offers individuals the opportunity to receive hospital level treatment delivered in their home, where clinically appropriate. HITH is consistent with the approach of providing care in the community, closer to where individuals live. HITH is delivered by multidisciplinary teams including medical and nursing staff. People admitted into this program remain under the care of a treating hospital doctor. HITH is delivered in the community, but measured and funded via 'beds', and therefore falls under the hospital beds stream for funding purposes. Cost per inpatient bedday is defined as expenditure on inpatient services divided by the number of inpatient beddays.

A key objective of the Plan is the realignment of bed-based services to ensure that beds of the right type are in the right places, in the right quantity, and delivered at an efficient price. This efficiency indicator aligns with the key hospital-based bed types identified in the Plan, and reflects key indicators identified in the Plan's Evaluation Framework. This indicator will enable greater transparency of services in the context of the developing Activity Based Funding environment, and over time will enable monitoring of progress towards the targets and goals identified in the Plan.

Rationale

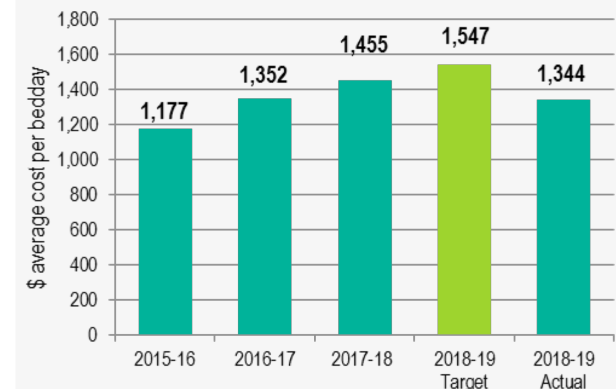
The unit cost of admitted patient care in HITH specialised mental health units is closely monitored in order to ensure cost effectiveness.

Results

In 2018-19, the average cost per bedday in HITH mental health units was $1,344. This result is 13.1% lower than the 2018-19 target of $1,547 and is 7.6% lower than the 2017-18 result of $1,455.

A separation from a HITH unit typically involves time spent in both a HITH bed and a hospital ward. In order to identify the level of funding specific to HITH, a proportion of the overall costs are allocated to HITH based on the level of activity observed in HITH services relative to hospital based care services.

(Results continue over page)



Data source: *The Commission's Financial Systems. BedState, Department of Health.*
Time period: *Data is for the financial year.*

Detailed Key Efficiency Indicators Information

In 2018-19, Western Australia saw a higher than expected level of patient complexity, resulting in a higher need for hospital based care services relative to HITH services. This led to a lower proportion of the overall funding being allocated to HITH, resulting in a lower than expected average cost per bedday.

2.7 Average length of stay in purchased forensic mental health units

Description

Forensic mental health acute inpatient beds are authorised to provide secure mental health care for patients within the criminal justice system on special orders. These beds include both acute and sub-acute beds. These beds provide specialist multidisciplinary forensic mental health care including close observation, assessment, evidence-based treatments, court reports and physical health care. Forensic sub-acute beds are for those people who may have been in an acute forensic inpatient bed and are awaiting discharge for treatment under the Mental Health Act 2014 into the community or to prison. People in this service are likely to be there due to a special order. Average length of stay is defined as the number of inpatient patient days divided by the number of separations.

Average length of stay is included to present a more meaningful picture of the efficiency of each bed type. In national reports, such as the Report on Government Services, average length of stay is commonly reported together with cost per inpatient bedday to provide an overall picture of the cost of inpatient care.

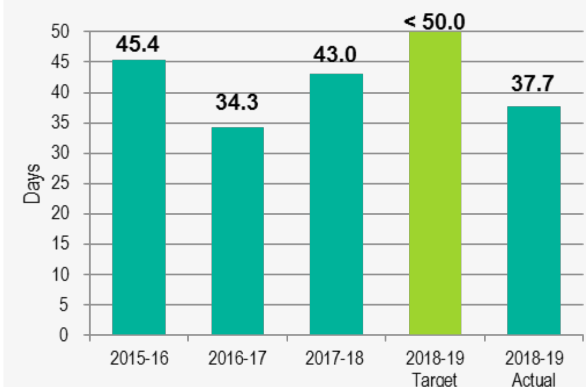
Rationale

The purpose of this indicator is to better understand underlying factors which cause variation in forensic mental health care costs. It may also demonstrate the degrees of accessibility to forensic mental health units. The length of stay indicates the relative volume of care provided to people in forensic units and is the main driver of variation in costs.

Results

In 2018-19, the average length of stay for patients with a separation (eg discharged) in purchased forensic mental health units was 37.7 days. This result is 25.0% lower than the 2018-19 target of less than 50 days, and is 12.4% lower than the 2017-18 result of 43.0 days.

The variance between the 2018-19 result and the 2018-19 target is due to an unexpected reduction in the number of long stay patient separations (eg patient discharges) resulting in a decrease in the average length of stay.



Data source: *Hospital Morbidity Data Collection, Department of Health.*

Time period: *Data for the financial year is for the 12-month period from April to March to allow for a three month lag for coding and auditing purposes.*

2.8 Average cost per purchased bedday in forensic mental health units

Description

Forensic beds include both acute and sub-acute beds. Forensic mental health acute inpatient beds are authorised to provide secure mental health care for patients within the criminal justice system on special orders. These beds provide specialist multidisciplinary forensic mental health care including close observation, assessment, evidence-based treatments, court reports and physical health care. Forensic sub-acute beds are for those people who may have been in an acute forensic inpatient bed and are awaiting discharge back into the community or back to prison. People in this service are likely to be there due to a special order. Cost per inpatient bedday is defined as expenditure on inpatient services divided by the number of inpatient beddays.

A key objective of the Plan is the realignment of bed-based services to ensure that beds of the right type are in the right places, in the right quantity, and delivered at an efficient price. This indicator will enable greater transparency of services in the context of the developing Activity Based Funding environment, and over time will enable monitoring of progress towards the targets and goals identified in the Plan.

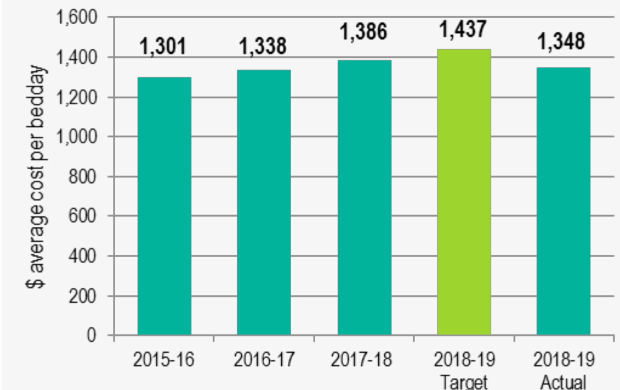
Rationale

The unit cost of admitted patient care in forensic specialised mental health units is closely monitored in order to ensure cost effectiveness.

Data source: *The Commission's Financial Systems. BedState, Department of Health.*
Time period: *Data is for the financial year.*

Results

In 2018-19, the average cost per bedday in forensic units was $1,348. This result is 6.2% lower than the 2018-19 target of $1,437 and is 2.7% lower than the 2017-18 result of $1,386.



Service three: Community Bed-Based Services

3.1 Average cost per purchased bedday for 24 hour staffed community bed-based services (national indicator).

Description

Non-government organisations (NGOs) provide accommodation in residential units for people affected by mental illness who require support to live in the community. Non-acute (24 hours support) residential care facilities provide support with self-management of personal care and daily living activities as well as initiating appropriate treatment and rehabilitation to improve the quality of life. These services are staffed 24 hours a day by appropriately trained staff (either with formal qualifications and/or on the job training) and staff are present and actively engaged with service provision (ie they are not sleeping or off-site) during their shift. This accommodation support is available to people with complex mental health issues and significant behavioural problems. They are unable to live independently in the community without support and care.

Rationale

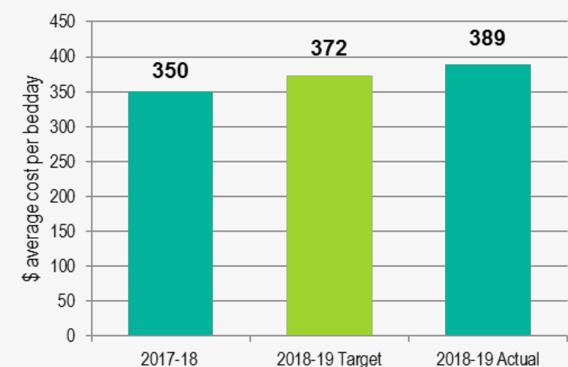
The unit cost of (24 hours support) community bed-based services is closely monitored in order to ensure cost effectiveness. The hours staffed provides a measure of service intensity for the reporting and analysis of staff, financial and activity data.

Data source: *The Commission's Financial Systems. The Commission's Contract Acquittal Data Collection (CADC; formerly the Non-Government Organisation Establishment State Data Online Collection). Activity data for 6 months (July 2018 to December 2018) extrapolated to 12 months. Cost data is for the 2018-19 financial year.*

Time period: *Data is for the financial year.*

Results

In 2018-19, the average cost per purchased bedday for 24 hour staffed community bed-based services was $389. This result is 4.4% higher than the 2018-19 target of $372, and is 11.1% higher than the 2017-18 result of $350.



3.2 Average cost per purchased bedday for non-24 hour staffed community bed-based units (national indicator).

Description

NGOs provide accommodation in residential units for people affected by mental illness who require support to live in the community. Services are specifically designed for adults who have complex and persistent symptoms of mental illness, and who have support and care needs above those that enable them to live independently in the community. The services provide assessment and residential support for consumers in a mental health recovery framework.

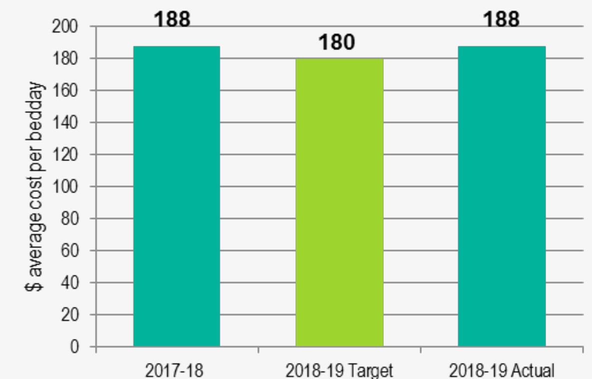
These services are not staffed 24 hours a day due to the less severe mental health and behavioural problems of the people accessing the services. Appropriate staff are still available through mechanisms such as being on call when required.

Rationale

The unit cost of (non-24 hours support) community bed-based services is closely monitored in order to ensure cost effectiveness. The hours staffed provides a measure of service intensity for the reporting and analysis of staff, financial and activity data.

Results

In 2018-19, the average cost per purchased bedday for non-24 hour staffed community bed-based units was $188. This is 4.5% higher than the 2018-19 target of $180, and is equal to the 2017-18 result of $188.



Data source: *The Commission's Financial Systems. The Commission's Contract Acquittal Data Collection (CADC; formerly the Non-Government Organisation Establishment State Data Online Collection). Activity data for 6 months (July 2018 to December 2018) extrapolated to 12 months. Cost data is for the 2018-19 financial year.*

Time period: *Data is for the financial year.*

3.3 Average cost per purchased bedday in step up/step down community bed-based units

Description

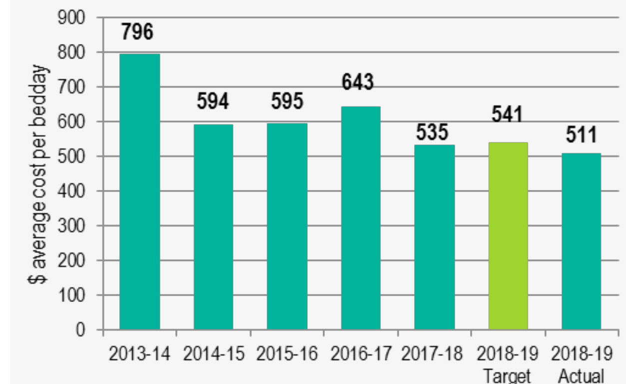
The community mental health step up/step down service provides short-term mental health care, in a residential setting, that promotes recovery and reduces the disability associated with mental illness. These are comprehensive services designed to deliver support to individuals that is aimed at improving symptoms, encouraging the use of functional abilities and assists in facilitating a return to the usual environment. This is achieved within a framework of recovery and rehabilitation, and is delivered predominantly through non-clinical activities. This service provides for people who have recently experienced, or who are at risk of experiencing, an acute episode of mental illness. This usually requires short-term treatment and support to reduce distress that cannot be adequately provided in the person's home but does not require the treatment intensity provided by acute inpatient services.

Rationale

This indicator enables assessment of the efficiency of step up/step down community bed-based services both over time and relative to other services.

Results

In 2018-19, the average cost per purchased bedday in step up/step down community bed-based units was $511. This is 5.6% lower than the 2018-19 target of $541, and is 4.5% lower than the 2017-18 result of $535.



Data source: *The Commission's Financial Systems. The Commission's Contract Acquittal Data Collection (CADC; formerly the Non-Government Organisation Establishment State Data Online Collection). Activity data for 6 months (July 2018 to December 2018) extrapolated to 12 months. Cost data is for the 2018-19 financial year.*

Time period: *Data is for the financial year.*

3.4 Cost per completed treatment episode in alcohol and other drug residential rehabilitation services

Description

AOD community bed-based services include residential rehabilitation and low medical withdrawal services which provide 24 hour, seven days per week recovery orientated treatment in a residential setting. Bed-based low medical withdrawal provides a supportive care model, based on non-medical or low medical interventions with support provided by a visiting doctor or nurse specialist. These programs are most appropriate when the withdrawal symptoms are likely to be low to moderate and there is a lack of social support or an unstable home environment. Residential rehabilitation provides clients (following withdrawal) with a structured program of medium to longer-term duration that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills and group work.

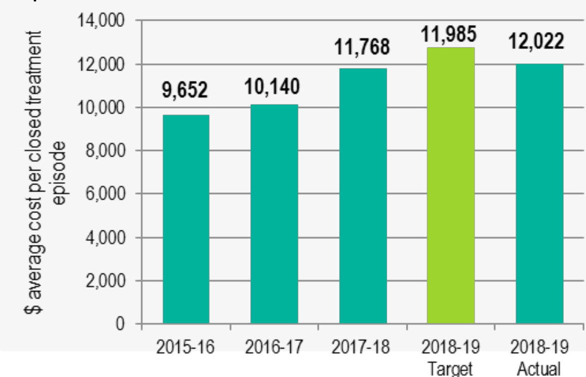
Rationale

This indicator enables assessment of the efficiency of residential rehabilitation services both over time and relative to other services.

Results

In 2018-19, the average cost per completed treatment episode in AOD residential rehabilitation services was $11,985. This is 6.2% lower than the 2018-19 target of $12,781 and 1.8% higher than the 2017-18 result of $11,768.

In previous years, treatment episodes from low medical and residential rehabilitation services not purchased by the Commission had been included which resulted in a lower cost per treatment episode. Since 2017-18 the method was changed to more accurately reflect the cost of a closed treatment episode by only including activity from services purchased by the Commission. This change had been possible through improvements in data governance and overall capture processes.



Data source: *The Commission's Financial Systems and De-identified Treatment Agency Database.*

Time period: *Treatment episode data for the financial year is for the 12-month period from April to March to allow for a three month lag for coding and auditing purposes. Cost data is presented by the financial year.*

Service four: Community Treatment

4.1 Average cost per purchased treatment day of ambulatory care provided by public clinical mental health services (national indicator)

Description

An ambulatory mental health care service (ie community treatment) is a specialised mental health organisation that provides services to people who are not currently admitted to a mental health inpatient or residential service. Services are delivered by health professionals with specialist mental health qualifications or training. This indicator is the total expenditure on mental health ambulatory care services divided by the number of community treatment days provided by ambulatory mental health services, where a treatment day is defined as any day on which one or more community contacts are recorded for a consumer during their episode of care.

Rationale

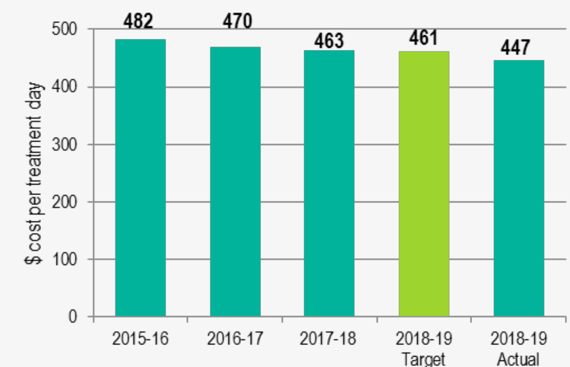
This indicator enables monitoring of the unit cost of ambulatory care in order to ensure quality care and cost effectiveness. Efficient functioning of public ambulatory mental health services is critical to ensure that funds are used effectively to deliver maximum community benefit.

Data source: *The Commission's Financial Systems. Mental Health Information System (MHIS), Department of Health. The Commission's Contract Acquittal Data Collection (CADC; formerly the Non-Government Organisation Establishment State Data Online Collection). Non-government organisation activity data for 6 months (July 2018 to December 2018) extrapolated to 12 months. Cost data is for the 2018-19 financial year.*

Time period: *Data is for the financial year.*

Results

In 2018-19, the average cost per purchased treatment day of ambulatory care provided by public clinical mental health services was $447. This is 2.9% lower than the 2018-19 target of $461 and 3.4% lower than the 2017-18 result of $463.



4.2 Average treatment days per episode of ambulatory care provided by public clinical mental health services

Description

An ambulatory mental health care service (ie community treatment) is a specialised mental health organisation that provides services to people who are not currently admitted to a mental health inpatient or residential service. Services are delivered by health professionals with specialist mental health qualifications or training. Frequency of servicing is the main driver of variation in community care costs and may reflect differences between health service organisation practices.

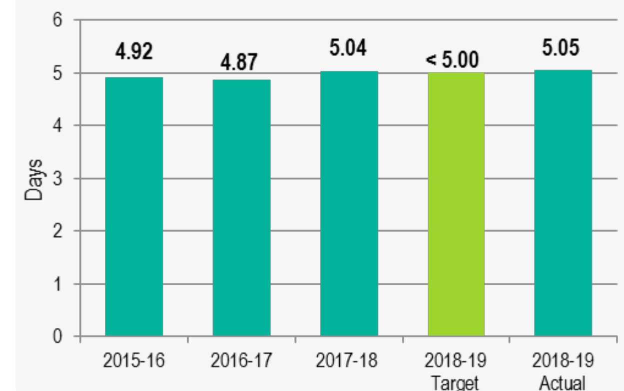
This indicator is the number of community treatment days provided by ambulatory mental health services, per three month period (ie per ambulatory care statistical episodes). The number of treatment days is the community treatment equivalent to length of stay and it indicates the relative volume of care provided.

Rationale

The purpose of this indicator is to better understand underlying factors which cause variation in community care costs. It may also demonstrate the accessibility to public sector community mental health services. This indicator provides an understanding of the extent or duration of community care treatment.

Results

In 2018-19, the average number of days per community treatment episode provided by public clinical mental health services was 5.05 days. This result is 1.1% higher than the 2018-19 target of less than five days, and is 0.2% higher than the 2017-18 result of 5.04 days.



Data source: *Mental Health Information System (MHIS), Department of Health.*
Time period: *Data is for the financial year.*

4.3 Cost per completed treatment episode in community based alcohol and other drug services.

Description

The Commission supports a comprehensive range of outpatient counselling, pharmacotherapy and support and case management services, including specialist indigenous, youth, women's and family services, which are provided primarily by non-government agencies specialising in AOD treatment.

The Western Australian Diversion Program aims to reduce crime by diverting offenders with drug use problems away from the criminal justice system and into treatment to break the cycle of offending and address their drug use. The Alcohol and Drug Support Service (ADSS) is a 24-hour, Statewide, confidential telephone service providing information, advice, counselling and referral to anyone concerned about their own or another person's AOD use. Callers have the option of talking to a professional counsellor, a volunteer parent or both.

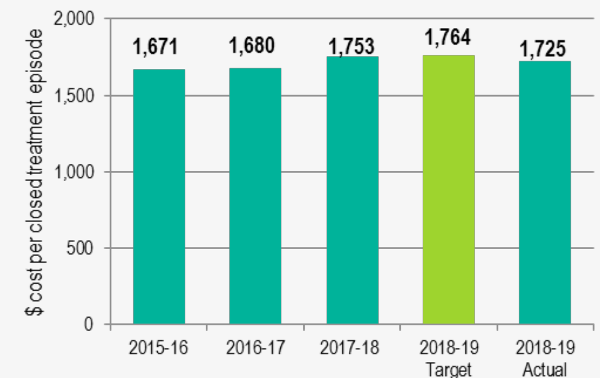
This indicator is the cost for these community-based services divided by the combined number of treatment episodes provided and the number of ADSS contacts answered with an outcome of counselling (excluding tobacco-related contacts). A treatment episode is the period of care between the start and end of treatment, whereas for ADSS this refers to a single contact (eg a phone call).

Rationale

This indicator enables assessment of the efficiency of community-based AOD services both over time and relative to other services.

Results

In 2018-19, the average cost of a completed treatment episode in community-based alcohol and other drug services was $1,725. This is 2.2% lower than the 2018-19 target of $1,764, and is 1.6% lower than the 2017-18 result of $1,753.



Data source: *The Commission's Financial Systems, the De-identified Treatment Agency Database and the Alcohol and Drug Information Service Database.*

Time period: *Treatment episode data for the financial year is for the 12-month period from April to March to allow for a three month lag for coding and auditing purposes. Cost data is presented by the financial year.*

Service five: Community Support

5.1 Average cost per hour of community support provided to people with mental health problems

Description

Community-based support programs assist people with mental health problems to develop/maintain skills required for daily living, improving personal and social interaction, and increasing 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 determined by the needs and goals of the individual.

This indicator is the total expenditure on mental health community support services divided by the total number of direct contact hours of community support.

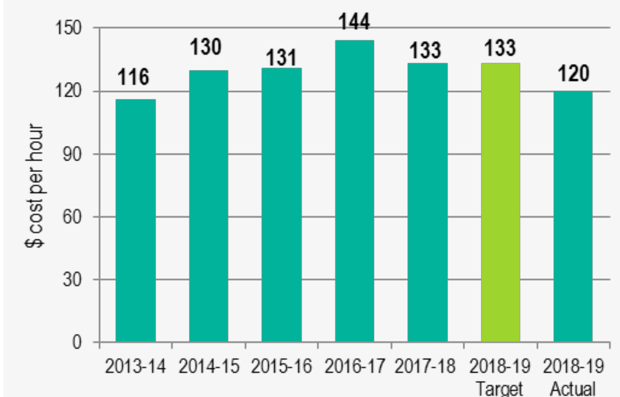
Rationale

This indicator enables assessment of the efficiency of community support provided to people with mental health problems both over time and relative to other services.

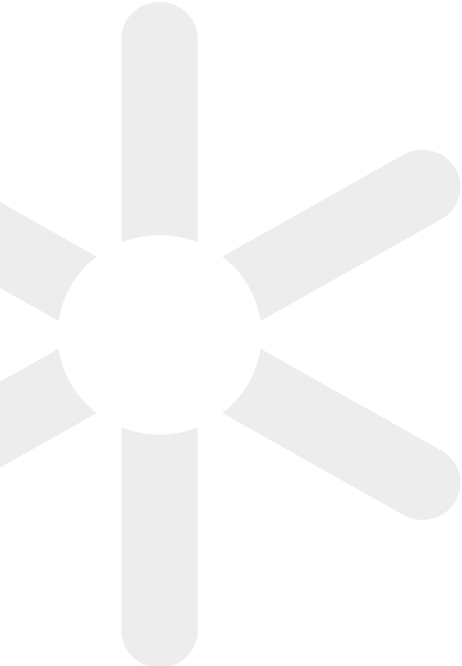
Results

In 2018-19, the average cost per hour of community support provided to people with mental health problems was $120. This result is 9.9% lower than the 2018-19 target and the 2017-18 result of $133.

This is because, in 2018-19, the Commission implemented a Hostel Recovery Support Project (HRSP) in collaboration with the National Disability Insurance Agency. As part of the HRSP project, a number of NGOs were contracted to provide Community Support services, increasing the amount of hours of community support.



Data source: *The Commission's Financial Systems and the The Commission's Contract Acquittal Data Collection (CADC; formerly the Non-Government Organisation Establishment State Data Online Collection). Activity data for 6 months (July 2018 to December 2018) extrapolated to 12 months. Cost data is for the 2018-19 financial year.*
Time period: *Data is for the financial year.*



5.2 Average cost per episode of community support provided for alcohol and other drug services

Description

The Transitional Housing and Support Program (THASP) provides inreach community support for people staying in short-term accommodation following residential AOD treatment. There are currently 15 THASP houses operational across Western Australia. A 2018 evaluation of the program has demonstrated a range of positive outcomes including assisting clients to transition to safe housing options, increased participation in employment and training and assisting them to reconnect with social and family networks. This indicator is calculated by dividing the overall cost of THASP services by the number of closed treatment episodes. A treatment episode is the period of care between the start and end of treatment.

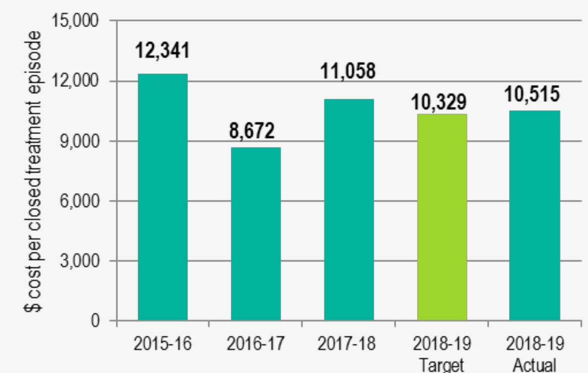
Rationale

This indicator enables assessment of the efficiency of THASP both over time and relative to other services.

Data source: *The Commission's Financial Systems and the De-identified Treatment Agency Database.* ***Time period:*** *Treatment episode data for the financial year is for the 12-month period from April to March to allow for a three month lag for coding and auditing purposes. Cost data is presented by the financial year.*

Results

In 2018-19, the average cost per completed episode of community support provided for alcohol and other drug services was $10,515. This result is 1.8% higher than the 2018-19 target of $10,329, and is 4.9% lower than the 2017-18 result of $11,058.



5.3 Average cost per package of care provided for the Individualised Community Living Strategy

Description

The ICLS is a collaborative partnership approach between Health Service Providers, Community Managed Organisations, Community Housing Organisations and the Department of Communities – Housing to provide clinical and psychosocial supports and services, in addition to appropriate housing (individual packages of support exclusive of housing are also provided) for individuals to maximise their success in recovery and living in the community. Individuals accessing ICLS can expect to:

- have an increasing ability to fully participate in their ongoing clinical and psychosocial support needs;
- develop and sustain meaningful social connections and relationships;
- participate and contribute to their community and relationships in personally meaningful ways
- have an increasing ability to participate in educational, vocational and/or employment activities;
- develop their skills to self-manage their lifestyle and well-being;
- demonstrate an increasing ability to maintain and sustain their housing and tenancy; and
- improve their quality of life.

The target group includes individuals that have a range of complexities and challenges and there is a mix of individuals requiring low, medium, high and very high levels of support. Individuals have a severe mental illness and can only access the service by being nominated by a public mental health service Case Manager or Psychiatrist.

Rationale

This indicator represents the average total funding available per package. Actual funding is allocated based on identified need reflected in the individual's plan. This varies from year to year based on the specific needs of the individuals. The program is distinct from funding provided for other community mental health support services.

Data source: *The Commission's Financial Systems and Individualised Community Living Strategy (ICLS) service providers report the number of packages delivered to the Commission.*

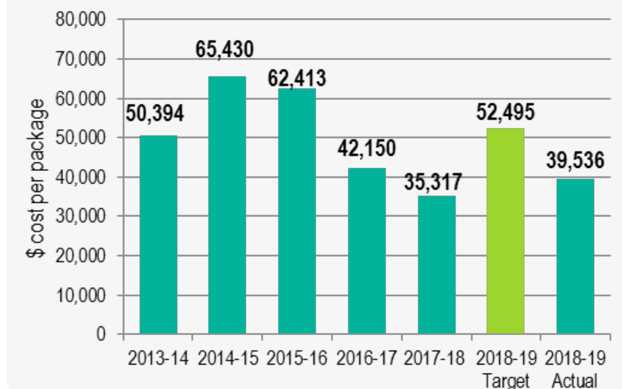
Time period: *Data is for the financial year.*

Results

In 2018-19, the average cost per package of care provided for the ICLS was $39,536. This result is 24.7% lower than the 2018-19 target of $52,495, and is 11.9% higher than the 2017-18 result of $35,317.

The variance between the 2018-19 result and the 2018-19 target is due to the success of the support provided to assist individuals with their recovery journey resulting in lower levels of support required than anticipated.

There are also lead times for the identification of new referrals and then the development of individual plans for new entrants when backfilling vacancies.



5.4 Cost per treatment episode of care in safe places for intoxicated people

Description

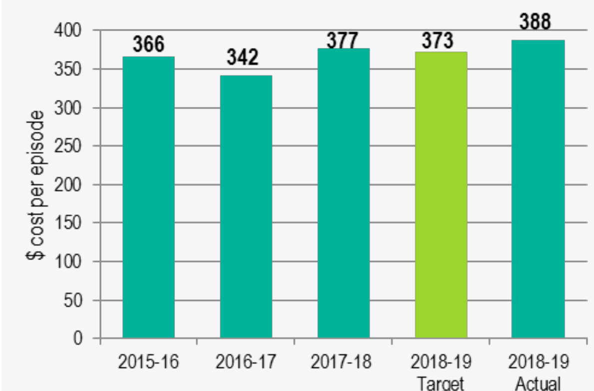
Safe places for intoxicated individuals or sobering up centres provide residential care overnight for intoxicated individuals. As at 30 June 2018, there were nine sobering up centres in Western Australia providing a safe, care-oriented environment in which people found intoxicated in public may sober up. Sobering up centres help to reduce the harm associated with intoxication for the individual, their families and the broader community, and play a key role in the response to family and domestic violence. People may refer themselves to a centre or be brought in by the police, a local patrol, health/ welfare agencies, or other means. Attendance at a centre is voluntary. A person being cared for in a sobering up centre can expect: a safe environment; a shower, clean bed, clean clothes, and a simple nutritious meal; non-discriminatory and non-judgemental care; and referral to other agencies and services if required. This indicator is calculated by dividing the overall cost of Sobering up centres by the number of episodes delivered. An episode is defined as an admission to a sobering up centre which may be for a few hours or overnight.

Rationale

This indicator aims to address how well the sobering-up centre services use their resources (inputs) to produce outputs, that is, whether the sobering up service is delivered in the most efficient manner. This indicator provides greater transparency of funded services and enables monitoring of progress towards the targets and goals identified in the Plan.

Results

In 2018-19, the average cost per treatment episode of care in safe places for intoxicated people was $388. This result is 4.0% higher than the 2018-19 target of $373, and is 2.9% higher than the 2017-18 result of $377.



Data source: *The Commission's Finance Systems and the Sobering Up Centre database.*

Time period: *Sobering up episode data for the financial year is for the 12-month period from April to March to allow for a three month lag for coding and auditing purposes. Cost data is presented for the financial year.*

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 Minister with portfolio responsibility for the Commission during 2018-19.

Other Financial Disclosures

Personal expenditure

In accordance with section 903(13)(iv) of the Treasurer's Instructions, personal expenditure incurred on a Western Australian Government Purchasing Card must be disclosed. During the reporting period there were 3 instances of personal expenditure incurred by Commission staff, as per the summary below.

Number of instances the Purchasing Card has been used for Personal Use:	**3**
Aggregate amount:	**$130.50**
Aggregate amount settled by due date:	**$130.50**
Aggregate amount settled after due date:	**nil**
Aggregate amount outstanding:	**nil**
Number of referrals for disciplinary action:	**nil**

Governance Disclosures

Treasurer's Instruction 903(14) requires the Commission to disclose particulars of any shares in the statutory authority, or any subsidiary body of the agency held as a nominee or held beneficially by a senior officer of the agency, as well as any insurance premiums paid to indemnify any 'director' against a liability incurred under sections 13 or 14 of the act. The Commission has no such declarations to make for 2018-19.

As per Related Party Disclosures (AASB124), conflicts of interest have been identified in relation to the former Mental Health Commissioner, who departed the role in June 2019. The former Commissioner is the Deputy Chair of the beyondblue Board of Directors.

In 2018-19, Western Australia was also represented on the board by the Assistant Commissioner, Planning, Policy and Strategy.

A not-for-profit organisation, beyondblue focuses on raising awareness and understanding of anxiety and depression in Australia, and currently receives $342,000 per annum funding from the Commission. This funding, which commenced in 2000, predates the establishment of the Commission and has remained at approximately this level since 2005. The Commission's current contract with beyondblue is for five years and was approved by the Director, Non-Government Organisations Purchasing and Development, in 2015. While employed by the Commission, the Commissioner took annual leave to attend beyondblue meetings and was excluded from any contractual matters and decisions between the Commission and beyondblue. Likewise, the Assistant Commissioner, Planning, Policy and Strategy is also excluded from contractual matters and decisions between the Commission and beyondblue.

The conflict is managed by delegating all decision-making regarding Commission funding and contract management to the Director, Commissioning and Contracting.

Other Legal Requirements and Government Policy Requirements

The Commission has no other legal requirements or Government Policy Requirements to be disclosed in accordance with section 903(15 and 16).

Board and Committee Remuneration

Mental Health Tribunal

In the interests of security and sensitivity, the names and details of the MHT members have been excluded from this report. However, gross remuneration for the President and averages for the Tribunal members, for the 2018-19 financial year is as follows:

President:	$288,362.84
Member (high):	$108,734.60
Member (average):	$37,822.76
Member (low):	$446.76

Alcohol and Other Drugs Advisory Board

The Alcohol and Other Drugs Advisory Board (AODAB), which provides advice to the Commission on matters relevant to section 11 functions of the *Alcohol and Other Drug Act 1974*, has been in abeyance pending Cabinet consideration and therefore did not meet during the 2018-19 financial year. The membership for the AODAB is currently under consideration.

Ministerial Council for Suicide Prevention

The Ministerial Council for Suicide Prevention (MCSP) was involved in developing the previous OneLife suicide prevention strategy, and also led the development of the current Suicide Prevention 2020 strategy. The Commission will be developing a new Suicide Prevention Action Plan, in line with the cross-jurisdictional framework for implementing national action articulated in the *Fifth National Mental Health and Suicide Prevention Plan*. As part of the development of the new Action Plan, a contemporary and broadened consultation process will be undertaken Statewide. The MCSP therefore ceased operation from 30 June 2019.

Position	Members name	Type of remuneration	Period of membership (within 2018-19)	Gross remuneration 2018-19 financial year
Chair	Dr Neale Fong	Salary $22,000	Full Year	$24,013
Deputy Chair	Mr Glenn Pearson	Salary $11,500	Full Year	$14,483
Member	Ms Anne Richards	Per Meeting	Term completed 3 October 2018	$985.50
Member	Ms Dani Wright Toussaint	Per Meeting	Term completed 30 June 2019	$657
Member	Ms Tamisha King	Per Meeting	Term completed 3 October 2018	$985.50
Member	Ms Cobie Rudd	Per Meeting	Term completed 27 November 2018	$985.50
Member	Mr Chris Salisbury	Did not accept payment	Term completed 3 October 2018	$0
Member	Mr Chris Gostelow (ex-officio)[1]	N/A	Term completed 30 June 2019	$0
Member	Mr Timothy Marney (ex-officio)[1]	N/A	Term completed 4 June 2019	$0

[1] Committee Members who are public servants or academics with administrative responsibilities are ineligible to receive remuneration.

Mental Health Advisory Council

The Mental Health Advisory Council (MHAC), which provides strategic advice and guidance to the Mental Health Commissioner regarding major issues affecting people with mental health problems, their families and service providers, has been in abeyance pending Cabinet consideration and therefore did not meet during the 2018-19 financial year. The membership for MHAC is currently under consideration.

The payments outlined in the following table were made in the 2018-19 financial year, but relate to meetings held in 2017-18.

Position	Member's name	Type of remuneration	Period of membership (2018-19)	Gross remuneration 2018-19 financial year
Chair	Mr Barry MacKinnon	Annual	N/A[1]	$5,290.77
Deputy Chair	The Hon. Eric Ripper	Annual	N/A[1]	$4,877.76
Member	Mr Rod Astbury	Sessional	N/A[1]	$492.07
Member	Ms Margaret Doherty	Sessional	N/A[1]	$1,084.85

[1]Services undertaken in 2017-18

Other Legal Requirements

Expenditure on advertising, market research, polling and direct mail

In accordance with section 175ZE of the *Electoral Act 1907*, the following table outlines all expenditure incurred by, or on behalf of, the Commission on advertising agencies, market research, polling, direct mail and media advertising during the reporting period.

Category	Name	Spend
Advertising Agencies	The Brand Agency	$70,324
Market Research Agencies	-	-
Polling Organisations	-	-
Direct Mail Organisations	-	-
Media Organisations	Public Education Campaigns via Curtin University	$2,411,338
	Initiative Media Australia	$5,616
Total Expenditure		**$2,487,277**

Recordkeeping plans

The State Records Act 2000 (the Records Act) was established to standardise statutory recordkeeping practices for every government agency. Government agency practice is subject to the provisions of the Records Act and the standards and policies of the State Records Commission. The Commission established a formal Recordkeeping Plan to ensure compliance with these requirements, which was reviewed in December 2018. Results of the review committed the Commission to producing an updated Recordkeeping Plan which reflects the Commissions corporate vision, mission and values, current operations, and strategic priorities. The updated Recordkeeping Plan was submitted to the State Records Commission in May 2019.

The Commission provides all new staff with a comprehensive induction on recordkeeping and its Electronic Document Records Management System (EDRMS). The staff induction includes a presentation on responsibilities and services and recordkeeping is embedded in the Commission's Code of Conduct. In addition to inductions, all new starters are enrolled in mandatory online Recordkeeping Awareness Training and face-to-face EDRMS training. A total of 18 Recordkeeping and EDRMS Training sessions were delivered to staff by the Information Management Team. In 2018-19, 81% of Commission employees completed the Recordkeeping Awareness Training. This training provides an understanding of the fundamentals of recordkeeping and employee responsibilities in creating, managing and protecting records. A total of 50 publications were created for training purposes which include fact and advice sheets, training videos and a monthly electronic newsletter regarding recordkeeping matters, these are available to all staff via the corporate intranet.

Staffing, occupational safety, health and injury management

Our Commitment

The Commissioner and Corporate Executive are committed to providing a safe workplace to achieve high standards in safety and health for employees, contractors and visitors. To support and demonstrate this commitment, the Commission has developed and implemented safe systems and work practices in line with the *Occupational Safety and Health Act 1984*, and provides early intervention and proactive injury management in line with the requirements of the *Workers Compensation and Injury Management Act 1981*.

The Commission's senior leaders recognise Occupational Safety and Health (OSH) practices are a major contributor to reducing hazards and risks and are focused on embedding strong OSH practices in all training, planning, purchasing and business activities. The Commission has an OSH policy and an Injury Management policy in place which communicates our commitment to safety and health to our employees.

Consultation mechanisms

The Occupational Safety and Health Committee meet regularly and provide a forum for employee representatives across the Commission to discuss safety and health issues. The Committee reviews accidents, incidents and hazard reports and promotes a range of health and safety initiatives in place at the Commission. The minutes are made available to employees on the intranet.

In 2018-19 the Commission appointed an additional two safety and health representatives. The contact details of all safety and health representatives are available to employees on the Commission's intranet and noticeboards.

Workers' compensation and injury management

The Commission is committed to assisting injured employees to return to work as soon as medically appropriate and has in place a documented injury management system and return to work programs in accordance with the *Workers Compensation and Injury Management Act 1981*. The Injury / Rehabilitation Management policy is available for employees and managers to access via the Commission's intranet.

Assessment of the occupational safety and health management system

In February 2019, the Commission engaged an external assessor who undertook a review of the occupational safety and health management system, in line with the WorkSafe Plan. Overall the assessment identified that the Commission had sufficient policies and procedures in place, the Commission is currently in the process of addressing the four minor recommendations identified in the assessment. These are estimated to be completed by December 2019.

Employee health and wellbeing

The Commission is committed to ensuring employees are supported and provided with an environment that actively assists them to maximise their overall health. The Wellness Committee champions the Commission's *Healthy Workplace Strategy* and develops the annual Mental Health Commission Wellness Program to ensure the wellbeing needs and preferences of employees are being met.

During 2018-19, the following wellness events and activities were held to improve employee wellbeing:

- influenza vaccinations;
- health checks;
- corporate step challenge;
- weekly yoga classes; and
- wellness information sessions covering topics such as mindfulness, meditation and healthy sleep habits.

As a leader in mental health, the Commission believes that protecting and supporting the mental health of our employees and creating an environment that fosters the development of positive mental health is central to our ability to ensure the delivery of an effective service to the Western Australian community. During 2018-19 the Commission continued to focus on the mental health and wellbeing of employees through:

- the provision of an Employee Assistance Program;
- the availability of Mental Health First Aid Officers;
- offering Mental Health First Aid training to all employees; and
- developing a Thrive at Work Action Plan to address key challenges identified by employee focus groups.

Occupational Safety and Health Reporting

Measure	Results 2016-17	Results 2017-18	Results 2018-19	Target	Comments toward targets
Number of Workers Compensation Claims Received	4	5	3	Zero (0)	
Number of fatalities	0	0	0	Zero (0)	
Lost time injury/disease incidence rate	0.6	0.8	0.69	Zero (0) or a 10% improvement on the previous three years	
Lost time injury/disease severity rate	0	50	0	Zero (0) or a 10% improvement on the previous three years	
Percentage of injured workers returned to work within: 13 weeks	100%	50%	100%	Greater than or equal to 80% return to work within 26 weeks	
Percentage of managers trained in occupational safety, health and injury management responsibilities	88%	83%	44%	Greater than or equal to 80%	2018-19 result is primarily due to outstanding renewals. Strategies are in place to address completion rates

Employee numbers

Measure	Headcount 2017-18	Headcount 2018-19
Mental Health Commission	296	302
Office of the Chief Psychiatrist	16	17
Mental Health Advocacy Service	9	6
Mental Health Tribunal	8	7
Total Employees	**329**	**332**

Disability access and inclusion plan outcomes

The Commission continued the work of its Disability Access and Inclusion Plan (DAIP) for 2017-2021, ensuring it is consistently accessible to and inclusive of all groups. The DAIP demonstrates the Commission's commitment to ensuring proactive removal of any barriers that may exclude people from accessing information, services, facilities, events and employment opportunities within the Commission. The DAIP is available to members of the public through the Commission's website and to all employees through the Commission's Intranet.

Key achievements in 2018-19 included:

- major events held by the Commission, including the Mental Health Network Open Day and information sessions conducted during public consultation processes, were held in easily accessible venues and accommodations were made for participants with disabilities to ensure they could access the event and the information provided;
- stakeholders were provided with a variety of feedback options during multiple public consultation processes conducted throughout the year;
- all major publications released by the Commission were made available online as a fully accessible document and in alternative formats for people with a disability, upon request;
- updating of job advertisement template and applicant information pack to improve accessibility and methods for attracting and retaining diverse applicants, including people with a disability; and
- offered Mental Health First Aid training to all employees to assist in the provision of a consistent and inclusive service to people with mental health issues and create a culture where individuals with mental health issues feel supported and included.

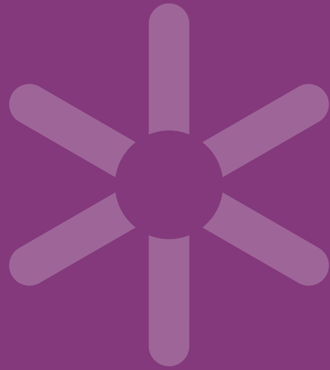
Compliance with public sector standards and ethical codes

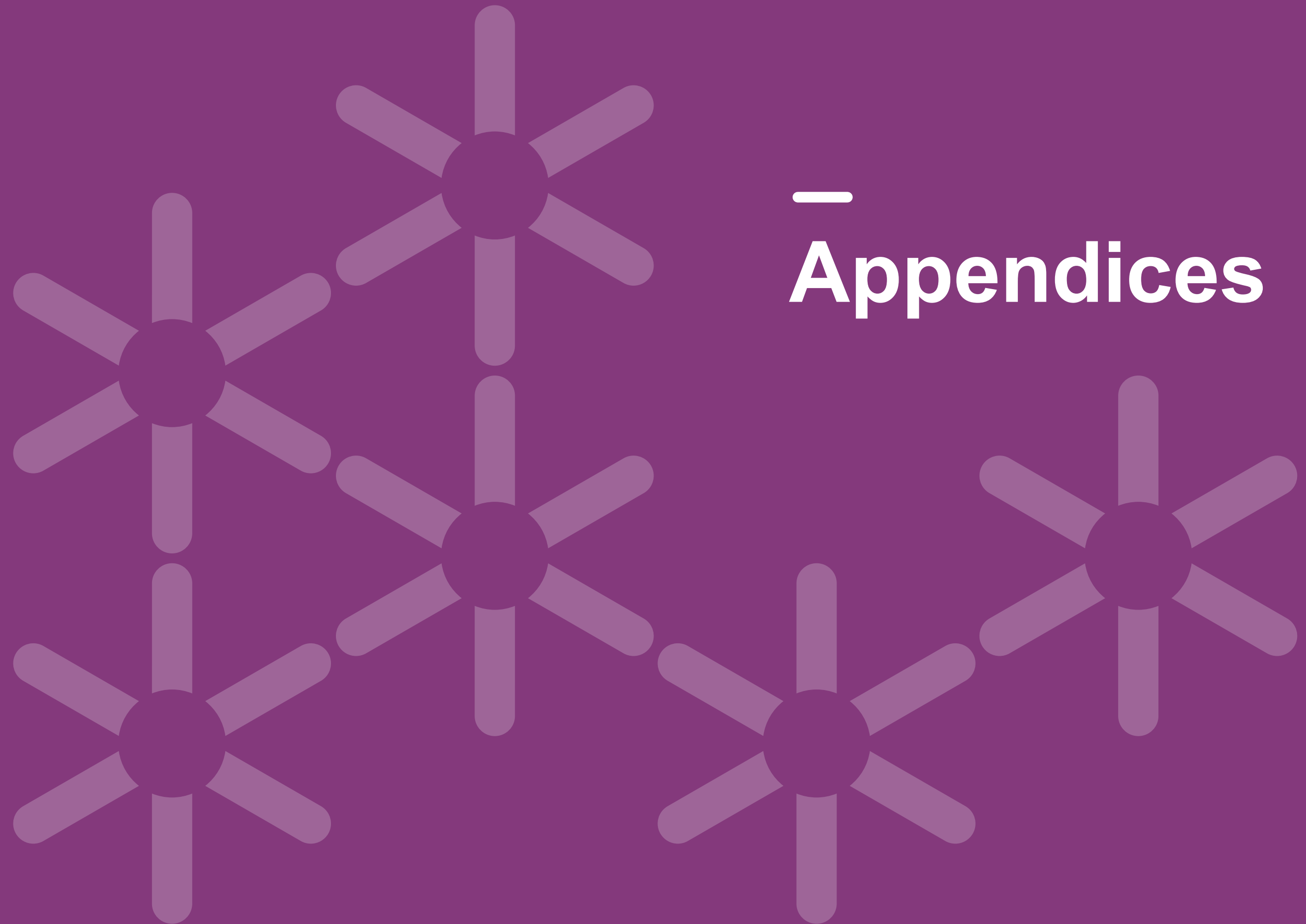
Pursuant to section 31(1) of the *Public Sector Management Act 1994*, the Commission fully complied with the public sector standards, the Western Australian Code of Ethics and the Mental Health Commission Code of Conduct.

During 2018-19 the Commission conducted an internal communications program, focussed on raising awareness and embedding appropriate behaviour in relation to the Code of Conduct, Public Interest Disclosure and Gifts and Hospitality Policies. This program included:

- Regular internal messaging on noticeboards, via email and placed on the Commission's intranet with relevant information and related articles and videos on the core principles of the Commissions Code of Conduct;
- All staff forums with guest speakers from:
  - The Corruption and Crime Commission, to discuss how corruption works and it effects; and
  - The Public Sector Commission, to discuss how employees can report integrity issues, including Public Interest Disclosure.

This campaign was in addition to regular and ongoing training provided to Commission employees, including a mandatory comprehensive induction process on key policies, processes and conduct expectations.



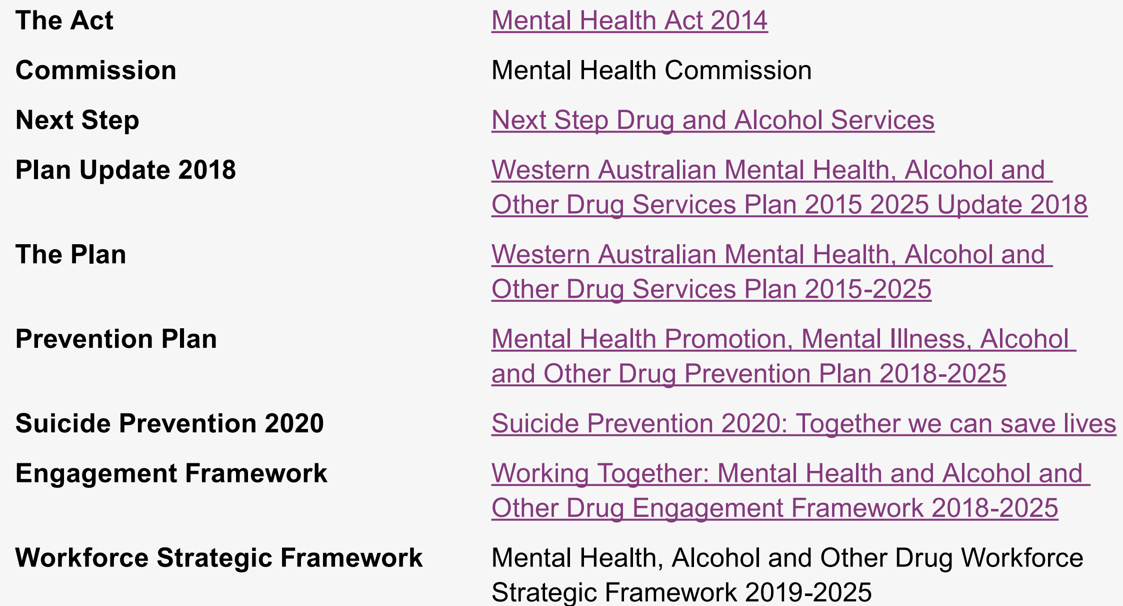


Appendices

Acronyms

AAT	Alcohol Assessment and Treatment
ADSS	Alcohol & Drug Support Service
AOD	Alcohol and Other Drugs
CAHS	Child and Adolescent Health Service
CADS	Community Alcohol and Drug Services
CTWD	Centre for Transformative Work Design
DAYS	Drug and Alcohol Youth Service
DoH	Department of Health
EMHS	East Metropolitan Health Service
EMyU	East Metropolitan Youth Unit
FRAC	Finance Risk Audit Committee
HSPs	Health Service Providers
HiTH	Hospital in The Home
MAP	Methamphetamine Action Plan
MCSP	Ministerial Council for Suicide Prevention
MHAC	Mental Health Advisory Council
MHAS	Mental Health Advocacy Service
MHN	Mental Health Network
MHOA	Mental Health Observation Area
MHT	Mental Health Tribunal
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
NMHS	North Metropolitan Health Service
NSMHS	National Standards for Mental Health Service
OCP	Office of the Chief Psychiatrist
PEHPP	Public Education and Health Promotion Programs
SMHS	South Metropolitan Health Service
SSAMHS	Statewide Specialist Aboriginal Mental Health Service
SSSMAP	Strong Spirit Strong Mind Aboriginal Programs
SSSM	Strong Spirit Strong Mind Metro Project
WAADIS	Western Australian Alcohol and Drug Interagency Strategy 2018-2022
WACHS	WA Country Health Service
WAAMH	Western Australia Association for Mental Health
WALGA	Western Australian Local Government Association
WAPHA	WA Primary Health Alliance
WANADA	Western Australian Network of Alcohol & other Drug Agencies

Abbreviations



The Act	Mental Health Act 2014
Commission	Mental Health Commission
Next Step	Next Step Drug and Alcohol Services
Plan Update 2018	Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015 2025 Update 2018
The Plan	Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025
Prevention Plan	Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025
Suicide Prevention 2020	Suicide Prevention 2020: Together we can save lives
Engagement Framework	Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025
Workforce Strategic Framework	Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2019-2025

Glossary

Forensic mental health services	Refers to mental health services that principally provide assessment, treatment and care of people with a mental health issue and/or mental illness who are in the criminal justice system, or who have been found not guilty of an offence because of mental impairment. Forensic mental health services are provided in a range of settings, including prisons, hospitals and the community.
Secure (mental health/beds)	A bed staffed 24 hours a day that is designated by the Department of Health or authorised by the Chief Psychiatrist to accommodate patients requiring a higher level of care and involuntary containment where clinically appropriate.
Separations	Discharge from hospital.

Service Stream Descriptions

Prevention

Mental health and AOD prevention refers to initiatives and strategies to reduce the incidence and prevalence of mental health problems, and delay the uptake and reduce the harmful use of AOD and associated harms. Mental health promotion strategies aim to promote positive mental health and resilience.

The Commission continues to support a range of evidence-based prevention initiatives aimed at the whole population and specific priority target groups. Strategies include:

- public education campaigns such as the Alcohol.Think Again, Strong Spirit Strong Mind Metro Project, Meth Can Take Control and Think Mental Health campaigns;
- creation of supportive environments, for example through monitoring of liquor licensing applications; and
- building community capacity to promote optimal mental health, and prevent mental illness, suicide and AOD harm through training for communities.

Community support services

Community support services include programs that help people with mental health and AOD issues to access the help and support they need to participate in their community. Community support includes:

- programs that help people identify and achieve their personal goals;
- personalised support programs (eg. to assist in accessing and maintaining employment/ education and social activities);
- peer support;
- initiatives to promote good health and wellbeing;
- home in reach support to attain and maintain housing;
- family and carer support (including support for young carers and children of parents with a mental illness);
- flexible respite;
- individual advocacy services; and
- AOD harm-reduction programs.

Service Stream Descriptions

Community treatment

Community treatment services provide non-residential, clinical care in the community for people with mental health and AOD issues including families and carers. Community treatment services generally operate with multidisciplinary teams who provide outreach, transition support, relapse prevention planning, physical health assessment and support for good general health and wellbeing.

Community treatment services aim to provide appropriate mental health and AOD treatment and care in the community closer to where people live and where connections with, and support from, families and carers can be maintained.

Community bed-based services

Community bed-based services provide 24 hour, seven days per week recovery oriented services in a residential style setting (in the case of mental health services), and withdrawal services and structured, intensive residential rehabilitation for people with an AOD issue.

In mental health, community bed-based services provide support to enable individuals to move to more independent living. The primary aim of interventions is to improve functioning and reduce difficulties that limit an individual's independence. There are four types of mental health community beds: short stay; medium-stay; long-stay and long-stay (nursing home.)

All community bed-based services are expected (where appropriate) to have the capability of meeting the needs of people with co-occurring mental health and AOD issues.

Hospital bed-based services

Hospital bed-based services include acute, subacute and non-acute inpatient units, emergency departments, consultation and liaison services, mental health observation areas (MHOAs), and inpatient AOD withdrawal services. Hospital-based services provide treatment and support in line with mental health recovery oriented service provision, including promoting good general health and wellbeing.

Government of **Western Australia**
Mental Health Commission

GPO Box X2299, Perth
Business Centre WA 6847

Level 1, 1 Nash Street,
Perth, WA 6000

T (08) 6553 0600
mhc.wa.gov.au