Government of **Western Australia**
Mental Health Commission

Mental Health Commission

2017–18 ANNUAL REPORT

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 2018.

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

Timothy Marney
COMMISSIONER
MENTAL HEALTH COMMISSION

17 August 2018

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 2018.

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, are available from the Commission's website at www.mhc.wa.gov.au

To make this annual report as accessible as possible, it is also provided as an interactive online PDF, which has links to other sections within the annual report as well as external links to content on the Commission's website and other external sites (excluding financial statements from pages 50 to 94). This annual report can also be made available in alternative formats upon request for those with visual or other impairments, including Word, audio, large print and Braille.

Contents

Abbreviations:

Mental Health Act 2014	The Act
Mental Health Commission	Commission
Next Step Drug and Alcohol Services	Next Step
State Records Act 2000	Records Act
Suicide Prevention 2020: Together We Can Save Lives	Suicide Prevention 2020
Sustainable Health Review Panel	SHR Panel
Western Australian Alcohol and Drug Interagency Strategy 2018-2022	Strategy
Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025	Accommodation and Support Strategy
Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025	The Plan
Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025	Prevention Plan
Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025	Workforce Strategic Framework
Working Together: Mental Health, Alcohol and Other Drug Engagement Framework 2018-2025	Engagement Framework

Acronyms:

Alcohol and Other Drug	AOD
Alcohol and Drug Support Service	ADSS
Child and Adolescent Health Service	CAHS
Community Alcohol and Drug Services	CADS
Department of Health	DoH
East Metropolitan Health Service	EMHS
Health Service Providers	HSPs
Hospital in the Home	HITH
Lesbian, Gay, Bisexual, Transgender and Intersex	LGBTI
Mental Health Advocacy Service	MHAS
Mental Health Network	MHN
Mental Health Tribunal	MHT
Methamphetamine Action Plan	MAP
National Standards for Mental Health Services	NSMHS
North Metropolitan Health Service	NMHS
Office of the Chief Psychiatrist	OCP
South Metropolitan Health Service	SMHS
Strong Spirit Strong Mind Aboriginal Programs	SSSMAP
Strong Spirit Strong Mind Metro Project	SSSM
Western Australian Country Health Service	WACHS

Glossary:

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

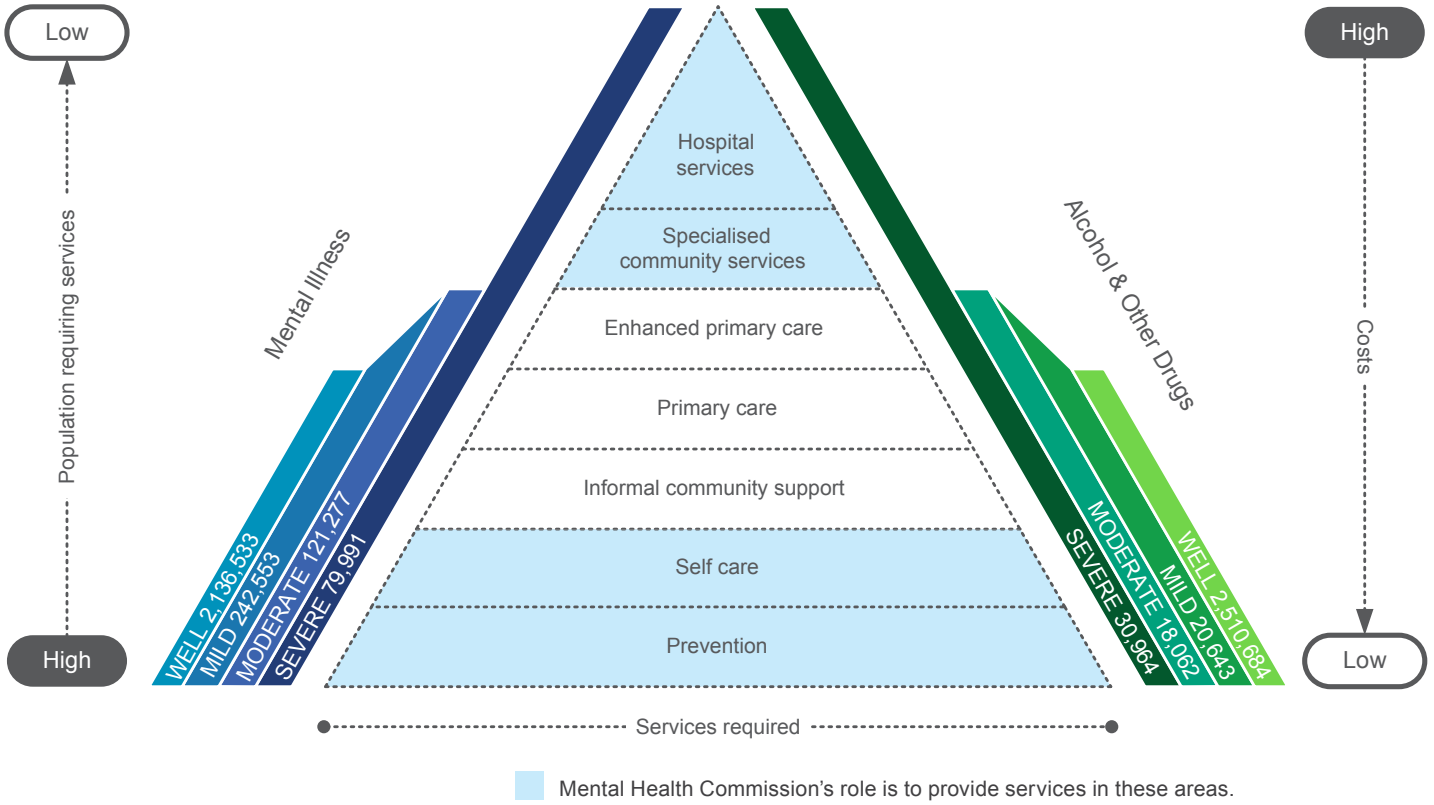
OVERVIEW

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.



Estimated number of the Western Australian population affected by mental health and alcohol and other drug issues

Commissioner's Foreword

Mr Timothy Marney

Guided by the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (The Plan), the Commission delivered a range of initiatives in 2017-18 to enhance the treatment, services and supports to people with mental health and/or alcohol and other drug (AOD) issues.

We provided funding to 111 non-government organisations (NGOs) for the provision of services across the spectrum of care, and $703,016,294 for the delivery of specialised mental health services in the public health system, through contracts with Health Service Providers (HSPs).

In addition, we delivered counselling, clinical and training services directly, through our Alcohol and Drug Support Service (ADSS), Next Step Drug and Alcohol Services (Next Step), and Workforce Development and Strong Spirit Strong Mind Aboriginal Programs (SSSMAP) teams.

We made progress implementing the Government's election commitments relating to mental health and AOD, including the *Methamphetamine Action Plan (*MAP), through:

- $16 million for the continuation of 52 AOD residential rehabilitation beds and eight low-medical withdrawal beds;
- $9.3 million in service delivery from 2018-19 to 2021-22 for the establishment of up to 33 additional AOD residential rehabilitation and low-medical withdrawal beds in the South West;
- An additional $4.5 million from 2018-19 to 2020-21 for the continuation of 13 full-time community treatment positions for the Community Alcohol and Drugs Services (CADS) network across Western Australia;
- $0.4 million in 2018-19 for the proactive targeting of youth education and prevention programs to reduce methamphetamine demand and harm; and
- $0.2 million in 2017-18 to identify and undertake planning and consultation required to address the gaps in Alcohol and Other Drug treatment services in the Kimberley.

A MAP Taskforce was also announced by the State Government, on 26 June 2017.

We continued to produce a number of plans, strategies and frameworks, including the:

- *Working Together: Mental Health, Alcohol and Other Drug Engagement Framework 2018-2025*;
- Two-year update of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*;
- *Western Australian Alcohol and Other Drug Interagency Strategy 2018-2022*;
- *Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025*;
- *Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025*; and
- *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025*.

Other significant work throughout 2017-18 included:

- Development of a model of service for the establishment of a Recovery College model in Western Australia;
- A two-year post-implementation review of the *Mental Health Act 2014* (The Act);
- Work towards establishing additional community mental health step up/step down services across regional Western Australia;
- Continued development of the child and adolescent, and youth service streams;
- Transition to 17 culturally secure beds in our Next Step inpatient withdrawal unit;
- The Minister for Health and Mental Health's *Preventative Health Summit*;
- A new Statewide public education campaign, *Think Mental Health*;
- The successful relocation of residents affected by the closure of the Franciscan House Licensed Private Psychiatric Hostel;
- The transition of the Statewide Specialist Aboriginal Mental Health Service (SSAMHS) into the Commission's ongoing mental health base funding;
- Funding to re-open four older adult mental health inpatient beds at Rockingham General Hospital;
- Progress in the planning of decommissioning of services at the Graylands Health Campus; and
- Strengthened engagement with consumers, families and carers.

Internally, we introduced an Elder in Residence Program to provide cultural guidance and expertise to all Commission employees and advise the Corporate Executive; we conducted a series of focus groups to explore employee perceptions around workplace matters such as resilience, workload management, managing relationships, role clarity and job control; and we provided our employees with professional development opportunities to assist them in delivering both individual and organisational goals.

To improve current performance monitoring and evaluation of mental health services, we also commenced a uniform and comprehensive analysis of each HSP's Community Treatment Services, to further understand the breadth, quantity and quality of services that we fund across the State.

These are just some of the highlights from our achievements in 2017-18, with a more expansive summary provided under Key Achievements.

I am pleased to present this annual report and I thank each and every person who has worked with us over the past year.

I also extend my genuine thanks to every member of my diligent team at the Commission, for their dedication and achievements, as we work together towards achieving a Western Australian community that experiences minimal AOD-related harms and optimal mental health.

Timothy Marney
Mental Health Commissioner

Executive Summary

2017-18 Highlights

Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025

$TOTAL

$894.91 million

$20.5 million

Prevention

- Dedicated funding for suicide prevention services. e.g. Suicide prevention coordinators in place across the State; Children and Young People Responsive Suicide Support (CYPRESS) program; Response to Suicide and Self Harm in Schools Program
- Targeted grants for suicide prevention training for at-risk communities
- *Preventative Health Summit*
- Development of the *Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025*
- *Think Mental Health* Statewide public education campaign
- New Drug Aware Safer Events and Venues campaign, *The Medix*

$44.84 million

Community Support Services

- $200,000 in State Government funding for the Commission to plan for a Recovery College model of service for Western Australia
- Funding to the WA AIDS Council to provide support for the LGBTI community ahead of the marriage equality survey
- Successful relocation of residents from Franciscan House into alternative supported accommodation before the hostel closed
- Assistance to other licensed private psychiatric hostels to support the completion of the required actions recommended in their quality evaluation reports, to meet the requirements of the *National Standards for Mental Health Services 2010*
- *Community Services Procurement Schedule* for the procurement of mental health and AOD services. Provides a transparent overview of the Commission's future procurement timeframes and assists NGOs to plan in advance

$399.68 million

Community Treatment Services

- Additional $18.2 million to continue the delivery of the Statewide Specialist Aboriginal Mental Health Service (SSAMHS)
- $4.5 million for the continuation of 13 full-time community treatment positions for the CADS network
- Expansion of amphetamine treatment and support across the metropolitan area
- Over 20,790 occasions-of-service through the Alcohol and Drug Support Service
- Continuation of the Mental Health-Police Co-Response program
- Continuation of funding for the North West Drug and Alcohol Program
- $1.8 million for the reform and expansion of the Mid West Community Mental Health Team
- $0.5 million for the introduction of after-hours and weekend services for community mental health in the South West
- $0.5 million for the enhancement of Child and Adolescent community mental health services in Katanning, Narrogin, and the Wheatbelt

$48.49 million

Community Bed-Based Services

- $16.0 million for the continuation of 52 AOD residential rehabilitation beds and eight low-medical withdrawal beds as part of the MAP
- $9.3 million to establish up to 33 beds in the South West for AOD residential rehabilitation and low-medical withdrawal beds
- $9.0 million to establish a 10-bed Kalgoorlie step up/step down
- $7.7 million to establish a 10-bed Geraldton step up/step down
- $0.2 million to plan for the expansion of AOD services in the Kimberley

$381.40 million

Hospital-Based Services

- Planning for the divestment of infrastructure and the decommissioning and recommissioning of services provided by the Graylands Health Campus and Selby Older Adult Hospital
- Funding for 41 inpatient beds for children, adolescents and youth in the public mental health system, and an additional seven inpatient beds when Perth Children's Hospital opened
- Additional activity funding to the SMHS to re-open four specialised older adult mental health inpatient beds at Rockingham General Hospital
- Next Step clinical liaison services for the Royal Perth Hospital Department of Pain Medicine and Department of Consultant Liaison Psychiatry

Operational Structure

The Hon. Roger Cook MLA

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.

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

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.

Parliamentary Secretary to the Deputy Premier and Minister for Mental Health, the Hon. Alanna Clohesy MLC

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.

Accountable authority

The Commission was established by the Governor in Executive Council under section 35 of the *Public Sector Management Act 1994*. The accountable authority of the Commission is the Mental Health Commissioner, Mr Timothy Marney.

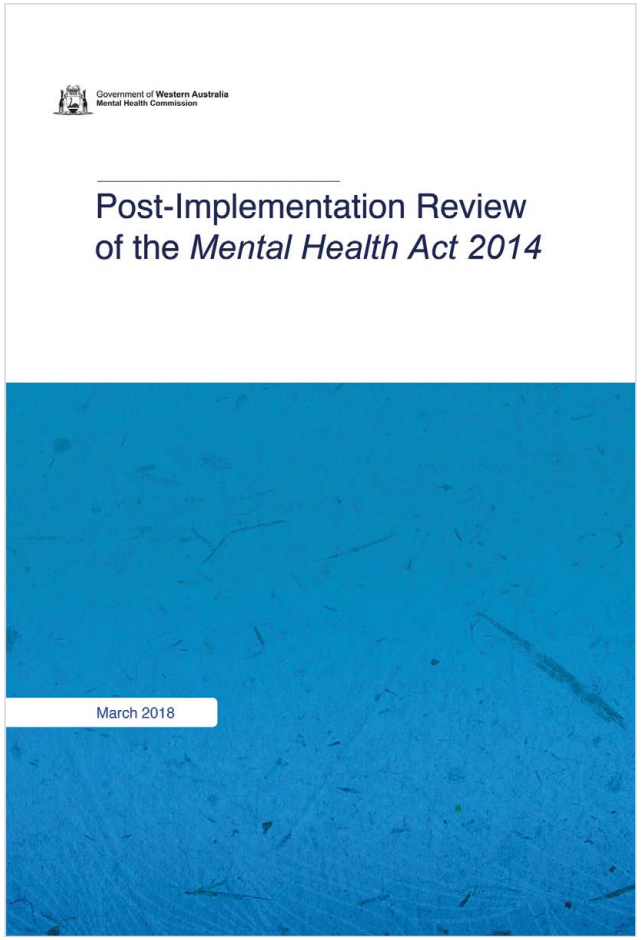
Administered legislation

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*.

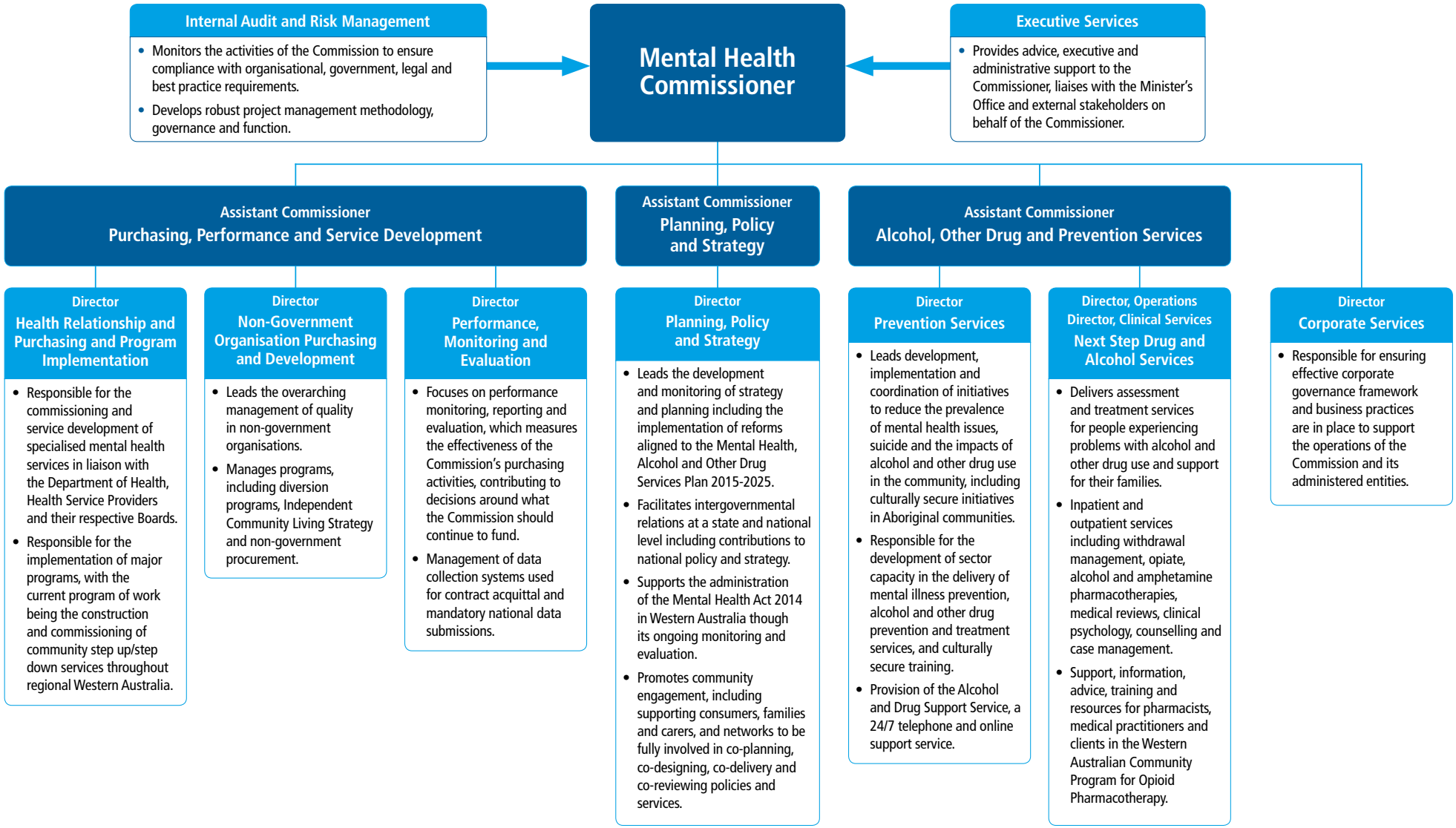
Other key legislation

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



Organisational Structure



Timothy Marney

Mental Health Commissioner

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, as well as government procurement policies and practices. As the Mental Health Commissioner, Mr Marney is 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.

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 has witnessed the significantly increased profile of mental health and AOD issues from within the sector and supported the increased role of consumers, carers and families in defining their own 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. Mr Axworthy has been Assistant Commissioner since April 2016. During the first half of the 2017-18 financial year he was on extended leave and Director Planning, Policy and Strategy, Ms Julia Knapton, acted in the role.

Sue Jones

Assistant Commissioner, Alcohol, Other Drug and Prevention Services

Ms Jones leads the Prevention Services directorate and Next Step. 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.

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 statutory 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, with exposure to the work of government agencies engaged in Local Government, Culture and Arts, Sport, Justice, Industrial Relations, Communities, Disability Services, and Education and Training. Mr Watt oversaw the commencement and establishment of the Western Australian State Administrative Tribunal and administration of the then Mental Health Review Board.

AGENCY PERFORMANCE

Performance Summaries – Report on Operations

Summary of financial performance

The tables below provide an overview of the Commission's financial performance. The detailed information and notes are provided in the Financial Statements section from page 50.

FINANCIAL TARGET	2017-18 BUDGET $'000	2017-18 ACTUAL $'000	VARIATION $'000
Total cost of service (expense limit)	914,357	894,909	(19,448)
Net cost of services	727,450	696,493	(30,957)
Total equity	45,429	57,628	12,199
Net increase/(decrease) in cash held	(1,995)	8,577	10,572

STAFFING Approved full-time equivalent staff level	2017-18 BUDGET	2017-18 ACTUAL	VARIANT
Mental Health Commission	279	272	-7
Office of the Chief Psychiatrist	14	16	2
Mental Health Advocacy Service	8	8	0
Mental Health Tribunal	7	8	1
TOTAL	**308**	**304**	**-4**

Working cash targets

	2017-18 AGREED LIMIT $'000	2017-18 TARGET / ACTUAL $'000	VARIATION $'000
Agreed Working Cash Limit (at Budget)	45,492	45,492	0
Agreed Working Cash Limit (at Actuals)	45,487	44,615	872

Summary of key effectiveness and efficiency indicators

The Commission reports each year on efficiency and effectiveness indicators that contribute to its agency outcomes. A summary of its performance is provided in the table below. More detailed information and analysis of its efficiency and effectiveness indicators are provided in the Key Performance Indicators section from page page 95.

KEY EFFECTIVENESS INDICATOR		2017-18 TARGET	2017-18 ACTUAL
Outcome 1 – Improved mental health and wellbeing			
1.1	Percentage of the population with high or very high levels of psychological distress	<=9.9%	9.9%
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	<=21.6%	18.4%
2.2	Percentage of the population aged 14 years and over reporting recent use of illicit drugs	<=17.0%	16.8%
2.3	Rate of hospitalisation for alcohol and other drug use	N/A	988.3 per 100,000 population
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)	<=12.0%	18.1%
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)	>=75.0%	75.7%
3.3	Percentage of closed alcohol and other drug treatment episodes completed as planned	>=76.0%	72.3%
3.4	Percentage of contracted non-government mental health services that met the National Standards for Mental Health Services through independent evaluation	100.0%	80.0%
3.5	Percentage of contracted non-government alcohol and other drugs services that met an approved accreditation standard	90.0%	81.0%
3.6	Percentage of the population receiving public clinical mental health care (national indicator)	>=2.3%	2.4%
3.7	Percentage of the population receiving public alcohol and other drug treatment	>=0.7%	0.7%

KEY EFFICIENCY INDICATOR		2017-18 TARGET	2017-18 ACTUAL
Service 1 – Prevention			
1.1	Cost per capita to enhance mental health and wellbeing and prevent suicide (illness prevention, promotion and protection activities)	$4.23	$3.90
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	$4.53	$4.92
1.3	Cost per person of alcohol and other drug campaign target groups who are aware of, and correctly recall, the main campaign messages	$0.91	$0.99
Service 2 – Hospital-Based Services			
2.1	Average length of stay in purchased acute specialised mental health units	<15 days	15.3
2.2	Average cost per purchased bedday in acute specialised mental health units	$1,520	$1,496
2.3	Average length of stay in purchased sub-acute specialised mental health units	<103 days	152.6
2.4	Average cost per purchased bedday in sub-acute specialised mental health units	$1,467	$1,377
2.5	Average length of stay in purchased Hospital in the Home mental health units	<22 days	20.2
2.6	Average cost per purchased bedday in Hospital in the Home mental health units	$1,382	$1,455
2.7	Average length of stay in purchased forensic mental health units	<50 days	43.0
2.8	Average cost per purchased bedday in forensic mental health units	$1,383	$1,386
Service 3 – Community Bed-Based Services			
3.1	Average cost per purchased bedday for 24 hour staffed community bed-based services (national indicator)	$360	$350
3.2	Average cost per purchased bedday for non-24 hour staffed community bed-based units (national indicator)	$170	$188
3.3	Average cost per purchased bedday in step up/step down community bed-based units	$523	$535
3.4	Cost per completed treatment episode in alcohol and other drug residential rehabilitation services	$10,208	$11,768

KEY EFFICIENCY INDICATOR		2017-18 TARGET	2017-18 ACTUAL
Service 4 – Community Treatment			
4.1	Average cost per purchased treatment day of ambulatory care provided by public clinical mental health services (national indicator)	$487	$463
4.2	Average treatment days per episode of ambulatory care provided by public clinical mental health services	<5.00 days	5.04
4.3	Cost per completed treatment episode in community based alcohol and other drug services	$1,580	$1,753
Service 5 – Community Support			
5.1	Average cost per hour of community support provided to people with mental health problems	$135	$133
5.2	Average cost per episode of community support provided for alcohol and other drug services	$8,783	$11,058
5.3	Average cost per package of care provided for the Individualised Community Living Strategy	$65,790	$35,317
5.4	Cost per episode of care in safe places for intoxicated people	$336	$377

Summary of specialised services and activity contracted by the Commission

Prevention $20.5 million	$3.90 per capita to enhance mental health and prevent suicide	
	$4.92 per capita for initiatives that delay uptake and reduce AOD harm	
Community Support $44.8 million	Mental health Community Support services	204,126 hours of support
	AOD transitional housing and support	47 completed treatment episodes
	Individualised Community Living Strategy	148 support packages for individuals
	Safe places for intoxicated people	16,448 episodes of care
Community Treatment $399.7 million	Ambulatory care by public clinical mental health treatment teams	730,675 treatment days
	AOD community-based treatment teams	21,160 completed treatment episodes and 8,182 ADSS calls
Community Bed-Based Services $48.5 million	24 hours staffed	35,372 beddays
	Non-24 hours staffed	60,928 beddays
	step up/step down	9,372 beddays
	AOD residential rehabilitation	1,513 closed treatment episodes
Hospital-Based Services $381.4 million	Acute	641 beds and 209,749 beddays
	Sub-acute	79 beds and 24,405 beddays
	Hospital in the Home	48 beds and 11,913 beddays
	Forensic	37 beds and 11,987 beddays

The $381.4 million in Hospital-Based Services can also be broken down as follows ...

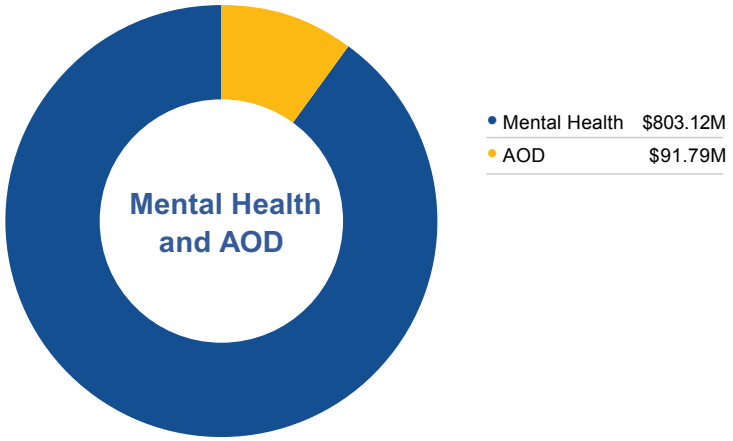
Child and Adolescent	20 beds and 4,746 beddays
Youth	28 beds and 6,694 beddays
Adult	589 beds and 192,431 beddays
Older Person	152 beds and 50,436 beddays
Mother and Baby	16 beds and 3,747 beddays

Key Achievements

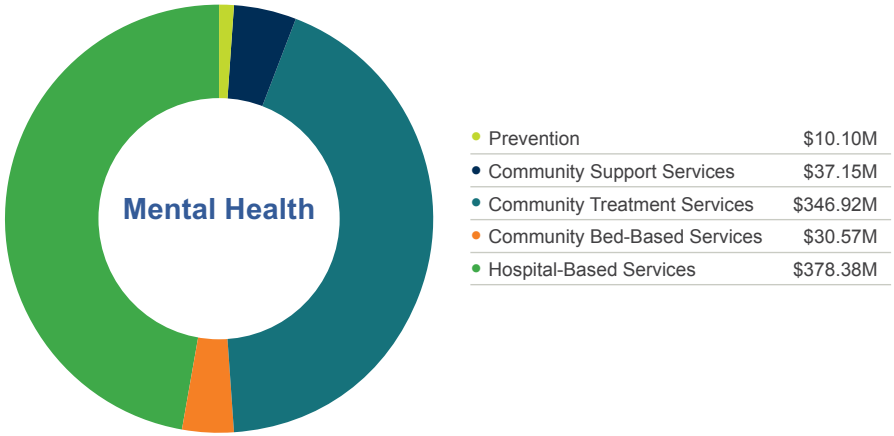
In 2017-18 the Commission's expenditure on mental health and AOD services grew by 3.7%.

A total of $894.91 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 optimal level of mental health and AOD services to the Western Australian community.

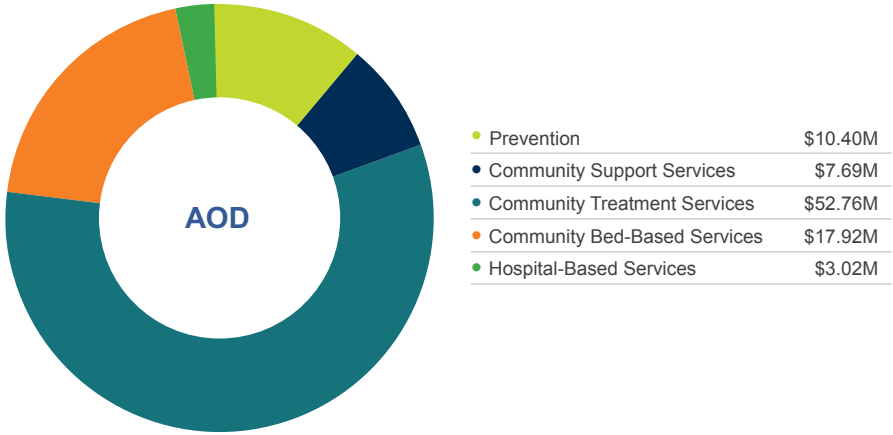
AOD services accounted for $91.79 million in expenditure, up 3.8%, while mental health services received $803.12 million, up 2.8%.



Of the mental health services funding, Prevention received $10.10 million; Community Support Services $37.15 million; Community Treatment Services $346.92 million; Community Bed-Based Services $30.57 million and Hospital-Based Services $378.38 million.



Of the funding for AOD services, Prevention received $10.40 million; Community Support Services $7.69 million; Community Treatment Services $52.76 million; Community Bed-Based Services $17.92 million and Hospital-Based Services $3.02 million.



The Commission's key achievements in these areas throughout 2017-18 are as follows ...

Prevention

In 2017-18 the Commission invested $20.5 million in prevention services, to assist in improving the mental health of Western Australians and in reducing their risk of mental illness, suicide and AOD-related harms.

Some of the NGO prevention services to receive funding from the Commission in 2017-18 included:

AHCWA Aboriginal Health Council of Western Australia	LDAG Local Drug ACTION Groups inc.	MCAAY McCusker Centre for Action on Alcohol and Youth
$ 401,550	$573,760	$2,747,488
SDERA EDUCATING FOR SMARTER CHOICES	youthfocus	360 health + community
$1,429,027	$853,928	$ 569,203

Several key suicide prevention projects continued to receive funding from the Commission in 2017-18 under *Suicide Prevention 2020: Together We Can Save Lives* (Suicide Prevention 2020). These included 10 Suicide Prevention Coordinators who develop community action plans to address suicide-related issues at a local level in regions across Western Australia, the Active Life Enhancing Intervention (ALIVE) program, Children and Young People Responsive Suicide Support (CYPRESS) program, Response to Suicide and Self Harm in Schools program, and Aboriginal Family Wellbeing Project.

In addition, a targeted round of suicide prevention grants was released, contributing more than $188,000 to 12 community organisations, for the delivery of suicide prevention training for communities.

In partnership with the Department of Health and Healthway, the Commission contributed to the development of a *Preventative Health Summit* hosted by the Deputy Premier, to encourage broader thinking and community engagement about ways to foster healthy lifestyles among Western Australians. Priority alcohol prevention areas of focus included a minimum floor price for alcohol, reducing children's exposure to alcohol advertising, low risk alcohol availability, effective health campaigns and education.

Preventative Health Summit

In conjunction with key stakeholders, the Commission is developing a *Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025* (the Prevention Plan), to help promote optimal mental health, prevent and reduce the incidence of mental health issues, suicide attempts and suicide, and prevent and reduce drug use and harmful alcohol use in the Western Australian community. Consultation has been undertaken for the Prevention Plan, which will provide a guide for all stakeholders in the development and implementation of effective, evidence-based primary prevention activities.

To create greater public awareness and united action around mental health and wellbeing and reduce the risk of suicide, the Commission launched a new Statewide public education campaign, *Think Mental Health*, across social media, radio and television. A key initiative of Suicide Prevention 2020, *Think Mental Health* is dedicated to destigmatising mental health issues and assisting the Western Australian community to navigate the range of mental health services available.

Campaign highlights throughout 2017-18 included:

- Western Australia recorded significantly greater awareness of the national low-risk drinking guidelines than the national average;
- A new Drug Aware 'Safer Events and Venues' campaign, *The Medix*, ran during 2017-18. It won the Best of Year creative award at the *2018 Campaign Brief Awards* for 'Use of Data';
- Awareness of the Drug Aware *Meth Can Take Control* campaign further increased, with 77% of 17 to 25 year olds surveyed aware of the campaign. This is the highest awareness rate achieved for any Drug Aware campaign since the program commenced in 1996; and
- *Think Mental Health* targeted men aged 25 to 54, and their families and friends, in recognition that three in four deaths by suicide in Western Australia are males.

Scene from the Think Mental Health campaign

The Strong Spirit Strong Mind Metro Project (SSSM) also ran a public AOD education campaign in 2017-18 that consisted of outdoor, social media, online, radio and digital media. A post-campaign evaluation of 167 Aboriginal young people found 69% were more aware of where to get help from AOD support services after being exposed to the campaign, compared to 40% in the previous evaluation.

Other key achievements in 2017-18 included:

- Assisted with the development, implementation, review and evaluation of 35 AOD management plans that seek to address local AOD-related harm across the State;
- Monitored liquor licence applications across the State and investigated 251 matters regarding the potential for, and minimisation of, alcohol-related harm and ill-health;
- Assisted the Chief Health Officer with 47 interventions regarding liquor licence applications, of which 38 were for the purpose of suggesting conditions on a licence to minimise harm;
- Continued the Commission's partnership with the WA Local Government Association (WALGA) to respond to local government requests for evidence-based information about alcohol management;
- Launched an evidence-based Volatile Substance Use (VSU) website to assist frontline workers, service providers and other professionals who work directly, or indirectly, with people affected by VSU; and
- Professional development for AOD services that work with Aboriginal young people.

Community Support Services

The Commission expended $44.84 million on community support services in 2017-18.

On 1 September 2017, the owner of the 75-bed Franciscan House Licensed Private Psychiatric Hostel provided notice of intention to close by 31 December 2017. In line with the *Hostel Closure Strategy 2016*, a Hostel Closure Working Group was established, overseen by an interagency Executive Committee chaired by the Chief Executive of the East Metropolitan Health Service (EMHS). Interagency collaboration between the Commission, EMHS and the Mental Health Advocacy Service (MHAS), along with the goodwill and assistance of the NGO sector, resulted in 67 residents being successfully relocated to alternative supported accommodation by 19 December 2017. Indications are that many of the individuals have experienced significant improvement in their physical and mental health since the move. The Commission also worked with other licensed private psychiatric hostels to support the completion of the required actions recommended in their quality evaluation reports so they could meet the requirements of the *National Standards for Mental Health Services 2010*.

Ahead of the marriage equality survey, the Commission provided grant funding to the Western Australian AIDS Council to provide support for the Lesbian, Gay, Bisexual, Transgender and Intersex community (LGBTI). Additional counselling, information and support services were provided to reduce isolation and improve resilience and coping strategies.

A Western Australian Recovery College Expert Panel was appointed to progress the co-design of a comprehensive, evidence-informed Model of Service for Recovery Colleges, that addresses the particular needs of Western Australians who experience mental health and co-occurring AOD issues. A literature review was commissioned to inform the Expert Panel of various Australian and international Recovery Colleges and Recovery College experts from the United Kingdom were engaged to provide community information sessions. Community consultation, which included grants for 15 community organisations to conduct community forums across Western Australia, was also undertaken to inform the *Draft Model of Service*. In addition, the Commission invited community participation via an online survey, phone line and written submissions.

Recovery College information session delivered by Ms Jane Rennison from the United Kingdom

A *Community Services Procurement Schedule* (the Schedule) was developed for the procurement of mental health and AOD services. The Schedule provides a transparent overview of the Commission's future procurement timeframes and assists NGOs to plan and prepare for future service developments.

Community Treatment Services

In 2017-18, the Commission spent $399.68 million on community treatment services.

The Statewide Specialist Aboriginal Mental Health Service (SSAMHS) received an additional $18.2 million in the 2017-18 State Budget, which will support the transition of the service into the Commission's ongoing mental health base funding. The SSAMHS provides culturally secure, specialised services to Aboriginal people with severe and persistent mental illness.

Next Step continued to expand amphetamine treatment and support across the metropolitan area, developing a Model of Care and resource kit for amphetamine treatment and support for Next Step and Metropolitan CADS clients. Life-saving naloxone was also made widely available with a total of 709 naloxone kits distributed through Next Step and the Metropolitan CADS. At the end of 2017-18, there were 120 reported opioid overdose reversals using the naloxone kits. A service level agreement between Next Step and the WA AIDS Council to provide an outreach service to the M Clinic sexual health facility saw an increase in individuals being assessed.

Over 20,790 occasions-of-service were provided to Western Australians through the Commission's ADSS. Contacts were made via the ADSS' free 24/7 telephone counselling, information, referral and support lines for AOD, live chat and email. Of these contacts, 24% of callers identified alcohol as the primary drug of concern, followed by methamphetamine at 22%, and people who contacted the helplines regarding their own use accounted for 62% of contacts. The *Working Away Alcohol and Drug Support Line* was decommissioned in 2017-18 due to a low volume of calls, with the *Alcohol and Drug Support Line* promoted as an alternate support line.

The Commission's ADSS provides free 24/7 counselling, information, referral and support telephone lines for AOD, as well as live chat and email support

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, underwent further enhancements. These included the addition of a dedicated Diversion Officer to provide assessment and referral to AOD treatment providers from the Start Court. There were 321 referrals to Start Court in 2017-18, and 91% of cases that exited the program experienced clinical improvement. The Links Clinical Assessment Team provided advice, clinical assessment or assistance to 396 referrals during 2017-18, and 79% of the children who were case managed by Outcare had their community support needs met.

As part of the MAP, the Commission received continuation of funding for the expansion of existing CADS for methamphetamine users. The 13 full-time positions provide additional resources across the State, to provide counselling, information and referrals to people experiencing methamphetamine-related harm, and their families. In 2017-18 the CADS teams delivered 11,415 treatment episodes.

Royalties for Regions funding was continued for the North West Drug and Alcohol Program, for outpatient counselling and prevention services across the Kimberley and the Pilbara, and for the Sobering Up Centre in Carnarvon. The funding has enabled a significant expansion of services, with treatment hubs being established or expanded in Broome, Derby, Kununurra, Halls Creek, Fitzroy Crossing, Port Hedland, Karratha, Newman and Tom Price. Outreach services to remote towns and communities are also provided from these hubs.

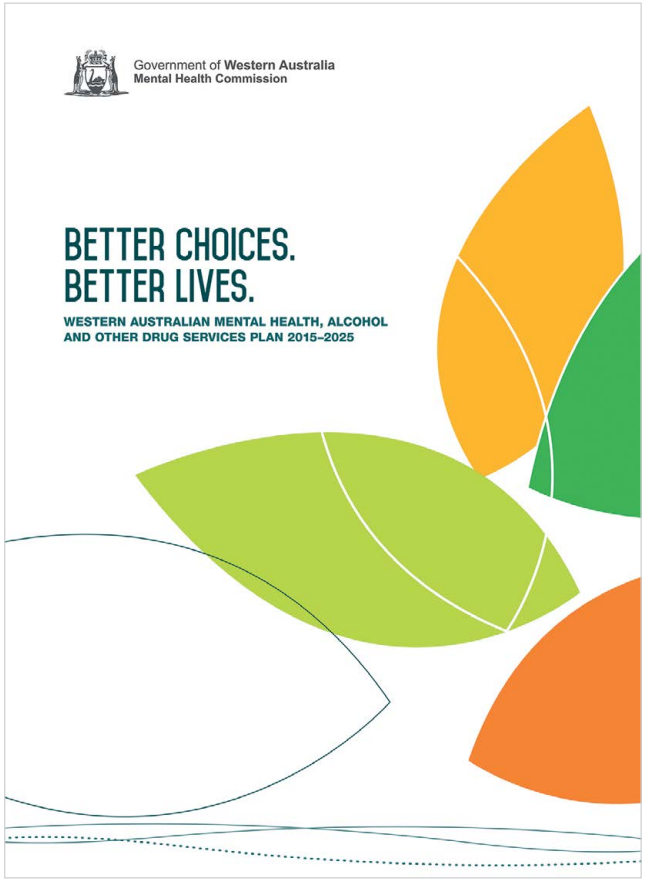
The Commission continued procurement and administration of a Statewide network of Alcohol Assessment and Treatment (AAT) providers, for interlock-restricted drivers who breach the conditions of the WA Alcohol Interlock Scheme and are referred for compulsory AAT.

There were 126 individuals referred for AAT in 2017-18. The Commission is also liaising with Aboriginal service providers regarding the provision of AAT to Aboriginal people in regional areas.

Included in The Plan, are actions to increase the availability and effective coordination of community treatment services. The Commission progressed some of these actions through the allocation of resources to HSPs, to fund new, or enhance existing, public mental health and AOD community treatment initiatives.

Key funding for this area in 2017-18 included:

- $1.8 million for the Western Australian Country Health Service (WACHS) to enhance the Mid West Community Mental Health service;
- New funding of $176,000 to the North Metropolitan Health Service's (NMHS) Women and Newborn Health Service for the provision of four 10-week Mother-Baby Nurture groups designed to support parents and infants through the early days of parenting, and the provision of an early intervention and specialist Foetal Alcohol Spectrum Disorder assessment and diagnosis service;
- $1.4 million to the South Metropolitan Health Service (SMHS) for continuation of the Youth Community Assessment and Treatment Team (YCATT), which supports young people aged 16 to 24 years who are at a higher risk of developing serious mental health problems, through intensive community mental health treatment as an alternative to hospital admission;
- Continuation of the Mental Health Co-Response program in its current form (formal evaluation completed in April 2018);
- $0.5 million for the introduction of after-hours and weekend services for community mental health in the South West; and
- $0.5 million for the enhancement of child and adolescent community mental health services in Katanning, Narrogin, and the Wheatbelt.



Actions to increase the availability and effective coordination of community treatment services are included in The Plan

2017-18 expenditure on mental health community treatment services provided by public Health Service Providers

**These figures do not include overheads or AOD Community Treatment services*

Community Bed-Based Services

In 2017-18 the Commission expended $48.49 million on community bed-based services.

As part of the MAP, the Commission received $16 million over four years (2018-19 to 2021-22) for the continuation of 52 AOD residential rehabilitation beds at existing service providers (24 beds in the metropolitan area and 28 beds in regional areas) and eight low-medical withdrawal beds (four beds in the metropolitan area and four in regional areas).

During the Request for Registration of Interest process for up to 30 AOD residential rehabilitation and three low-medical withdrawal beds in the South West, the Commission identified existing AOD treatment service providers with the capacity to provide the services. As purchasing services is more time and cost-efficient than building new facilities, it is anticipated that the new services will be operational from January 2019 – two years ahead of the original schedule. The extra beds will be established through an Open Tender process and will be in addition to the existing AOD residential rehabilitation service in Nannup, which provides 14 AOD residential rehabilitation beds and two low-medical withdrawal beds.

In addition to the two operational community mental health step up/step down services in Joondalup (22 beds) and Rockingham (10 beds), planning, design and procurement activity was underway throughout 2017-18 to establish additional step up/step down services, providing a further 48 beds over the next four years in regional Western Australia. These are in Albany (six beds), Bunbury (10 beds), Kalgoorlie (10 beds), Karratha (six beds), Broome (six beds) and Geraldton (10 beds). Step up/step down services provide short-term residential support and individualised care for people following discharge from hospital, or those who are in the community experiencing a change in their mental health, to avoid the need for a possible hospitalisation.

Albany step up/step down
PHOTO SUPPLIED BY ROBERTS GARDINER ARCHITECTS, ALBANY

Hospital-Based Services

In 2017-18 the Commission spent $381.40 million in public mental health inpatient services, through contracts with each of the State's HSPs – the Child and Adolescent Health Service (CAHS), NMHS, SMHS, EMHS and WACHS, and Next Step. More than 258,000 inpatient beddays were provided to people across metropolitan and regional areas via the HSPs, as well as through the Commission's medical AOD withdrawal service at Next Step.

This includes 61,512 inpatient weighted activity units, achieved through approximately 13,500 separations from specialised mental health wards.

The Commission is working with the HSPs to continue to develop the child and adolescent, and youth service streams, since the opening of the Perth Children's Hospital (PCH). Forty-one inpatient beds for children, adolescents and youth were funded in the public mental health system throughout 2017-18, and when PCH opened in June 2018 an additional seven inpatient beds increased the overall child and adolescent/youth bed capacity to 48. PCH provides 20 beds for children aged 0-15 years of age (and 16 year olds where clinically appropriate), and a further 28 beds for youth aged 16-24 years of age are provided through:

- 14 beds at the Fiona Stanley Hospital Youth Unit;
- Six-bed Bentley Adolescent Unit which is to be available for 16 and 17 year olds through the East Metropolitan Youth Unit (increasing to 12 beds for 16-24 year olds in 2018-19); and
- Eight NMHS Youth Hospital in the Home beds for 16-24 year olds.

Child and adolescent mental health bed in Ward 5A at Perth Children's Hospital

The Commission has also been working in partnership with the Department of Health and the NMHS in the planning for, and commissioning of, additional acute mental health beds at the Joondalup Health Campus and has undertaken modelling to inform the assignment of these beds so the priority needs of the community are met.

The Commission provided funding to re-open four specialised older adult mental health inpatient beds at Rockingham General Hospital, increasing capacity to 10 beds.

At the Commission's Next Step Inpatient Withdrawal Unit, there were 670 admissions in 2017-18, and 491 of admitted clients completed their treatment as planned.

Next Step also continued to provide support to hospitals, contributing direct clinical service to 530 patients who presented at Rockingham General Hospital's emergency department, through inreach into the hospital via the South Metropolitan CADS.

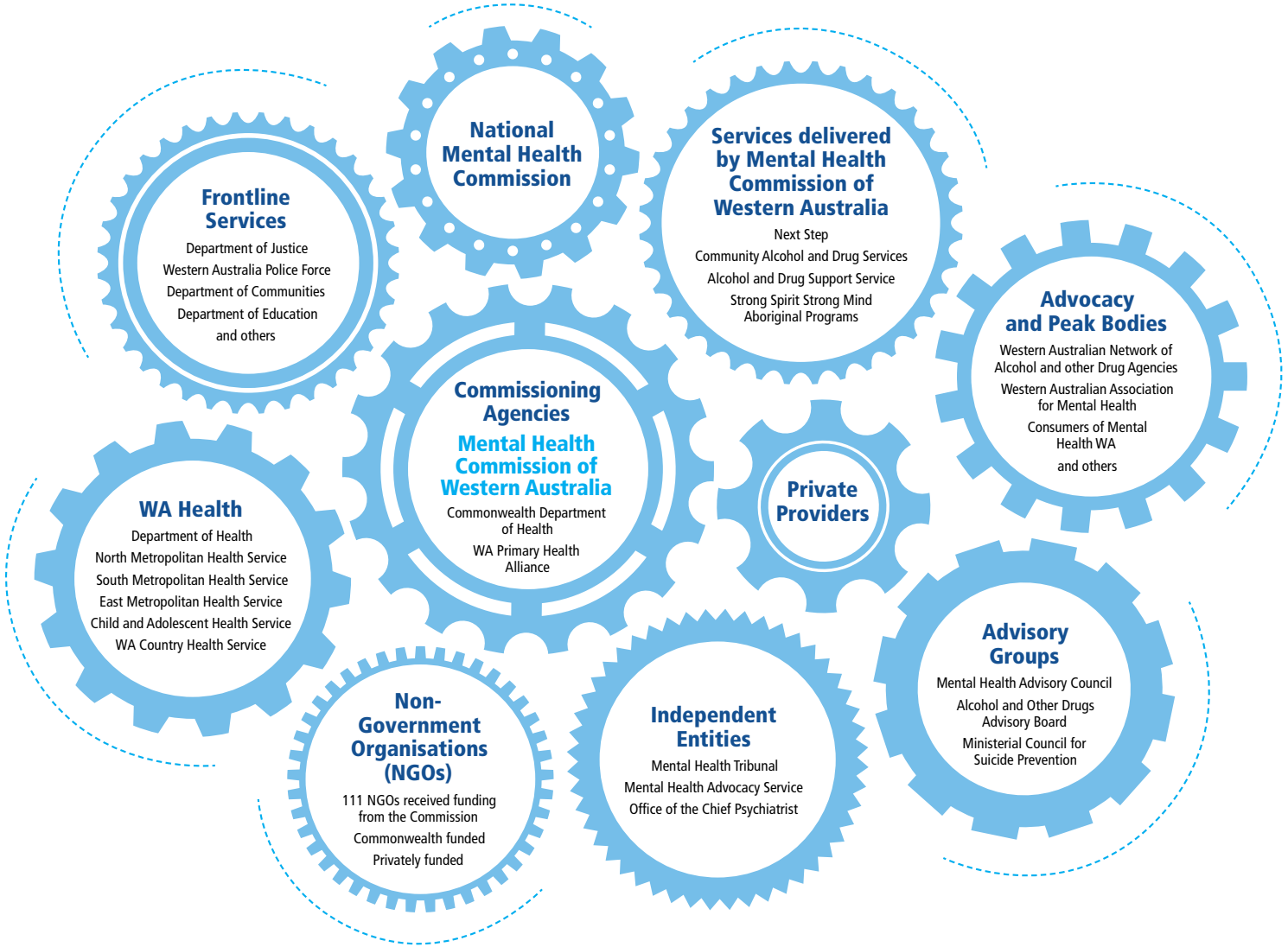
Forty-four percent of these patients presented for AOD-related concerns, while 56% were related to assault or injury, suicidal and other mental health reasons, or general health. More than 270 patients were provided with advice and/or support to access treatment for AOD-related concerns that did not relate to their initial reason for presentation.

At Joondalup Health Campus and Joondalup Community Mental Health Services, via the North Metropolitan CADS, Next Step provided direct clinical service to 833 patients. Clinical liaison services were also provided to Royal Perth Hospital's Department of Pain Medicine and Department of Consultant Liaison Psychiatry by Next Step addiction medicine consultants. Approximately 100 patients were assessed, and support and advice regarding patient care and referral pathways was provided. Over 50 training sessions were also delivered.

In collaboration with the Department of Health and the NMHS, planning for the decommissioning of services at the Graylands Health Campus continued to progress, with the development of a comprehensive business case to identify the services needed to replace those in ageing facilities at Graylands and the infrastructure required to enable contemporary service models. This may include Hospital in the Home beds, inpatient beds, community bed-based services and community support services (including accommodation).

System wide

The Western Australian mental health and AOD sector is a complex system, consisting of numerous services and stakeholders.



Key achievements across the system in 2017-18 included:

Post-implementation review of the Mental Health Act

A two-year, post-implementation review of the Act reinforced the need for the Act, to protect the rights of consumers of mental health services, as well as the rights and involvement of their families and carers. Many positive findings were identified, including the addition of rights for children under the Act, an increase in the number of reviews by the Mental Health Tribunal (MHT), increased assistance provided to consumers by the MHAS at tribunal hearings, and some initial improvements in collaboration with Aboriginal mental health workers and significant members of the consumers' community in comparison to the preceding *1996 Mental Health Act*. Two consistent themes for improvement were identified: a need for further training and education for those working in mental health services, around both compliance with the Act and implementing the intent of the Act; and the need for improved data recording and reporting to improve knowledge of how each detailed aspect of the Act is implemented.

Two-year update of the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025

As the Commission's key planning tool for the mental health and AOD sector, The Plan provides a roadmap for service development, transformation and expansion of mental health and AOD services over a 10-year period. To ensure The Plan remains up-to-date, the Commission committed to revisiting the service modelling using nationally agreed planning tools, every two years. While the original Plan continues to be the primary reference for mental health and AOD services development, the update ensures the latest evidence and population demographics are taken into account to ensure implementation remains responsive to emerging trends in the community.

The update also provides an opportunity to report on key achievements and review changes since the release of The Plan in December 2015. It is anticipated that *The Plan Update 2018* will be released in 2018.

Consumer, carer and family engagement

The Commission strengthened engagement with consumers, families and carers in many areas of its work in 2017-18. Key engagement activities included:

- The co-design of the *Working Together: Mental Health, Alcohol and Other Drug Engagement Framework 2018-2025* (Engagement Framework) and Toolkit, incorporating the contribution of 24 stakeholders, including consumers, family members and carers across three workshops, co-facilitated by a lived experience consultant to develop the principles, strategies and approaches for engagement with consumers, families and carers. Broad community consultation was undertaken and the final Engagement Framework and Toolkit will be released in the second half of 2018;
- Contribution from 18 participants in a dedicated workshop to identify consumer, family and carer key priorities, to guide and inform the development of the *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025* (Workforce Strategic Framework) and the *Prevention Plan*;
- Consumer and carer representation on an Advisory Group, to guide the development of the *Workforce Strategic Framework*;
- Lived experience and carer representation on the Mental Health Court Diversion Adult Program Operational Committee, which inputs into the operational review, promotion and improvement of outcomes for the Start Court program;

- A dedicated Expert Panel which includes people with lived experience, to guide the development of a Recovery College Model of Service for Western Australia;
- Extensive stakeholder consultation in 2016 and 2017 to inform the *Draft Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025* (Draft Accommodation and Support Strategy). The draft document will be released for public consultation in the second half of 2018;
- A grant for HelpingMinds to conduct an additional trial of the nationally developed *Practical Guide for Working with Carers* (the Guide), in clinical out-patient mental health services;
- In partnership with Consumers of Mental Health WA, 20 students received scholarships to complete the Certificate IV Peer Work qualification through North Metropolitan TAFE; and
- Along with the Ministerial Council on Suicide Prevention (MCSP), the progression of the six action areas of *Suicide Prevention 2020*. This involved the MCSP visiting the Goldfields region to hold community forums on mental health and suicide prevention in the mining industry and on men's mental health.

Next Step and the Metropolitan CADS appointed a consumer co-chair to the Integrated Services Consumer Committee for a second term, the Consumer Committee co-designed and implemented a training package tailored to the needs of AOD consumers, and two consumer advisors were appointed to the Integrated Services Clinical Management Committee.

Parent and Family Drug Support trained nine parent peer-volunteers as facilitators for the Be SMART (Self-Management And Recovery Training for family and friends) program. Facilitators delivered five, six-week Be SMART courses and continued to provide peer support groups in East Perth and Currambine.

The Mental Health Advisory Council (MHAC) provided the Commissioner with advice on mental health treatment and support for people in prison, the Mental Health Police Co-Response trial, the development of the *Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025* and the Draft Accommodation and Support Strategy. A complete list of MHAC members and their remuneration is provided in Appendix 2.

Aboriginal People

The Next Step inpatient withdrawal unit transitioned from having four beds specifically for Aboriginal people, to a culturally secure 17-bed unit where Aboriginal clients are supported in the admission process by Aboriginal health workers. The transition was overseen by a stakeholder reference group and included consultation with Aboriginal staff, clients and key Aboriginal services. Next Step also signed a Memorandum of Understanding with the Wungening Aboriginal Corporation to facilitate referrals to Next Step Services.

Please refer to Workforce Development (page 36), Reconciliation Action Plan (page 166), Prevention (page 22), Community Treatment Services (page 25) and National and International Partnerships (page 39) for detailed information on programs undertaken by the Commission in 2017-18 in support of Aboriginal people and communities.

Bringing everyone together

Mental Health Network

On 1 July 2017, the governance of the Mental Health Network (MHN) transferred from the Department of Health to the Commission, and the Commission now provides executive, administrative and policy support to the MHN. The transfer ensures strong alignment between the MHN and the primary objectives of The Plan. Following the transfer, the Commission commenced a review of the MHN to examine its structure and functions. It is anticipated that the review will be released later in 2018. The MHN and its 10 sub-networks continue to build engagement, co-operation and consensus between consumers, families, carers, health professionals, hospitals, health services, community managed organisations, the Commission and the Department of Health. The outcome is to inform mental health policy and reform, and strengthen and increase coordination of mental health care and support, across the State.

Methamphetamine Action Plan Taskforce

Mr Ron Alexander is the Chair of the MAP Taskforce (the Taskforce), which is responsible for providing advice to Government on how methamphetamine programs can be best delivered and targeted to areas of greatest need, opportunities for cross-sector collaboration to reduce methamphetamine harm, demand and supply, and the best ways to measure the performance and success of the Government's initiatives. The Taskforce includes representatives from the State Government agencies of Health, Education, and Police, and subject matter experts from the non-government sector. The Commission leads the MAP Implementation Reporting to the Directors General Implementation Group, and the Community Safety and Family Support Cabinet Sub-Committee.

Corporate Services

In 2016-17 the Commission began a program of work aligned to the whole of government Digital WA Strategy, transitioning on-premise infrastructure to the new GovNext-ICT cloud arrangement.

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. The transition was completed in June 2018 and presents opportunities for the Commission to be technologically responsive to the agency's needs, reduce the overheads of managing physical server infrastructure and allow for more effective ICT investment.

Significant work was undertaken to review human resource, finance and information and technology processes in relation to management audit findings, with 11 out of 16 issues resolved since the amalgamation with the Drug and Alcohol Office in 2015. The review resulted in an interim solution of establishing an internal clearing house to improve compliance with internal policies, procedures and the *Delegations of Authority Framework*.

The Commission also developed a suite of publicly available mental health and AOD resources.

The Commission's Helping Someone In Distress resources provide information on how to assist people experiencing mental health, alcohol or other drug issues

Commission employee development and wellness

In 2017-18, the Commission reviewed and updated the MyPDP performance development process to assist employees and supervisors to more effectively plan and deliver individual and organisational goals. This included the launch of an online capability through the learning management system, ELMO, to record and report on all performance development meetings.

A number of agency-wide development programs were introduced, including:

- A three-year Building and Leading High Performance Teams program for supervisors, which includes topics of leadership, managing conflict, building resilience, coaching and development conversations;
- Opportunities for employees to express their interest in a variety of external development activities including conferences, mentoring programs, the National Mental Health Leaders Fellowship and the Public Sector Management Program;
- Additional online training through ELMO, including courses on developing resilience, leadership and developing cultural understanding;
- Continuation of the Commission's Wellness Committee and employee wellness programs, which offer a range of activities to develop and support employees in maximising their overall health and wellness; and
- As part of the Thrive@Work pilot program, the Commission conducted a series of internal focus groups to explore employee perceptions around workplace matters such as resilience, workload management, managing relationships, role clarity and job control. The feedback from the focus groups will inform the Commission's Healthy Workplace programs.

Workforce Development

The Commission's Workforce Development team provides a range of training and events for professionals, volunteers and the community.

Key achievements throughout 2017-18 included:

- 52 training events about methamphetamine toxicity and opioid overdose, with 'Recognising and Responding to Amphetamine Intoxication/Toxicity and Opioid overdose' provided to 875 participants across the State;

- 213 evidence-based training events delivered to 4,095 participants from a range of health, welfare, justice, AOD and mental health services, including training in regional areas of Western Australia;
- The dissemination of more than 12,500 resources to support the workforce around the State;
- Training to Wandoo Prison staff to support the establishment of Wandoo as the State's first therapeutic community AOD prison;
- Redevelopment of the Online Needle and Syringe Program orientation and training, and Needle and Syringe Program for Pharmacists training packages, in conjunction with the Department of Health's Sexual Health and Blood-borne Viruses Program;
- Twenty seven placements in the annual Volunteer Drug and Alcohol Counsellors' Training Program; and
- Seven workshops about trauma informed care and practice around the State.

The *Draft Workforce Strategic Framework* has also been developed, to guide the growth of an appropriately qualified and skilled workforce that will provide individualised, high quality mental health and AOD programs for the Western Australian community, now and into the future.

In partnership with the Western Australian Network of Alcohol and other Drug Agencies (WANADA), the Commission hosted the *2018 Western Australian Alcohol and Other Drug Conference, 'Leading the Way: Embracing New Opportunities for the Alcohol and Other Drug Sector'*, on 20 and 21 March 2018. The conference featured expert speakers in the field of AOD and provided opportunities for professional networking, collaboration, discussion and debate. Attended by approximately 350 delegates from around the State, nationally and internationally, the conference included the *2018 Western Australian Alcohol and Other Drug Excellence Awards*, which recognised the achievements of those who demonstrated initiatives in supporting consumers of mental health services, as well as their families and carers.

The Commission's Next Step won awards for its Hepatitis C treatment in a Drug and Alcohol Service and Take Home Naloxone program, as well as two awards in partnership with Integrated Services and external stakeholders, for the Inreach Service into Joondalup Health Campus and Thriving DAYS program. The Commission's Workforce Development team won an award for its Recognising and Responding to Amphetamine Intoxication/Toxicity and Opioid Overdose training and resources, and its ADSS Parent and Family Drug Support won an award for its Be SMART program.

The Be SMART program was the recipient of the Families category award at the 2018 Western Australian Alcohol and Other Drug Excellence Awards – pictured with The Hon. Alanna Clohesy MLC, Parliamentary Secretary to the Deputy Premier and Minister for Mental Health

In 2017-18, the Commission's SSSMAP team delivered training programs designed to increase cultural understanding and build better working relationships with Aboriginal clients. These included:

- Ten 'Ways of Working' Part 1 and Part 2 training events, with 142 participants attending the Part 1 sessions and 46 participants attending Part 2;
- Three Fetal Alcohol Spectrum Disorder training events (in conjunction with Workforce Development), attended by 78 participants;
- Twenty-one Quitline Aboriginal Liaison Team training events, attended by 250 participants;
- Certificate III Community Services Work – Aboriginal AOD Worker Training program, with 25 students registered; and
- Certificate IV Alcohol and Other Drugs – Aboriginal AOD Worker Training program, completed by 19 students.

In partnership with the Notre Dame University of Australia, the Commission's Next Step developed a subsidised *Graduate Certificate of Mental Health Nursing and Allied Health* course of study for its nursing workforce. Six nurses are enrolled for the course which is delivered over two semesters. In August 2017, Next Step hosted its biennial Community Program for Opioid Pharmacotherapy conference for its community prescribers.

Organisational effectiveness and efficiency

In 2017-18, the Commission's project governance processes were further strengthened, with the implementation of a program management approach that consolidated related IT projects to ensure efficient and coordinated delivery. The robust governance, assurance and reporting processes of this approach enabled the effective transition of core IT infrastructure to a contemporary managed service.

Strategic direction development

The Draft Accommodation and Support Strategy establishes a framework to guide the collective efforts of stakeholders in the development of appropriate accommodation and support for people with mental health and AOD issues. The vision of the *Draft Accommodation and Support Strategy* is that Western Australians with mental health and/or AOD issues will have timely access to a range of accommodation and support options to meet their personal and cultural needs.

Due for release later in 2018, the *Western Australian Alcohol and Drug Interagency Strategy 2018-2022* (the Strategy), is led by the Commission and overseen by the Drug and Alcohol Strategic Senior Officers' Group. It provides a guide for government and non-government agencies and the community, in addressing the adverse impacts of AOD-related use in Western Australia. Aligned to the *National Drug Strategy 2017-2026* framework of supply, demand and harm reduction, the Strategy provides a strategic framework for across-government responses, to address the complexities of harms relating to AOD use.

National and international partnerships

The Mental Health Commissioner represents Western Australia on the Mental Health Principal Committee (MHPC), a national committee that provides advice on mental health issues to the Australian Health Ministers' Advisory Council. A number of MHPC working groups were established to implement priority areas of the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan), which is intended to reduce duplication and ensure coordinated approaches to service planning and commissioning across agencies. Priority areas included:

- The Mental Health Expert Advisory Group;
- The Suicide Prevention Project Reference Group;
- The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group; and
- The Stigma and Discrimination Working Group.

In 2017-18, the Commission also provided support and representation on the following national committees:

- National Mental Health Consumer and Carer Forum;
- National Mental Health Commission's Advisory Group for Suicide Prevention;
- Mental Health Information Strategy Standing Committee;
- Safety and Quality Partnership Standing Committee;
- National Drug Committee (formerly the Inter-Governmental Committee on Drugs); and
- National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) in the development of:
  - *The Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide*, to assist Australian governments, mental health commissions and various parts of the Australian mental health system implement the Gayaa Dhuwi Declaration; and
  - Health in Culture: Policy Concordance – which is intended to simplify the process of cross referencing across the large number of documents that touch on Aboriginal and Torres Strait Islander and related social and emotional wellbeing, mental health and suicide prevention policy.

Research and evaluation

To support workplaces to become mentally healthy organisations, the Commission contracted The University of Western Australia's Centre for Transformative Work Design, to develop resources and activities as part of the Thrive@Work program. Evidence-based research was used to understand the role of good work design in alleviating psychosocial risk factors, in order to leverage positive workplace outcomes. Thrive@Work will include reference to the *Western Australian Workplace Mental Health Standards* developed under Suicide Prevention 2020 and the Commission is piloting aspects of Thrive@Work to inform its own Employee Wellness Program.

In 2017-18 funding was also provided to the Centre for Transformative Work Design by the State Government, to carry out research into the wellbeing and mental health impact of fly-in fly-out (FIFO) work on individuals. Over 5,000 responses to the survey were received. The research is in response to calls for changes to the industry, from families and loved ones who have been impacted by suicide by FIFO workers. The 2015 Education and Health Standing Committee inquiry into the impacts of FIFO work arrangements on mental health in the resources industry, also recommended independent research and evaluation in this area. The report findings are due in September 2018.

Evaluations were also completed for the Statewide Specialist Aboriginal Mental Health Service and the *Western Australian Meth Strategy 2016*.

SIGNIFICANT ISSUES

Significant Issues Impacting The Commission

Public sector reform

Three Inquiries have been undertaken by the Government – the *Special Inquiry into Government Programs and Projects* (*Langoulant Inquiry*), the *Service Priority Review* and the *Sustainable Health Review*.

The Commission is responding to the findings of the *Langoulant Inquiry* by ensuring transparency, robust project planning, business case development, evaluation and where possible, the simplification or standardisation of its procurement arrangements.

The *Service Priority Review* '*Blueprint for Reform'*, identifies four directions for reform, with 17 recommendations and 37 action items. The Commission is working with the Department of Premier and Cabinet and other government agencies in the delivery of the reform directions. Ongoing, and strengthening, engagement with consumers, families and carers will be a major focus of the Commission's implementation of the reforms.

The *Sustainable Health Review* will prioritise the delivery of patient-centred, high quality and financially sustainable healthcare across the State. Following extensive engagement with stakeholders across Western Australia, the Sustainable Health Review Panel (SHR Panel) has published its Interim Report. The Interim Report presents the SHR Panel's initial observations, preliminary directions and recommendations for immediate action, and areas for further work to develop a more sustainable Western Australian health system. The Commission is providing feedback to the SHR Panel for possible inclusion in the Final Report and Recommendations, due to the Government in November 2018.

While expanding services that focus on prevention and community-based care will ultimately reduce the use of higher cost hospital-based services, responding to the increased demand remains a challenge within the context of a fiscally constrained environment.

The Commission remains focussed on best practice in matters of financial and risk management, governance, procurement, contract management, project planning and evaluation, relative to attendant scale, risk and complexity.

Whole of government savings

In order to meet the Government savings targets, the Commission reviewed its Senior Executive Structure to achieve a 20% reduction in the size of its Senior Executive Service cohort. Seven of the Commission's employees also accepted voluntary severances in accordance with the Government's Voluntary Targeted Separation Scheme, to achieve workforce reduction targets.

National Disability Insurance Scheme

The Commission will be carefully monitoring the impact of Western Australia's transition to the nationally delivered *National Disability Insurance Scheme* (NDIS) on individuals currently participating in Commission-funded programs, and the supports they receive. The transition to the NDIS will affect the programs in various ways and to differing degrees, based on the eligibility assessment criteria for individuals within the programs. In response to this changing environment, a *National Psychosocial Support Bilateral Agreement* was developed to address the provision of psychosocial support funding for people with a mental illness, who are not eligible for the NDIS.

The Commission is working in partnership with the WA Primary Health Alliance on the possible uses of this funding, to ensure the initiative achieves positive outcomes.

Focus on methamphetamine

There is growing community concern regarding the prevalence and impact of methamphetamine use. This is reflected in treatment data, which shows that amphetamine-type stimulants have overtaken alcohol as the primary drug for which people seek treatment. The implementation of the State Government's MAP has required significant investment from the Commission, for the coordination, development and implementation of initiatives to reduce the demand for, supply of and harm from methamphetamine. The development of these programs and services continue to be aligned to The Plan and the priorities of the Government.

Emergency Department wait times

In 2017-18 there were 57,047 presentations to emergency departments for mental health-related issues, with an average waiting time of 113 minutes to be admitted to a bed. Mental health accounted for 5.5% of all emergency department presentations and 1.7% of all inpatient admissions. However, patient flow reports indicate a small number of mental health patients waiting an extended period of time for a specialised mental health bed when presenting at hospital emergency departments. Long wait times are not acceptable and do not represent the most appropriate clinical care setting for these vulnerable patients. The Commission continues to raise accessibility to specialised mental health beds and the need for a reformed assertive patient flow process as a high priority with the Department of Health to ensure wait times in emergency departments are kept to a minimum.

Need for community support

To address the growing need for accommodation and support services within the community, the Commission is developing a system-wide, multi-agency strategy to guide stakeholders in the development of accommodation and support options for people with mental health and/or AOD issues. It will enable government agencies, non-government organisations and the private sector to work together with consumers, families and carers to provide an integrated accommodation and support system.

There has been a need for the Commission to maintain a strong focus on community consultation. As part of the early stages of planning for new services, including the expansion of step up/step down services into regional communities, there is ongoing engagement and consultation with the community, to establish a thorough understanding of services to be established within their region.

Closure of Franciscan House

The Commission, EMHS, MHAS and NGO sector, successfully relocated 67 residents to alternative supported accommodation after the closure of Franciscan House Licensed Private Psychiatric Hostel. This required additional resourcing from the Commission, additional funding to the EMHS to implement the relocation, and strong collaboration by all involved.

Detailed information about the Commission's activities throughout 2017-18 is available in Key Achievements.

DISCLOSURES AND LEGAL COMPLIANCE

Certification of Financial Statements for the year ended 30 June 2018

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 2018 and the financial position as at 30 June 2018.

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
Chief Financial Officer
Mental Health Commission

17 August 2018

Timothy Marney
Accountable Authority
Mental Health Commission

17 August 2018

Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

MENTAL HEALTH COMMISSION

Report on the Financial Statements

Auditor General

Opinion

I have audited the financial statements of the Mental Health Commission which comprise the Statement of Financial Position as at 30 June 2018, the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows, Schedule of Income and Expenses by Service, Schedule of Assets and Liabilities by Service, and Summary of Consolidated Account Appropriations and Income Estimates for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information, including Administered transactions and balances.

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 2018 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 2018.

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 2018. 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 2018.

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.

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance 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 2018 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
ACTING DEPUTY AUDITOR GENERAL
Delegate of the Auditor General for Western Australia
Perth, Western Australia
20 August 2018

Financial Statements

Mental Health Commission
Statement of Comprehensive Income
For the year ended 30 June 2018

	Notes	2018 $	2017 $
COST OF SERVICES			
Expenses			
Employee benefits expenses	3.1 (a)	37,120,240	35,975,411
Service agreement - WA Health	3.2	702,194,456	670,265,489
Service agreement - non government and other organisations	3.2	137,877,380	139,015,908
Supplies and services	3.4	9,553,414	10,389,927
Grants and subsidies	3.3	2,486,286	2,864,341
Depreciation expense	5.1.1	493,554	473,756
Accommodation expense	3.4	2,467,396	2,249,106
Other expenses	3.4	2,716,637	1,873,235
Total cost of services		**894,909,363**	**863,107,173**
Income			
Revenue			
Commonwealth grants and contributions	4.2	193,249,500	163,338,110
Other grants and contributions	4.2	4,799,349	4,304,596
Other revenue	4.3	367,564	882,539
Total revenue		**198,416,413**	**168,525,245**
Total income other than income from State Government		**198,416,413**	**168,525,245**
NET COST OF SERVICES		**696,492,950**	**694,581,928**
Income from State Government			
Service appropriation	4.1	696,654,964	684,695,000
Services received free of charge	4.1	3,428,198	3,196,476
Royalties for Regions Fund	4.1	6,613,000	5,422,609
Total income from State Government		**706,696,162**	**693,314,085**
SURPLUS/(DEFICIT) FOR THE PERIOD		**10,203,212**	**(1,267,843)**
OTHER COMPREHENSIVE INCOME		-	-
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**10,203,212**	**(1,267,843)**

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

Financial Statements

Mental Health Commission
Statement of Financial Position
As at 30 June 2018

	Notes	2018 $	2017 $
ASSETS			
Current Assets			
Cash and cash equivalents	7.1.1	32,614,649	24,611,247
Restricted cash and cash equivalents	7.1.1	6,490,296	6,022,264
Receivables	6.1	603,832	490,446
Inventories	6.3	24,358	18,244
Other current assets	6.4	20,565	27,626
Total Current Assets		**39,753,700**	**31,169,827**
Non-Current Assets			
Restricted cash and cash equivalents	7.1.1	228,720	123,552
Amounts receivable for services	6.2	5,827,123	5,486,123
Property, plant and equipment	5.1	21,602,391	22,426,272
Total Non-Current Assets		**27,658,234**	**28,035,947**
TOTAL ASSETS		**67,411,934**	**59,205,774**
LIABILITIES			
Current Liabilities			
Payables	6.5	2,464,762	4,331,079
Employee benefits provisions	3.1 (b)	5,126,438	5,351,712
Total Current Liabilities		**7,591,200**	**9,682,791**
Non-Current Liabilities			
Employee benefits provisions	3.1 (b)	2,193,078	2,098,539
Total Non-Current Liabilities		**2,193,078**	**2,098,539**
TOTAL LIABILITIES		**9,784,278**	**11,781,330**
NET ASSETS		**57,627,656**	**47,424,444**
EQUITY			
Contributed equity	9.9	32,135,558	32,135,558
Accumulated surplus	9.9	25,492,098	15,288,886
TOTAL EQUITY		**57,627,656**	**47,424,444**

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

Financial Statements

Mental Health Commission
Statement of Changes in Equity
For the year ended 30 June 2018

	Notes	2018 $	2017 $
CONTRIBUTED EQUITY	9.9		
Balance at start of period		32,135,558	31,025,558
Transactions with owners in their capacity as owners:			
Other contribution by owners - Royalties for Region Fund		-	1,110,000
Balance at end of period		32,135,558	32,135,558
ACCUMULATED SURPLUS	9.9		
Balance at start of period		15,288,886	16,556,729
Surplus/(deficit) for the period		10,203,212	(1,267,843)
Balance at end of period		25,492,098	15,288,886
TOTAL EQUITY	9.9		
Balance at start of period		47,424,444	47,582,287
Total comprehensive income/(loss) for the period		10,203,212	(1,267,843)
Transactions with owners in their capacity as owners		-	1,110,000
Balance at end of period		**57,627,656**	**47,424,444**

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

Financial Statements

Mental Health Commission
Statement of Cash Flows
For the year ended 30 June 2018

	Notes	2018 $ Inflows (Outflows)	2017 $ Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		696,313,964	684,354,000
Royalties for Regions Fund - Capital	9.9	-	1,110,000
Royalties for Regions Fund - Recurrent		6,613,000	5,422,609
Net cash provided by State Government		**702,926,964**	**690,886,609**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits expenses		(36,799,975)	(36,122,797)
Service agreement - WA Health		(702,194,456)	(670,265,489)
Service agreement - non government and other organisations		(138,381,292)	(139,086,788)
Supplies and services		(7,530,375)	(6,326,892)
Grants and subsidies		(2,453,382)	(3,193,909)
Accommodation expense		(2,651,087)	(2,025,210)
Other payments		(2,294,987)	(1,919,112)
Receipts			
Commonwealth grants and contributions		193,249,500	163,338,110
Other grants and contributions		4,799,349	4,304,596
Other receipts		59,343	643,244
Net cash used in operating activities	7.1.2	**(694,197,362)**	**(690,654,247)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets		(153,000)	(244,757)
Net cash used in investing activities		**(153,000)**	**(244,757)**
Net increase / (decrease) in cash and cash equivalents		8,576,602	(12,395)
Cash and cash equivalents at the beginning of the period		30,757,063	30,769,458
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.1.1	**39,333,665**	**30,757,063**

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

Financial Statements

Mental Health Commission
Summary of Consolidated Account Appropriations and Income Estimates
For the year ended 30 June 2018

	2018 Estimate $	2018 Actual $	Variance $	2018 Actual $	2017 Actual $	Variance $
Delivery of Services						
Item 12 Net amount appropriated to deliver services	705,661,000	695,845,964	(9,815,036)	695,845,964	683,886,000	11,959,964
Amount Authorised by Other Statutes						
- *Salaries and Allowances Act 1975*	809,000	809,000	-	809,000	809,000	-
Total appropriations provided to deliver services	706,470,000	696,654,964	(9,815,036)	696,654,964	684,695,000	11,959,964
Administered Transactions						
Administered grants, subsidies and other transfer payments	7,539,000	8,230,000	691,000	8,230,000	7,569,000	661,000
Total administered transactions	7,539,000	8,230,000	691,000	8,230,000	7,569,000	661,000
GRAND TOTAL	714,009,000	704,884,964	(9,124,036)	704,884,964	692,264,000	12,620,964
Details of Expenses by Service						
Prevention	20,975,000	20,493,423	(481,577)	20,493,423	20,541,951	(48,528)
Hospital Bed Based Services	379,837,000	381,410,370	1,573,370	381,410,370	367,769,966	13,640,404
Community Bed Based Services	61,409,000	48,504,089	(12,904,911)	48,504,089	44,622,640	3,881,449
Community Treatment	402,385,000	399,666,521	(2,718,479)	399,666,521	383,737,449	15,929,072
Community Support	49,751,000	44,834,960	(4,916,040)	44,834,960	46,435,167	(1,600,207)
Total Cost of Services	914,357,000	894,909,363	(19,447,637)	894,909,363	863,107,173	31,802,190
Less Total income	(186,907,000)	(198,416,413)	(11,509,413)	(198,416,413)	(168,525,245)	(29,891,168)
Net Cost of Services	727,450,000	696,492,950	(30,957,050)	696,492,950	694,581,928	1,911,022
Adjustments (a)	(20,980,000)	162,014	21,142,014	162,014	(9,886,928)	10,048,942
Total appropriations provided to deliver services	706,470,000	696,654,964	(9,815,036)	696,654,964	684,695,000	11,959,964
Details of Income Estimates						
Income disclosed as Administered Income	7,539,000	9,415,449	1,876,449	9,415,449	8,649,914	765,535
	7,539,000	9,415,449	1,876,449	9,415,449	8,649,914	765,535

(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 9.11 'Explanatory statement' and note 10.3 'Explanatory statement for Administered Items' provide details of any significant variations between estimates and actual results for 2018 and between actual results for 2018 and 2017.

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2018

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 entity 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.

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2018

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.

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2018

2.2 Schedule of Income and Expenses by Service

	Prevention		Hospital Bed Based Services		Community Bed Based Services		Community Treatment		Community Support		Total	
	2018 $	2017 $	2018 $	2017 $	2018 $	2017 $	2018 $	2017 $	2018 $	2017 $	2018 $	2017 $
COST OF SERVICES												
Expenses												
Employee benefits expenses	850,054	856,215	15,820,646	15,329,123	2,011,917	1,859,929	16,577,899	15,994,667	1,859,724	1,935,477	37,120,240	35,975,411
Service agreement - WA Health	16,080,253	15,952,319	299,275,277	285,600,125	38,058,940	34,652,726	313,600,044	298,000,036	35,179,942	36,060,283	702,194,456	670,265,489
Service agreement - non government and other organisations	3,157,392	3,308,579	58,763,339	59,234,678	7,472,954	7,187,122	61,576,038	61,806,473	6,907,657	7,479,056	137,877,380	139,015,908
Supplies and services	218,773	247,280	4,071,665	4,427,148	517,795	537,159	4,266,555	4,619,362	478,626	558,978	9,553,414	10,389,927
Grants and subsidies	56,936	68,171	1,059,655	1,220,496	134,757	148,086	1,110,375	1,273,486	124,563	154,102	2,486,286	2,864,341
Depreciation expense	11,302	11,275	210,353	201,867	26,751	24,493	220,421	210,633	24,727	25,488	493,554	473,756
Accommodation expense	56,503	53,529	1,051,604	958,344	133,733	116,279	1,101,939	999,952	123,617	121,002	2,467,396	2,249,106
Other expenses	62,210	44,583	1,157,831	798,185	147,242	96,846	1,213,250	832,840	136,104	100,781	2,716,637	1,873,235
Total cost of services	20,493,423	20,541,951	381,410,370	367,769,966	48,504,089	44,622,640	399,666,521	383,737,449	44,834,960	46,435,167	894,909,363	863,107,173
Income												
Commonwealth grants and contributions	181,000	336,000	114,705,577	96,549,948	-	-	78,362,923	66,270,402	-	181,760	193,249,500	163,338,110
Other grants and contributions	2,235,201	2,226,312	100,000	100,000	-	-	2,464,148	1,978,284	-	-	4,799,349	4,304,596
Other revenue	8,417	21,004	156,656	376,050	19,922	45,627	164,154	392,377	18,415	47,481	367,564	882,539
Total income other than income from State Government	2,424,618	2,583,316	114,962,233	97,025,998	19,922	45,627	80,991,225	68,641,063	18,415	229,241	198,416,413	168,525,245
NET COST OF SERVICES	18,068,805	17,958,635	266,448,137	270,743,968	48,484,167	44,577,013	318,675,296	315,096,386	44,816,545	46,205,926	696,492,950	694,581,928
Income from State Government												
Service appropriation	17,877,531	17,662,100	269,250,408	268,841,722	48,840,533	44,346,207	316,218,539	308,492,226	44,467,953	45,352,745	696,654,964	684,695,000
Services received free of charge	78,506	76,076	1,461,098	1,362,019	185,808	165,258	1,531,033	1,421,153	171,753	171,970	3,428,198	3,196,476
Royalties for Regions Fund	346,422	190,283	85,240	-	10,840	-	5,482,478	4,619,326	688,020	613,000	6,613,000	5,422,609
Total income from State Government	18,302,459	17,928,459	270,796,746	270,203,741	49,037,181	44,511,465	323,232,050	314,532,705	45,327,726	46,137,715	706,696,162	693,314,085
SURPLUS/(DEFICIT) FOR THE PERIOD	233,654	(30,176)	4,348,609	(540,227)	553,014	(65,548)	4,556,754	(563,681)	511,181	(68,211)	10,203,212	(1,267,843)

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

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2.3 Schedule of Assets and Liabilities by Service

	Prevention		Hospital Bed Based Services		Community Bed Based Services		Community Treatment		Community Support		Total	
	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017
	$	$	$	$	$	$	$	$	$	$	$	$
ASSETS												
Current assets	910,360	741,842	16,943,027	13,281,463	2,154,651	1,611,480	17,754,002	13,858,105	1,991,660	1,676,937	39,753,700	31,169,827
Non-current assets	633,374	667,256	11,787,939	11,946,117	1,499,076	1,449,458	12,352,167	12,464,782	1,385,678	1,508,334	27,658,234	28,035,947
Total Assets	1,543,734	1,409,098	28,730,966	25,227,580	3,653,727	3,060,938	30,106,169	26,322,887	3,377,338	3,185,271	67,411,934	59,205,774
LIABILITIES												
Current liabilities	173,839	230,450	3,235,369	4,125,837	411,443	500,600	3,390,230	4,304,970	380,319	520,934	7,591,200	9,682,791
Non-current liabilities	50,221	49,945	934,690	894,187	118,865	108,494	979,429	933,012	109,873	112,901	2,193,078	2,098,539
Total Liabilities	224,060	280,395	4,170,059	5,020,024	530,308	609,094	4,369,659	5,237,982	490,192	633,835	9,784,278	11,781,330
NET ASSETS	1,319,674	1,128,703	24,560,907	20,207,556	3,123,419	2,451,844	25,736,510	21,084,905	2,887,146	2,551,436	57,627,656	47,424,444

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

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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	2018 $	2017 $
Employee benefits expenses	3.1(a)	37,120,240	35,975,411
Employee benefits provisions	3.1(b)	7,319,516	7,450,251
Service agreements	3.2	840,071,836	809,281,397
Grants and subsidies	3.3	2,486,286	2,864,341
Other expenses	3.4	14,737,447	14,512,268

3.1(a) Employee benefits expenses

Wages and salaries	33,099,367	32,432,144
Termination benefits	848,943	369,174
Superannuation - defined contribution plans (a)	3,171,930	3,174,093
Total employee benefits expenses	**37,120,240**	**35,975,411**

(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 $2,828,978 (2016-17 $2,892,957).

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

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.

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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.

	2018 $	2017 $
Current		
Employee benefits provision		
Annual leave (a)	2,504,505	2,551,321
Long service leave (b)	2,445,484	2,589,029
Deferred salary scheme (c)	176,449	211,362
Total current employee benefits provisions	**5,126,438**	**5,351,712**
Non-current		
Employee benefits provision		
Long service leave (b)	2,193,078	2,098,539
Total employee benefits provisions	**7,319,516**	**7,450,251**

(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:

Within 12 months of the end of the reporting period	1,772,717	1,792,352
More than 12 months after the end of the reporting period	731,788	758,969
	2,504,505	2,551,321

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:

Within 12 months of the end of the reporting period	613,226	524,201
More than 12 months after the end of the reporting period	4,025,336	4,163,367
	4,638,562	4,687,568

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:

Within 12 months of the end of the reporting period	78,826	103,065
More than 12 months after the end of the reporting period	97,623	108,297
	176,449	211,362

Employment on-costs: Employment on-costs, including workers' compensation insurance, are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment on-costs are included as part of 'Other expenses, Note 3.4 and are not included as part of the Commission's 'employee benefits expense'.

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Mental Health Commission
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		2018	2017
3.2	**Service agreements**	$	$
	Service agreement - WA Health		
	East Metropolitan Health Service	170,698,132	163,094,963
	North Metropolitan Health Service	242,582,489	235,021,901
	South Metropolitan Health Service	121,661,508	116,588,065
	Child and Adolescent Health Service	60,216,879	59,464,397
	WA Country Health Service	107,035,448	96,096,163
	Total service agreement - WA Health	**702,194,456**	**670,265,489**

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	137,877,380	139,015,908

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

	Total service agreements	**840,071,836**	**809,281,397**
3.3	**Grants and subsidies**		
	Recurrent		
	Suicide Prevention Strategy	997,281	1,074,830
	Prevention and Anti-Stigma	200,000	100,000
	Crisis Accommodation Support	447,807	442,000
	Alcohol Assessment and Treatment Services	-	608,310
	Other grants	841,198	639,201
	Total grants and subsidies	**2,486,286**	**2,864,341**

Grants and subsidies include payment to Department of Education $327,000 (2016-17 $417,390), Department of Communities $494,802 merged with Disability Services Commission (2016-17 $50,000) and Department for Child Protection (2016-17 $533,785), refund to Road Safety Commission $0 (2016-17 $608,310).

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.

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3.4 Other expenses	2018 $	2017 $
Supplies and services		
Specific project expenses - other government organisations (a)	441,132	529,976
Purchase of outsourced services (b) (c)	3,430,078	4,074,044
Corporate support services (d)	3,291,064	3,188,663
Computer related services	290,444	240,336
Consulting fees (b) (c)	1,059,312	1,336,746
Consumables	453,418	394,702
Equipment lease expenses	-	4,190
Communications (b)	283,057	296,717
Printing and Stationery	265,203	281,739
Other	39,706	42,814
Total supplies and services	**9,553,414**	**10,389,927**
Accommodation expense		
Office accommodation expenses	**2,467,396**	**2,249,106**
Other expenditures		
Workers' compensation insurance (a)	480,467	195,522
Other employee related expenses	366,354	361,973
Consumable equipment, repairs and maintenance (b) (g)	414,458	433,678
Loss on revaluation of land	174,900	-
Loss on revaluation of buildings	155,427	69,801
Travel related expenses (c)	158,907	168,370
Audit fees (d)	338,971	124,887
Legal fees (e)	116,055	73,803
Administration (f)	162,456	206,328
Advertising	25,353	66,677
Other insurance (a)	100,008	105,539
Disposal of non-current asset	-	4,299
Other (b) (h)	223,281	62,358
Total other expenditures	**2,716,637**	**1,873,235**
Total other expenses	**14,737,447**	**14,512,268**

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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 $441,132 (previously Department of Corrective Services 2016-17 $434,537) and Western Australia Police Service $0 (2016-17 $95,439).
(b) Department of Finance $1,789 has been reclassified as purchase of outsourced services and $8,895 as communications (2016-17 $122,389 as purchase of outsourced services, $8,807 communications and $246,420 as consulting fees).
(c) Department of Health $21,152 has been reclassified as consulting fees (2016-17 $0) and $5,372 as purchase of outsourced services (2016-17 $0).
(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 $3,291,064 (2016-17 $3,095,297).

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 $2,323,471 (2016-17 $2,066,920) inclusive of services provided free of charge $37,039 (2016-17 $28,478) and Department of Lands $10,000 (2016-17 $0).

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

(a) Include expense to Riskcover, $480,467 has been classified as workers' compensation insurance and $102,222 as other insurance (2016-17 $195,522 workers' compensation insurance and $115,985 other insurance).
(b) Include expense to Department of Finance, $99,656 has been classified as consumable equipment, repairs and maintenance (2016-17 $15,879 classified as consumable equipment, repairs and maintenance and $277 as other).
(c) Include expense to Statefleet $69,488 (2016-17 $79,196) and State Solicitor's Office $2,853 (2016-17 $0).
(d) Include expense to Office of the Auditor General $189,300 (2016-17 $0). In 2015-16 expense to Office of the Auditor General is inclusive of 2014-15 payment and accrued 2015-16 audit fee. In 2016-17, accrued 2015-16 fee is paid however no fee is accrued at the end of financial year 2016-17. So net expense to Office of the Audit General is $0 in 2016-17.
(e) Include expense to State Solicitor's Office $102,475 (2016-17 $72,701) and Department of Finance $1,289 (2016-17 $0).
(f) Include expense to Department of Training and Workforce Development of $5,632 (2016-17 $0).
(g) Include expense to Department of Fire and Emergency $6,524 (2016-17 $0).
(h) Include expense to Department of Treasury $94,656 (2016-17 $0).

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.

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4. Use of our funding

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	2018 $	2017 $
Income from State Government	4.1	706,696,162	693,314,085
Grant income	4.2	198,048,849	167,642,706
Other revenue	4.3	367,564	882,539

4.1 Income from State Government

Service appropriation received during the period:

Amount appropriated to deliver services	695,845,964	683,886,000
Amount authorised by other statutes:		
Salaries and Allowances Act 1975	809,000	809,000
	696,654,964	**684,695,000**

Services received free of charge from other State government agencies during the period:

State Solicitor's Office - legal advisory services	100,095	72,701
Department of Finance - office accommodation leasing services	37,039	28,478
Health Support Services (a)	3,291,064	3,095,297
Total services received	**3,428,198**	**3,196,476**

(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.

Royalties for Regions Fund

Regional Community Services Account	**6,613,000**	**5,422,609**
Total income from State Government	**706,696,162**	**693,314,085**

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.

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Mental Health Commission
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4.2 Grant income

	2018 $	2017 $
Commonwealth grants and contributions		
National Health Reform Agreement (a)	193,068,500	162,820,350
National Partnership Agreement:		
Pay Equity Funding	-	181,760
Indigenous Advancement Strategy	181,000	181,000
Cost Shared Funding Model (CSFM) Projects	-	155,000
Total commonwealth grants and contributions	**193,249,500**	**163,338,110**

(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.

Other grants and contributions		
Department of Health	492,842	685,131
WA Country Health Service	1,129,745	1,129,745
Department for Communities	706,000	-
Department for Child Protection and Family Support	-	706,000
Department of Education	156,585	155,296
WA Police	1,376,000	-
Road Safety Commission	-	600,000
Healthway	838,177	838,424
Department of Regional Development	-	90,000
Other	100,000	100,000
Total other grants and contributions	**4,799,349**	**4,304,596**
Total grant income	**198,048,849**	**167,642,706**

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.

4.3 Other revenue

	2018 $	2017 $
Refund of prior year's payment on contract for services (a)	99,698	360,919
Interest revenue	95,932	93,890
Services to external organisations	131,171	155,198
Asset revenue (b)	-	242,700
Other revenue	40,763	29,832
Total other revenue	**367,564**	**882,539**

(a) Refunds were received from non-government organisations in 2017/18 and 2016/17, as the funds paid in prior year were in excess of the requirement.
(b) Revenue is related to an increment in value of assets after revaluation. It is recognised as other revenue to the extent it reverses the loss on revaluation recognised as other expense in previous years. No revaluation surplus exists in previous year.

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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

	Notes	2018 $	2017 $
Property, plant and equipment	5.1	21,602,391	22,426,272
Depreciation expense	5.1.1	493,554	473,756

5.1 Property, plant and equipment

Land		
Carrying amount at start of period (fair value)	**8,681,900**	**8,439,200**
Revaluation increments / (decrements)	(174,900)	242,700
Carrying amount at end of period	**8,507,000**	**8,681,900**
Buildings		
Carrying amount at start of period (fair value)	**13,288,100**	**13,780,168**
Transfer from Work in Progress	-	-
Revaluation increments / (decrements)	(155,427)	(69,801)
Depreciation	(420,250)	(422,267)
Carrying amount at end of period	**12,712,423**	**13,288,100**
Computer equipment		
Gross carrying amount	49,886	49,886
Accumulated depreciation	(33,257)	(16,629)
Carrying amount at start of period	**16,629**	**33,257**
Depreciation	(16,629)	(16,628)
Carrying amount at end of period	**-**	**16,629**
Furniture and fittings		
Gross carrying amount	-	6,273
Accumulated depreciation	-	(1,974)
Carrying amount at start of period	**-**	**4,299**
Disposals	-	(4,299)
Carrying amount at end of period	**-**	**-**
Medical equipment		
Gross carrying amount	167,819	14,819
Accumulated depreciation	(3,293)	(1,647)
Carrying amount at start of period	**164,526**	**13,172**
Additions	-	153,001
Depreciation	(25,325)	(1,647)
Carrying amount at end of period	**139,201**	**164,526**

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		2018	2017
5.1	**Property, plant and equipment (cont.)**	**$**	**$**
	Other plant and equipment		
	Gross carrying amount	310,623	303,853
	Accumulated depreciation	(47,506)	(14,292)
	Carrying amount at the start of year	**263,117**	**289,561**
	Additions		6,770
	Depreciation	(31,350)	(33,214)
	Carrying amount at the end of year	**231,767**	**263,117**
	Artworks		
	Gross carrying amount	12,000	12,000
	Carrying amount at the start of year	**12,000**	**12,000**
	Carrying amount at the end of year	**12,000**	**12,000**
	Total property, plant and equipment		
	Gross carrying amount	22,510,328	22,606,199
	Accumulated depreciation	(84,056)	(34,542)
	Carrying amount at the start of year	**22,426,272**	**22,571,657**
	Additions	-	159,771
	Disposals	-	(4,299)
	Revaluation increments/(decrements)	(330,327)	172,899
	Depreciation	(493,554)	(473,756)
	Carrying amount at the end of year	**21,602,391**	**22,426,272**

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).

Assets transferred as part of a machinery of government change are transferred at their fair value. The cost of a leasehold improvement is capitalised and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the leasehold improvement.

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.

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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 2017 by the Western Australian Land Information Authority (Valuations and Property Analytics).The valuations were performed during the year ended 30 June 2018 and recognised at 30 June 2018. In undertaking the revaluation, fair value was determined by reference to market values for land: $639,000 (2016-17 $780,000) and buildings $1,091,000 (2016-17 $1,190,000). 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.

5.1.1 Depreciation expense	2018 $	2017 $
Buildings	420,250	422,267
Computer equipment	16,629	16,628
Medical equipment	25,325	1,647
Other plant and equipment	31,350	33,214
Total depreciation expense for the period	**493,554**	**473,756**

As at 30 June 2018 there were no indications of impairment to property, plant and equipment.

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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	22 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. The depreciation method for buildings was changed to straight line on 1 July 2016. Up to 30 June 2016, buildings were depreciated using the diminishing value.

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 2018. 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.

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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	2018 $	2017 $
Receivables	6.1	603,832	490,446
Amounts receivable for services	6.2	5,827,123	5,486,123
Inventories	6.3	24,358	18,244
Other current assets	6.4	20,565	27,626
Payables	6.5	2,464,762	4,331,079

6.1 Receivables

Current		
Receivables (a)	520,110	170,263
Accrued revenue	33,413	109,563
GST receivables	50,309	210,620
Total receivables	**603,832**	**490,446**

(a) Includes $378,400 other grants and contribution to be received from WA Police.

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

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, 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.

6.2 Amounts receivable for services

Non-current	5,827,123	5,486,123

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.

The Commission receives funding on an accrual basis. The appropriations are paid partly in cash and partly as an asset (holding account receivable). The accrued amount receivable is accessible on the emergence of the cash funding requirement to cover leave entitlements and asset replacement.

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		2018	2017
6.3	**Inventories**	$	$
	Current		
	Pharmaceutical stores - at cost	24,358	18,244

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

Prepayments	20,565	27,626

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

Current		
Trade creditors (a)	727,410	1,469,249
Accrued salaries	657,026	421,544
Accrued expenses (a)	1,080,326	2,435,695
Other creditors	-	4,591
Balance at end of period	**2,464,762**	**4,331,079**

(a) Includes expenses not paid yet to Department of Finance $72,850 (2016-17 $384,504), Department of Communities $57,776 (2016-17 $0) and WA Police $0 (2016-17 $95,439).

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.

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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

	2018 $	2017 $
Cash and cash equivalents	32,614,649	24,611,247
Restricted cash and cash equivalents		
- Commonwealth special purpose account (b)	4,814,657	4,723,793
- Royalties for Regions Fund (c)	1,675,639	1,298,471
- Accrued salaries suspense account (a)	228,720	123,552
Balance at end of period	**39,333,665**	**30,757,063**

(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

Net cost of services		(696,492,950)	(694,581,928)
Non-cash items:			
Services received free of charge	4.1	3,428,198	3,196,476
Depreciation expense	5.1.1	493,554	473,756
Loss from disposal of non-current assets		-	4,299
Increment on revaluation of Land		-	(242,700)
Loss on revaluation of land		174,900	-
Loss on revaluation of buildings		155,427	69,801

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7.1.2 Reconciliation of net cost of services to net cash flows provided by/(used in) operating activities (cont.)	2018 $	2017 $
(Increase)/decrease in assets:		
Current receivables	(113,386)	74,447
Inventories	(6,114)	1,764
Other current assets	7,061	12,059
Increase/(decrease) in liabilities:		
Current payables	(1,713,317)	518,941
Current provisions	(225,274)	(418,931)
Non-current provisions	94,539	237,769
Net cash provided by/(used in) operating activities	**(694,197,362)**	**(690,654,247)**

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:

Within 1 year	2,756,742	2,648,809
Later than 1 year and not later than 5 years	10,722,060	10,090,779
Later than 5 years	5,628,046	7,664,512
	19,106,848	**20,404,100**

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 leases relating to buildings and office equipment do not have contingent rental obligations. There are no restrictions imposed by these leasing arrangements on other financing transactions.

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:

Within 1 year	105,117,715	150,124,573
Later than 1 year and not later than 5 years	101,571,604	45,493,204
	206,689,319	**195,617,777**

The 2018/19 service agreement was not signed prior to 30 June 2018. The 2017/18 service agreement between the Mental Health Commission, Department of Health and Area Health Services for the provision of mental health services in public hospitals was signed prior to 30 June 2017. The expenditure commitment is payable as follows:

Within 1 year	-	692,116,136

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:

Within 1 year	40,508	6,995

Judgements made by management in applying accounting policies – operating lease commitments
The Commission has entered into a number of leases for office accommodation. It has been determined that the lessor retains substantially all the risks and rewards incidental to ownership. Accordingly, these leases have been classified as operating leases.

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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.

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment, as shown in the table at note 8.1(c) 'Financial Instruments Disclosures' and note 6.1 'Receivables'.

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

Liquidity risk

Liquidity risk arises when the Commission is unable to meet its financial obligations as they fall due. The Commission is exposed to liquidity risk through its 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:

	2018 $	2017 $
Financial Assets		
Cash and cash equivalents	32,614,649	24,611,247
Restricted cash and cash equivalents	6,719,016	6,145,816
Receivables (a)	553,523	279,826
Amounts receivable for services	5,827,123	5,486,123
Financial Liabilities		
Financial liabilities measured at amortised cost	2,464,762	4,331,079

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

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8.1 Financial risk management (cont.)

(c) Financial instrument disclosures

Credit risk

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

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

Aged analysis of financial assets

			Past due but not impaired				
	Carrying amount	Not past due and not impaired	up to 1 month	1 - 3 months	3 months to 1 year	1 - 5 years	Impaired financial assets
	$	$	$	$	$	$	$
2018							
Cash and cash equivalents	32,614,649	32,614,649	-	-	-	-	-
Restricted cash and cash equivalents	6,719,016	6,719,016	-	-	-	-	-
Receivables (a)	553,523	106,367	379,429	3,378	3,021	61,328	-
Amounts receivable for services	5,827,123	5,827,123	-	-	-	-	-
	45,714,311	45,267,155	379,429	3,378	3,021	61,328	-
2017							
Cash and cash equivalents	24,611,247	24,611,247	-	-	-	-	-
Restricted cash and cash equivalents	6,145,816	6,145,816	-	-	-	-	-
Receivables (a)	279,826	175,829	38,283	8,324	10,723	46,667	-
Amounts receivable for services	5,486,123	5,486,123	-	-	-	-	-
	36,523,012	36,419,015	38,283	8,324	10,723	46,667	-

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

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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 liablities

		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 $
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 Liabilites											
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	-	-	-	-
2017											
Financial Assets											
Cash and cash equivalents	-	24,611,247	-	-	24,611,247	24,611,247	24,611,247	-	-	-	-
Restricted cash and cash equivalents	2.0%	6,145,816	-	4,723,793	1,422,023	6,145,816	6,145,816	-	-	-	-
Receivables (a)	-	279,826	-	-	279,826	279,826	279,826	-	-	-	-
Amounts receivable for services	-	5,486,123	-	-	5,486,123	5,486,123	-	-	-	-	5,486,123
		36,523,012	-	4,723,793	31,799,219	36,523,012	31,036,889	-	-	-	5,486,123
Financial Liabilites											
Payables	-	4,331,079	-	-	4,331,079	4,331,079	4,331,079	-	-	-	-
		4,331,079	-	-	4,331,079	4,331,079	4,331,079	-	-	-	-

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

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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
	$	$	$	$	$
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

		-100 basis points		+100 basis points	
	Carrying amount	Surplus	Equity	Surplus	Equity
	$	$	$	$	$
2017					
Financial Assets					
Restricted cash and cash equivalents	4,723,793	(47,238)	(47,238)	47,238	47,238
Total Increase/(Decrease)		(47,238)	(47,238)	47,238	47,238

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.

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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.

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

8.3 Fair value measurements

Assets measured at fair value:	Level 1	Level 2	Level 3	Fair Value At end of period
2018	$	$	$	$
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**
2017				
Land (Note 5.1)	-	780,000	7,901,900	8,681,900
Buildings (Note 5.1)	-	1,190,000	12,098,100	13,288,100
	-	**1,970,000**	**20,000,000**	**21,970,000**

There were no transfers between Levels 1, 2, or 3 during the current period.

Valuation techniques to derive Level 2 fair values

Level 2 fair values of Land and Buildings are derived using the market approach. Market evidence of sales prices of comparable land and buildings in close proximity is used to determine price per square metre.

Fair value measurements using significant unobservable inputs (Level 3)	Land	Buildings
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**
2017		
Fair value at start of period	7,404,200	12,455,168
Revaluation increments/(decrements) recognised in Profit or Loss	497,700	38,699
Depreciation expense	-	(395,767)
Fair value at end of period	**7,901,900**	**12,098,100**

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8.3 Fair value measurements (cont.)

Valuation processes

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 basis.

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.

Amendments to AASB 136

Mandatory application of AASB 2016-4 Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities has no financial impact for the Commission as the Commission is classified as not-for-profit and regularly revalues specialised property, plant and equipment assets. Therefore, fair value the recoverable amount of such assets is expected to be materially the same as fair value.

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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
Future impact of Australian Accounting Standards not yet operative	9.2
Compensation of Key Management Personnel	9.3
Related Party Transactions	9.4
Related bodies	9.5
Affiliated bodies	9.6
Special purpose accounts	9.7
Remuneration of auditor	9.8
Equity	9.9
Services provided free of charge	9.10
Explanatory statement	9.11

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 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 9	*Financial Instruments* This Standard supersedes *AASB 139 Financial Instruments: Recognition and Measurement*, introducing a number of changes to accounting treatments. The mandatory application date of this Standard is currently 1 January 2018 after being amended by AASB 2012-6, AASB 2013-9 and AASB 2014-1 *Amendments to Australian Accounting Standards*. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 15	*Revenue from Contracts with Customers* 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 a contract with a customer. The Commission's income is principally derived from appropriations which will be measured under AASB 1058 *Income of Not-for-Profit Entities* and will be unaffected by this change. However, the Commission has not yet detremined the potential impact of the Standard on	1 Jan 2019

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

Title		Operative for reporting periods beginning on/after
AASB 16	*Leases* 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. Whilst the impact of AASB 16 has not yet been quantified, the entity currently has operating lease commitments for $19,106,848. The Commission anticipates most of this amount will be brought onto the statement of financial position, excepting amounts pertinent to short term or low value leases. Interest and amortisation expenses will increase and rental expenses will decrease.	1 Jan 2019
AASB 1058	*Income of Not-for-Profit Entities* This Standard clarifies and simplifies the income recognition requirements that apply to not-for-profit (NFP) entites, 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, a performance obligation (a promise to transfer a good or service), or, an obligation to acquire an asset. The commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2019
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The mandatory application date of this Standard has been amended by AASB 2012-6 and AASB 2014-1 to 1 January 2018. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-1	*Amendments to Australian Accounting Standards* Part E of this Standard makes amendments to AASB 9 and consequential amendments to other Standards. It has not yet been assessed by the Commission to determine the application or potential impact of the Standard.	1 Jan 2018
AASB 2014-5	*Amendments to Australian Accounting Standards arising from AASB 15* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 15. The mandatory application date of this Standard has been amended by AASB 2015-8 to 1 January 2018. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 9 (December 2014). The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2018

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

Title		Operative for reporting periods beginning on/after
AASB 2015-8	*Amendments to Australian Accounting Standards - Effective Date of AASB 15* This Standard amends the mandatory effective date (application date) of AASB 15 *Revenue from Contracts with Customers* so that AASB15 is required to be applied for annual reporting periods beginning on or after 1 January 2018 instead of 1 January 2017. For Not-For-Profit entities, the mandatory effective date has subsequently been amended to 1 January 2019 by AASB 2016-7. The Commission has not yet determined the application or the potential impact of AASB 15.	1 Jan 2018
AASB 2016-3	*Amendments to Australian Accounting Standards - Clarifications to AASB 15* This Standard clarifies identifying performance obligations, principal versus agent considerations, timing of recognising revenue from granting a licence, and, provides further transitional provisions to AASB 15. The Commission has not yet determined the application or the potential impact.	1 Jan 2018
AASB 2016-7	*Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not for Profit Entities* This Standard amends the mandatory effective date (application date) of AASB 15 and defers the consequential amendments that were originally set out in AASB 2014 5 Amendments to Australian Accounting Standards arising from AASB 15 for not for profit entities to annual reporting periods beginning on or after 1 January 2019, instead of 1 January 2018. There is no financial impact arising from this standard.	1 Jan 2018
AASB 2016-8	*Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not for Profit Entities* 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. There is no financial impact.	1 Jan 2019

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9.3 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 ($)	**2018**	**2017**
440,001 - 450,000 (a)	1	-
410,001 - 420,000 (a)	-	1
330,001 - 340,000	-	1
290,001 - 300,000	1	-
280,001 - 290,000	1	-
230,001 - 240,000	-	1
220,001 - 230,000	1	-
210,001 - 220,000	1	-
200,001 - 210,000	-	3
190,001 - 200,000	1	2
180,001 - 190,000	4	-
170,001 - 180,000	2	-
160,001 - 170,000	-	2
130,001 - 140,000	1	1
120,001 - 130,000	-	1
110,001 - 120,000	1	-
100,001 - 110,000	1	-
80,001 - 90,000	1	1
60,001 - 70,000	-	1
50,001 - 60,000	1	-
40,001 - 50,000	1	1
20,001 - 30,000	-	1
10,001 - 20,000	1	-
	$	**$**
Short-term employee benefits	2,671,069	2,204,888
Post-employment benefits	316,740	281,574
Other long-term benefits	344,939	298,194
Total compensation of key management personnel	**3,332,748**	**2,784,656**

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

(a) The 2016-17 comparative reflects a leave accrual movement of negative $32,433.

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9.4 Related Party Transactions

The Commission is a wholly-owned public sector entity that is controlled by the State of the Western Australia. In conducting its activities, the Commission is required to pay various taxes and levies based on the standard terms and conditions that apply to all tax and levy payers to the State and entities related to the State.

Related parties of the Commission include:

- all 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

Significant transactions include:

- service appropriation (Note 4.1);
- other contribution by owners (Note 9.9);
- 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 & 6.1).
- royalties for regions fund (Note 4.1 & 9.9);
- services agreement WA Health (Note 3.2);
- grants and subsidies payment to other government agencies (Note 3.3 & 6.5);
- specific project expenses - Department of Juctice (previously Department of Corrective Services) and Western Australia Police Service (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 and consulting fees to Department of Finance (Note 3.4 & 6.5);
- 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);
- legal fees and other travel related expense to State Solicitor's Office (Note 3.4);
- 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);
- services provided free of charge to the other state government agencies (Note 9.10).

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9.4 Related Party Transactions (cont)

Material transactions with related parties

The 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 2017/18. 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)).

9.5 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.

9.6 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:	2018 $	2017 $
Albany Halfway House Association Incorporated	1,427,306	1,415,557
Consumers of Mental Health WA	428,986	341,650
Even Keel Bipolar Support Association Incorporated	127,555	126,505
Holyoake Australian Institute for Alcohol and Drug Addiction Resolution Inc	4,274,756	4,294,999
Home Health Pty Ltd (trading as Tender Care)	1,224,369	1,203,311
June O'Conner Centre Incorporated	-	1,924,506
Local Drug Action Groups Inc	673,657	1,189,047
Palmerston Association Inc	8,590,864	8,064,279
Pathways Southwest Inc.	759,132	752,883
Richmond Wellbeing Incorporated	10,634,427	10,304,424
St Vincent De Paul Society	750,092	743,917
WA Council on Addictions (trading as Cyrenian House)	9,068,974	8,411,784
Total affiliated bodies	**37,960,118**	**38,772,862**

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 $2,943,000 for 2017/18 ($2,653,000 for 2016/17)

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 $2,660,000 for 2017/18 ($2,654,000 for 2016/17)

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 $2,627,000 for 2017/18 ($2,262,000 for 2016/17)

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9.7 Special purpose accounts

State Managed Fund (Mental Health) Account

The purpose of the special purpose account is to hold money received by the Mental Health Commission, for the purposes of health funding under the National Health Reform Agreement that is required to be undertaken in the State through a State Managed Fund.

	2018 $	2017 $
Balance at the start of period	-	-
Receipts:		
Service appropriations (State Government)	276,444,498	253,932,217
Commonwealth grants and contributions	86,088,705	73,699,322
	362,533,203	**327,631,539**
Payments:		
Block grant funding to local hospital networks in WA Health	(341,819,057)	(323,991,924)
Block grant funding to non-government organisation	(3,667,545)	(3,639,615)
Block grant funding to next step drug and alcohol services	(17,046,601)	-
Balance at the end of period	-	-

Commonwealth block funding for next step drug and alcohol services commenced in 17/18. Prior to 17/18 it was fully funded by state appropriation so no comparative in special purpose account.

9.8 Remuneration of auditor

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

Auditing the accounts, controls, financial statements and key performance indicators	**179,480**	**185,000**

9.9 Equity

Contributed equity		
Balance at start of period	32,135,558	31,025,558
Other contribution by owners - Royalties for Region Fund - Regional Community Services Account	-	1,110,000
Balance at end of period	**32,135,558**	**32,135,558**
Accumulated surplus / (deficit)		
Balance at start of period	15,288,886	16,556,729
Result for the period	10,203,212	(1,267,843)
Balance at end of period	**25,492,098**	**15,288,886**
Total Equity at end of period	**57,627,656**	**47,424,444**

9.10 Services provided free of charge

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

Mental Health Tribunal - corporate services	314,572	312,110
Mental Health Advocacy Service - corporate services	328,313	346,141
Office of the Chief Psychiatrist - corporate services and accommodation	479,035	393,511
Total Services provided free of charge	**1,121,920**	**1,051,762**

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9.11 Explanatory statement (Controlled Operations)

All variances between estimates (original budget) and actual results for 2018, and between the actual results for 2018 and 2017 are shown below. Narratives are provided for selected major variances, which are generally greater than:

5% and $17.2 million for the Statements of Comprehensive Income and Cash Flows; and 5% and $1.1 million for the Statements of Financial Position.

9.11.1 Explanatory statement (Statement of Comprehensive Income)

	Variance Note	Estimate 2018 $	Actual 2018 $	Actual 2017 $	Variance between estimate and actual $	Variance between actual results for 2018 and 2017 $
COST OF SERVICES						
Expenses						
Employee benefits expenses		36,358,000	37,120,240	35,975,411	762,240	1,144,829
Service agreement - WA Health	A	705,668,000	702,194,456	670,265,489	(3,473,544)	31,928,967
Service agreement - non government and other organisations		148,338,000	137,877,380	139,015,908	(10,460,620)	(1,138,528)
Supplies and services		7,848,000	9,553,414	10,389,927	1,705,414	(836,513)
Grants and subsidies		11,210,000	2,486,286	2,864,341	(8,723,714)	(378,055)
Depreciation expense		341,000	493,554	473,756	152,554	19,798
Accommodation expense		2,445,000	2,467,396	2,249,106	22,396	218,290
Other expenses		2,149,000	2,716,637	1,873,235	567,637	843,402
Total cost of services		**914,357,000**	**894,909,363**	**863,107,173**	**(19,447,637)**	**31,802,190**
Income						
Revenue						
Commonwealth grants and contributions	B	181,748,000	193,249,500	163,338,110	11,501,500	29,911,390
Other grants and contributions		4,671,000	4,799,349	4,304,596	128,349	494,753
Other revenue		488,000	367,564	882,539	(120,436)	(514,975)
Total income other than income from State Government		**186,907,000**	**198,416,413**	**168,525,245**	**11,509,413**	**29,891,168**
NET COST OF SERVICES		**727,450,000**	**696,492,950**	**694,581,928**	**(30,957,050)**	**1,911,022**
Income from State Government						
Service appropriation		706,470,000	696,654,964	684,695,000	(9,815,036)	11,959,964
Services received free of charge		4,037,000	3,428,198	3,196,476	(608,802)	231,722
Royalties for Regions Fund		14,803,000	6,613,000	5,422,609	(8,190,000)	1,190,391
Total income from State Government		**725,310,000**	**706,696,162**	**693,314,085**	**(18,613,838)**	**13,382,077**
SURPLUS / (DEFICIT) FOR THE PERIOD		**(2,140,000)**	**10,203,212**	**(1,267,843)**	**12,343,212**	**11,471,055**
OTHER COMPREHENSIVE INCOME		-	-	-	-	-
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(2,140,000)**	**10,203,212**	**(1,267,843)**	**12,343,212**	**11,471,055**

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9.11.2 Explanatory statement (Statement of Financial Position)

	Variance Note	Estimate 2018 $	Actual 2018 $	Actual 2017 $	Variance between estimate and actual $	Variance between actual results for 2018 and 2017 $
ASSETS						
Current Assets						
Cash and cash equivalents		22,565,000	32,614,649	24,611,247	10,049,649	8,003,402
Restricted cash and cash equivalents		4,837,000	6,490,296	6,022,264	1,653,296	468,032
Receivables		565,000	603,832	490,446	38,832	113,386
Inventories		20,000	24,358	18,244	4,358	6,114
Other current assets		41,000	20,565	27,626	(20,435)	(7,061)
Total Current Assets		**28,028,000**	**39,753,700**	**31,169,827**	**11,725,700**	**8,583,873**
Non-Current Assets						
Restricted cash and cash equivalents		290,000	228,720	123,552	(61,280)	105,168
Amounts receivable for services		5,827,000	5,827,123	5,486,123	123	341,000
Property, plant and equipment		22,057,000	21,602,391	22,426,272	(454,609)	(823,881)
Total Non-Current Assets		**28,174,000**	**27,658,234**	**28,035,947**	**(515,766)**	**(377,713)**
TOTAL ASSETS		**56,202,000**	**67,411,934**	**59,205,774**	**11,209,934**	**8,206,160**
LIABILITIES						
Current Liabilities						
Payables		4,156,000	2,464,762	4,331,079	(1,691,238)	(1,866,317)
Employee benefits provisions		5,023,000	5,126,438	5,351,712	103,438	(225,274)
Total Current Liabilities		**9,179,000**	**7,591,200**	**9,682,791**	**(1,587,800)**	**(2,091,591)**
Non-Current Liabilities						
Employee benefits provisions		1,594,000	2,193,078	2,098,539	599,078	94,539
Total Non-Current Liabilities		**1,594,000**	**2,193,078**	**2,098,539**	**599,078**	**94,539**
TOTAL LIABILITIES		**10,773,000**	**9,784,278**	**11,781,330**	**(988,722)**	**(1,997,052)**
NET ASSETS		**45,429,000**	**57,627,656**	**47,424,444**	**12,198,656**	**10,203,212**
EQUITY						
Contributed equity		25,763,000	32,135,558	32,135,558	6,372,558	-
Reserves		608,000	-	-	(608,000)	-
Accumulated surplus		19,058,000	25,492,098	15,288,886	6,434,098	10,203,212
TOTAL EQUITY		**45,429,000**	**57,627,656**	**47,424,444**	**12,198,656**	**10,203,212**

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9.11.3 Explanatory statement (Statement of Cash Flows)

	Variance Note	Estimate 2018 $	Actual 2018 $	Actual 2017 $	Variance between estimate and actual $	Variance between actual results for 2018 and 2017 $
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation		706,129,000	696,313,964	684,354,000	(9,815,036)	11,959,964
Royalties for Regions Fund - Capital		-	-	1,110,000	-	(1,110,000)
Royalties for Regions Fund - Recurrent		14,803,000	6,613,000	5,422,609	(8,190,000)	1,190,391
Net cash provided by State Government		**720,932,000**	**702,926,964**	**690,886,609**	**-18,005,036**	**12,040,355**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits expenses		(36,213,000)	(36,799,975)	(36,122,797)	(586,975)	(677,178)
Service agreement - WA Health	A	(705,668,000)	(702,194,456)	(670,265,489)	3,473,544	(31,928,967)
Service agreement - non government and other organisations		(148,338,000)	(138,381,292)	(139,086,788)	9,956,708	705,496
Supplies and services		(3,944,000)	(7,530,375)	(6,326,892)	(3,586,375)	(1,203,483)
Grants and subsidies		(11,210,000)	(2,453,382)	(3,193,909)	8,756,618	740,527
Accommodation expense		(2,415,000)	(2,651,087)	(2,025,210)	(236,087)	(625,877)
Other payments		(2,046,000)	(2,294,987)	(1,919,112)	(248,987)	(375,875)
Receipts						
Commonwealth grants and contributions	B	181,748,000	193,249,500	163,338,110	11,501,500	29,911,390
Other grants and contributions		4,671,000	4,799,349	4,304,596	128,349	494,753
Other receipts		488,000	59,343	643,244	(428,657)	(583,901)
Net cash used in operating activities		**(722,927,000)**	**(694,197,362)**	**(690,654,247)**	**28,729,638**	**(3,543,115)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets		-	(153,000)	(244,757)	(153,000)	91,757
Net cash used in investing activities		**-**	**(153,000)**	**(244,757)**	**(153,000)**	**91,757**
Net increase / (decrease) in cash and cash equivalents		(1,995,000)	8,576,602	(12,395)	10,571,602	8,588,997
Cash and cash equivalents at the beginning of the period		29,687,000	30,757,063	30,769,458	1,070,063	(12,395)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**27,692,000**	**39,333,665**	**30,757,063**	**11,641,665**	**8,576,602**

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9.11 Explanatory statement (Controlled Operations) (cont.)

Major Actual (2018) and Comparative (2017) Variance Narratives for Controlled Operations

A Service Agreement-WA Health expenditure increased by $31.9 million (4.8%) in 2017-18 from 2016-17 reflecting an activity and cost growth for public mental health services.

B Commonwealth grants and contributions revenue increased by $29.9 million (18.3%) in 2017-18 from 2016-17 due to increased National Health Reform Funding for specialised mental health services arising from a change in the mix of services eligible as in-scope activity.

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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 Items	10.3

10.1 Disclosure of administered income and expenses by service

	2018 Hospital Bed Based Services $	2017 Hospital Bed Based Services $
Income		
Appropriations from Government for transfer to :		
Mental Health Tribunal	2,660,000	2,653,000
Mental Health Advocacy Service	2,627,000	2,654,000
Office of Chief Psychiatrist	2,943,000	2,262,000
Service received free of charge (a)	1,182,550	1,080,044
Other revenue	2,899	870
Total administered income	**9,415,449**	**8,649,914**
Expenses		
Employee benefits expense	7,670,185	6,638,163
Supplies and services	1,242,619	1,226,585
Accommodation expense	398,559	364,379
Other expenses	265,007	245,072
Total administered expenses	**9,576,370**	**8,474,199**

(a) Service received free of charge in 2017/18 includes $1,121,920 ($1,051,762 in 2016/17) from Mental Health Commission (refer to note 9.10 'Services provided free of charge') and $60,630 ($28,282 in 2016/17) from State Solicitor Office.

10.2 Disclosure of administered assets and liabilities

Current Assets		
Cash and cash equivalents	1,942,409	1,682,595
Receivables	58,325	73,811
Total Administered Current Assets	2,000,734	1,756,406
Total Administered Assets	**2,000,734**	**1,756,406**
Current Liabilities		
Payables	250,884	240,027
Provision	1,119,588	749,756
Total Administered Current Liabilities	1,370,472	989,783
Non-Current Liabilities		
Provision	199,604	175,046
Total Administered Non-Current Liabilities	199,604	175,046
Total Administered Liabilities	**1,570,076**	**1,164,829**

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10.3 Explanatory statement for Administered Items

All variances between estimates (original budget) and actual results for 2018, between the actual results for 2018 and 2017 are below. Narratives are provided for key major variances, which are generally greater than 5% and $173 thousand.

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

	Variance Note	Estimate 2018 $	Actual 2018 $	Actual 2017 $	Variance between estimate and actual $	Variance between actual results for 2018 and 2017 $
Income						
For transfer:						
Service appropriation						
Mental Health Tribunal		2,630,000	2,660,000	2,653,000	30,000	7,000
Mental Health Advocacy Service		2,627,000	2,627,000	2,654,000	-	(27,000)
Office of Chief Psychiatrist	A	2,943,000	2,943,000	2,262,000	-	681,000
Service received free of charge	1	-	1,182,550	1,080,044	1,182,550	102,506
Other revenue		-	2,899	870	2,899	2,029
Total administered income		**8,200,000**	**9,415,449**	**8,649,914**	**1,215,449**	**765,535**
Expenses						
Employee benefits expense	B	-	7,670,185	6,638,163	7,670,185	1,032,022
Supplies and services		8,200,000	1,242,619	1,226,585	(6,957,381)	16,034
Accommodation expense		-	398,559	364,379	398,559	34,180
Other expenses		-	265,007	245,072	265,007	19,935
Total administered expenses	2	**8,200,000**	**9,576,370**	**8,474,199**	**1,376,370**	**1,102,171**

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2018

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 2018 and 2017 are below. Narratives are provided for key major variances, which are generally greater than 5%.

	Variance Note	Estimate 2018 $	Actual 2018 $	Actual 2017 $	Variance between estimate and actual $	Variance between actual results for 2018 and 2017 $
ASSETS						
Current Assets						
Cash and cash equivalents		-	1,942,409	1,682,595	1,942,409	259,814
Receivables		-	58,325	73,811	58,325	(15,486)
Total Administered Current Assets		-	**2,000,734**	**1,756,406**	**2,000,734**	**244,328**
TOTAL ADMINISTERED ASSETS		-	**2,000,734**	**1,756,406**	**2,000,734**	**244,328**
LIABILITIES						
Current Liabilities						
Payables		-	250,884	240,027	250,884	10,857
Provisions	C	-	1,119,588	749,756	1,119,588	369,832
Total Administered Current Liabilities		-	**1,370,472**	**989,783**	**1,370,472**	**380,689**
Non-Current Liabilities						
Provisions	C	-	199,604	175,046	199,604	24,558
Total Administered Non-Current Liabilities		-	**199,604**	**175,046**	**199,604**	**24,558**
TOTAL ADMINISTERED LIABILITIES		-	**1,570,076**	**1,164,829**	**1,570,076**	**405,247**

The Mental Health Act 2014 established the Mental Health Tribunal, Mental Health Advocacy Service, and Office of Chief Psychiatrist, effective in the 2015/16 financial year.

Financial Statements

Mental Health Commission
Notes to the Financial Statements
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10.3 Explanatory statement for Administered Items (cont.)

Major Estimate and Actual (2018) Variance Narratives

1 Variance of $1.2 million for services received free of charge is due to the recognition of the corporate services provided by the Commission, while no budget was allocated in the 2017-18 Budget.

2 Variance of $1.3 million (16.8%) for total administered expenses is mainly due to $1.2 million for services received free of charge. A change in practices was adopted to recognise the corporate services provided by the Commission. At the time when the 2017-18 Budget was finalised no budget was allocated, therefore the variance is due to the timing of recognising the actual and establishing a budget for this item.

Major Actual (2018) and Comparative (2017) Variance Narratives

A The increase of $0.7 million (30.1%) in Service Appropriation income is due to the transfer two employees from WA Health to the Office of the Chief Psychiatrist.

B The increase of $1.1 million (13.0%) is mainly due to $0.7 million for the transfer of two employees from WA Health to the Office of the Chief Psychiatrist and an increase in employee costs of $0.2 million for the Mental Health Tribunal.

C The increase in provisions of $0.4 million (42.7%) is mainly due to the increase of two employees to the Office of the Chief Psychiatrist and the associated value of leave balances transferred in for new employees.

Key Performance Indicators

Mental Health Commission

Certificate of Key Performance Indicators for the year ended 30 June 2018

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 2018.

Timothy Marney

COMMISSIONER
Mental Health Commission
Accountable Authority

17 August 2018

Performance Management Framework 2017-18 – Outcome Based Management Framework

Strategic Outcomes

WESTERN AUSTRALIAN STRATEGIC OUTCOME: WHOLE OF GOVERNMENT GOAL
Strong Communities: Safe communities and supported families

Agency Level Outcomes

Outcome 1	Outcome 2	Outcome 3
Improved mental health and wellbeing	Reduced incidence of use and harm associated with alcohol and other drug use	Accessible, high quality and appropriate mental health and alcohol and other drug treatments and supports

Key Effectiveness Indicators

Outcome 1	Outcome 2	Outcome 3
1.1 Percentage of the population with high or very high levels of psychological distress	**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 **2.2** Percentage of the population aged 14 years and over reporting recent use of illicit drugs **2.3** Rate of hospitalisation for alcohol and other drug use	**3.1** Readmissions to hospital within 28 days of discharge from acute specialised mental health units (national indicator) **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) **3.3** Percentage of closed alcohol and other drug treatment episodes completed as planned **3.4** Percentage of contracted non-government mental health services that met the National Standards for Mental Health Services through independent evaluation **3.5** Percentage of contracted non-government alcohol and other drug services that met an approved accreditation standard **3.6** Percentage of the population receiving public clinical mental health care (national indicator) **3.7** Percentage of the population receiving public alcohol and other drug treatment

The Commission did not share any responsibilities with other agencies

Performance Management Framework 2017-18 – Outcome Based Management Framework

	Service 1 Prevention	Service 2 Hospital-Based Services	Service 3 Community Bed-Based Services	Service 4 Community Treatment	Service 5 Community Support
Key Efficiency Indicators	**1.1** Cost per capita to enhance mental health and wellbeing and prevent suicide (illness prevention, promotion and protection activities) **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 **1.3** Cost per person of alcohol and other drug campaign target groups who are aware of, and correctly recall, the main campaign messages	**Acute** **2.1** Average length of stay in purchased acute specialised mental health units **2.2** Average cost per purchased bedday in acute specialised mental health units **Sub-acute** **2.3** Average length of stay in purchased sub-acute specialised mental health units **2.4** Average cost per purchased bedday in sub-acute specialised mental health units **Hospital in the Home** **2.5** Average length of stay in purchased Hospital in the Home mental health units **2.6** Average cost per purchased bedday in Hospital in the Home mental health units **Forensic** **2.7** Average length of stay in purchased forensic mental health units **2.8** Average cost per purchased bedday in forensic mental health units	**3.1** Average cost per purchased bedday for 24 hour staffed community bed-based services (national indicator) **3.2** Average cost per purchased bedday for non-24 hour staffed community bed-based units (national indicator) **3.3** Average cost per bedday in step up/step down community bed-based units **3.4** Cost per completed treatment episode in alcohol and other drug residential rehabilitation services	**4.1** Average cost per purchased treatment day of ambulatory care provided by public clinical mental health services (national indicator) **4.2** Average treatment days per episode of ambulatory care provided by public clinical mental health services **4.3** Cost per completed treatment episode in community based alcohol and other drug services	**5.1** Average cost per hour for community support provided to people with mental health problems **5.2** Average cost per episode of community based support provided for alcohol and other drug services **5.3** Average cost per package of care provided for the Individualised Community Living Strategy **5.4** Cost per episode of care in safe places for intoxicated people

The Commission did not share any responsibilities with other agencies

Key Effectiveness Indicators

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 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.

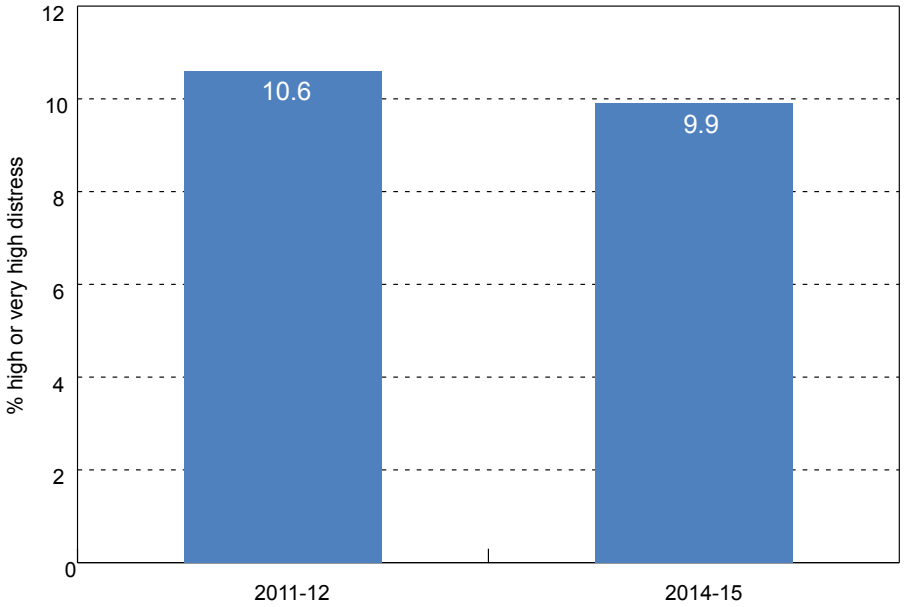
Rationale

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 most recent survey (2014-15) stated that the proportion of the Western Australian population with high or very high levels of psychological distress (9.9%) was 0.7 percentage points lower than the proportion reported in 2011-12 (10.6%). The 2017-18 results should be available later in 2018-19 with a target of less than or equal to the 2014-15 result (9.9%).

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



The percentage of Western Australians who report high or very high psychological distress is

1.8 percentage points lower

than the national average

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.*

There have been two changes to the reporting of this indicator since the 2016-17 Annual Report. Firstly, the National results have been removed as the focus of this indicator is the Western Australian population from one survey to the next, with comparison to the National figure providing context only. In the 2014-15 survey, the Western Australian result was 1.8 percentage points below the National figure of 11.7%.

Secondly, 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, 2011-12 and 2014-15. The 2014-15 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 19,000 people in nearly 15,000 private dwellings.*

Time Period: *The National Health Survey is only conducted every three years. The 2011-12 results were published in 2012-13 and the 2014-15 results were published in 2015-16. The next survey will be conducted in 2017-18 and published in 2018-19, so no results are available for 2017-18.*

Key Effectiveness Indicators

Outcome two
Reduce incidence of use and harm 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.

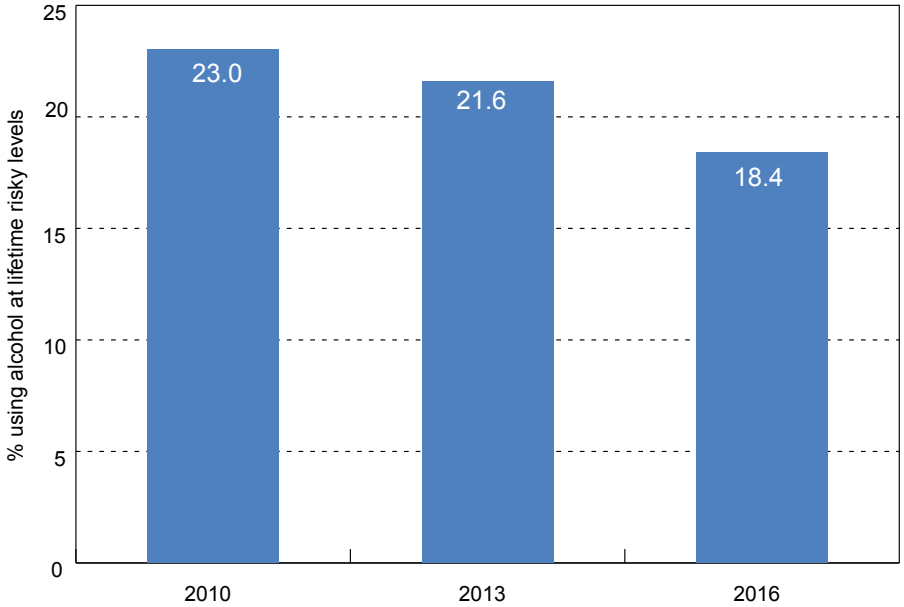
Rationale

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 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 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 2019 survey are not anticipated to be released until 2020 with a target of less than or equal to the 2016 result (18.4%).

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



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.*

There have been two changes to the reporting of this indicator since the 2016-17 Annual Report. Firstly, the National results have been removed as the focus of this indicator is the Western Australian population from one survey to the next, with comparison to the National figure providing context only. In the 2016 survey, the Western Australian result was 1.3 percentage points above the National figure of 17.1%.

BETWEEN 2013 AND 2016 THERE HAS BEEN A

14.8%

REDUCTION

IN WESTERN AUSTRALIANS AGED 14 AND OVER WHO REPORTED USING ALCOHOL AT LIFETIME RISKY LEVELS

Secondly, 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.*

Key Effectiveness Indicators

Outcome two
Reduce incidence of use and harm with alcohol and other drug use

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.

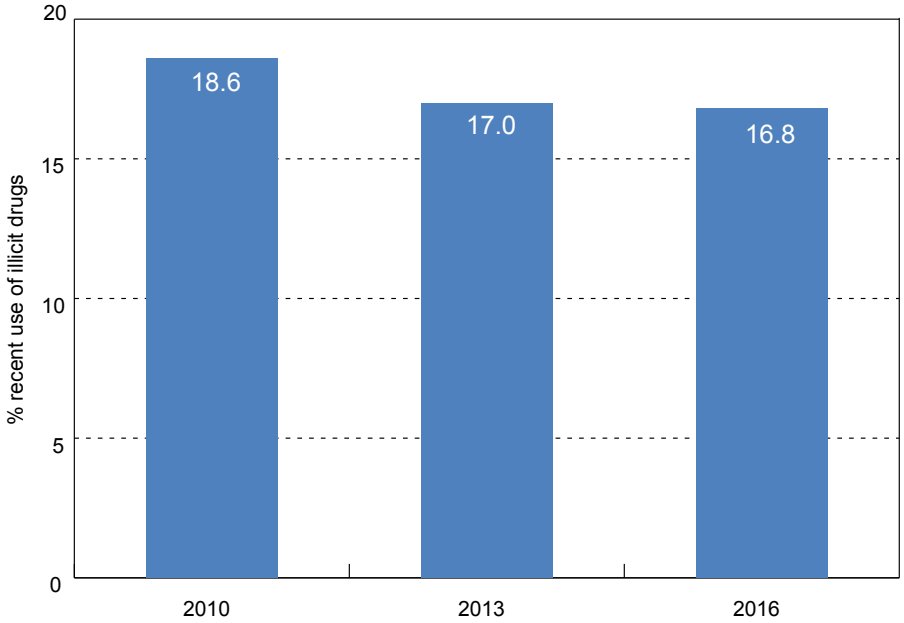
Rationale

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 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 in the 2013 survey (17.0%). Results of the 2019 survey are not anticipated to be released until 2020 with a target of less than or equal to the 2016 result (16.8%).

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



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.*

There have been two changes to the reporting of this indicator since the 2016-17 Annual Report. Firstly, the National results have been removed as the focus of this indicator is the Western Australian population from one survey to the next, with comparison to the National figure providing context only. In the 2016 survey, the Western Australian result was 1.2 percentage points above the National figure of 15.6%.

Secondly, 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.*

Key Effectiveness Indicators

Outcome two
Reduce incidence of use and harm with alcohol and other drug use

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 AODs in the community.

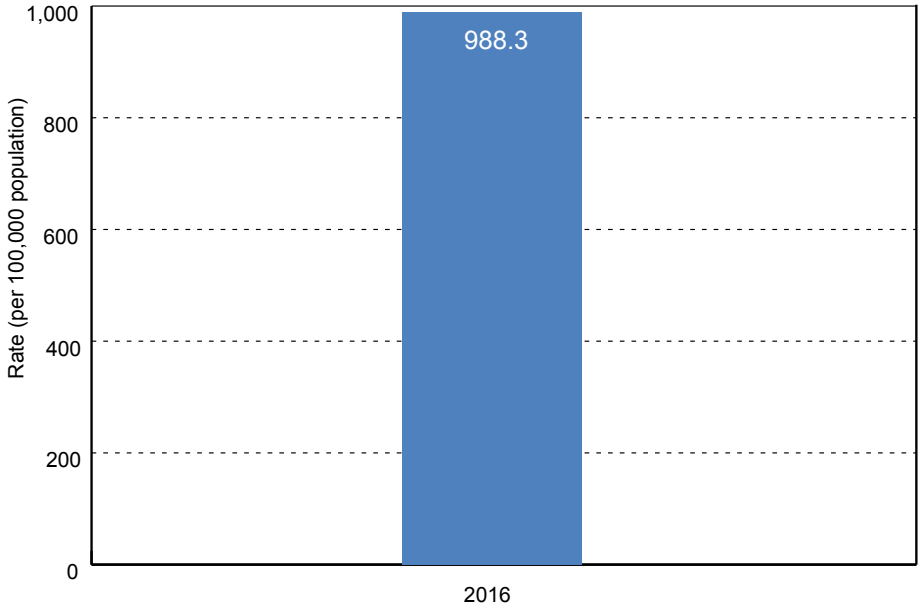
Rationale

The impact of preventative initiatives to reduce the incidence of harm associated with AODs may be measured indirectly through the rate of hospitalisation for AODs. 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.

Results

This is a new indicator and the methodology to present a combined rate of AOD hospitalisations was under development when the 2017-18 targets were set in 2016-17. As such, there was no target for 2017-18. The latest available data is for the calendar year 2016 and the age-standardised rate of hospitalisations attributable to AOD use is 988.3 per 100,000 population.

2.3: Rate of hospitalisation for alcohol and other drug use



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

This measure can be broadly interpreted as a measure of the impact of AOD use on the health of the general population of Western Australia

Key Effectiveness Indicators

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 re-admission to the same or another specialised mental health inpatient unit within 28 days of discharge.

Rationale

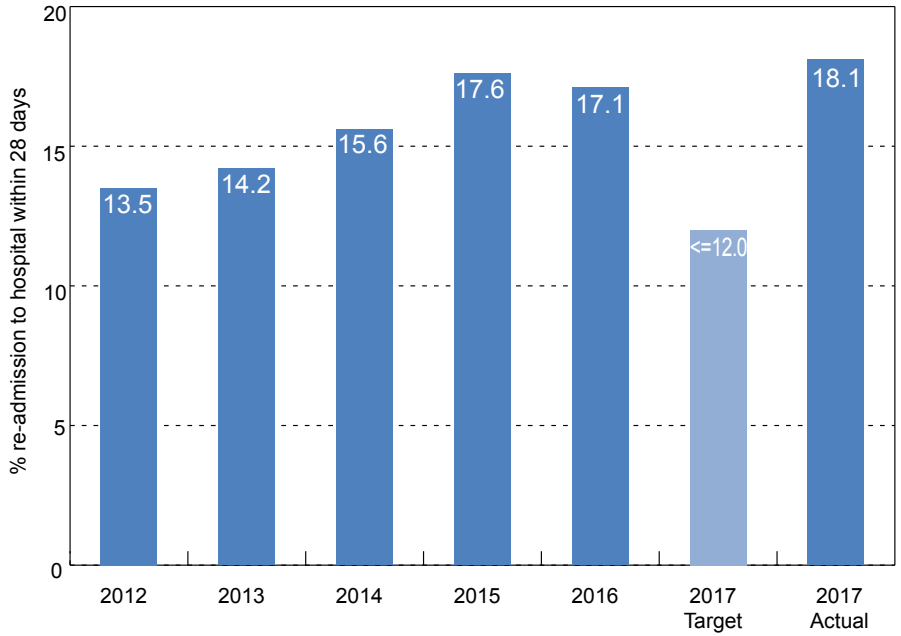
This indicator measures the appropriateness and quality of care provided by mental health services. The re-admission rate is an indicator of the objective to provide effective care and continuity of care in the delivery of mental health services. This indicator is a nationally endorsed and widely reported 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 re-admission. This is particularly important in the vulnerable period following discharge from hospital.

Results

In 2017, the re-admission rate to acute mental health inpatient facilities within 28 days of discharge was 18.1%. This result is 6.1 percentage points higher than the target of less than or equal to 12.0% and one percentage point higher than the 2016 result of 17.1%. Since 2014, re-admission rates have been impacted by the introduction of new models of care such as Hospital in the Home as well as data recording and reporting practices in regard to these new models.

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



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.*

Key Effectiveness Indicators

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

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)

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

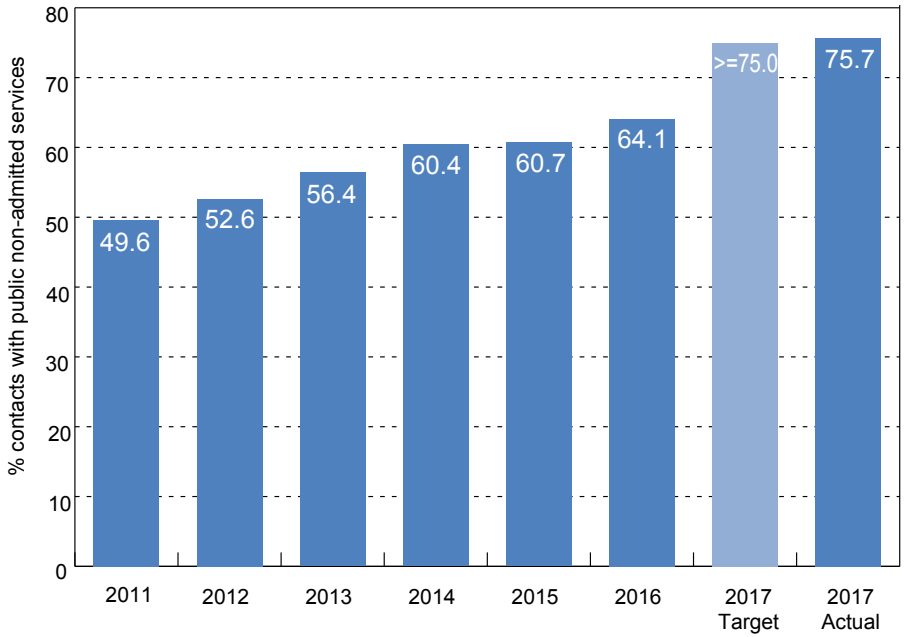
This indicator measures the quality of care provided by mental health services. It is an indicator of the objective to provide continuity of care in the delivery of mental health services. A large proportion of people with a mental health problem have a chronic or recurrent type illness that results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

Results

The national target of greater than or equal to 70% was revised in 2016-17 to greater than or equal to 75%. In 2017, 75.7% 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 11.6 percentage points higher than the 2016 result of 64.1% and 0.7 percentage points above the revised national target of greater than or equal to 75%. As seen over the six year period, the Commission's focus on regular review and reporting of this indicator is assisting HSPs in making progress, and the national target is now being met for the first time.

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)



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.

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.*

75.7% of patients had contact with a community mental health treatment service within seven days post discharge from a public mental health inpatient unit

... up 11.6 percentage points from 2016

Key Effectiveness Indicators

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

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 as 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).

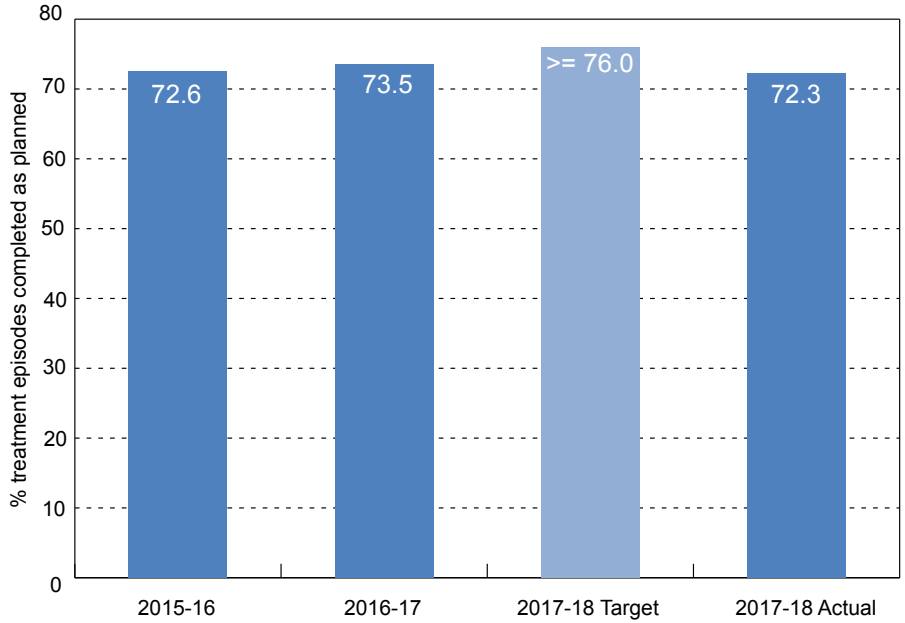
Rationale

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.

Results

In 2017-18, the percentage of closed treatment episodes that were completed as planned was 72.3%. This result is very close to the 2016-17 result and 3.7 percentage points lower than the 2017-18 target of greater than or equal to 76.0%.

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



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

Time Period: *Data is for the April 2017 to March 2018 time period to allow for a three month lag for coding and auditing purposes.*

Palmerston Association delivers AOD treatment and support services. Palmerston Farm Therapeutic Community is a 10-acre semi-rural property south of Perth that offers residential rehabilitation

Key Effectiveness Indicators

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

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 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 (i.e. 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 10 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.

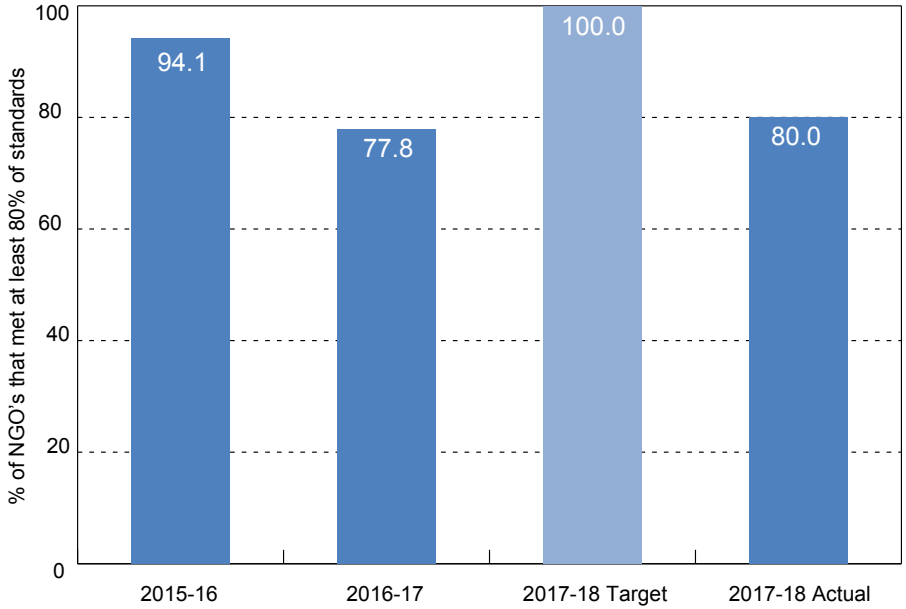
Rationale

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.

Results

In 2017-18, the percentage of non-government organisations contracted to provide mental health services that met at least eight of the ten NSMHS standards was 80.0%. This is 2.2 percentage points higher than the 2016-17 result of 77.8% but significantly below the target of 100%. Four of the 20 service providers assessed in 2017-18 did not meet at least eight of the standards. 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.

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



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

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

Key Effectiveness Indicators

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

3.5: Percentage of contracted non-government alcohol and other drugs 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 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.

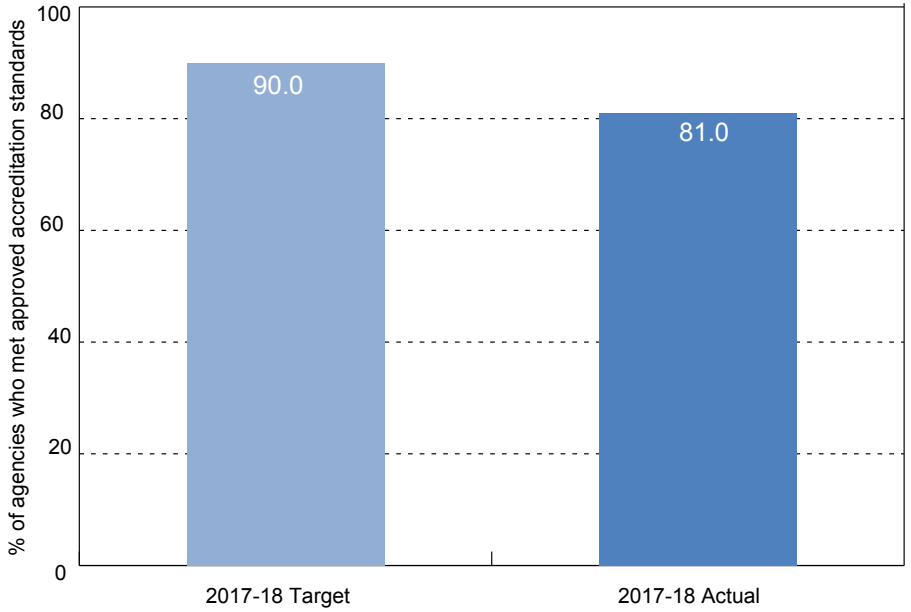
Rationale

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

As of 30 June 2018, 17 out of 21 (81.0%) contracted non-government AODs services met an approved accreditation standard. This is nine percentage points below the target of 90%. All four services who did not meet an approved accreditation standard are currently in the process of seeking accreditation, with three due late 2018. This is a new indicator for 2017-18 and as such no historical data is presented.

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



Data Source: The 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 current as of the financial year – existing service agreements with service providers allow up to three years for them to achieve accreditation.*

Key Effectiveness Indicators

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

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.

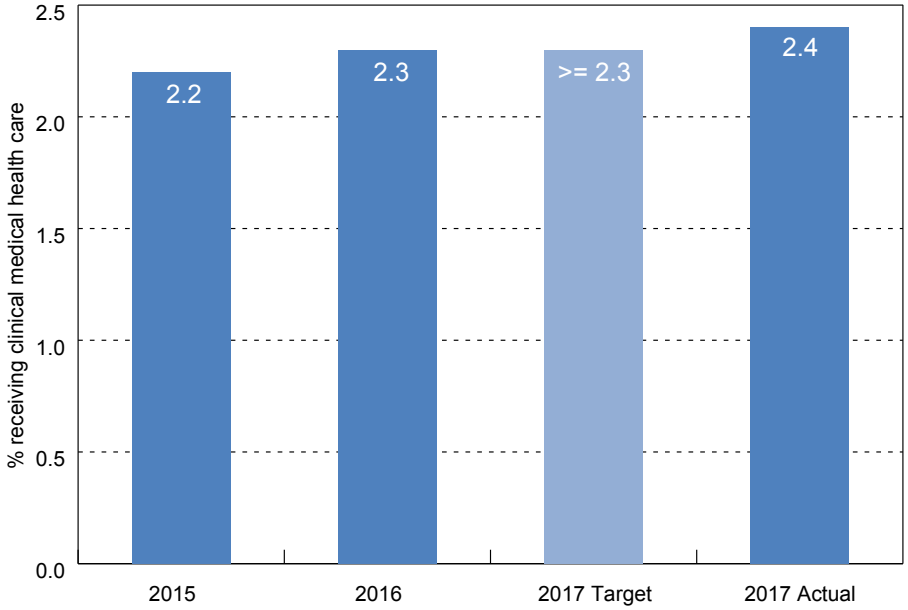
Rationale

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.

Results

In 2017, the percentage of the Western Australian population receiving public mental health care was 2.4%. This result is 0.1 percentage points higher than the 2016 result (2.3%) and the 2017 target (greater than or equal to 2.3%). As some individuals receive treatment through the private sector and some may not seek treatment it is expected that the result of 2.4% accessing public mental health services would be below the estimated population prevalence of severe mental health disorders (3.0%).

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



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 for the calendar year is subject to revision. The population data is a June 2017 population estimate calculated by the ABS in March 2018, the latest estimate available.*

Key Effectiveness Indicators

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

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 Centres).

Therefore, this KPI is likely to be an underestimation of the total percentage of the population receiving AOD treatment.

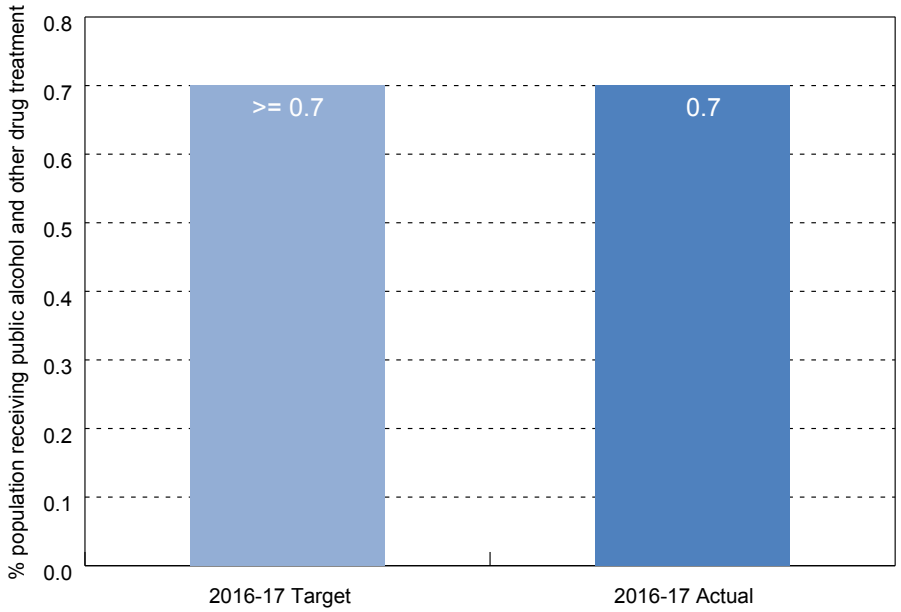
Rationale

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.

Results

In 2016-17 the percentage of the population receiving public AOD treatment was 0.7%. This result is equal to the target of greater than or equal to 0.7%. Similar to Key Efficiency Indicator 3.6, this is likely to be an underestimation of the total percentage of the population receiving AOD treatment as people receive treatment for AOD-related issues in a variety of settings not counted here. This is a new indicator for 2017-18 and as such no historical data is presented.

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



Note: Due to the timetable for data submissions and jurisdiction sign-off set by the Australian Institute of Health and Welfare, the 2017-18 collection period is not yet available.

Data Source: *Australian Institute of Health and Welfare, AOD treatment services in Australia 2016-17. 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 AOD treatment is for the previous financial year, the population data is a June 2016 population estimate calculated by the ABS in March 2018.*

The Hon. Alanna Clohesy MLC, Parliamentary Secretary to the Deputy Premier and Minister for Mental Health, opening the 2018 Western Australian Alcohol and Other Drug Conference

Key Efficiency Indicators

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.

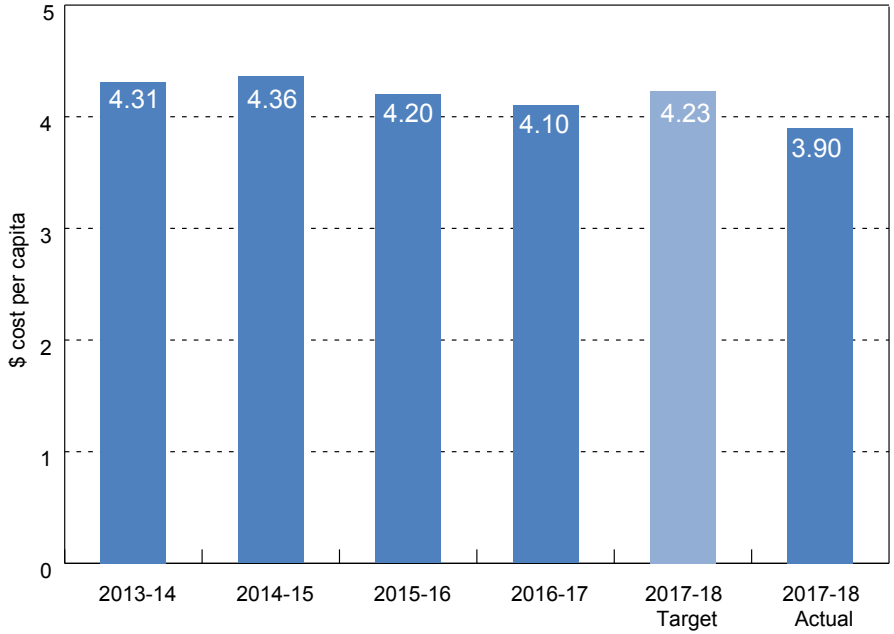
Rationale

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.

Results

In 2017-18, the cost per capita to provide prevention, promotion, protection and related activities to enhance mental health wellbeing was $3.90. The result is 4.9% lower than the 2016-17 result and 7.8% lower than the 2017-18 target of $4.23. This is due to a gradual decline in expenditure in 2017-18 on suicide prevention, as the four-year allocation of $25.9 million for *Suicide Prevention 2020* draws to an end.

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



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 is a June 2017 population estimate calculated by the ABS in March 2018, the latest estimate available. Cost data is presented by financial year.*

think MENTAL HEALTH

The Think Mental Health campaign was launched in November 2017

Key Efficiency Indicators

Service one
Prevention

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.

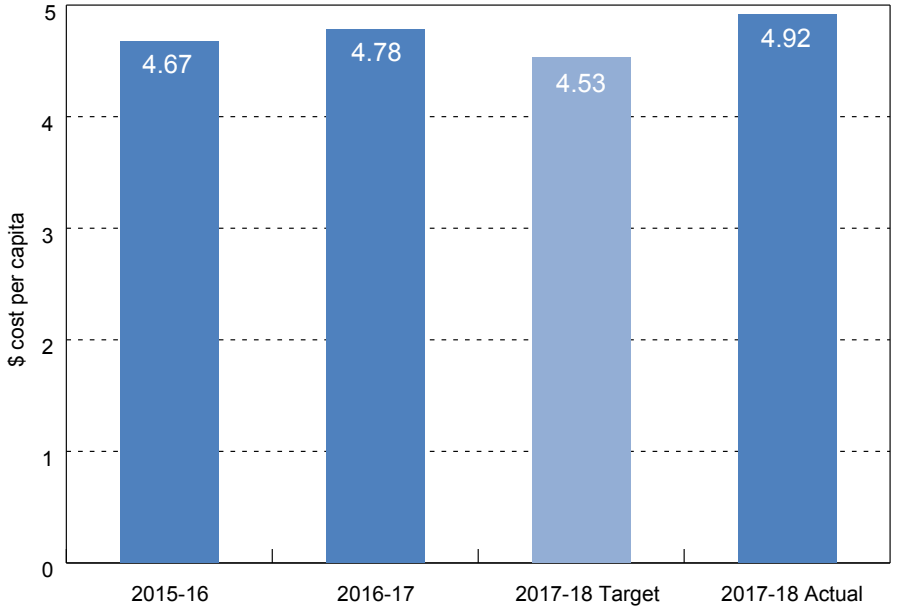
Rationale

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.

Results

In 2017-18, the cost per capita for initiatives that delay the uptake and reduce the harm associated with AODs was $4.92. This result is 8.6% above the 2017-18 target of $4.53 and 2.9% higher than the 2016-17 result of $4.78. This result is primarily due to the realignment of expenditure within AOD prevention, resulting in the integration of AOD prevention and suicide prevention functions in 2017-18 compared to 2016-17.

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



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 is a June 2017 population estimate calculated by the ABS in March 2018, the latest estimate available. Cost data is presented by financial year.*

alcoholthinkagain

The Commission's Alcohol.Think Again prevention campaign aims to reduce AOD harm and ill-health in Western Australia

Key Efficiency Indicators

Service one
Prevention

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 Prevention Campaigns. The campaigns aim to build awareness and understanding of the risks and harms associated with AOD use.

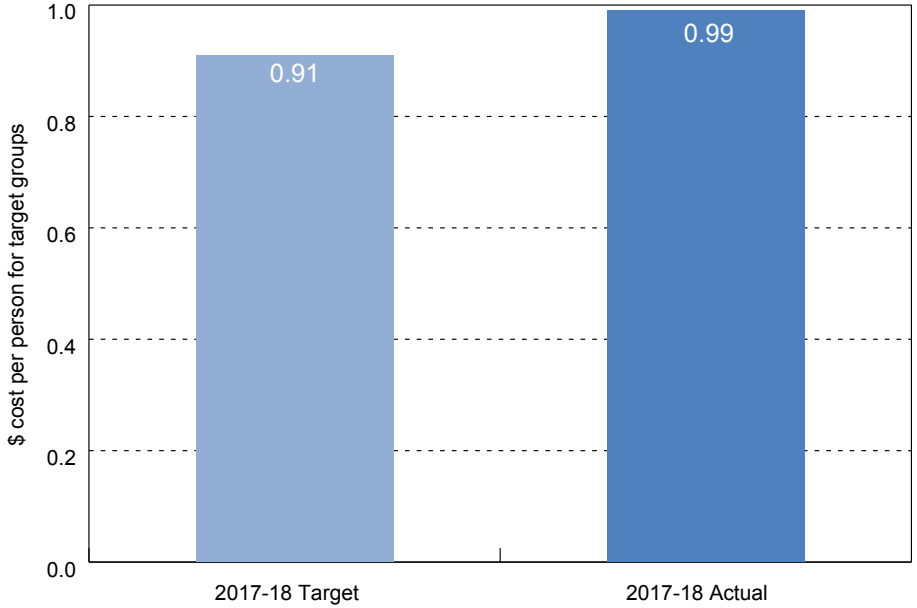
Rationale

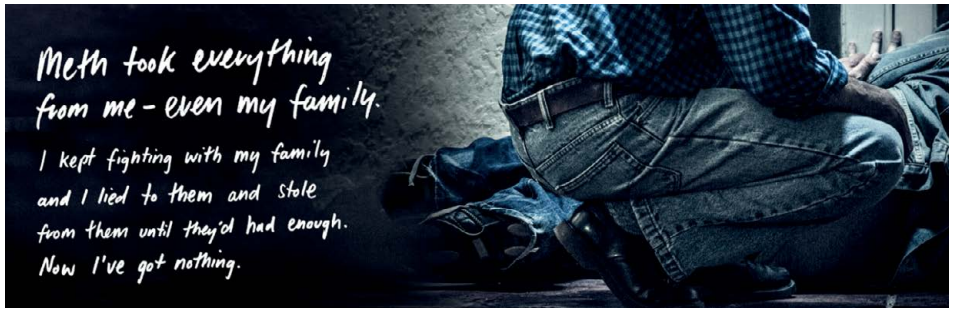
This indicator provides a measure of how much it costs to reach each person aware of the campaign and who correctly understood the message(s) presented by the campaign. This provides an indication of how cost efficient the campaign was in delivering the message(s) intended by the campaign to the target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

Results

In 2017-18 this indicator was revised to include both “Alcohol.Think Again” and “Meth Can Take Control” campaigns, as such this is a new indicator and no historical data is provided. In 2017-18 the cost per person of AOD campaign target groups who are aware of, and correctly recall, the main campaign messages was $0.99. This is 8.8% higher than the 2017-18 target of $0.91 which could be attributed to results of the alcohol campaign “I See”.

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





The Commission's Drug Aware, Meth Can Take Control prevention campaign aims to prevent and delay the uptake of methamphetamine use and stop use

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 WA 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. TNS Global – percentage of target group who were 'aware' and 'correctly' identified campaign message. The total sample size was 402 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 76%. The confidence interval is 95% and the standard error rate is 4.59%. Population figures – ABS time series workbook 3101.0 Population by age and sex, Australian States and Territories, Western Australia.*

Methamphetamine: *The Commission's Prevention Branch – Total cost of the campaign. TNS-Global – percentage of target group who were 'aware' and 'correctly' identified campaign message. The total sample size was 401 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 25%. The confidence interval is 95% and the standard error rate is 4.99%. Population figures – ABS time series workbook 3101.0 Population by age and sex, Australian States and Territories, Western Australia.*

Time Period: *Population data is a June 2017 population estimate calculated by the ABS in March 2018, the latest estimate available. Cost data is for the financial year.*

Key Efficiency Indicators

Service two
Hospital-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.

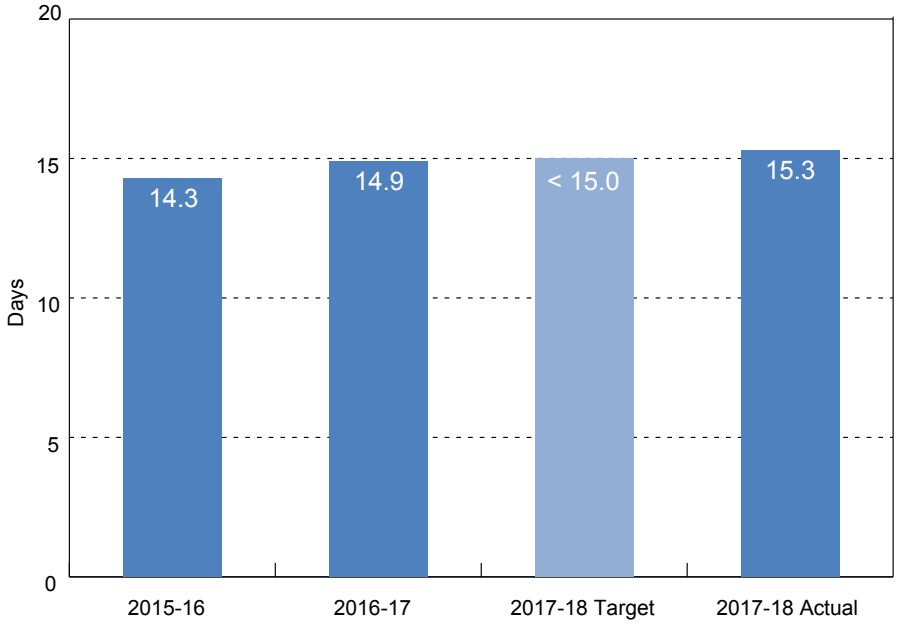
Rationale

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 2017-18, the average length of stay in acute mental health hospital beds was 15.3 days. This result is comparable to the target and previous actuals.

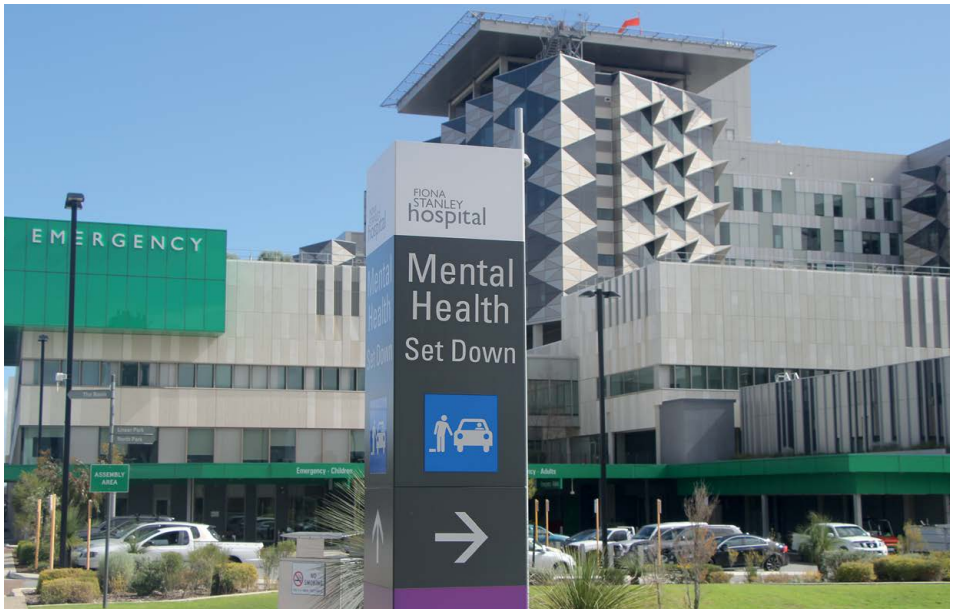
2.1: Average length of stay in purchased acute specialised mental health units



Note: *This indicator also includes a small amount of activity from the Next Step inpatient withdrawal units (for AOD 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 is for the April 2017 to March 2018 time period to allow for a three month lag for coding and auditing purposes.*



In 2017-18, the Commission funded mental health services at Fiona Stanley Hospital through the SMHS. These included the provision of 14 beds at the Fiona Stanley Hospital Youth Unit

Key Efficiency Indicators

Service two
Hospital-Based Services

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.

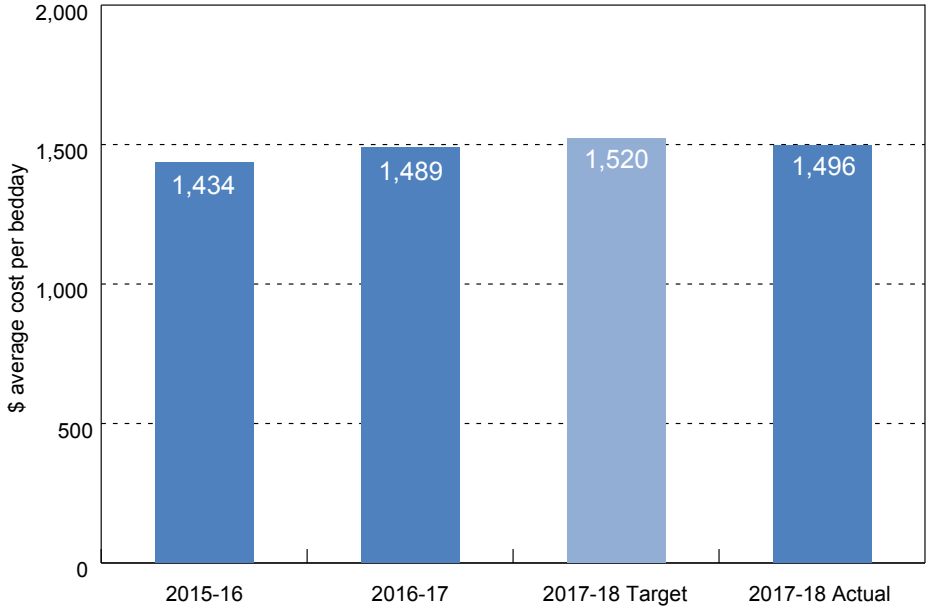
Rationale

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

Results

In 2017-18, the average cost per bedday in acute mental health hospital beds was $1,496. This result is similar to the 2017-18 target and the actual.

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



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.*

In Western Australia in 2017-18, the average cost per day for a mental health bed was

$1,496

in acute specialised mental health units

Compared to:

$535

in community mental health step up/step down service

Key Efficiency Indicators

Service two
Hospital-Based Services

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.

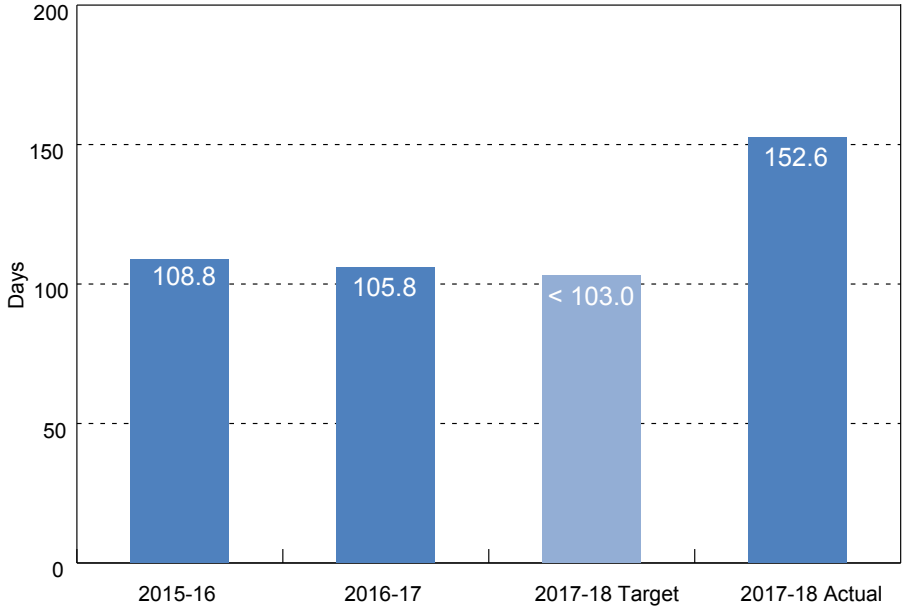
Rationale

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 2017-18, the average length of stay in sub-acute mental health hospital beds was 152.6 days. This result is 48.1% higher than the 2017-18 target and substantially higher than previous year's results. This is due to a change in the model of care, and therefore the reclassification, of a ward from sub-acute to acute in the 2017-18 financial year. This ward was responsible for a high number of separations with a short length of stay when compared to the other sub-acute wards, which, when removed, increases the average length of stay for this indicator.

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



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

Time Period: *Data is for the April 2017 to March 2018 time period to allow for a three month lag for coding and auditing purposes.*

Key Efficiency Indicators

Service two
Hospital-Based Services

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.

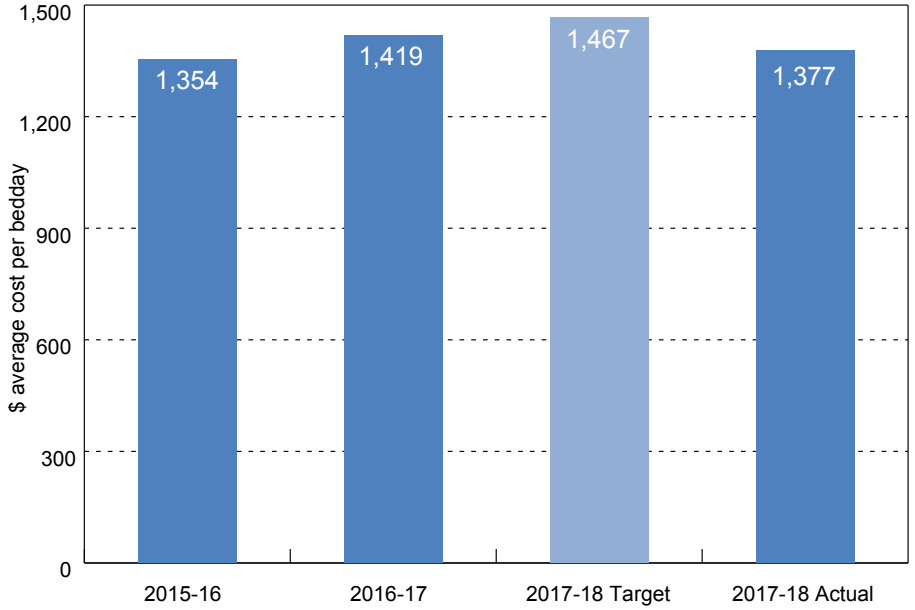
Rationale

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 2017-18, the average cost per bedday in sub-acute mental health hospital beds was $1,377. This result is 6.2% lower than the 2017-18 target of $1,467 and 3.0% lower than the 2016-17 result of $1,419. The lower average cost is due to the reclassification of a higher cost ward from sub-acute to acute during the 2017-18 financial year.

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



Data Source: The Commission's Financial Systems. BedState, Department of Health.

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

Key Efficiency Indicators

Service two
Hospital-Based Services

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.

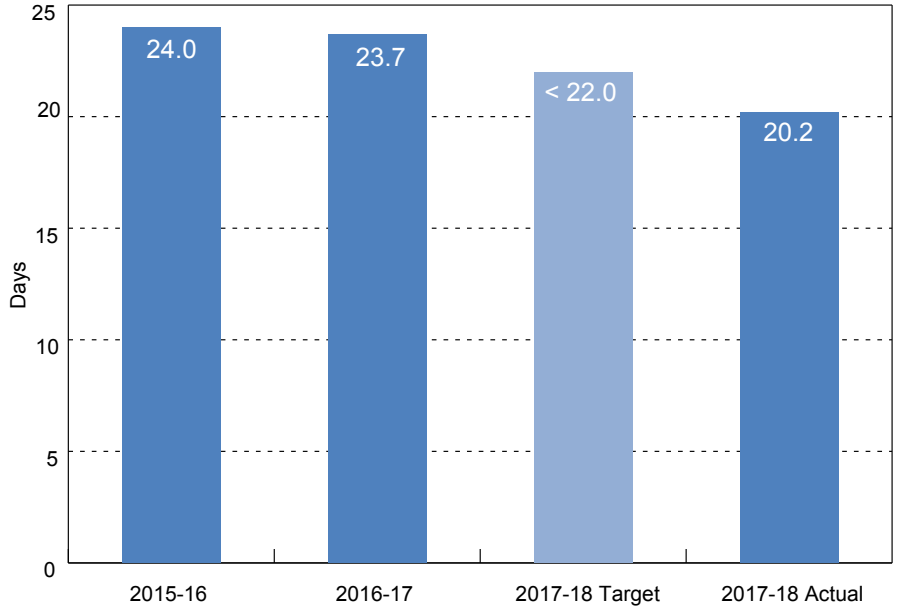
Rationale

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 2017-18, the average length of stay in purchased hospital in the home mental health units was 20.2 days. This result is 8.2% lower than the 2017-18 target of less than 22 days and 14.8% lower than the 2016-17 result of 23.7 days. This is likely due to the introduction of youth HITH model of care at Sir Charles Gairdner Hospital which has a lower average length of stay compared to other HITH units.

2.5: Average length of stay in purchased Hospital in the Home mental health units



Data Source: Hospital Morbidity Data Collection, Department of Health.

Time Period: *Data is for the April 2017 to March 2018 time period to allow for a three month lag for coding and auditing purposes.*

Hospital in the Home is consistent with the approach of providing care in the community, closer to where individuals live

Key Efficiency Indicators

Service two
Hospital-Based Services

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.

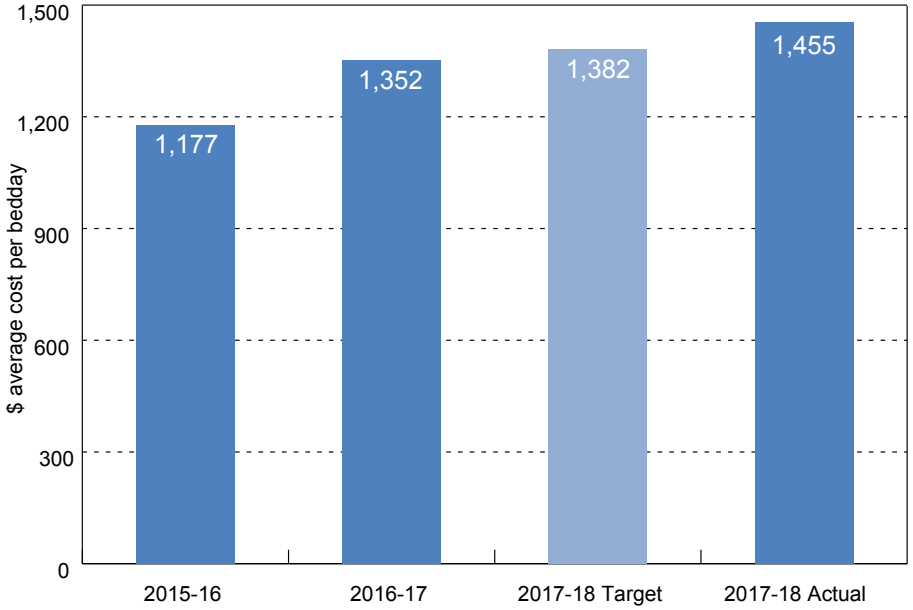
Rationale

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

Results

In 2017-18, the average cost per bedday in HITH mental health units was $1,455. This result is comparable with the 2017-18 target and the 2016-17 actuals.

2.6: Average cost per purchased bedday in Hospital in the Home mental health units



Data Source: *The Commission's Financial Systems. BedState, Department of Health.*

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

Key Efficiency Indicators

Service two
Hospital-Based Services

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 Act 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.

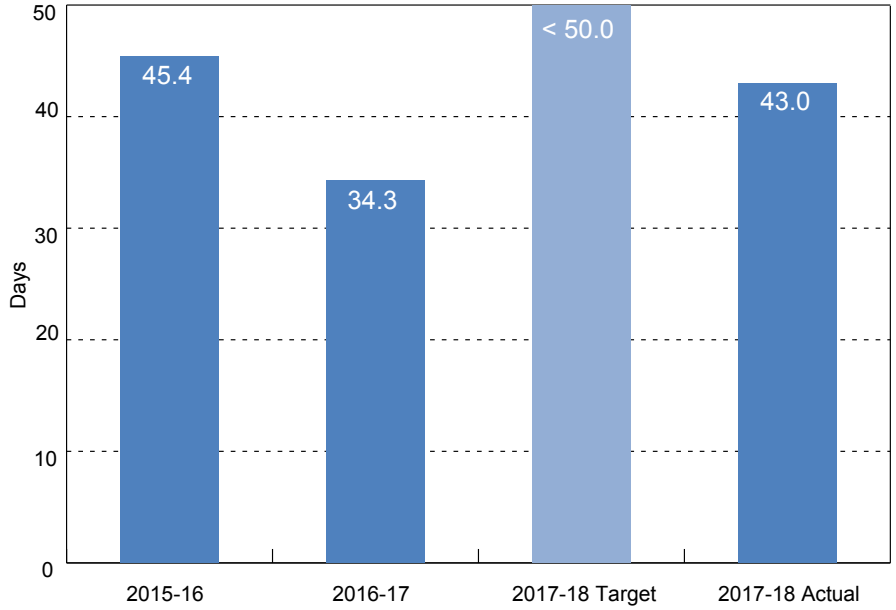
Rationale

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 2017-18, the average length of stay in purchased forensic mental health units was 43 days. This result is 14.0% lower than the 2017-18 target of less than 50 days. This is likely due to a small volume of cases and a high demand for limited capacity.

2.7: Average length of stay in purchased forensic mental health units



Data Source: Hospital Morbidity Data Collection, Department of Health.

Time Period: *Data is for the April 2017 to March 2018 time period to allow for a three month lag for coding and auditing purposes.*

The average length of stay in purchased forensic mental health units was 43 days. This is 14% lower than the 2017-18 target of less than 50 days

Key Efficiency Indicators

Service two
Hospital-Based Services

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.

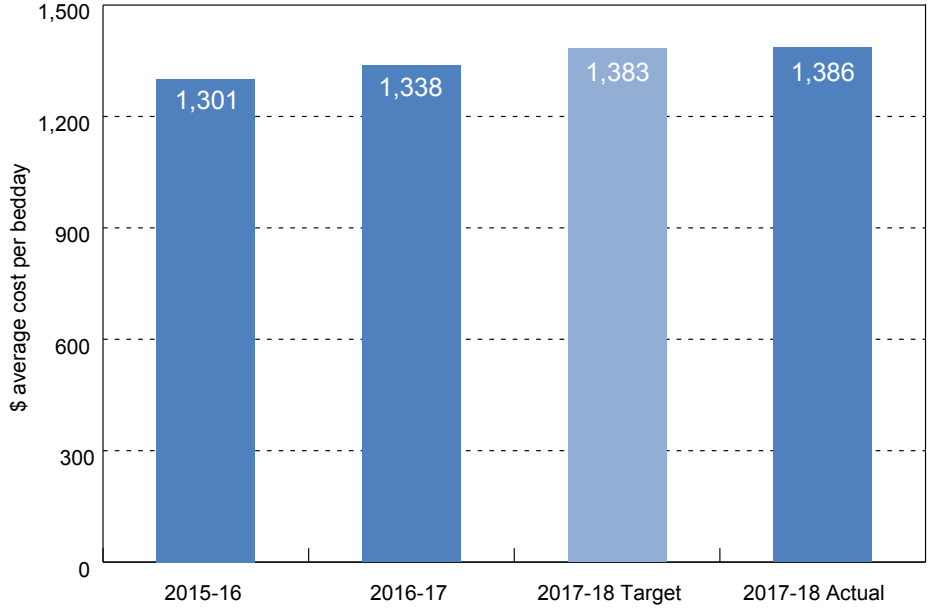
Rationale

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

Results

In 2017-18, the average cost per bedday in forensic units was $1,386, in line with the target.

2.8: Average cost per purchased bedday in forensic mental health units



Data Source: The Commission's Financial Systems. BedState, Department of Health.

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

Key Efficiency Indicators

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 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 (i.e. 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.

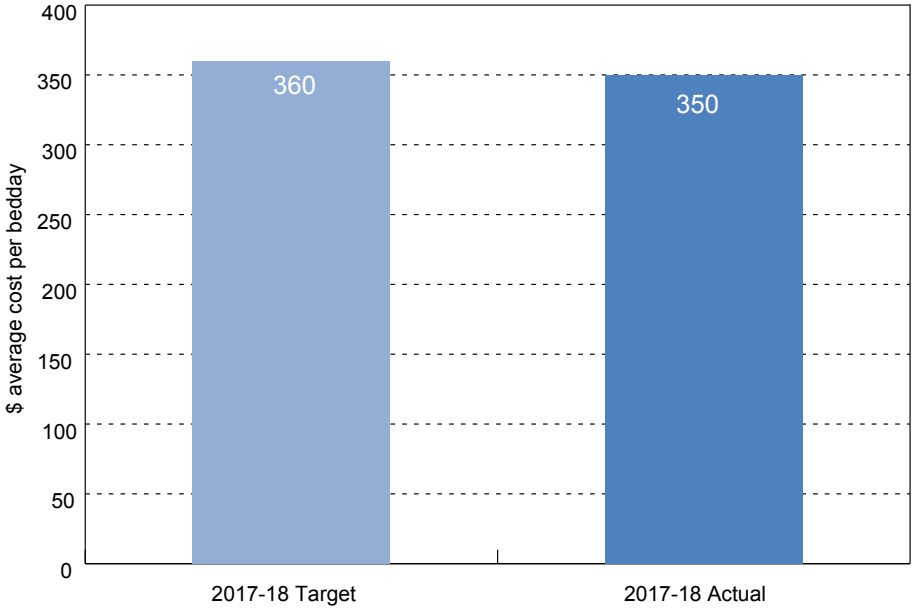
Rationale

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.

Results

In 2017-18, the average cost per purchased bedday for 24 hour staffed community bed-based services was $350, 2.7% lower than the 2017-18 target of $360. This indicator was changed to align with the national definition of 24 hour staffed community bed-based services, as such this is a new indicator and no historical data is presented.

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



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 2017 to December 2017) extrapolated to 12 months.

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

Joondalup step up/step down, operated by Neami National, is one 24 hour staffed Community Bed-Based Service funded by the Commission

Key Efficiency Indicators

Service three
Community Bed-Based Services

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

Description

Non-government organisations 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, ongoing treatment, rehabilitation and residential support for consumers.

Due to the lower severity mental health and behavioural problems of the people admitted to these services, these services are not staffed 24 hours a day by appropriately trained staff (either with formal qualifications and/or on the job training). When required, appropriate staff are still available through mechanisms such as being on call.

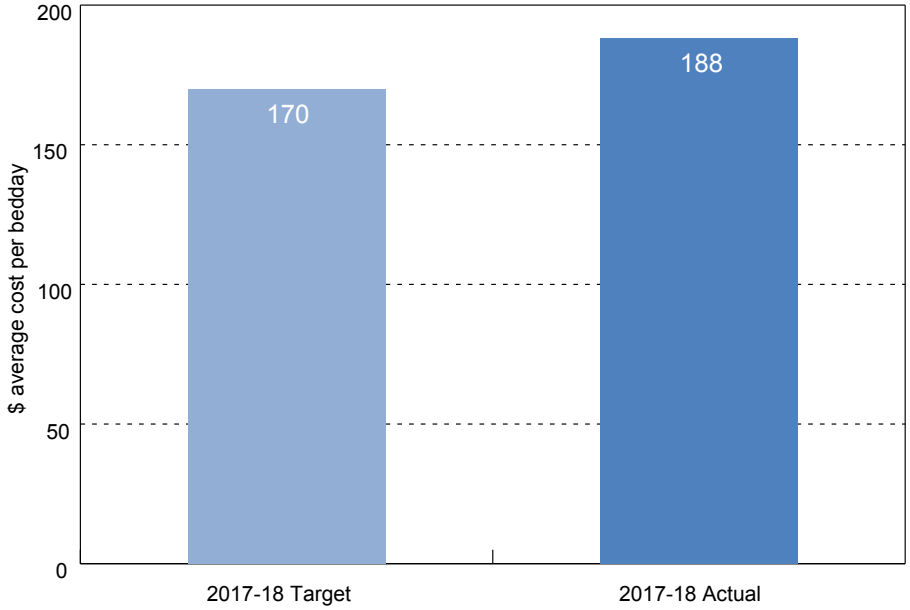
Rationale

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 2017-18, the average cost per purchased bedday for non-24 hour staffed community bed-based units was $188. This is 10.7% higher than the 2017-18 target of $170 and is due to lower than predicted activity. This indicator was changed to align with the national definition of non-24 hour staffed community bed-based services, as such this is a new indicator and no historical data is presented.

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



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 2017 to December 2017) extrapolated to 12 months.

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

Key Efficiency Indicators

Service three
Community Bed-Based Services

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

Description

The Mental Health step up/step down service is a new initiative in Western Australia that 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.

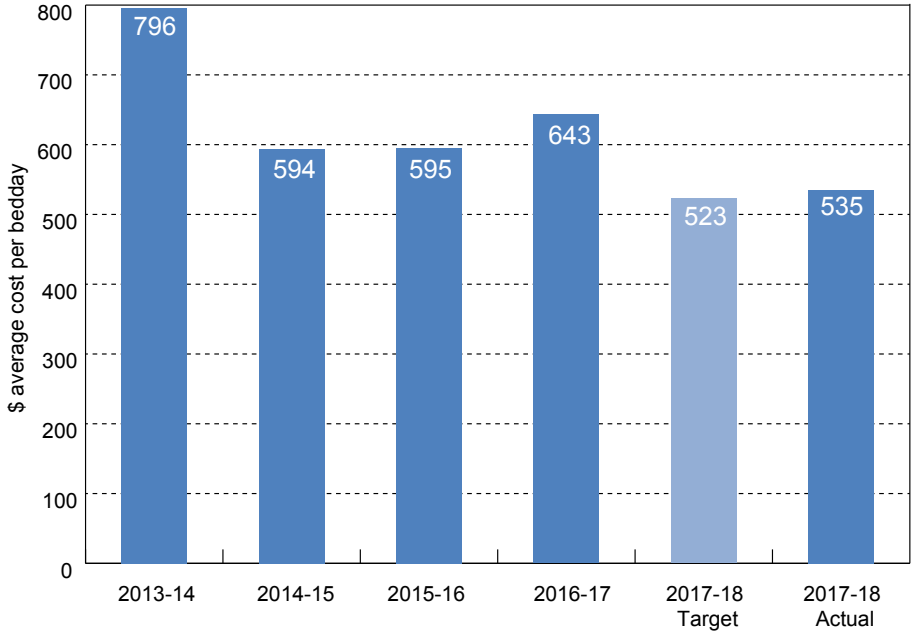
Rationale

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 2017-18, the average cost per purchased bedday in step up/step down community bed-based units was $535. This is 2.3% higher than the 2017-18 target of $523. Fluctuation in the average cost per purchased bedday across years may be attributable to variability in the number of occupied beddays. The increase in 2016-17 is due to service development costs associated with the setting up of additional step up/step down bed capacity in Rockingham, which has since stabilised, and this is reflected in the 2017-18 actual.

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



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 2017 to December 2017) extrapolated to 12 months.*

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

L-R: The Hon. Dr Mathew Coleman, Psychiatrist with Great Southern Mental Health Services; The Hon. Peter Watson, Speaker Legislative Assembly and Member for Albany; The Hon. Roger Cook MLA, Deputy Premier and Minister for Mental Health; Janette Kostos, Manager Great Southern Mental Health Services and David Naughton, WA Country Health Service Regional Director (Great Southern), at the announcement of the Albany step up/step down in January 2018

Key Efficiency Indicators

Service three
Community Bed-Based Services

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.

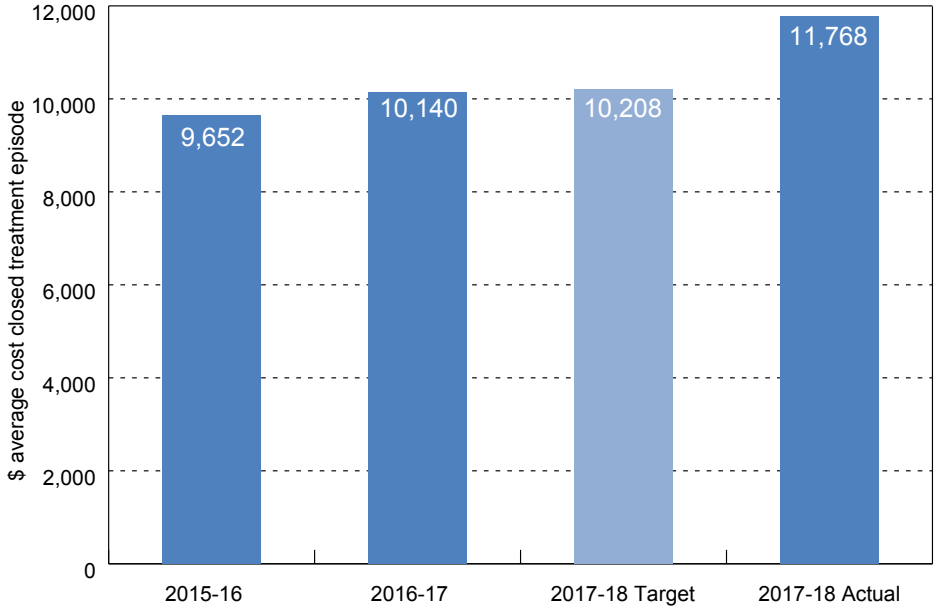
Rationale

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

Results

In 2017-18, the average cost per completed treatment episode in AOD residential rehabilitation services was $11,768. This is 15.3% higher than the 2017-18 target of $10,208 and higher than the 2016-17 result of $10,140. In previous years treatment episodes from low-medical and residential rehabilitation services not funded by the Commission had been included which resulted in a lower cost per treatment episode. For 2017-18 the method was changed to more accurately reflect the cost of a closed treatment episode by only including activity from services funded by the Commission. This change has been possible through improvements in data governance and overall capture processes.

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



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

Time Period: *Treatment episode data is for the April 2017 to March 2018 time period to allow for a three month lag for coding and auditing purposes. Cost data is presented by financial year.*

Key Efficiency Indicators

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 (i.e. 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.

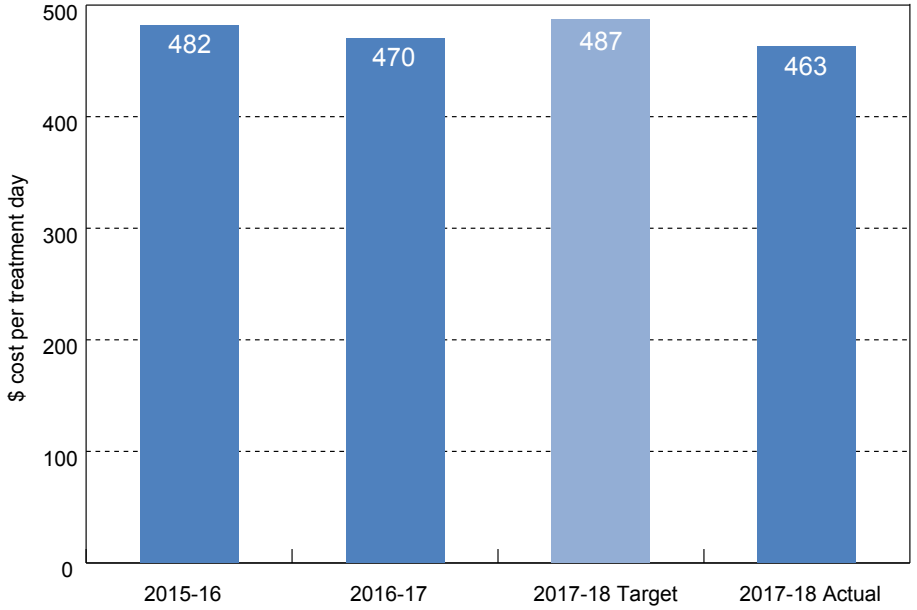
Rationale

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.

Results

In 2017-18, the average cost per purchased treatment day of ambulatory care provided by public clinical mental health services was $463. This is 4.9% lower than the 2017-18 target of $487 and 1.5% lower than the 2016-17 result of $470, due to growth in the number of treatment days.

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



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 2017 to December 2017) extrapolated to 12 months.

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

In 2017-18, the average cost per purchased treatment day of ambulatory care provided by public clinical mental health services was 4.9% lower than the 2017-18 target and 1.5% lower than the 2016-17 result

Key Efficiency Indicators

Service four
Community Treatment

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

Description

An ambulatory mental health care service (i.e. 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 (i.e. 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.

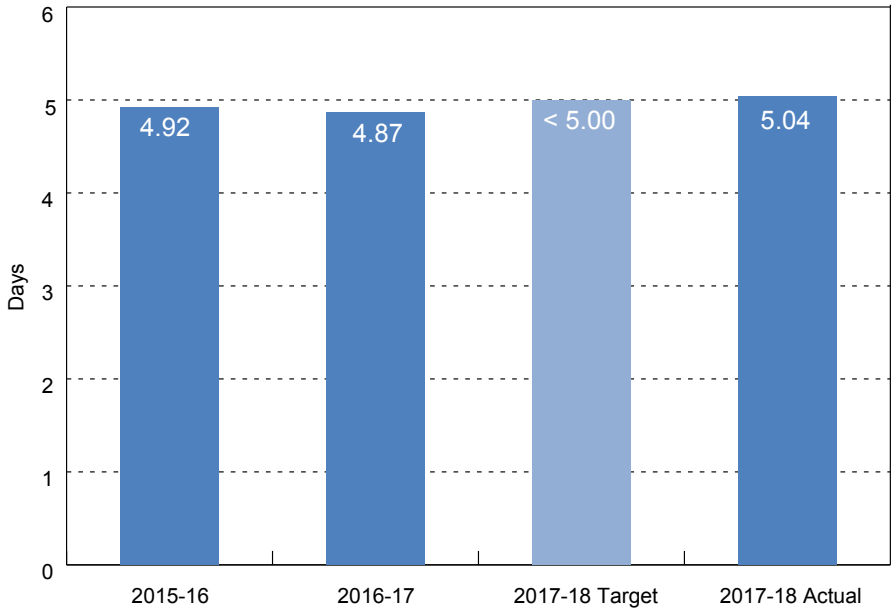
Rationale

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 2017-18, the average number of days per community treatment episode provided by public clinical mental health services was 5.04 days, very close to the target of less than five days.

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



Data Source: Mental Health Information System (MHIS), Department of Health.

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

Key Efficiency Indicators

Service four
Community Treatment

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 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 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 (e.g. a phone call).

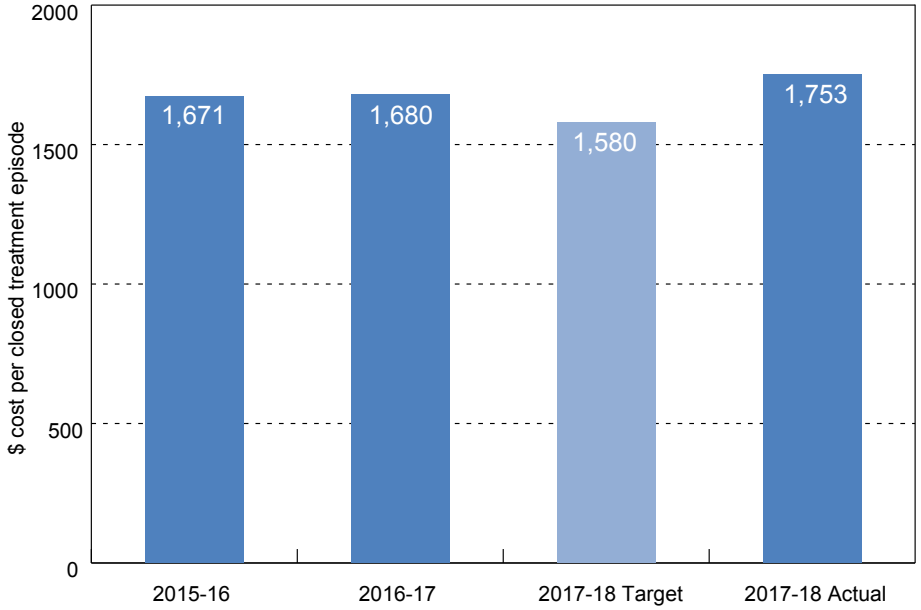
Rationale

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

Results

In 2017-18, the average cost of a completed treatment episode in community-based AOD services was $1,753. This is 11.0% higher than the 2017-18 target of $1,580 but only 4.3% above the 2016-17 result of $1,680. This is because when the 2017-18 target was set, there had been a regular increase in the activity. However, over the last two years the activity has not increased as expected which can largely be attributed to an increase in the average number of days spent in treatment per client due to increased complexity of treating individuals for methamphetamine use.

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



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

Time Period: *Treatment episode data is for the April 2016 to March 2017 time period to allow for a three month lag for coding and auditing purposes. Cost data is presented by financial year.*

Palmerston's South East Metropolitan CADS Armadale Office provides community-based AOD services

Key Efficiency Indicators

Service five
Community Support

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

Description

Community-based support programs support 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.

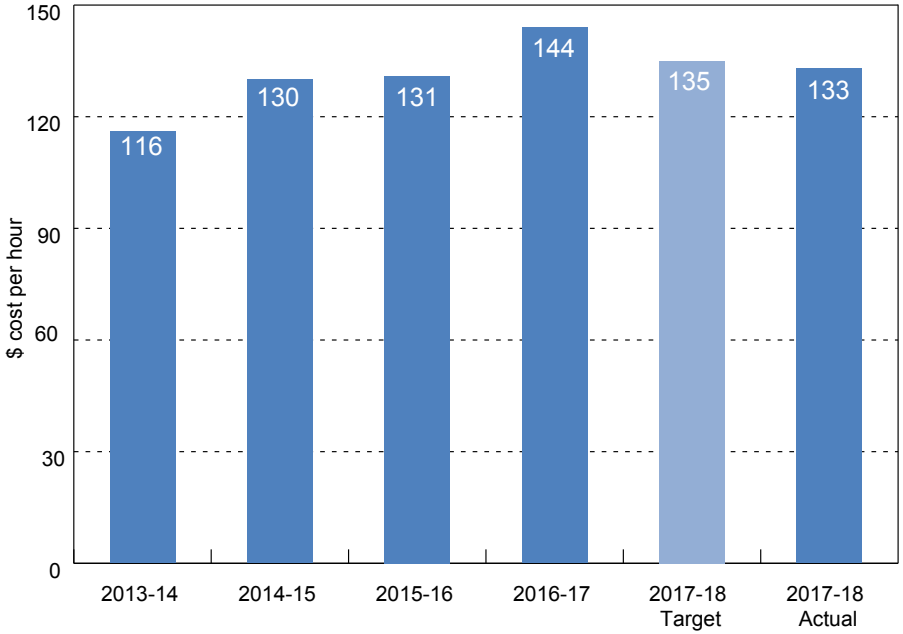
Rationale

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 2017-18, the average cost per hour of community support provided to people with mental health problems was $133. This result is similar to the 2017-18 target of $135, lower than the 2016-17 result of $144 but consistent with 2014-15 and 2015-16 results.

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



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 2017 to December 2017) extrapolated to 12 months.

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

Key Efficiency Indicators

Service five
Community Support

5.2: Average cost per closed treatment episode of community based support provided and 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 2013 evaluation of the program has demonstrated a range of positive outcomes including reductions in relapse rates, improvements in wellbeing, increased life and independent living skills and reduced levels of homelessness. 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.

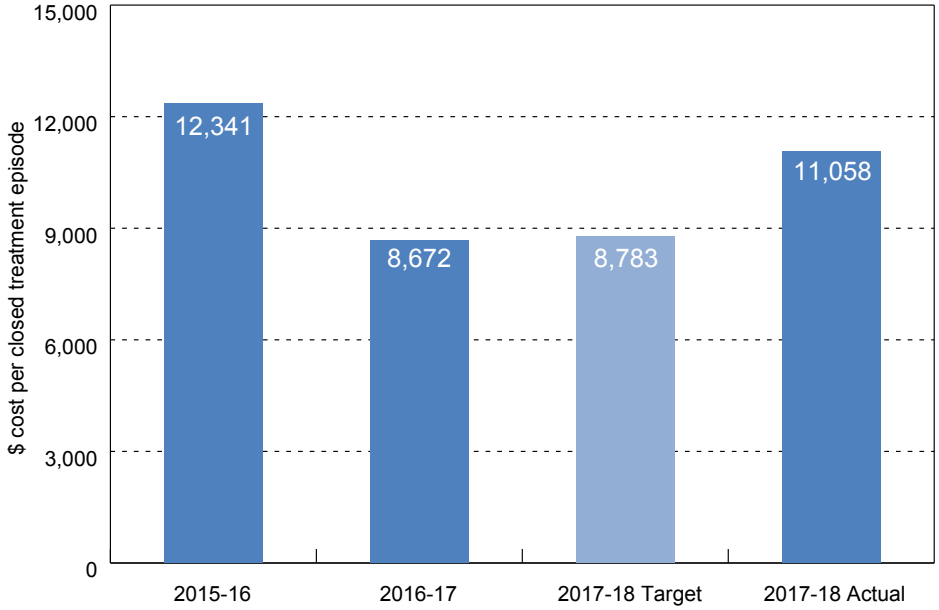
Rationale

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

Results

In 2017-18, the average cost per completed episode of community support provided for AOD services was $11,058, 25.9% higher than the 2017-18 target of $8,783 and 27.5% higher than the 2016-17 result. Due to the long-term nature of this service, there is a small volume of cases accommodated by 15 houses. These low volumes can result in high variability in cost over the various reporting periods. The 2017-18 Budget Target was set based on the 2016-17 activity of 59 episodes and activity for the 2017-18 Estimated Actual is 47 episodes (closed episodes from April 2017 to March 2018).

5.2: Average cost per closed treatment episode of community based support provided and alcohol and other drug services



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

Time Period: *Treatment episode data is for the April 2017 to March 2018 time period to allow for a three month lag for coding and auditing purposes. Cost data is presented by financial year.*

The Transitional Housing and Support Program provides inreach community support for people staying in short-term accommodation following residential AOD treatment

Key Efficiency Indicators

Service five
Community Support

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

Description

The ICLS provides coordinated clinical and psychosocial support to assist individuals to achieve their recovery goals and live well in the community. ICLS supports people to live in their own home in the community with the principles of choice, personalised planning, self-direction and portability of funding. A significant emphasis is placed on planning processes that will focus on the development and achievement of each person's individual recovery goals. Prior to any service commencing, individual plans are completed by the service provider in conjunction with the individual and any other related parties and submitted to the Commission for review. 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 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.

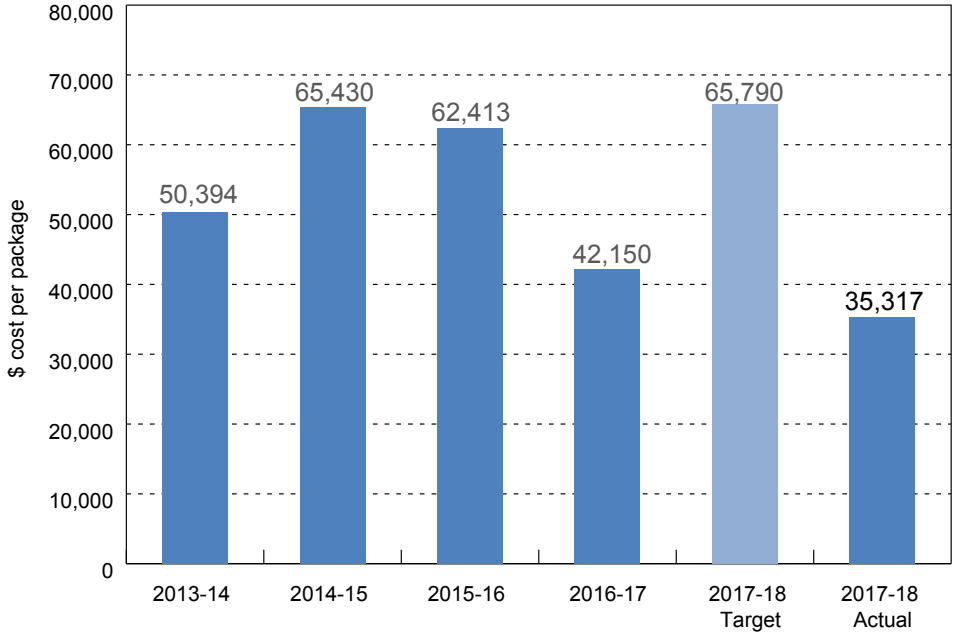
Rationale

This indicator represents the average total funding available per package. Actual funding is allocated based on identified need reflected in the individuals 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.

Results

The 2017-18 cost of $35,317 was 46.3% below the 2017-18 target of $65,790 and 16.2% lower than 2016-17. This is because ICLS support packages are allocated and commence at staggered times throughout the financial year and therefore include part payments that are not reflective of the full year costs for an individual. There are also lead times for the development of support packages for new entrants when backfilling client vacancies (20 individuals exited in 2017-18). In addition, the purpose of the ICLS is to provide coordinated clinical and psychosocial supports to assist eligible individual's to achieve their recovery goals and live well in the community. Therefore it is expected that the average cost per package would decline over time, in line with a gradual decline in the individual's level of need for recovery focused supports. The decline in funding is a positive outcome of the ICLS program and demonstrates program success by supporting individuals to maximise their recovery and maintain independent living in the community.

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



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.*

Key Efficiency Indicators

Service five
Community Support

5.4: Average 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 Centre 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.

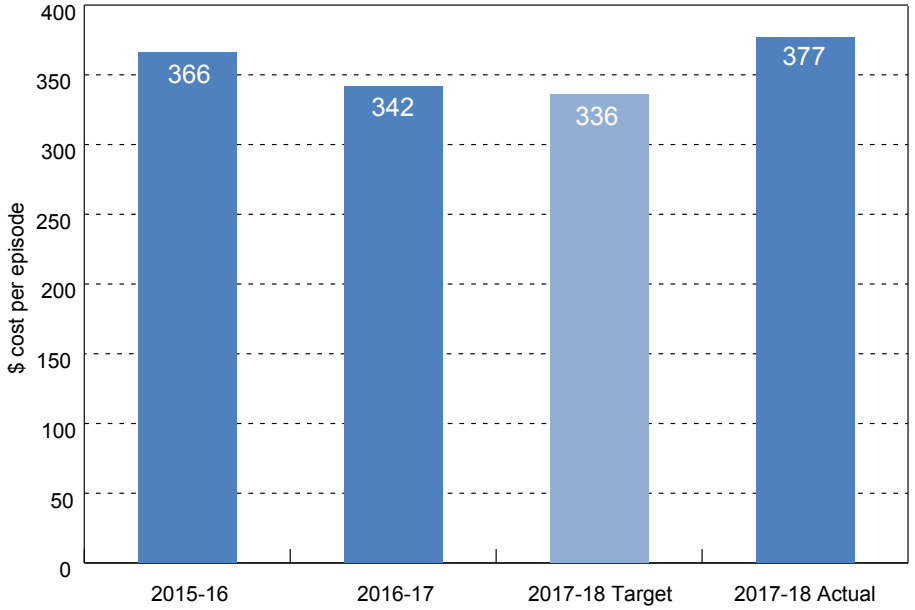
Rationale

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 2017-18, the average cost per episode of care in safe places for intoxicated people was $377, 12.2% above the 2017-18 target of $336 and 10.2% above the 2015-16 result of $342. This is due to a lower than anticipated number of episodes across most services. Providers reported varying reasons for this decline including a reduction in the number of individuals camping, the relocation of some frequent users of the service to metropolitan areas for treatment, stricter enforcement of liquor management strategies and possible impacts of the introduction of the cashless debit card in regional test sites.

5.4: Average cost per treatment episode of care in safe places for intoxicated people



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

Time Period: *Sobering up episode data is for the April 2017 to March 2018 time period to allow for a three month lag for coding and auditing purposes. Cost data is presented by financial year.*

Carnarvon Dual Purpose Centre (Sobering Up Centre)
PHOTO COURTESY OF SANDOVER PINDER ARCHITECTS

Other legal and government policy requirements and financial disclosures

Ministerial directives

Treasurer's Instruction 903 (12) requires the Commission to disclose information on any Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financial activities. No such directives were issued by the Minister with portfolio responsibility for the Commission during 2017-18.

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*.

An area of focus for the Commission during 2017-18 was a review of the recruitment, selection and appointment policy and processes, to ensure impartial decision making and compliance with the employment standards. Several training programs for panel members were conducted to enable managers and supervisors to be better informed about best practice, human resource standards and equity and diversity principles. Several other policies were reviewed throughout the year to ensure they met public sector integrity best practice and provide employees with practical tools to assist with decision making processes. These related to study assistance, managing underperformance and declaring conflicts of interest.

Personal expenditure

In accordance with section 903(13)(iv) of the Treasurer's Instructions, no personal expenditure was incurred on a Western Australian Government Purchasing Card during the reporting period.

Board and committee remuneration reporting

A number of advisory committees were established by the Commission outside of the Cabinet process as they were required to support specific projects such as the development of the Western Australian Recovery College *Draft Model of Service* by the Expert Panel, and the Engagement Framework Steering Committee. Where appropriate, some of these members were remunerated in accordance with the Commission's Consumer, Family, Carer and Community Paid Partnership Policy.

Contracts with senior officers

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

As per Related Party Disclosures (AASB124), conflicts of interest have been identified in relation to the Mental Health Commissioner.
The Commissioner is:

- The Deputy Chair of the beyondblue Board of Directors.
  A not-for-profit organisation, beyondblue focuses on raising awareness and understanding of anxiety and depression in Australia, and currently receives $342,000 pa 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. The Commissioner takes annual leave to attend beyondblue meetings and is excluded from any contractual matters and decisions between the Commission and beyondblue.

These conflicts continue to be managed by delegating all decision-making regarding Commission funding and contract management to the Director, Non-Government Organisations Purchasing and Development.

Compliance with Electoral Act advertising

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

2017-18 expenditure on advertising agencies, market research, polling, direct mail and media advertising

EXPENDITURE CLASS	NAME OF AGENCY	AMOUNT SPENT	TOTAL
Advertising agencies:	Carat Australia Media Services Pty Ltd	$759.97	$41,682
	Remember Software	$145.00	
	Lester Blades	$1,103.83	
	Speirins Media P/L	$181.82	
	Adcorp	$22,089.79	
	The Brand Agency	$17,401.30	
Market research organisations:	The University of Sheffield	$146,430.49	$411,065
	Curtin University	$3,000.00	
	Miles Morgan Australia	$15,414.77	
	Taylor Nelson Sofres	$246,220.00	
Polling organisations:	Nil		
Direct mail organisations:	Nil		
Media advertising organisations:	The Brand Agency and Initiative via Curtin University	$2,462,823.05	$2,479,150
	Facebook	$681.80	
	Matthew Poon Photography	$3,900.00	
	Alucinor	$650.00	
	Clip Media Motion	$7,255.00	
	Bessen Consulting	$3,840.00	
TOTAL			**$2,931,897**

**The prevention campaigns are managed by Curtin University under a Partnership Service Agreement with the Commission*

Disability Access and Inclusion Plan

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 Commission regularly considers how information, services and facilities are accessed by members of the public and makes provisions to meet any alternative requirements individuals may have. This has included several new initiatives, campaigns and programs launched throughout 2017-18, such as the accessible public information sessions on Recovery Colleges, *Think Mental Health* campaign and increased use of online training to improve access for people with disability.

Reconciliation Action Plan

The Commission continued implementing the *2015-2017 Reconciliation Action Plan* (RAP), while working with Reconciliation Australia on the development of its new RAP for 2018-2021, which is expected to be launched in late 2018. The Reconciliation Committee, which is chaired by the Commissioner, continues to meet on a quarterly basis.

Reconciliation activities throughout 2017-18 included:

- An Elder in Residence Program to provide cultural guidance and expertise to all Commission directorates and advise the Corporate Executive. Noongar Elders Mr Charlie and Mrs Helen Kickett joined the program in May 2018. They have worked with a number of the Commission's key partnership agencies and have extensive knowledge and experience in policy development and training;
- Online and face-to-face cultural awareness training for all Commission employees. Currently 57% of employees have completed the training and the Commission is on track to meet the RAP target of a 70% completion rate by December 2018; and
- A range of events commemorating National Sorry Day, National Reconciliation Week, NAIDOC Week and other culturally significant dates throughout the year, including cultural immersion programs.

NAIDOC Week smoking ceremony at the Commission in July 2017

Occupational safety, health and injury management

The Commission is committed to providing a safe workplace to achieve high standards in safety and health for employees, contractors and visitors. Occupational Safety and Health (OSH) practices are recognised as a major contributor to reducing hazards and risks and are embedded in all training, planning, purchasing and business activities. The Commission provides early intervention and proactive injury management, in line with the requirements of the *Workers Compensation and Injury Management Act 1981*.

The Commission's OSH Committee meets bi-monthly to discuss health and safety issues, which includes reviewing incidents and hazards. Health and safety issues are also a standing agenda item at the People and Communications Governance Committee meetings, a sub-committee of the Corporate Executive group. OSH training and support is provided to all Occupational Safety and Health Representatives and ergonomic assessments at workstations are provided for all new staff and as required. A Wellness Committee is in place, taking a proactive approach in supporting an environment that actively assists employees to maximise their overall health, in-line with the Commission's *Healthy Workplace Strategy*. On a quarterly basis, Corporate Executives are provided with a report on the uptake of employee assistance programs, including the number of contacts with Mental Health First Aiders.

The following table details the Commission's 2017-18 key performance indicators against occupational safety and health and injury management measures:

INDICATOR	ACTUAL 2017-2018
Number of Workers Compensation Claims Received	5
Number of fatalities	0
Lost time injury/disease incidence rate	0.8%
Lost time injury/disease severity rate	50%
Percentage of injured workers returned to work within 13 weeks	50%
Percentage of injured workers returned to work within 26 weeks	75%
Percentage of managers trained in occupational safety, health and injury management responsibilities	83%*
Percentage of employees trained in Mental Health First Aid	16.1%*
Number of contacts made to access the in-house Mental Health First Aider Program	58

** Approximate figure*

Recordkeeping plans

The *State Records Act 2000* (the Records Act) was established to standardise statutory record keeping 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 will be reviewed in the next financial year.

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.

In 2017-18, 90% 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 46 training publications were created, which include fact and advice sheets, and in May 2018 a monthly electronic magazine on recordkeeping matters was developed and is distributed to staff by email and the Commission's intranet.

A review of the Commission's *Recordkeeping Plan*, *Recordkeeping Awareness Training* effectiveness and *Records Induction* is currently underway and will be completed by December 2018. This review will contribute to the development of a new *Recordkeeping Plan* in 2018-19.

The Commission's online Recordkeeping Awareness Training is mandatory

APPENDICES

Appendix 1 Non-Government Organisations that the Commission provided funding for during 2017-18*

SERVICE PROVIDER	PLAN SERVICE STREAM	AREA
360 Health and Community	Community Treatment Services	Metropolitan
55 Central	Community Support Services	North Metropolitan
Aboriginal Health Council of Western Australia	Prevention	Statewide
Access Housing Australia	Community Support Services	South Metropolitan
Albany Halfway House	Community Bed-Based Services Community Support Services	Great Southern Great Southern
Amana Living	Community Bed-Based Services	Metropolitan
Anglicare WA	Prevention	Metropolitan
Association For Services To Torture and Trauma Survivors	Community Treatment Services	Metropolitan
Australian Association for Infant Mental Health (WA Branch)	Prevention	Statewide
Australian Medical Procedures Research Foundation	Community Bed-Based Services Community Support Services Community Treatment Services	Metropolitan Mid West Metropolitan
Avivo	Community Support Services	Metropolitan
Bay of Isles Community Outreach	Community Support Services	Goldfields
Bega Garnbirringu Health Services	Community Support Services	Goldfields
beyondblue	Prevention	Statewide
Black Swan Health	Community Treatment Services	South Metropolitan
Bloodwood Tree Association	Community Support Services Community Treatment Services	Pilbara Pilbara
BP Luxury Care	Community Support Services	South Metropolitan
Brightwater Care Group Ltd	Community Bed-Based Services	South Metropolitan
Burswood Care Pty Ltd	Community Support Services	South Metropolitan

SERVICE PROVIDER	PLAN SERVICE STREAM	AREA
Carers Association of Western Australia	Community Support Services	Statewide
Carnarvon Family Support Service	Community Support Services	Mid West
Casson Homes	Community Support Services	North Metropolitan
Catholic Education Office of WA (SDERA)	Prevention	Statewide
Centrecare	Community Treatment Services Community Support Services	Goldfields Goldfields
Collie Family Centre	Community Treatment Services	South West
Community First International	Community Support Services	Statewide
Connect Groups Support Groups Association WA	Prevention	Metropolitan
Consumers of Mental Health WA (CoMHWA)	Prevention Community Support	Statewide Statewide
Curtin University of Technology (National Drug Research Institute)	Prevention	Statewide
Curtin University of Technology (Aussie Optimism)	Prevention	Metropolitan
Curtin University of Technology (Mentally Healthy WA)	Prevention	Statewide
Curtin University of Technology (MCAAY)	Prevention	Statewide
Devenish Lodge	Community Support Services	South Metropolitan
Even Keel Bipolar Disorder Support Association	Community Support Services	Metropolitan
Foundation Housing	Community Support Services	North Metropolitan
Franciscan House	Community Support Services	South Metropolitan
Fremantle Multicultural Centre	Community Support Services	Metropolitan
Fremantle Women's Health Centre	Community Treatment Services	South Metropolitan
Fusion Australia	Community Bed-Based Services	Mid West
Garl Garl Walbu Aboriginal Corporation	Community Support Services	Kimberley

SERVICE PROVIDER	PLAN SERVICE STREAM	AREA
Goldfields Rehabilitation Services	Community Bed-Based Services Community Support Services	Goldfields Goldfields
Gosnells Women's Health Service	Community Treatment Services	South Metropolitan
GP Down South	Prevention	South Metropolitan
Great Southern Community Housing Association	Community Support Services	Great Southern
GROW	Community Support Services Prevention	Metropolitan South West Statewide
HealtheCare Abbotsford	Community Bed-Based Services	South West
HelpingMinds	Community Support Services Prevention	Statewide Metropolitan South West
Holyoake Australian Institute for Alcohol and Drug Addiction Resolution	Community Treatment Services	Metropolitan North East Metropolitan Wheatbelt
Home Health (trading as Tendercare)	Community Support Services	North Metropolitan South West Wheatbelt
Honeybrook Lodge	Community Support Services	North Metropolitan
Hope Community Services	Community Bed-Based Services Community Support Services Community Treatment Services	Mid West Mid West Goldfields
Ishar Multicultural Women's Health Centre	Community Support Services	Metropolitan
Jennie Bertram & Associates	Community Support Services	Metropolitan
Kununurra Waringarri Aboriginal Corporation	Community Support Services	Kimberley

SERVICE PROVIDER	PLAN SERVICE STREAM	AREA
Lamp	Community Support Services	South West
Life Without Barriers	Community Bed-Based Services Community Support Services	South Metropolitan Statewide
Lifeline WA (The Living Stone Foundation)	Prevention	Statewide
Local Drug Action Groups	Prevention	Statewide
Mates in Construction	Prevention	Statewide
Mental Health Law Centre	Community Support Services	Statewide
Mental Illness Fellowship of WA	Community Support Services Prevention	Metropolitan Statewide
Midland Women's Health Care Place	Community Treatment Services	East Metropolitan
Milliya Rumurra Aboriginal Corporation	Community Support Services Community Treatment Services	Kimberley Kimberley
Mind Australia	Community Bed-Based Services	South Metropolitan
Mission Australia	Community Bed-Based Services Community Support Services Community Treatment Services	Metropolitan Metropolitan Metropolitan Pilbara
National Rugby League State of Mind	Prevention	Statewide
Neami	Community Bed-Based Services Community Support Services	Metropolitan Metropolitan
Ngaanyatjarra Health Service Aboriginal Corporation	Community Treatment Services	Goldfields
Ngnowar Aerwah Aboriginal Corporation	Community Support Services Community Treatment Services	Kimberley Kimberley
Nindillingarri Cultural Health Services	Community Treatment Services	Kimberley
Nyoongar Patrol System	Community Support Services	Metropolitan

SERVICE PROVIDER	PLAN SERVICE STREAM	AREA
Outcare	Community Support Services	Metropolitan
Palmerston Association	Community Bed-Based Services Community Support Services Community Treatment Services	Metropolitan Metropolitan Great Southern Metropolitan South Metropolitan
Pathways South West	Community Support Services	South West
Peer Based Harm Reduction WA (previously Western Australian Substance Users Association)	Community Treatment Services	Metropolitan
Perth Inner City Youth Service	Community Support Services	Metropolitan
Regional Men's Health	Prevention	Statewide
Richmond Wellbeing	Community Bed-Based Services Community Support Services	Statewide Great Southern Metropolitan South Metropolitan Statewide (ICLS)
Rise Network	Community Support Services	North Metropolitan East Metropolitan Wheatbelt Statewide (ICLS only)
Romily House	Community Support Services	North Metropolitan
Ruah Community Services	Community Bed-Based Services Community Support Services	Mid West Metropolitan Mid West Great Southern Statewide (ICLS only)

SERVICE PROVIDER	PLAN SERVICE STREAM	AREA
Salisbury Home	Community Support Services	East Metropolitan
Share & Care Community Services Group	Community Support Services	Wheatbelt
South Coastal Health and Community Services (previously South Coastal Women's Health Services Association)	Community Treatment Services	South Metropolitan
Southern Cross Care (WA)	Community Bed-Based Services Community Support Services	Metropolitan Metropolitan
Spirit of the Street Choir	Community Support Services	Metropolitan
St Bartholomew's House	Community Bed-Based Services Community Support Services	Metropolitan South Metropolitan
St John of God Health Care	Community Bed-Based Services Community Treatment Services	Metropolitan Metropolitan
St John of God Hospital Bunbury	Community Treatment Services	South West
St Jude's Hostel	Community Support Services	East Metropolitan
St Patrick's Community Support Centre	Community Support Services Community Treatment Services	Metropolitan Metropolitan
St Vincent De Paul Society (WA)	Community Support Services	Metropolitan
Teen Challenge Perth	Community Bed-Based Services	Statewide
The Federation of WA Police and Community Youth Centres	Community Treatment Services	Great Southern
The Salvation Army Western Australia Property Trust	Community Bed-Based Services Community Support Services Community Treatment Services	Metropolitan Metropolitan Metropolitan
The Samaritans	Community Support Services Prevention	Statewide Statewide

SERVICE PROVIDER	PLAN SERVICE STREAM	AREA
UnitingCare West	Community Support Services Community Treatment Services	North Metropolitan Metropolitan
University of Sheffield	Prevention	Statewide
University of Western Australia – Fly In / Fly Out Research Project Sheffield	Prevention	Statewide
WA Council on Addictions T/A Cyrenian House	Community Bed-Based Services Community Support Services Community Treatment Services	Metropolitan Metropolitan Kimberley Metropolitan
WA Network of Alcohol & Other Drug Agencies (WANADA)	Prevention	Statewide
Wanslea Family Services	Community Support Services	Metropolitan
Warmun Community (Turkey Creek)	Community Treatment Services	Kimberley
Western Australian AIDS Council	Prevention	Statewide
Western Australian Association for Mental Health (WAAMH)	Prevention Community Support Services	Statewide Statewide
Wheatbelt Men's Health Inc	Prevention	Statewide
Women's Healthcare Association	Community Support Services Community Treatment Services	Metropolitan Metropolitan
Wungening Aboriginal Corporation (previously Aboriginal Alcohol and Drug Service)	Community Treatment Services Prevention	Metropolitan Metropolitan
Yaandina Family Centre	Community Bed-Based Services	Pilbara
Youth Focus	Community Support Services Community Treatment Services	Pilbara Metropolitan
Zonta House	Prevention	Metropolitan

** Includes Service Agreements and Grants*

Appendix 1 Glossary Of Service Streams

SERVICE STREAM	DESCRIPTION
Prevention	Mental health, AOD prevention refers to the initiatives and strategies implemented on a national Statewide and local basis to reduce the incidence and prevalence of mental health issues and delay the uptake and reduce the harmful use of AODs and associated harms. Mental health promotion strategies aim to boost positive mental health and resilience. Initiatives can be targeted at the whole population or specific priority target groups. Effective strategies can include raising community awareness of mental health problems and AOD-related harms, the creation of supportive environments and communities that are also low risk, enhancing healthy community attitudes and skills, and building the community's capacity to address mental health, AOD problems.
Community Support Services	Community support services provide individuals with mental health, 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 (e.g. to assist in accessing and maintaining employment/education and social activities), peer support, initiatives to promote good health and wellbeing, home inreach 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 harm-reduction programs.
Community Treatment Services	Community treatment services provide clinical care in the community for individuals with mental health, AOD problems. 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. Services provided to individuals are non-residential, and can be intensive, acute or ongoing. All community treatment services include carers in relevant treatment decisions, are family inclusive, trauma informed and mental health community treatment services are recovery-orientated. AOD community treatment services include pharmacotherapy programs, screening and assessment programs and counselling.
Community Bed-Based Services	Community bed-based services provide 24 hour, seven days per week recovery orientated services in a residential style setting (in the case of mental health services) and structured, intensive residential rehabilitation for people with an AOD issue (following withdrawal). Both mental health community beds and residential rehabilitation services need to have the capability to meet the needs of people with co-occurring mental health, AOD issues where appropriate. Community bed-based services support a person to enable them to move to more independent living. The primary aim of interventions is to improve functioning and reduce difficulties that limit an individual's independence. They assist people with mental health, AOD issues who may need additional support, where an admission to hospital is not required. They can also provide additional supports to assist people to successfully transition home from hospital, as well as work with individuals to prevent relapse and promote good general health and wellbeing.

Appendix 2 Board and Committee Remuneration

Mental Health Advisory Council:

POSITION	MEMBERS NAME	TYPE OF REMUNERATION	PERIOD OF MEMBERSHIP	GROSS REMUNERATION 2017-18 FINANCIAL YEAR
Chair	Mr Barry MacKinnon	Annual	1 July 2017 – 30 June 2018	$21,163.08
Deputy Chair	The Hon. Eric Ripper	Annual	1 July 2017 – 30 June 2018	$17,428.04
Member	Ms Margaret Doherty	Sessional	1 July 2017 – 1 June 2018	$3,084.65
Member	Ms Pamela Gardner	Sessional	1 July 2017 – 1 June 2018	$3,222.63
Member	Prof Dianne Wynaden	Not applicable[3]	1 July 2017 – 1 June 2018	Nil
Member – Ex officio[2]	Ms Aimee Sinclair	Sessional	1 July 2017 – 12 October 2018	$2,010.43
Member	Mr Christopher Gostelow	Not applicable[1]	1 July 2017 – 30 June 2018	Nil
Member	Dr Michael Wright	Not applicable[1]	1 July 2017 – 30 June 2018	Nil
Member	Dr Amit Banerjee	Not applicable[1]	1 July 2017 – 30 June 2018	Nil
Member	Mr Rod Astbury	Sessional	1 July 2017 – 30 June 2018	$5,507.90
Member	Petra Liedel	Not applicable[1]	1 July 2017 – 2 May 2018	Nil

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

[2] *Ex Officio: Due to role held as CoMHWA representative*

[3] *Did not seek any remuneration*

Ministerial Council for Suicide Prevention:

POSITION	MEMBERS NAME	TYPE OF REMUNERATION	PERIOD OF MEMBERSHIP	GROSS REMUNERATION 2017-18 FINANCIAL YEAR
Chair	Dr Neale Fong	Annual	1 July 2017 – 30 June 2018	$24,013.08
Deputy Chair	Mr Glenn Pearson	Annual	1 July 2017 – 30 June 2018	$9,655.46
Member	Ms Tamisha King	Sessional	1 July 2017 – 30 June 2018	$1,642.50
Member	Ms Anne Richards	Sessional	1 July 2017 – 30 June 2018	$2,299.50
Member	Prof Cobie Rudd	Sessional	1 July 2017 – 30 June 2018	$1,971.00
Member	Ms Donna Watson	Sessional	1 July 2017 – 2 July 2018	$1,774.00
Member	Dani Wright Toussaint	Sessional	1 July 2017 – 30 June 2018	$2,803.20
Member	Mr Timothy Marney	Not applicable[1]	1 July 2017 – 30 June 2018	Nil
Member	Mr Chris Gostelow	Not applicable[1]	1 July 2017 – 30 June 2018	Nil

[1] *Committee Members who are public servants with administrative responsibilities are ineligible to receive 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 2017-18 financial year is as follows:

President:	$273,808.84
Member (high):	$102,557.70
Member (average):	$29,320.69
Member (low):	$2,470.32

Please note: 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*, is currently in abeyance pending Cabinet consideration.

Government of **Western Australia**
Mental Health Commission

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