Government of **Western Australia**
Mental Health Commission

Mental Health Commission

Annual Report

2010-2011

Contents

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STATEMENT OF COMPLIANCE

HON HELEN MORTON MLC
MINISTER FOR MENTAL HEALTH

In accordance with section 61 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the Annual Report of the Mental Health Commission for the financial year ended 30 June 2011.

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

Eddie Bartnik
MENTAL HEALTH COMMISSIONER
Accountable Authority

23 September 2011

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OVERVIEW

Executive summary

This was the first full year of operation for the Mental Health Commission and there are many 'firsts' to acknowledge. They highlight the achievements of establishing the Commission as a stand alone agency with a corporate executive, a new organisational structure, a dedicated budget and other governance, policy, planning, commissioning and reporting arrangements.

The Commission was allocated a budget of more than half a billion dollars to drive the mental health reform agenda in the key areas of governance, treatment, accommodation, mental health promotion and prevention and support. This places Western Australia among international leaders like New Zealand, Canada and Scotland in recognising and responding to the need for dedicated leadership to solve mental health challenges. This year more than $45 million was invested in nongovernment organisations for mental health services and supports in addition to substantial investment in public and private specialised mental health services. All services and supports are purchased using grant agreements or service agreements that specify the level, price and quality of services to be provided.

Identifying and engaging a wide range of stakeholders was the hallmark of the Commission's approach to establishing priorities and partnerships that will underpin the reform agenda. The intent is to embrace engagement as fundamental to the way in which the Commission does business. Over time, processes will become more systematic and new stakeholders will be given opportunities to become involved.

The Commission has played an important role in strengthening the voice of people with mental health problems and/or mental illness, as well as their family, carers, friends and community. Strategic planning has been guided by extensive statewide community consultation based on the 'WA Mental Health Towards 2020: Consultation Paper'. We have taken feedback on board and made substantial changes to direction to make it more accessible and with a whole of government and community focus, not just on the mental health system. There is also increased emphasis on the important role of a sustainable and high quality community services sector, and opportunities for more personalised supports and services.

Significant developments such as establishing the Mental Health Advisory Council to provide independent advice on mental health reform, developing an association for mental health consumers, planned recruitment of a dedicated consumer advisor position at the Commission and increased funding for the Western Australian Association for Mental Health have helped put mental health consumers, families and carers closer to the centre of decision making. A stronger collaboration has been established with the nongovernment sector through the Commission's participation as a member on the state government's partnership forum and as a lead agency in implementing new partnership initiatives. These new arrangements have complemented the important collaboration with traditional roles such as the Chief Psychiatrist, and the heads of the Mental Health Review Board and the Council of Official Visitors.

The aspirations and needs of people with mental health problems and/or mental illness and those who care for and support them, must now become a central focus of deliberations around policy, planning and funding. The Commission is working to introduce new forms of individualised funding and personalised support, as part of a broad government reform direction. This will provide opportunities for people to have more choice and control over the supports and services they receive, with a strong focus on recovery.

Importantly also, the Commission has worked effectively across government. Mental health is everybody's business and requires a comprehensive statewide response. The Commission has played a lead role in facilitating new partnerships between government organisations and also between government and nongovernment organisations. Examples include the joint funding with the Drug and Alcohol Office of the new Prospect Lodge residential rehabilitation service in Kalgoorlie and also the multi agency People with Exceptionally Complex Needs project. These new partnerships aim to deliver more efficient, effective and sustainable solutions for people with mental health problems and/or mental illness. We will continue to facilitate better coordination and remove barriers between Federal, state and local governments as well as with private and community organisations.

The Commission has worked closely with the Department of Health to launch a number of new services during the year including the Child and Adolescent Attention and Hyperactivity Disorder Clinic in Murdoch, the new Rockingham Hospital inpatient facility and also funding for the Broome Recovery Centre.

OVERVIEW

Executive summary continued

This year marked the commencement of the new Statewide Specialist Aboriginal Mental Health Service – a comprehensive dedicated service for Aboriginal people with mental health problems and/or mental illness. Additional funding for suicide prevention and intervention in Aboriginal communities was allocated by the Mental Health Commission, along with the Western Australian Suicide Prevention Strategy which made major progress in funding community action plans for Perth and rural and remote areas.

Better access to safe and affordable accommodation for people with mental health problems and/or mental illness is essential. Thirty new dwellings for people with mental health problems and/or mental illness were made available through the Nation Building Housing Stimulus Program, in partnership with the Department of Housing. Nine units in the south metropolitan area and 21 in the north metropolitan area were provided for people who were homeless or at risk of homelessness. We also commenced comprehensive planning for further accommodation options in Perth and regional Western Australia and increased our investment in mental health promotion and prevention to help break down the stigma associated with mental illness and to promote social inclusion.

A new Mental Health Act is essential if we are to maintain a modern mental health system and considerable progress was made in 2010/11 towards completing the draft Bill that will be introduced into Parliament during this term of government. This went hand-in-hand with work to develop a new quality assurance framework that will help strengthen the rights of people with mental health problems and/or mental illness.

It has been a busy and productive year for the Mental Health Commission. I expect the pace of work will increase in 2011/12 as reform at both the state and national level gathers pace. I would like to thank all those in the mental health sector who have supported, advised and challenged the Commission to improve the care and support for people with a mental health problem and/or mental illness. I look forward to our continued partnership in 2011/12.

And last but not least, I thank all the staff of the Commission, without whose dedicated effort, this reform agenda would not be possible.

Eddie Bartnik
COMMISSIONER
MENTAL HEALTH COMMISSION

23 September 2011

OVERVIEW

Operational structure

Enabling Legislation

The Mental Health Commission was established by the Governor in Executive Council under section 35 of the *Public Sector Management Act 1994*. The Mental Health Commissioner as the Chief Executive Officer of the Mental Health Commission is responsible to the Minister for Mental Health for the efficient and effective management of the organisation. The Mental Health Commission does not administer any Acts.

Responsible Minister

Hon. Helen Morton MLC
Minister for Mental Health

Chief Executive Officer

The Mental Health Commissioner as the Chief Executive Officer of the Mental Health Commission is Mr Eddie Bartnik. Mr Bartnik is also the Accountable Authority, as prescribed under section 52 of the *Financial Management Act 2006*.

Organisational structure

The establishment of the Mental Health Commission, the first in Australia, highlighted the importance the State Government places on mental health reform and improving and enhancing mental health services in Western Australia. The Mental Health Commission focuses on mental health strategic policy, planning and procurement of services and promotes social inclusion, raises public awareness of mental wellbeing and addresses stigma and discrimination surrounding mental illness.

In 2010/11 the organisational structure was reviewed and implemented with approval for the final executive structure received from the Public Sector Commissioner in July 2011. A key activity throughout the year has been transitioning staff into new roles within the Commission to take best advantage of the wide skill set available. Recruitment of senior executives will be finalised towards the end of 2011. A challenge for 2010/11 has been to manage the ongoing roles and functions of an operational agency while defining and continually incorporating new roles within the evolving structure.

Our vision

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

Our mission

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

Our values

Hope and optimism

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

Leadership

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

Integrity

Acting ethically and taking personal responsibility.

OVERVIEW

Operational structure continued

Innovation and excellence
Recognising and rewarding ideas; focusing on quality improvement in all that we do.

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

Transparency
Clearly communicating our contribution in achieving outcomes.

Our direction

The Mental Health Commission's work in 2010/11 has focused on three key strategic directions:

- Developing recovery oriented, person centred support and service for people with mental health problems and/or mental illness.
- More connected approaches across government agencies, and with community, private, primary care services and the university sector.
- Planning for a full range of services in a comprehensive and contemporary mental health system.

Our functions

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

OVERVIEW

Operational structure continued

Organisational chart

The following chart outlines the corporate structure and reporting lines of the Mental Health Commission as at 30 June 2011:

COMMISSIONER
Eddie Bartnik

POLICY STRATEGY AND PLANNING DIRECTORATE

This Directorate leads reform and provides strategic direction and management of strategic policy and planning to improve outcomes for clients. It shapes the future policy direction for mental health services and infrastructure planning statewide, ensuring alignment with the Mental Health Commission's and Government's priorities and strategic objectives.

Acting Director Myra Browne

PERFORMANCE AND REPORTING DIRECTORATE

This Directorate is responsible for leading and directing the development, implementation, and management of the Commission's strategic information program. The program is key to ensuring the availability and effective use of information; to drive policy development, planning, resource allocation and performance reporting necessary to implement the Mental Health Commission's and Government's strategic objectives and priorities.

Director Danuta Pawelek

ORGANISATIONAL REFORM

This Directorate provides leadership and strategic direction to plan, develop and influence the implementation of the mental health reform agenda and the Mental Health Commission's and Government's key priorities and strategic objectives and drives the development and implementation of system wide mental health reform across the portfolio, with key stakeholders and Government.

Acting Director Lesley van Schoubroeck

SERVICES PURCHASING AND DEVELOPMENT DIRECTORATE

This Directorate leads the purchasing and development of mental health services and supports across the state and drives improved service outcomes for clients with an emphasis on coordinated service integration and client centric, individualised approaches to service delivery across the sector. It oversees service delivery performance and ensures compliance with relevant standards and legislative requirements.

Acting Director Eric Dillon

CORPORATE SERVICES DIRECTORATE

This Directorate provides strategic leadership, management and specialised services associated with corporate services and governance to shape and support achievement of the Mental Health Commission's objectives and outcomes and ensure alignment with the mental health reform agenda. The Director also acts as the agency's Chief Finance Officer to meet the requirements of the *Financial Management Act 2006* and other relevant legislation.

Acting Director Annette Keller

OVERVIEW

Operational structure continued

Senior officers as at 30 June 2010

Mental Health Commissioner

Eddie Bartnik was appointed the State's first Mental Health Commissioner in August 2010. He has worked in the human services sector for many years and has significant national and international experience. Eddie is passionate about mental health reform to achieve better outcomes for the community.

He has held senior positions within the Western Australian public service across various agencies. This includes leadership roles in policy, funding and statewide service delivery with the Disability Services Commission. He was previously the Acting Director General of the Department for Communities. He has championed the local area coordination approach to personalised support and individualised funding for people with a disability and their families. He has also worked in the nongovernment sector as a clinical psychologist.

Neil Guard was Acting Mental Health Commissioner for the period 1 July to 17 August 2010.

Executive staff

Myra Browne, Acting Director Policy, Strategy and Planning

Myra Browne holds a BA (Hons) in Anthropology and a Postgraduate Diploma in Health Promotions. Myra has substantial experience and skills in cross government working; strategic thinking; planning, review and reporting; consultation, policy development, implementation, coordination and review; intergovernmental relations, and partnerships with nongovernment and tertiary organisations.

Eric Dillon, Acting Director Purchasing and Development

Eric Dillon holds a BSc Hons and MSc Environmental Science and other postgraduate qualifications. Eric has significant experience in local government in the United Kingdom and over 23 years experience in state government in Western Australia, much of which has been at senior executive level working within the health sector and in collaboration with nongovernment organisations.

Danuta Pawelek, Director Performance and Reporting

Danuta Pawelek has 25 years experience working in the Western Australian public sector. She has considerable expertise in policy development and evaluation; strategic development and change management; and a thorough understanding of accountability mechanisms in the public sector. She has extensive practical experience in information and systems development and implementation. Danuta holds a Magister (Master) of Economics from Lodz University in Poland.

Lesley van Schoubroeck, Acting Director Organisational Reform

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

Annette Keller, Acting Director Corporate Services and Governance

Annette Keller has 25 years experience working in a government operating environment having worked in both the Western Australian public sector and local government in the United Kingdom. She has extensive experience in financial management functions, strategic human resource management and corporate governance and accountability. She holds a Bachelor of Business, is a Certified Practicing Accountant and is the designated Chief Finance Officer for the Mental Health Commission.

Our people

We have created a diverse, dynamic and dedicated team that works collaboratively with our stakeholders to transform the way in which mental health services are delivered. Our vision, mission and organisational values have been developed collaboratively and reflect the aspirations of our stakeholders, especially consumers, carers and family members.

The Wellbeing Team is a staff initiative designed to help support the physical and mental health of our staff. In 2010/11, they organised healthy heart checks, stretching classes, information and resources on a range of health and wellbeing topics, health education sessions and social and competitive events to promote staff cohesion and morale.

OVERVIEW

Operational structure continued

We provide a flexible and family friendly workplace because we recognise the key role this plays in addressing the challenges of attracting a skilled workforce. At the same time we are building a culture that provides opportunities for people from other public sector agencies and the nongovernment sector to undertake temporary work placements.

Administered Legislation

The Mental Health Commission does not directly administer any legislation.

Other key Legislation

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

- *Auditor General Act 2006*
- *Disability Services Act 1993*
- *Equal Opportunity Act 1984*
- *Financial Management Act 2006*
- *Freedom of Information Act 1992*
- *Industrial Relations Act 1979*
- *Mental Health Act 1996*
- *Minimum Conditions of Employment Act 1993*
- *Occupational Safety and Health Act 1984*
- *Public Interest Disclosure Act 2003*
- *Public Sector Management Act 1994*
- *Salaries and Allowances Act 1975*
- *State Records Act 2000*
- *State Superannuation Act 2000*
- *State Supply Commission Act 1991*
- *Workers' Compensation Reform Act 2004.*

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

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

OVERVIEW

Performance management framework

Outcomes, services and performance information

The Mental Health Commission has the lead responsibility for mental health reform across the state and will focus on mental health strategic policy, planning, procurement and performance monitoring and evaluation of services. The Mental Health Commission will promote social inclusion, raise public awareness of mental wellbeing and address stigma and discrimination surrounding mental illness. The Mental Health Commission is not a direct service provider.

Key performance indicators published in this annual report relate to publicly funded mental health services.

The following diagram shows the whole of government goal, the Mental Health Commission's current desired outcome, services purchased and performance indicators.

The Mental Health Commission is reviewing its outcome based management framework including key performance indicators for the next reporting period.

Outcome based management framework

WESTERN AUSTRALIAN STRATEGIC OUTCOME WHOLE OF GOVERNMENT GOAL

Outcomes based service delivery: greater focus on achieving results in key service delivery areas for the benefit of all Western Australians.

MENTAL HEALTH COMMISSION'S DESIRED OUTCOME

The best possible mental health and wellbeing for all Western Australians.

Key effectiveness indicators:

- Rate of suicide in Western Australia.
- Proportion of people receiving community support from nongovernment organisations for people with mental health problems and/or mental illness.
- Percent of contacts with community based public mental health non admitted services within seven days post discharge from public mental health inpatient units.
- Percent of contacts with community based public mental health non admitted services within seven days prior to admission to a public mental health inpatient unit.

Service one

Specialised mental health admitted patient

Key efficiency indicator:

- Average cost per bedday in a specialised mental health unit.

Service two

Specialised community mental health

Key efficiency indicators:

- Cost per capita of providing activities to enhance mental health and wellbeing (illness prevention, promotion and protection activities).
- Average cost per hour for community support provided by nongovernment organisations to people with mental health problems.
- Average Mental Health Commission subsidy per bedday for people with mental illness living in community supported residential accommodation.
- Average Mental Health Commission subsidy per person to support residents in metropolitan licensed private psychiatric hostels.
- Average cost per episode of community care provided by public mental health services.

Changes to outcome based management framework

There are no changes to agency level government desired outcomes, services and key performance indicators from the previous year.

The Mental Health Commission is reviewing its outcome based management framework including key performance indicators for the next reporting period.

AGENCY PERFORMANCE

Report on operations

Actual results versus budget targets

Financial performance

A summary of highlights from the financial statements comparing actual results with budget targets is provided below:

	2010/11 Budget $'000	2010/11 Actual (1) $'000	Variation (2) $'000
Total cost of services (expense limit)	508,181	490,693	(17,488) (3)
Net cost of services	507,511	488,089	(19,422) (3)
Total equity	4	320	316
Net increase / (decrease) in cash held	(950)	(962)	12
Approved full time equivalent staff level	47	45	(2)

1. For further details on actual results refer to the financial statements section of this annual report.
2. Further explanations are also contained in note 25 'explanatory statement' to the financial statements.
3. The decrease in budget to actual is mainly due to:
   - a reduction in the Mental Health Commission expense limit of $12.8 million due to the transfer of funding to the Department of Housing for the construction of two intermediate care facilities on behalf of the Mental Health Commission
   - the part carryover of specific mental health programs relating to the Western Australian Suicide Prevention Strategy 2009-13 and National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. These funds will be carried over and expended in 2011/12.

AGENCY PERFORMANCE

Report on operations continued

Summary of key performance indicators

	2010/11		
	Target[1]	Actual	Variation[2]
Outcome: The best possible mental health and wellbeing for all Western Australians. Key effectiveness indicators: Rate of suicide in Western Australia.(3)	↓	12.6 (2009)	
Proportion of people receiving community support from nongovernment organisations for mental health problems.	40%	39.2%	(0.8%)
Percent of contacts with community based public mental health non admitted services within seven days post discharge from public mental health inpatient units.	>=70%	66%	(4%)
Percent of contacts with community based public mental health non admitted services within seven days prior to admission to a public mental health inpatient unit.	>=70%	62%	(8%)
Service 1: Specialised mental health admitted patient. Key efficiency indicator: Average cost per bedday in a specialised mental health unit.	$1,071	$1,086	$15
Service 2: Specialised community mental health. Key efficiency indicators: Cost per capita of providing activities to enhance mental health and wellbeing (illness prevention, promotion and protection activities).	$6	$7	$1
Average cost per hour for community support provided by nongovernment organisations to people with mental health problems.	$74	$67	($7)
Average Mental Health Commission subsidy per bedday for people with mental illness living in community supported residential accommodation.	$218	$168	($50)
Average Mental Health Commission subsidy per person to support residents in metropolitan licensed private psychiatric hostels.	$8,530	$6,836	($1,694)
Average cost per episode of community care provided by public mental health services.	$1,792	$1,809	$17

(1) As specified in budget statements and/or based on national rate or targets.

(2) Explanations of variations between targets and actual results are presented in key performance indicator documentation commencing on page 54.

(3) Data on suicide is only available until 2009 and this figure is published in the 'actual' column. Target – the intention is to reduce the age standardised rate. Rate is per 100,000 population.

AGENCY PERFORMANCE

Key achievements in 2010/11

Introduction

The 2010/11 financial year was the first full year of operation for the Mental Health Commission, which commenced operations on 8 March 2010. During the year the Mental Health Commission has focused on leading the development of strategies that will deliver better mental health outcomes for Western Australians. This work has involved strengthening engagement with the community, building a new vision for reform, and continuing to work with key government and nongovernment partner agencies. At the same time, mental health reform has gained momentum at the national level.

The Mental Health Commission purchases a range of services from government, private and nongovernment organisations to provide hospital treatment, clinical treatment in the community, accommodation services and community supports for people with a mental health problem and/or mental illness. The Commission also collaborates with, and funds government and nongovernment organisations to promote positive mental health, strengthen communities and reduce the stigma surrounding mental illness.

As indicated in the performance management framework, mental health services and activities are contracted according to two types of mental health specialised services and activities.

The key program area included in service one is specialised mental health admitted or hospital based services, covering both public and privately operated hospitals. Service two consists of accommodation support and community services, which includes a range of both government and nongovernment operated community services. A summary of services contracted by the Mental Health Commission in 2010/11 is listed in appendix one.

The Mental Health Commission directed approximately half of its funding into community based services in 2010/11, and aims to increase the proportion of funds in this area in the future.

Understanding mental health

As in other countries, mental disorders are widespread in Australia and account for 13 percent of the overall disease burden.[1] The national survey of mental health and wellbeing conducted by the Australian Bureau of Statistics shows that one in five Western Australians experience one or more common mental disorders in any given year and almost one in two at some time in their lives.

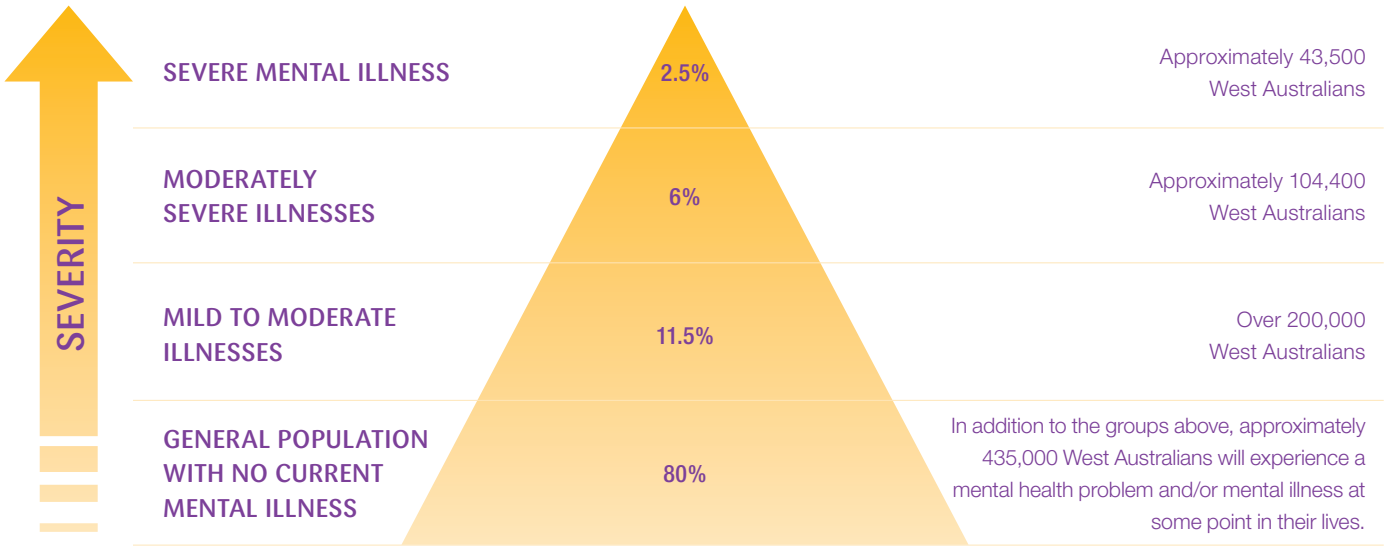
The measure of severity used in the 2007 national survey summarises all the mental disorders experienced in a 12 month period and their effect on a person's daily life and categorises this impact as severe, moderate or mild.[2] Figure 1 following, charts the approximate number of Western Australians against the severity of mental disorders experienced over a 12 month period.

1 Begg *et al* (2007), The burden of disease and injury in Australia 2003, AIHW PHE 82, April Canberra.
2 Source: Council of Australian Governments. National Action Plan for Mental Health 2006-2011. Second Progress Report 2007-08.

AGENCY PERFORMANCE

Key achievements in 2010/11 continued

Figure 1: Prevalence and severity of mental disorders in Western Australia in one year[3]



Based on the June 2009 Western Australian estimated residential population (ERP) of persons aged 16 to 85 years (1,740,809).

The Mental Health Commission is committed to reforming the mental health system to achieve more balance between services for people who are in an acute stage of illness, and those services which have a focus on mental health promotion and illness prevention, early intervention and supporting recovery. With sustained reforms in this area, Western Australians will have greater access to the right care and support earlier in their life and earlier in the course of their problems or illness.

Portfolio support

The Mental Health Commission provides portfolio coordination for the Minister to meet many of her responsibilities which include the Mental Health Review Board and the Council of Official Visitors. The Ministerial Council for Suicide Prevention also reports to the Minister. The Commission works in partnership with the Department of Health to ensure coordinated advice to government from the Chief Psychiatrist and Mental Health Services within WA Health.

It provided specific coordination for:

- budget, Ministerial and Parliamentary responses that impacted across the portfolio
- appointments and reappointments to the Mental Health Review Board and the Council of Official Visitors
- preparation of the Government's response, 'Renewed Respect', to the Council of Official Visitors 2010 annual report
- representation on interagency working groups arising from the government report, 'Putting the Public First'.

Mental Health Strategic Policy

The Mental Health Commission is finalising the Mental Health Strategic Policy which will be publicly available in late 2011. It outlines a ten year vision for mental health in Western Australia and complements national policies and plans.

3 Concept adapted from strategic plan 2006-2011 Department of Health and Human Services Government of Tasmania.

AGENCY PERFORMANCE

Key achievements in 2010/11 continued

The Policy is based upon key reform areas that were identified during extensive community consultation undertaken for the 'WA Mental Health Towards 2020: Consultation Paper'. The consultation resulted in 177 returned surveys, 79 written submissions and online responses and 11 public forums. A total of 395 participants attended forums held in Albany, Broome, Bunbury, Esperance, Geraldton, Kalgoorlie, Karratha, Northam, Perth and Port Hedland, with one forum facilitated by the Department of Indigenous Affairs. Carers WA also organised their own forum and invited representatives from the Mental Health Commission to provide an overview of the consultations and a summary of feedback received from the other forums. There was a high level of input from several government departments, nongovernment organisations, peak bodies and local and international experts. A summary report of the consultation 'Everybody's business – community consultations summary' and a technical feedback report on the consultations were produced and are available on the Mental Health Commission website.

Stakeholder engagement

Identifying and engaging stakeholders were the hallmark of the Commission's approach to establishing priorities and processes that will underpin the reform agenda for the coming five years and more. The intent is to embrace engagement as fundamental to the way in which the Commission does its business. Over time, processes will become more systematic and new stakeholders will be given opportunities for their voices to be heard through the measures described below.

Strengthening consumer and carer involvement in policy and planning and creating reform that is consumer focused, integrated and reflective of the needs of the community and of the people it serves is a key achievement of the Commission in this first year. To provide leadership and assist the Mental Health Commissioner with driving this change, key mechanisms were initiated.

Mental Health Advisory Council

The Mental Health Advisory Council was established to provide high level, independent advice to the Mental Health Commissioner on major issues affecting mental health care reform. The Council has identified its key initial priorities as providing input into the Mental Health Bill, overseeing the Mental Health Strategic Policy, establishing effective consultation processes, and refugee and migrant mental health.

The members of the Council are:

Mr Barry MacKinnon AM (Chair), Dr Judy Edwards (Deputy Chair), Mr Joe Calleja, Mr Geoff Diver, Ms Margaret Doherty, Dr John Edwards, Ms Pam Gardner, Ms Katherine Hams, Mr John Hesketh, Mr Lindsay Smoker, Dr Alexandra Welborn, Dr Bernadette Wright and Professor Dianne Wynaden (see appendix two).

Western Australian Association of Mental Health Consumers

Consumers will have a strengthened role in policy and planning with the establishment of the Western Australian Association of Mental Health Consumers. The Commission issued an expression of interest in April 2011 for the establishment of a consumer led association. Recently, the Consumers of Mental Health WA (CoMHWA) was selected as the preferred provider to establish the association. The Mental Health Commission has allocated $1.3 million over five years for the initiative.

The new association will:

- provide an informed and collective voice for people with a lived experience of mental health problems and/or mental illness
- protect the rights of people with a mental health problem and/or mental illness
- promote wellbeing and recovery.

The voice of consumers will be further supported by the establishment of a consumer advisory role in the Mental Health Commission. This will complement the strong partnerships already forged with carer organisations such as Mental Health Matters 2, ARAFMI and Carers WA.

AGENCY PERFORMANCE

Key achievements in 2010/11 continued

Legislation and quality assurance

A key role for the Commission is to ensure the rights of people with mental health problems and/or mental illness (along with their families, carers and supporters), are protected, and to give them greater control and choice over the supports and services they access.

Three key initiatives were advanced to contribute to this reform agenda.

- Mental Health Bill

  Considerable progress was made towards completing the draft Mental Health Bill, and work is on track to have new legislation introduced in this term of Government. An expert group including the key statutory roles from the Mental Health Review Board, the Council of Official Visitors and the Chief Psychiatrist as well as consumer and carer representatives and professionals provided advice and considered latest research on mental health legislation and written submissions from key stakeholder groups. The group highlighted a number of areas where revised drafting instructions were required arising from developments such as:
  - the establishment of the Mental Health Commission
  - Australia's ratification of the UN Convention on the Rights of People with Disabilities
  - legislative reform in other jurisdictions, which has set new benchmarks for best practice.

- Quality assurance framework

  The Mental Health Commission awarded a tender to international experts, Gregor Henderson Ltd to provide advice to inform the development of a new quality assurance framework for mental health services in Western Australia.

  The review will recommend functions and processes to ensure Western Australians with a mental health problem and/or mental illness receive the best available evidence based care. It will consider the roles of the Mental Health Commission and other entities involved in the delivery and monitoring of services. A final report will be provided late in 2011. The recommendations will focus on protecting the rights of the most vulnerable consumers, particularly those detained involuntarily, and seek to streamline and strengthen quality management processes that are currently in place.

- National standards

  The Mental Health Commission has established a steering group to oversee the implementation of new national standards for mental health services. These standards will form an integral part of the quality assurance framework. They accept that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life.

Supporting mentally healthy communities

Investment in mental health promotion and illness prevention is a priority for the Mental Health Commission in building a mentally healthy and resilient Western Australia. This requires strong partnerships with nongovernment, government, community sectors, carers and consumers to ensure that mental health and wellbeing is everyone's business.

The Mental Health Commission increased investment in mental health promotion and illness prevention initiatives. These initiatives aim to promote mental wellbeing and social inclusion, reduce stigma and strengthen communities to be able to address suicide and suicidal behaviour.

Suicide prevention

Centrecare is the nongovernment organisation contracted to support the Ministerial Council for Suicide Prevention to implement the WA Suicide Prevention Strategy 2009-2013. Funding is being allocated to support the implementation of 50 community action plans and 50 agency action plans statewide.

AGENCY PERFORMANCE

Key achievements in 2010/11 continued

Following a series of suicides in 2011 in the Kimberley region of Western Australia, the Mental Health Commission provided additional funding to employ essential staff and to begin a long-term suicide prevention and community action plan for the region. An additional 11 temporary staff positions were appointed across the Kimberley to strengthen the Standby Suicide Response Strategy. In addition, the Kimberley Aboriginal Medical Services Council was allocated funding to employ and train four community coordinators (covering Wyndham and the East Kimberley region, Fitzroy Crossing and West Kimberley region, Broome, Derby and Halls Creek) to develop and implement the community action plans.

Community awareness

The Mental Health Commission provided funding to the WA Association of Mental Health to coordinate Mental Health Week (10 to 16 October 2010) and provide a series of statewide activities to increase community understanding of mental health issues and encourage help seeking behaviour.

The Mental Health Good Outcomes Award winners were announced during Mental Health Week. The Awards recognised outstanding individuals, groups and organisations in 11 categories. The 2010 Mental Health Good Outcomes Awards winners are listed in appendix three.

Additionally, the Commission contributed to an increase in community awareness and understanding of mental health issues and helped to break down stigma though various initiatives:

- A free statewide mental health magazine, 'Head 2 Head'.
- Four 'Let's Talk Culture' series forums designed to increase understanding of mental health issues and improve services for culturally and linguistically diverse, and Aboriginal communities. More than 700 people attended the forums which were a partnership with the University of Western Australia, Department of Health and Transcultural Mental Health Service.
- A free public forum attended by more than 150 people in May 2011 on 'Taking the Stigma out of Mental Illness'. Approximately 88% of attendees reported learning new ways to counter stigma as a result of the forum.

To engage young people, the Mental Health Commission invested in Music Feedback, an innovative multimedia anti stigma campaign. Music Feedback reached over 40,000 young people aged 12 to 25 years of age. The program encouraged young people to talk about mental health issues, seek help early and promote social inclusion. It was delivered in partnership with Ruah Community Services, Department for Communities (Office for Youth) and Inspire Foundation.

Music Feedback has since become a dynamic multiagency partnership to also include Cultural Infusion and the Indigenous Human Rights Network of Australia. A statewide publicity campaign to launch the 2011 CD/DVD production during National Youth Week in April was undertaken in partnership with the Office for Youth.

Collaboration with Cultural Infusion and the Office for Youth has also resulted in the development of a DIY Events Toolkit for young people to host their own Music Feedback branded events. The Commission has contributed funds as part of the partnership with the Office for Youth to continue this program.

In 2010, the Mental Health Commission contracted the Western Australian Association for Mental Health to host a series of symposia to promote dialogue about recovery which would inform the development of recovery practice and policies across the sector. The second of these symposia was held in April 2011.

The objectives were to:

- foster the development of partnerships across the sector, including consumers and carers, that lead to improved services and supports for people with a mental health problem and/or mental illness and their families
- consolidate participant understanding of recovery principles and practice.

Approximately 200 people attended including leaders in the nongovernment and public mental health sectors and consumer and carer representatives.

The Mental Health Commission also supported the visit in May 2011 of Consumer Consultant and former Mental Health Commissioner, Mary O'Hagan from New Zealand organised jointly by Consumers of Mental Health Western Australia and ARAFMI. She met with a range of people to increase the local understanding of how mental health experts can benefit from input from people with a lived experience.

AGENCY PERFORMANCE

Key achievements in 2010/11 continued

Strengthening partnerships

Developing strong connections at the policy, program and service levels is essential to achieving mental health reform. Developing interagency agreements and jointly planning initiatives between National and State Governments is a key component of building a more effective system of support and services for the community. Additionally, the Commission implemented workforce initiatives and targeted training; elements which are essential in achieving sustainable reform.

Personalised self directed community supports

To support and promote the introduction of increased personalisation, choice and individualisation in the provision of services and supports, the Mental Health Commission supported a range of training and development opportunities for individuals, families and carers, funded organisations and specialised mental health services. The aim of these initiatives was to focus on enhancing capacity and understanding of personalisation of services in the mental health sector through building and promoting joint partnerships.

Interagency collaboration

People with mental health problems and/or mental illness often experience other related social problems. The Mental Health Commission has played a major role in many interagency activities to ensure that co-occurring problems are addressed and there is a focus on helping people to lead productive lives:

- Joint facilitation of the Western Australian Collaboration for Substance Use and Mental Health (WACSUMH), which is working on integrated pathways, workforce development, prevention, promotion and early intervention to support people with a mental health problem and/or mental illness and drug and alcohol problems. WACSUMH is led by the Mental Health Commission and the Drug and Alcohol Office in partnership with the Commonwealth Department of Health and Ageing, the WA GP Network, Department of Health (Office of Aboriginal Health), the WA Public Mental Health Services, the WA Association of Mental Health and WA Networks of Alcohol and Other Drug Agencies.
- An across government program of intensive assistance for People with Exceptionally Complex Needs (PECN) involving seven agencies. Evaluation of the program, which was jointly funded by the Disability Services Commission, found most clients made significant improvements and two clients were discharged due to improvements in their life circumstances.
- Sponsorship of education events to enable Wraparound Milwaukee Director, Bruce Kamradt to meet with consumers, carers and representatives from the public, private and nongovernment sectors to learn about innovative approaches to delivering individualised support.
- Coordination of a whole of government submission to the Commissioner for Children and Young People's 'Inquiry into the Mental Health and Wellbeing of Children and Young People'. The inquiry found there was consensus across government on the need for further planning to promote illness prevention, treatment and support for infants, children and young people.
- Development of new formal arrangements with the Department of Health and the Department of Housing for all new mental health infrastructure initiatives in 2011/12.
- Commencement of planning for a comprehensive youth mental health service to provide developmentally appropriate mental health responses for young people and improve the transitions between child and adult mental health services. A shared vision, key priorities and good practice have been developed in consultation with representatives from Commonwealth, State and Local Government, community sector agencies, consumers and carers. This planning activity was supported by Professor Patrick McGorry, Clinical Director, Orygen Youth Health in Victoria, and 2010 Australian of the Year.
- Initiation of work with the Department of the Attorney General on a mental health court diversion service as recommended by the Law Reform Commission of Western Australia.
- Advanced planning on police diversion and transport options with the Western Australian Police and the Department of Corrective Services.
- Development of partnerships with the Department of Sport and Recreation to provide socially inclusive physical activity programs for high risk groups and people with a mental health problem and/or mental illness.

AGENCY PERFORMANCE

Key achievements in 2010/11 continued

- Identification of strategies for effectively addressing the mental health needs of infants and children in partnership with Child and Adolescent Health (from WA Health), Department for Communities, Curtin University of Technology and the Australian Association for Infant Mental Health Inc.
- Provision of funding for mental health first aid training.

Workforce development

Developing the capacity of the mental health workforce in Western Australia is a priority and the Mental Health Commission invested significant funding in this area including:

- supporting the Western Australian Association for Mental Health to provide workforce development and training to the nongovernment mental health sector
- additional child and adolescent psychiatry training positions in public mental health services
- scholarships for postgraduate studies in infant mental health
- supporting advanced training courses for rural and remote professional staff and perinatal mental health education for primary care professionals
- scholarships for nurses to attract them to pursue a career in mental health and for staff working in mental health services to undertake postgraduate studies in advanced mental health practice
- training to support workers to respond to co-occurring problems involving alcohol and other drugs and mental health
- training to assist the implementation of the national standards for mental health services
- supporting the development of the national cultural competency tool (NCCT), an instrument which will assist mental health services to embed processes that will increase their cultural responsiveness
- workforce development and training initiatives in the Department of Corrective Services, Public Trustees' Office and the Office of the Public Advocate to support responses for people with related health problems
- creating training opportunities that bring together consumers, carers and staff from the public and nongovernment sectors to enrich learning and solution building opportunities.

Research and evaluation

Research and evaluation are critical activities to build the capacity of the Mental Health Commission to develop evidence based policy options that address the needs of the community. Specific research and evaluation projects the Mental Health Commission contracted in 2010/11 included funding for:

- the School of Psychiatry and Clinical Neurosciences at the University of Western Australia to develop the clinical guidelines for the Physical Care of Mental Health Consumers Multisite Pilot Project
- the Western Australian Centre for Mental Health Policy Research to evaluate the long term effects of treatment in two specialised early intervention psychosis services in Western Australia
- the North Metropolitan Area Health Service to expand the Australian national survey of high impact psychosis study which aims to describe the prevalence and profile of psychosis in Australia and to identify factors associated with good outcomes
- Headwest to undertake research into the complex issues for people with acquired brain injury as they try to identify the most appropriate avenues to best meet their mental health needs.

AGENCY PERFORMANCE

Key achievements in 2010/11 continued

National partnerships

Western Australia signed the Heads of Agreement on National Health Reform in February 2011 allowing the state to benefit from the Council of Australian Governments (COAG) National Partnership Agreement on Improving Public Hospital Services. This agreement provides $351.6 million in Commonwealth Government funding to Western Australia between 2010/11 and 2013/14. Included in the agreement is $30.9 million for mental health services. The new funding includes additional subacute services, emergency department diversion services, capital upgrades and expanded community clinical teams for older adults in regional areas.

The COAG has also agreed to reward states and territories that deliver on nationally significant reforms through a series of National Partnership Agreements (NPA). The Mental Health Commission has supported the implementation of a number of NPAs that pertain specifically to mental health. These currently include Closing the Gap in Indigenous Health Outcomes, Homelessness and Improving Public Hospital Services.

In February 2011, the Australian Health Ministers Advisory Council (AHMAC) approved the development of two flagship initiatives to drive priority action areas in the Fourth National Mental Health Plan 2009-2014. The Queensland Health Department is leading the first initiative, social inclusion, and the Commonwealth Government is leading the second initiative which focuses on children and youth. The Commission will continue to work with respective lead agencies on the development and implementation of these initiatives.

The Mental Health Commission is represented on a number of national committees:

- Mental Health Standing Committee – represented by the Commissioner, this committee reports to the Australian Health Ministers' Conference (AHMC) through the Health Policy Priorities Principal Committee (HPPPC) and the Australian Health Ministers' Advisory Council (AHMAC). The key roles of the committee are to:
  - oversee and monitor the implementation of the current Fourth National Mental Health Plan and the 'COAG National Action Plan on Mental Health 2006-2011'
  - support cross jurisdictional communication and information exchange to improve both consistency and outcomes from national mental health reforms.
- Mental Health Information Strategy Subcommittee provides expert technical advice and, where required, recommends policy for consideration by the Mental Health Standing Committee.
- Safety and Quality Partnership Committee provides expert technical advice and recommendations on the development of national policy and strategic directions for safety and quality mental health. The committee may also provide advice in relation to monitoring and implementation of the national standards for mental health services.
- National Mental Health Workforce Advisory Committee is a subcommittee of the Mental Health Standing Committee (MHSC) and the Health Workforce Principal Committee (HWPC). It provides advice to MHSC and HWPC on mental health workforce related issues, with a particular focus on areas that may be appropriate for cross jurisdictional or national action.

Funded services

The Mental Health Commission is responsible for funding a wide range of clinical and nonclinical services and supports for consumers, their carers and their families.

This year more than $45 million was invested in nongovernment organisations for mental health services and supports including prevention and promotion, community support services and supported accommodation. This is in addition to substantial investment in public and private specialised mental health services. Services and supports are purchased using agreements that specify the level, price and quality of services to be provided. A summary of these services is shown in appendix one.

The Commission will be seeking over time to achieve an improved balance of services through future investment so that there is a significant increase in access to community based services. This direction has been reflected in the emphasis throughout the year of the important role of a sustainable and high quality community services sector, and the creation of opportunities for more personalised supports and services that assist people to live a good life in the community.

AGENCY PERFORMANCE

Key achievements in 2010/11 continued

Community sector support

Community sector support encompasses a range of direct services and supports for people with a mental health problem and/or mental illness, as well as prevention and promotion initiatives delivered for the wider community (for a summary of community sector agencies contracted by the Mental Health Commission, see appendix four). The Commission provided grant funding to the WA Association for Mental Health (WAAMH). This funding will assist WAAMH to develop the workforce and build capacity within the nongovernment mental health sector to engage with service reforms that address community needs and service sustainability.

The individual supports and services are provided in homes or residential facilities and include advocacy, psychosocial support, rehabilitation, housing support, day programs, residential services and respite care.

The Mental Health Commission provided additional funding for a range of community sector initiatives including:

- beyondblue for mental health promotion, research and support services
- expanding the Aussie Optimism Program to equip teachers to promote social and emotional wellbeing in schools
- enhancing the statewide Act-Belong-Commit campaign promoting the benefits of improving mental health and participating in healthy activities
- funding for ARAFMI to deliver the ARAFMI School Education Program to more than 60 schools in Perth and Bunbury, to dispel the myths around mental illness and to promote mental health
- expanded capacity for Youth Focus to assist more young people and their families to access counselling and support
- providing Lifeline with a grant to support their crisis telephone line.

The Commission also provided funding for culturally and linguistically diverse (CALD) initiatives for:

- the University of Western Australia to provide training in the national cultural competency tool (NCCT) which will be delivered over the next two years. The Community, Culture and Mental Health Unit at the University of Western Australia, will provide training for all public mental health services and all private and nongovernment organisations funded by the Commission to deliver a mental health service, including rural and remote mental health services
- the Stepping Out of the Shadows package for CALD communities to reduce stigma within these communities
- the production of the '6th Edition of the Directory of Bilingual/Bicultural Mental Health and General Practitioners' to support the mental health care of CALD clients.

Supported accommodation

Assisting people with a mental health problem and/or mental illness to access safe and affordable accommodation in our community is a priority for the Mental Health Commission. Almost half of all Mental Health Commission funding to nongovernment agencies was for supported accommodation services. More than 1,670 supported accommodation places were provided that assisted people with accommodation and to build connections in the community.

Thirty new dwellings for people with a mental health problem and/or mental illness were made available through the nation building economic stimulus plan in partnership with the Department of Housing. Nine units in the south metropolitan area and 21 in the north metropolitan area were provided for people who were homeless or at risk of homelessness.

Specialised services

Specialised mental health services deliver mental health assessment, clinical intervention and rehabilitation across a range of settings, including inpatient (hospital) and in the community. These services aim to reduce symptoms of mental illness and facilitate recovery.

An overview of the specialised mental health services funded by the Commission is provided in appendix one.

AGENCY PERFORMANCE

Key achievements in 2010/11 continued

Community based clinical services were expanded through:

- a new community based centre for young people with Attention Deficit Hyperactivity Disorder at Murdoch University that provides consultation, assessment and short term treatment intervention for children and adolescents aged up to 18 years
- new facilities at the Wheatbelt Mental Health Service's Northam Clinic to improve delivery of services for the community and to support the retention of staff in the region
- support for the establishment of the recovery centre in Broome
- new funding to establish a dedicated Statewide Specialist Aboriginal Mental Health Service to provide comprehensive assessment and treatment interventions for Aboriginal people with a serious mental health problem and/or mental illness. The initiative is part of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.

Hospital based clinical services were expanded:

- Broome Inpatient Unit: Site works commenced in January 2011 and a new specialised mental health inpatient unit at Broome Hospital is expected to be completed in early 2012, with a phased opening of a 14 bed inpatient unit.
- Rockingham Inpatient Unit: Starting in November 2010, the specialised mental health inpatient unit in Rockingham Hospital opened with 20 beds initially, with the full capacity of 30 inpatient beds to become available in 2011/12.
- Bentley Mental Health Families at Work: In October 2010, the Bentley Mental Health Families at Work unit reopened following an upgrade to the unit and redevelopment of the program for young people aged eight to 13 years with social, emotional or behavioural problems.
- Bentley Adolescent Inpatient Unit: Funding was allocated for refurbishment to improve the living environment for young people with complex mental health issues aged between 13 and 18 years and to provide staff training and development.
- Specialised Mental Health Inpatient Services: The Mental Health Commission provided significant additional funding to the Department of Health for repairs and minor works to specialised inpatient services highlighted in the Council of Official Visitors annual report 2009/10.

AGENCY PERFORMANCE

Significant issues impacting the Mental Health Commission

This year was marked by the emergence of key issues raised by the Western Australian community, as well as the development of some of the key strategic directions for the Mental Health Commission.

- In line with the State Government's '*Delivering Community Services in Partnership Policy*', and as an active member of the Partnership Forum which is working to strengthen the community sector, the Mental Health Commission will continue to expand the role of the community sector in mental health service delivery, with a clearer focus on outcomes and a greater individual focus for services and funding. In addition, the Mental Health Commission will be progressively implementing the Western Australian Government's procurement reforms that are aimed at reducing the burden of bureaucracy on community sector organisations.
- The Mental Health Commission supports access to greater opportunities for **self directed supports**. Individualised supports and funding will ensure people with a mental health problem and/or mental illness, their families, carers and supporters have opportunities for greater control over the supports and services they access. The Mental Health Commission will continue to promote the adoption of self directed services across the sector.
- Many people with a mental health problem and/or mental illness are at risk of becoming isolated from the people around them. Community coordination will support people with a mental health problem and/or mental illness to build relationships and reconnect with their communities as a means to reduce social isolation. **Community coordinators** will work directly with people with a mental health problem and/or mental illness and their families to help plan, coordinate and access the supports people require to aid their recovery and sustain a good life in the community.
- Some of the unique economic features of our State are having an impact on the mental health and wellbeing of the community. The mining boom has seen significant growth in the number of **fly-in fly-out** families with the associated mental health problems facing both the workers and the families left at home. **Drought** too has impacted particularly on our rural communities. Innovative ways of working with rural and remote communities will be developed to improve the availability of supports and services, particularly in the area of **suicide prevention**.
- It is estimated that 75% of all severe mental illness begins before the age of 24 years with a peak onset between 18 and 24 years of age.[4]
  - The Commission recognises the importance of supporting infants and children and the strong relationship between early childhood experiences and future mental health and wellbeing. Infancy and early childhood is the most influential developmental stage for promoting good mental health and modifying or preventing the development of mental health problems.
  - The prevalence of mental health issues in young people is disproportionately high. If this trend is not addressed, these young people will not develop to their full potential in leading meaningful lives, and adult mental health services will be unduly strained. The Commission will enhance youth mental health services in Western Australia to be more youth-friendly, specialised and integrated.
  - **Early intervention** has been shown to have the greatest impact on health and mental health outcomes. The Commission is developing key strategies for intervening earlier in mental health problems to reduce the negative impact of mental illness on people, families and communities.
- One of the key objectives for people with a mental health problem and/or mental illness and their families is to **stay out of hospital** and keep well in the community. The Mental Health Commission is developing a framework for the essential mix of community based supports and services, including **subacute services** in both a residential and home based setting.
- Mental health is also a priority on the national agenda and for Western Australia. This has meant balancing the state reform agenda with the national imperatives. In the coming year, the National Health Reforms are likely to continue to impact significantly with the roll out of the Ten Year Roadmap, the **National Partnership on Mental Health Reform**, Local Hospital Networks and Medicare Locals. Significant and enduring psychiatric disability has now been included in proposals for the new National Disability Insurance Scheme and the Commission will carefully monitor progress in this area.

4 Commonwealth of Australian 2004. 'Responding to the mental health needs of young people in Australia: discussion paper, principles and strategies', Canberra.

Significant issues impacting the Mental Health Commission continued

- People with a mental health problem and/or mental illness are over represented at all stages of the **criminal justice** system, and more appropriate mental health service intervention is essential. The Mental Health Commission is working closely in partnership with other agencies and departments, including the Department of the Attorney General, Western Australian Police and the Department of Corrective Services to develop alternative strategies to taking people into custody.
- Connecting with **partner agencies** in the development of mental health reform is a key community expectation. The Mental Health Commission will continue to develop constructive partnerships with key government departments to deliver more effective reform, including joint planning and integrated commissioning of services. It will also continue to refine its relationship with the Department of Health.

DISCLOSURE AND LEGAL COMPLIANCE

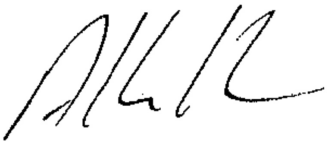
Financial statements

Certification of financial statements

MENTAL HEALTH COMMISSION
CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2011

The accompanying financial statements of the Mental Health Commission have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to represent fairly the financial transactions for the year ended 30 June 2011 and the financial position as at 30 June 2011.

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.



Annette Keller
Chief Finance Officer
Mental Health Commission

Date: 14 September 2011

Eric Dillon
A/Accountable Authority
Mental Health Commission

Date: 14 September 2011

DISCLOSURES AND LEGAL COMPLIANCE

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

MENTAL HEALTH COMMISSION

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

The financial statements comprise the Statement of Financial Position as at 30 June 2011, 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.

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

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

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

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

Opinion
In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the financial position of the Mental Health Commission at 30 June 2011 and its financial performance and cash flows for the year then ended. They are in accordance with Australian Accounting Standards and the Treasurer's Instructions.

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

DISCLOSURES AND LEGAL COMPLIANCE

Mental Health Commission

Report on Controls
I have audited the controls exercised by the Mental Health Commission. The Commissioner is responsible for ensuring that adequate control is maintained over the receipt, expenditure and investment of money, the acquisition and disposal of public and other property, and the incurring of liabilities in accordance with the Financial Management Act 2006 and the Treasurer's Instructions, and other relevant written law.

As required by the Auditor General Act 2006, my responsibility is to express an opinion on the controls exercised by the Commissioner based on my audit conducted in accordance with Australian Auditing Standards.

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

Report on the Key Performance Indicators
I have audited the key performance indicators of the Mental Health Commission. 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.

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

Opinion
In my opinion, the key performance indicators of the Mental Health Commission are relevant and appropriate to assist users to assess the Commission's performance and fairly represent indicated performance for the year ended 30 June 2011.

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

COLIN MURPHY
AUDITOR GENERAL
16 September 2011

DISCLOSURES AND LEGAL COMPLIANCE

Financial statements continued

Statement of comprehensive income

For the year ended 30 June 2011

	Note	2011 12 mths $	2010 4 mths $
COST OF SERVICES			
Expenses			
Employee benefits expense	6	5,569,448	1,485,946
Contracts for services	7	482,235,386	14,131,238
Supplies and services	8	1,294,867	245,658
Grants and subsidies	9	1,247,803	39,619
Other expenses	10	345,749	34,209
Total cost of services		**490,693,253**	**15,936,670**
Income			
Revenue			
Grants and contributions	11	2,592,089	–
Recoveries		12,205	1,900
Total revenue		**2,604,294**	**1,900**
Total income other than income from State Government		**2,604,294**	**1,900**
NET COST OF SERVICES		**488,088,959**	**15,934,770**
Income from State Government			
Service appropriation	12	486,570,000	16,704,000
Resources received free of charge	12	3,624	120,260
Total income from State Government		**486,573,624**	**16,824,260**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(1,515,335)**	**889,490**
OTHER COMPREHENSIVE INCOME		**–**	**–**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(1,515,335)**	**889,490**

Refer also to the 'schedule of income and expenses by service'.

The statement of comprehensive income should be read in conjunction with the accompanying notes.

DISCLOSURES AND LEGAL COMPLIANCE

Financial statements continued

Statement of financial position

As at 30 June 2011

	Note	2011 $	2010 $
ASSETS			
Current Assets			
Cash and cash equivalents		3,081,687	4,074,865
Receivables		319,042	–
Total Current Assets		3,400,729	4,074,865
Non-Current Assets			
Restricted cash and cash equivalents	13	88,320	–
Total Non-Current Assets		88,320	–
TOTAL ASSETS		**3,489,049**	**4,074,865**
LIABILITIES			
Current Liabilities			
Payables	14	1,898,657	1,340,073
Provisions	15	1,086,059	821,839
Total Current Liabilities		2,984,716	2,161,912
Non-Current Liabilities			
Provisions	15	184,278	135,301
Total Non-Current Liabilities		184,278	135,301
TOTAL LIABILITIES		**3,168,994**	**2,297,213**
NET ASSETS		**320,055**	**1,777,652**
EQUITY			
Contributed equity	16	945,900	888,162
Accumulated surplus/(deficit)	16	(625,845)	889,490
TOTAL EQUITY		**320,055**	**1,777,652**

The statement of financial position should be read in conjunction with the accompanying notes

DISCLOSURES AND LEGAL COMPLIANCE

Financial statements continued

Statement of changes in equity

For the year ended 30 June 2011

	Note	2011 $	2010 $
CONTRIBUTED EQUITY	16		
Balance at start of period		888,162	–
Transactions with owners in their capacity as owners:			
Contributions by owners		57,738	888,162
Balance at end of period		**945,900**	**888,162**
ACCUMULATED SURPLUS	16		
Balance at start of period		889,490	–
Surplus/(Deficit) for the period		(1,515,335)	889,490
Balance at end of period		**(625,845)**	**889,490**
TOTAL EQUITY			
Balance at start of period		1,777,652	–
Total comprehensive income/(loss) for the period		(1,515,335)	889,490
Transactions with owners in their capacity as owners		57,738	888,162
Balance at end of period		**320,055**	**1,777,652**

The statement of changes in equity should be read in conjunction with the accompanying notes.

DISCLOSURES AND LEGAL COMPLIANCE

Financial statements continued

Statement of cash flows

For the year ended 30 June 2011

	Note	2011 12 mths $	2010 4 mths $
		Inflows (Outflows)	Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations	12	486,570,000	16,704,000
Net cash provided by State Government		**486,570,000**	**16,704,000**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(4,980,452)	(1,039,956)
Contracts for services		(481,950,207)	(11,430,744)
Supplies and services		(1,299,982)	(95,370)
Grants and subsidies		(1,245,358)	(39,619)
Other payments		(343,492)	(25,346)
Receipts			
Grants and contributions		2,274,690	1,900
Recoveries		12,205	–
Net cash (used in)/provided by operating activities	**17**	**(487,532,596)**	**(12,629,135)**
Net increase/(decrease) in cash and cash equivalents		(962,596)	4,074,865
Cash and cash equivalents at the beginning of period		4,074,865	–
Cash and cash equivalents transferred from other sources		57,738	–
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	17	**3,170,007**	**4,074,865**

The statement of cash flows should be read in conjunction with the accompanying notes.

DISCLOSURES AND LEGAL COMPLIANCE

Financial statements continued

Schedule of income and expenses by service

For the year ended 30 June 2011

	Specialised Mental Health Admitted Patients		Specialised Community Mental Health		TOTAL	
	2011 12 mths $	2010 4 mths $	2011 12 mths $	2010 4 mths $	2011 12 mths $	2010 4 mths $
COST OF SERVICES						
Expenses						
Employee benefits expense	2,826,757	–	2,742,691	1,485,946	5,569,448	1,485,946
Contracts for services	244,757,122	–	237,478,264	14,131,238	482,235,386	14,131,238
Supplies and services	657,206	–	637,661	245,658	1,294,867	245,658
Grants and subsidies	633,319	–	614,484	39,619	1,247,803	39,619
Other expenses	175,484	–	170,265	34,209	345,749	34,209
Total cost of services	249,049,888	–	241,643,365	15,936,670	490,693,253	15,936,670
Income						
Grants and contributions	1,315,607	–	1,276,482	–	2,592,089	–
Recoveries	6,195	–	6,010	1,900	12,205	1,900
Total income other than income from State Government	1,321,802	–	1,282,492	1,900	2,604,294	1,900
NET COST OF SERVICES	247,728,086	–	240,360,873	15,934,770	488,088,959	15,934,770
Income from State Government						
Service appropriation	246,957,144	–	239,612,856	16,704,000	486,570,000	16,704,000
Resources received free of charge	1,839	–	1,785	120,260	3,624	120,260
Total income from State Government	246,958,983	–	239,614,641	16,824,260	486,573,624	16,824,260
SURPLUS/(DEFICIT) FOR THE PERIOD	(769,103)	–	(746,232)	889,490	(1,515,335)	889,490

The schedule of income and expenses by service should be read in conjunction with the notes to the financial statements.

DISCLOSURES AND LEGAL COMPLIANCE

Financial statements continued

Schedule of assets and liabilities by service

As at 30 June 2011

	Specialised Mental Health Admitted Patients		Specialised Community Mental Health		TOTAL	
	2011 $	2010 $	2011 $	2010 $	2011 $	2010 $
ASSETS						
Current assets	1,564,101	–	1,836,628	4,074,865	3,400,729	4,074,865
Non-current assets	44,827	–	43,493	–	88,320	–
Total Assets	1,608,928	–	1,880,121	4,074,865	3,489,049	4,074,865
LIABILITIES						
Current liabilities	852,310	–	2,132,406	2,161,912	2,984,716	2,161,912
Non-current liabilities	93,530	–	90,748	135,301	184,278	135,301
Total Liabilities	945,840	–	2,223,154	2,297,213	3,168,994	2,297,213
NET ASSETS	663,088	–	(343,033)	1,777,652	320,055	1,777,652

The schedule of assets and liabilities by service should be read in conjunction with the notes to the financial statements.

DISCLOSURES AND LEGAL COMPLIANCE

Financial statements continued

Summary of consolidated account appropriations and income estimates

For the year ended 30 June 2011

	2011 Estimate 12 mths $	2011 Actual 12 mths $	Variance $	2011 Actual 12 mths $	2010 Actual 4 mths $	Variance $
Delivery of Services						
Item 98 Net amount appropriated to deliver services	506,313,000	486,322,000	(19,991,000)	486,322,000	16,625,000	469,697,000
Amount Authorised by Other Statutes						
– *Salaries and Allowances Act 1975*	248,000	248,000	–	248,000	79,000	169,000
Total appropriations provided to deliver services	506,561,000	486,570,000	(19,991,000)	486,570,000	16,704,000	469,866,000
Details of Expenses by Service						
Specialised Mental Health Admitted Patient	231,083,000	249,049,888	17,966,888	249,049,888	–	249,049,888
Specialised Community Mental Health	277,098,000	241,643,365	(35,454,635)	241,643,365	15,936,670	225,706,695
Total Cost of Services	508,181,000	490,693,253	(17,487,747)	490,693,253	15,936,670	474,756,583
Less Total income	(670,000)	(2,604,294)	(1,934,294)	(2,604,294)	(1,900)	(2,602,394)
Net Cost of Services	507,511,000	488,088,959	(19,422,041)	488,088,959	15,934,770	472,154,189
Adjustments (a)	(950,000)	(1,518,959)	(568,959)	(1,518,959)	769,230	(2,288,189)
Total appropriations provided to deliver services	506,561,000	486,570,000	(19,991,000)	486,570,000	16,704,000	469,866,000

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

Note 25 'explanatory statement' provides details of any significant variations between estimates and actual results for 2011 and between actual results for 2010 and 2011.

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements

For the year ended 30 June 2011

Note 1 Australian Accounting Standards

General

The Commission's financial statements for the year ended 30 June 2011 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' includes Standards and Interpretations issued by the Australian Accounting Standard Board (AASB).

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

Early adoption of standards

The Commission cannot early adopt an Australian Accounting Standard unless specifically permitted by Treasurer's Instruction 1101 *'Application of Australian Accounting Standards and Other Pronouncements'.* No Australian Accounting Standards that have been issued or amended but are not operative have been early adopted by the Commission for the annual reporting period ended 30 June 2011.

Note 2 Summary of significant accounting policies

(a) General statement

The financial statements constitute general purpose financial statements that have been prepared in accordance with Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board as applied by the Treasurer's instructions. Several of these are modified by the Treasurer's instructions to vary application, disclosure, format and wording.

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

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

(b) Basis of preparation

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

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

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

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

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

(c) Reporting entity

The reporting entity comprises the Commission only.

Mission

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

The Commission is predominantly funded by Parliamentary appropriations.

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

Note 2 Summary of significant accounting policies (continued)

Services

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

Information about these services, income, expenses, assets and liabilities which are reliably attributable to those services are set out in the 'Schedule of Income and Expenses by Service' and the 'Schedule of Assets and Liabilities by Service'.

For the period 8 March 2010 to 30 June 2010, the Commission only operated under one service which is the 'Specialised community mental health'. Consequently, there was no requirement to prepare the 'Schedule of Income and Expenses by Service' and the 'Schedule of Assets and Liabilities by Service' for the previous financial year. From 1 July 2010, the Commission has also purchased the 'Specialised mental health admitted patient services'.

Specialised Mental Health Admitted Patients

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

Specialised Community Mental Health

Specialised community mental health is defined as those services with a primary function to provide community-based (non-admitted) care to people with mental disorders. Community mental health care comprises a range of community-based services including emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial and residential services provided by government agencies or non-government organisations.

(d) Contributed equity

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

The transfer of net assets to/from other agencies, other than as a result of a restructure of administrative arrangements, are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal. Refer also to note 16 'Contributed equity'.

(e) Income

Revenue recognition

Revenue is recognised and measured at the fair value of consideration received or receivable. Specific recognition criteria must be met before revenue is recognised as follows:

Service appropriations

Service Appropriations are recognised as revenues at fair value in the period in which the Commission gains control of the appropriated funds. The Commission gains control of appropriated funds at the time those funds are deposited to the bank account. Refer to note 12 'Income from State Government' for further information."

Net appropriation determination

The Treasurer may make a determination providing for prescribed receipts to be retained for services under the control of the Commission. A determination was not made for the 2009-2010 financial year. In accordance with the determination specified in the 2010-2011 Budget Statements, the Commission retained $2,604,294 in 2011 from the following:

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

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

Note 2 Summary of significant accounting policies (continued)

Grants, donations, gifts and other non-reciprocal contributions

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

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

Gains

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

(f) Leases

Leases of property, plant and equipment, where the Commission has substantially all of the risks and rewards of ownership, are classified as finance leases. The Commission does not have any finance leases.

Leases in which the lessor retains significantly all of the risks and rewards of ownership are classified as operating leases.

The Commission holds operating leases for office accomodation and equipment. Operating lease payments are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased items.

(g) Financial instruments

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

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

Financial instruments have been disaggregated into the following classes:

Financial assets

- Restricted cash and cash equivalents
- Cash and cash equivalents
- Receivables

Financial liabilities

- Payables

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

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

(h) Cash and cash equivalents

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

(i) Accrued salaries

Accrued salaries (see note 14 'Payables') represent the amount due to employees but unpaid at the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Commission considers the carrying amount of accrued salaries to be equivalent to its net fair value.

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

Note 2 Summary of significant accounting policies (continued)

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

(j) Receivables

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

Refer to note 2(g) 'Financial Instruments' .

Accounting procedure for Goods and Services Tax

Rights to collect amounts receivable from the Australian Taxation Office and responsibilities to make payment for GST were assigned on the 1st January 2006 to the Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals (Metropolitan Health Services). This change in accounting procedure was a result of application of the grouping provisions of "A New Tax System (Goods and Service Tax) Act 1999" whereby the Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals became the representative member for Health entities as part of governments' shared services initiative.

(k) Payables

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

Refer to note 2(g) 'Financial Instruments' and note 14 'Payables'.

(l) Provisions

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

Refer to note 15 'Provisions'.

Provisions – employee benefits

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

Annual leave

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

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

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

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

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

Note 2 Summary of significant accounting policies (continued)

Long service leave

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

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

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

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

Sick leave

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

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

Deferred leave

The provision for deferred leave relates to the Commission's employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. In the fifth year they will receive an amount equal to 80% of the salary they were otherwise entitled to in the fourth year of deferment. The provision recognises the value of salary set aside for employees to be used in the fifth year. The liability has been calculated on current remuneration rates in respect of services provided by the employees up to the end of the reporting period and includes related on-costs. Deferred leave is reported as a non-current provision until the fifth year.

Superannuation

The Government Employees Superannuation Board (GESB) administers public sector superannuation arrangements in Western Australia in accordance with legislative requirements.

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

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

The Commission has no liabilities under the Pension Scheme or the GSS. The liabilities for the unfunded Pension Scheme and the unfunded GSS transfer benefits attributable to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS obligations are funded by concurrent contributions made by the Commission to the GESB. The concurrently funded part of the GSS is a defined contribution scheme as these contributions extinguish all liabilities in respect of the concurrently funded GSS obligations.

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

Note 2 Summary of significant accounting policies (continued)

Employees commencing employment prior to 16 April 2007 who were not members of either the Pension or the GSS Schemes became non-contributory members of the West State Superannuation Scheme (WSS). Employees commencing employment on or after 16 April 2007 became members of the GESB Super Scheme (GESBS). Both of these schemes are accumulation schemes. The Commission makes concurrent contributions to GESB on behalf of employees in compliance with the *Commonwealth Government's Superannuation Guarantee (Administration) Act 1992*. These contributions extinguish the liability for superannuation charges in respect of the WSS and GESBS Schemes.

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

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

Employment on-costs

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

Refer to note 10 'Other expenses' and note 15 'Provisions'.

(m) Superannuation expense

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

(n) Resources received free of charge or for nominal cost

Resources received free of charge or for nominal cost that can be reliably measured are recognised as income at fair value. Where the resource received represents a service that the Commission would otherwise pay for, a corresponding expense is recognised. Receipts of assets are recognised in the Statement of Financial Position.

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

(o) Comparative figures

The Commission commenced operations on the 8th March 2010. Therefore the comparative figures reflected are for a period of four months only. Comparative figures are, where appropriate, reclassified to be comparable with the figures presented in the current financial year.

Note 3 Judgements made by management in applying accounting policies

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

Employee benefits provision

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

Operating lease commitments

The Commission has entered into a lease arrangement for office accommodation. It has been determined that the lessor retains substantially all the risks and rewards incidental to ownership. Accordingly, the lease has been classified as an operating lease.

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

Note 4 Key sources of estimation uncertainty

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

Employee benefits provision

In estimating the non-current long service leave provision, employees are assumed to leave the Commission each year on account of resignation or retirement at 10.8%. This assumption was based on an analysis of the turnover rates exhibited by employees over a five years period. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

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

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Commission has applied the following Australian Accounting Standards effective for annual reporting periods beginning on or after 1 July 2010 that impacted on the Commission.

Title	
AASB 2009-5	*Further Amendments to Australian Accounting Standards arising from the Annual Improvements Project [AASB 5, 8, 101, 107, 117, 118, 136 & 139]* There is no financial impact on the Commission resulting from the application of this revised Standard.

The following Australian Accounting Standards and Interpretations are not applicable to the Commission as they have no impact or do not apply to not-for-profit entities:

Interpretation 19	*Extinguishing Financial Liabilities with Equity Instruments*
AASB 2009-13	*Amendments to Australian Accounting Standards arising from Interpretation 19 [AASB 1]*
AASB 2010-1	*Amendments to Australian Accounting Standards – Limited Exemption from Comparative AASB 7 Disclosures for First-time Adopters [AASB 1 & AASB 7]*
AASB 2010-3	*Amendments to Australian Accounting Standards arising from the Annual Improvements Project [AASB 3, AASB 7, AASB 121, AASB 128, AASB 131, AASB 132 & AASB 139]*

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

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

Future impact of Australian Accounting Standards not yet operative

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

Title		Operative for reporting periods beginning on/after
AASB 2009-11	*Amendments to Australian Accounting Standards arising from AASB 9 [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 121, 127, 128, 131, 132, 136, 139, 1023 & 1038 and Interpretations 10 & 12].* The amendment to AASB 7 *'Financial Instruments: Disclosures'* requires modification to the disclosure of categories of financial assets. The Commission does not expect any financial impact when the Standard is first applied. The disclosure of categories of financial assets in the notes will change.	1 Jan 2013
AASB 2009-12	*Amendments to Australian Accounting Standards [AASBs 5, 8, 108, 110, 112, 119, 133, 137, 139, 1023 & 1031 and Interpretations 2, 4, 16, 1039 & 1052]* This Standard introduces a number of terminology changes. There is no financial impact resulting from the application of this revised Standard.	1 Jan 2011
AASB 1053	*Application of Tiers of Australian Accounting Standards* This Standard establishes a differential financial reporting framework consisting of two tiers of reporting requirements for preparing general purpose financial statements. The Standard does not have any financial impact on the Commission. However it may affect disclosures in the financial statements of the Commission if the reduced disclosure requirements apply. The Department of Treasury and Finance has not yet determined the application or the potential impact of the new Standard for agencies.	1 July 2013
AASB 2010-2	*Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements* This Standard makes amendments to many Australian Accounting Standards, including Interpretations, to introduce reduced disclosure requirements into these pronouncements for application by certain types of entities. The Standard is not expected to have any financial impact on the Commission. However this Standard may reduce some note disclosures in financial statements of the Commission. The Department of Treasury and Finance has not yet determined the application or the potential impact of the amendments to these Standards for agencies.	1 July 2013

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

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

Title		Operative for reporting periods beginning on/after
AASB 2011-2	*Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project – Reduced Disclosure Requirements [AASB 101 & 1054]* This Amending Standard removes disclosure requirements from other Standards and incorporates them in a single Standard to achieve convergence between Australian and New Zealand Accounting Standards for reduced disclosure reporting. The Department of Treasury and Finance has not yet determined the application or the potential impact of the amendments to these Standards for agencies.	1 July 2011
AASB 2010-5	*Amendments to Australian Accounting Standards [AASB 1, 3, 4, 5, 101, 107, 112, 118, 119, 121, 132, 133, 134, 137, 139, 140, 1023 & 1038 and Interpretations 112, 115, 127, 132 & 1042] (October 2010)* This Standard introduces a number of terminology changes as well as minor presentation changes to the Notes to the Financial Statements. There is no financial impact resulting from the application of this revised Standard.	1 Jan 2011
AASB 2010-6	*Amendments to Australian Accounting Standards – Disclosures on Transfers of Financial Assets [AASB 1 & AASB 7]* This Standard makes amendments to Australian Accounting Standards, introducing additional presentation and disclosure requirements for Financial Assets. The Standard is not expected to have any financial impact on the Commission. The Department of Treasury and Finance has not yet determined the application or the potential impact of the amendments to these Standards for agencies.	1 July 2011
AASB 9	*Financial Instruments* This Standard supersedes AASB 139 Financial Instruments: Recognition and Measurement, introducing a number of changes to accounting treatments. The Standard was reissued on 6 December 2010. The Department of Treasury and Finance has not yet determined the application or the potential impact of the Standard for agencies.	1 Jan 2013
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Interpretations 2, 5, 10, 12, 19 & 127]* This Amending Standard makes consequential adjustments to other Standards as a result of issuing AASB 9 Financial Instruments in December 2010. The Department of Treasury and Finance has not yet determined the application or the potential impact of the Standard for agencies.	1 Jan 2013
AASB 1054	*Australian Additional Disclosures* This Standard, in conjunction with AASB 2011-1 Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project, removes disclosure requirements from other Standards and incorporates them in a single Standard to achieve convergence between Australian and New Zealand Accounting Standards.	1 July 2011

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

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

Title		Operative for reporting periods beginning on/after
AASB 2011-1	*Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project [AASB 1, 5, 101, 107, 108, 121, 128, 132 & 134 and Interpretations 2, 112 & 113]* This Amending Standard, in conjunction with AASB 1054 Australian Additional Disclosures, removes disclosure requirements from other Standards and incorporates them in a single Standard to achieve convergence between Australian and New Zealand Accounting Standards.	1 July 2011

Note 6 Employee benefits expense

	2011 12 mths $	2010 4 mths $
Salaries and wages (a)	5,197,361	1,380,459
Superannuation – defined contribution plans (b)	372,087	105,487
	5,569,448	1,485,946

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

(b) Defined contribution plans include West State, Gold State and GESB Super Schemes (contributions paid).

Employment on-costs, such as workers' compensation insurance, are included at note 10 'Other expenses'.

Employment on-costs liability is included at note 15 'Provisions'.

Note 7 Contracts for services

Payments to public hospitals	433,313,299	–
Payments to other organisations	48,922,087	14,131,238
	482,235,386	14,131,238

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

Note 8 Supplies and services

Advertising	58,991	14,160
Communication	37,862	4,576
Computer related services	17,141	22,840
Consulting fees	439,778	64,572
Consumables	152,997	10,302
Operating lease expenses	479,229	125,028
Shared services charges	99,600	–
Other	9,269	4,180
	1,294,867	245,658

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

	2011 12 mths $	2010 4 mths $

Note 9 Grants and subsidies

Recurrent

Grants	1,159,654	5,991
Scholarships	88,149	33,628
	1,247,803	39,619

Note 10 Other expenses

Employment on-costs (a)	154,893	16,413
Repairs and maintenance	14,559	5,570
Travel related expenses	12,080	1,681
Audit fees	28,700	–
Legal fees	25,165	–
Other	110,352	10,545
	345,749	34,209

(a) Includes staff training and transport cost. The on-costs liability associated with the recognition of annual and long service leave liability is included at note 15 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Note 11 Grants and contributions

Disability Services Commission	1,799,289	–
Other	792,800	–
	2,592,089	–

Note 12 Income from State Government

Service appropriations (a)

Amount appropriated to deliver services	486,322,000	16,625,000
Amount authorised by other statutes:		
Salaries and Allowances Act 1975	248,000	79,000
	486,570,000	16,704,000

Resources received free of charge (b)

Determined on the basis of the following estimates provided by agencies:		
Health Corporate Network – office accommodation	–	83,904
Department of Health – office fit-out	–	36,356
State Solicitor's Office – legal advice	3,624	–
	3,624	120,260

(a) Service appropriations fund the net cost of services delivered. See note 2(e) 'Income'.

(b) Where assets and/or services have been received free of charge or for nominal cost, the Commission recognises revenues equivalent to the fair value of the assets and/or services that can be reliably measured and which would have been purchased if they were not donated. Contributions of assets or services in the nature of contributions by owners are recognised directly to equity.

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

	2011 $	2010 $

Note 13 Restricted cash and cash equivalents

Non-current

Accrued salaries suspense account (a)	88,320	–

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

Note 14 Payables

Current

Trade creditors	17,232	58,290
Accrued salaries	175,764	93,926
Accrued expenses	1,705,661	1,187,857
	1,898,657	1,340,073

Refer to note 2(k) 'Payables' and note 26 'Financial Instruments'.

Note 15 Provisions

Current

Employee benefits provision

Annual leave (a)	407,801	286,866
Long service leave (b)	524,379	401,528
Deferred salary scheme	153,879	133,445
	1,086,059	821,839

Non-current

Employee benefits provision

Long service leave (b)	184,278	135,301
	1,270,337	957,140

(a) Annual leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after the reporting period. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of the end of the reporting period	290,241	202,233
More than 12 months after the reporting period	117,560	84,633
	407,801	286,866

(b) Long service leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after the reporting period. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of the end of the reporting period	133,324	101,818
More than 12 months after the reporting period	575,333	435,011
	708,657	536,829

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

	2011 $	2010 $

Note 16 Equity

The Government holds the equity interest in the Commission on behalf of the community. Equity represents the residual interest in the net assets of the Commission.

Contributed equity

Balance at start of year	888,162	–
Transfer of net assets from the Department of Health (a)	57,738	888,162
Balance at end of year	945,900	888,162

(a) AASB 1004 *'Contributions'* requires transfers of net assets as a result of a restructure of administrative arrangements to be accounted for as contributions by owners and distributions to owners.

Treasurer's Instruction 955 *'Contributions by Owners Made to Wholly Owned Public Sector Entities'* designates non-discretionary and non-reciprocal transfers of net assets between state government agencies as contributions by owners in accordance with AASB Interpretation 1038 *'Contributions by Owners Made to Wholly-Owned Public Sector Entities'*. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.

Accumulated surplus

Balance at start of year	889,490	–
Result for the period	(1,515,335)	889,490
Balance at end of year	(625,845)	889,490

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

	2011 12 mths $	2010 4 mths $

Note 17 Notes to the statement of cash flows

Reconciliation of cash

Cash at the end of the financial year as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:

Cash and cash equivalents	3,081,687	4,074,865
Restricted cash and cash equivalents (refer to note 13)	88,320	–
	3,170,007	4,074,865

Reconciliation of net cost of services to net cash flows used in operating activities

Net cost of services (Statement of Comprehensive Income)	(488,088,959)	(15,934,770)
Non-cash items:		
Resources received free of charge	3,624	120,260
(Increase)/decrease in assets:		
Receivables	(319,042)	–
Prepayments	–	1,683,834
Increase/(decrease) in liabilities:		
Payables	558,584	1,340,073
Provisions	313,197	161,468
Net cash used in operating activities (Statement of Cash Flows)	(487,532,596)	(12,629,135)

At the end of the reporting period, the Commission had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

	2011 12 mths $	2010 4 mths $

Note 18 Commitments

Operating lease commitments

Commitments in relation to non-cancellable operating leases are payable as follows:

Within 1 year	9,504	9,504
Later than 1 year and not later than 5 years	7,920	19,008
	17,424	28,512

The leases are non-cancellable, with rent payable monthly in advance. Operating leases relating to office equipment do not have contingent rental obligations. There are no restrictions imposed by these leasing arrangements on other financing transactions.

The operating lease commitments are inclusive of GST.

Contracts for the provision of mental health services

Expenditure commitments in relation to private hospitals and non government organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:

Within 1 year	65,874,789	47,376,529
Later than 1 year and not later than 5 years	21,553,122	58,582,262
Later than 5 years and not later than 10 years	16,781,790	24,870,732
	104,209,701	130,829,523

The other expenditure commitments are inclusive of GST.

	2011 12 mths	2010 4 mths

Note 19 Remuneration of senior officers

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

$ 40,001	–	$ 50,000	–	1
$ 60,001	–	$ 70,000	–	
$ 50,001	–	$ 60,000	–	1
$ 70,001	–	$ 80,000	–	1
$130,001	–	$140,000	2	–
$140,001	–	$150,000	1	–
$150,001	–	$160,000	1	–
$160,001	–	$170,000	1	–
$220,001	–	$230,000	1	–
			6	3

	$	$
The total remuneration of senior officers is:	953,975	176,507

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

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

	2011 12 mths	2010 4 mths

Note 20 Remuneration of auditor

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

Auditing the accounts, financial statements and performance indicators	48,000	28,700

Note 21 Contingent liabilities and contingent assets

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

Note 22 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.

Note 23 Related bodies

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

The Commission had no related bodies during the financial year.

	2011 12 mths $	2010 4 mths $

Note 24 Affiliated bodies

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

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

Albany Halfway House Association	954,958	–
ARAFMI	1,642,404	–
Even Keel Incorporated	86,159	–
G.R.O.W. (WA)	586,401	–
Home Health P/L trading as Tendercare	871,966	–
The Richmond Fellowship of WA	5,912,987	–
	10,054,875	–

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

Note 25 Explanatory statement

Significant variations between estimates and actual results for income and expenses as presented in the financial statement titled 'Summary of Consolidated Account Appropriations and Income Estimates' are shown below. Significant variations are considered to be those greater than 10% or $5 million.

Significant variances between estimates and actual results for 2011:

	2011 Estimate $	2011 Actual $	Variance $
(a) Total appropriations provided to deliver services	506,561,000	486,570,000	(19,991,000)
(b) Total Cost of Services			
Specialised Mental Health Admitted Patient	231,083,000	249,049,888	17,966,888
Specialised Community Mental Health	277,098,000	241,643,365	(35,454,635)
The 2011 expenditure estimates reflect service level expenditure published in the Government Budget Statements for 2010-11 and have not been recast to reflect the service structure changes that have been adopted for 2011 Actual reporting.			
(c) Total Income	(670,000)	(2,604,294)	(1,934,294)
The increase is attributable to revenue received for Supported Accommodation Programs.			

Significant variances between actual for 2010 and 2011:

	2011 12 mths Actual $	2010 4 mths Actual $	Variance $
(a) Total appropriations provided to deliver services	486,570,000	16,704,000	469,866,000
(b) Total Cost of Services			
Specialised Mental Health Admitted Patient	249,049,888	–	249,049,888
Specialised Community Mental Health	241,643,365	15,936,670	225,706,695
(c) Total Income	(2,604,294)	(1,900)	(2,602,394)

The Commission commenced operations on the 8th March 2010. Therefore the comparative figures reflected for 2010 are for a period of four months only and cannot be directly compared to the actuals for 2011.

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

Note 26 Financial instruments

a) Financial risk management objectives and policies

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

Credit risk

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

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any provisions for impairment, as shown in the table at Note 26(c) 'Financial Instruments Disclosure'.

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

Liquidity risk

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

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

Market risk

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

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

b) Categories of financial instruments

In addition to cash, the carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are:

	2011 $	2010 $
Financial Assets		
Cash and cash equivalents	3,081,687	4,074,865
Restricted cash and cash equivalents	88,320	–
Loans and receivables	319,042	–
Financial Liabilities		
Financial liabilities measured at amortised cost	1,898,657	1,340,073

DISCLOSURES AND LEGAL COMPLIANCE

Notes to the financial statements continued

For the year ended 30 June 2011

Note 26 Financial instruments (continued)

c) Financial instrument disclosures

Credit risk and interest rate risk exposures

The following tables disclose the Commission's maximum exposure to credit risk, interest rate exposures 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 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.

Interest rate exposures and ageing analysis of financial assets

	Weighted average effective interest rate %	Carrying amount $	Interest rate exposure: Variable interest rate $	Interest rate exposure: Non-interest bearing $	Past due but not impaired $	Impaired Financial Assets $
Financial Assets						
2011						
Cash and cash equivalents	–	3,081,687	–	3,081,687		
Restricted cash and cash equivalents	–	88,320	–	88,320		
Receivables	–	319,042	–	319,042	–	–
		3,489,049	–	3,489,049	–	–
2010						
Cash and cash equivalents	–	4,074,865	–	4,074,865		
		4,074,865	–	4,074,865	–	–

Liquidity risk

The following table details the contractual maturity analysis for financial liabilities. The amounts disclosed are the contractual undiscounted cash flows of each class of financial liabilities at the end of the reporting period.

Interest rate exposure and maturity analysis of financial liabilities

	Weighted average effective interest rate %	Carrying amount $	Interest rate exposure: Variable interest rate $	Interest rate exposure: Non-interest bearing $	Maturity Date: Up to 3 months $
Financial Liabilities					
2011					
Payables	–	1,898,657	–	1,898,657	1,898,657
		1,898,657	–	1,898,657	1,898,657
2010					
Payables	–	1,340,073		1,340,073	1,340,073
		1,340,073	–	1,340,073	1,340,073

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators

Certification of key performance indicators

MENTAL HEALTH COMMISSION
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2011

I hereby certify the 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 2011.

Eric Dillon
A/Commissioner, Mental Health Commission
Accountable Authority

14 September 2011

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

Rate of suicide in Western Australia

Rationale

The Western Australian Suicide Prevention Strategy 2009-2013 provides Western Australia with a comprehensive framework to reduce suicide and self harm. The Strategy has been mandated by Cabinet to ensure that all State Government departments prioritise suicide prevention and participate in a coordinated response to the issue. The support of all levels of government and the nongovernment sector is essential to achieve positive outcomes in the area of suicide prevention.

Risk factors associated with suicide and suicide behaviour include genetic, biological, social, environmental and demographic factors, family characteristics and childhood experiences, personality and beliefs, mental disorders and alcohol and drug use. Often a combination of these factors can increase the risk of suicidal behaviour.

Age standardised rate per 100 000 population is used to compare deaths over time, as it accounts for any changes in the age structure of a population over time. A low and decreasing rate is desirable.

Results

In 2009, the age standardised rate of death due to suicide was 12.6 per 100,000 population in Western Australia.

Age standardised rate of death due to suicide Western Australia 2000 to 2009.

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Target
13.6	13.3	12.6	11.3	10.5	10.3	11.0	12.1	12.4	12.6	↓

Data sources

Mortality data extracted by the Australian Bureau of Statistics (ABS) and provided to Epidemiology Branch, Department of Health.

Notes

Age-standardised rates are per 100,000 population. Rates are based on three year moving averages.

The number of annual deaths is based on year of death.

2009 figures are preliminary.

ICD-10 codes X60-X84.9 were used to select deaths for suicide.

Target – The intention is to reduce the age standardised rate.

Data for suicide is always retrospective with a two to three year lag due to coronial processes and availability of ABS coded data and therefore cases will be added to years previously reported and consequently rates reported in previous years are not comparable.

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

Proportion of people receiving community support from nongovernment organisations for mental health problems

Rationale

A large proportion of people with a mental health problem may have a chronic or recurrent illness that results in only partial recovery between acute episodes and deterioration in functioning that can lead to challenges 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.

The target group for community based support programs is primarily adults living in Western Australia who have been treated for a mental health problem and discharged from a specialised mental health inpatient unit in the previous five years.

The aim of community based support programs delivered by nongovernment organisations is to support people to develop skills and abilities to maximise their capacity to live in the community. These programs support people with mental health problems to develop/maintain skills required for daily living, social interaction, and increase their participation in community life and activities.

Improving personal coping skills to allow people with mental health problems to remain independent enhances the quality of life for most people and aims to decrease the burden of care for carers.

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

As well as community based support provided by nongovernment organisations, people with mental health problems also have access to clinical support services provided by public mental health services, general practitioners, private psychiatrists and psychologists.

Results

In 2010/11, the proportion of people with mental health problems receiving community based support from nongovernment organisations was 39.2%. While the result is very close to the target, it is less than previous years. This is because nongovernment agencies are increasingly able to count individuals more accurately.

Proportion of people receiving community support from nongovernment organisations for mental health problems.

	2008/09	2009/10	2010/11	Target
Proportion of people receiving community support	52.7%	50.9%	39.2%	40%

Data sources

Nongovernment mental health service activity reports.
Mental Health Information System, Department of Health.

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

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

Rationale

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

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

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

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

Results

In 2010, 66% of patients had contact with a community based public mental health service within seven days post discharge from a public mental health inpatient unit. The target has been increased from 60% in previous years to be equal to or greater than 70% in 2010 to be in line with the national target. Public community mental health services continue to ensure follow up occurs as early as possible following discharge from hospital.

Percent of patients that had contact with a community based service within seven days post discharge.

	2010	Target
Percent of patients that had contact with a community based service within 7 days of discharge	66%	>=70%

Data sources

Mental Health Information System, Department of Health.

Notes

Data is for the calendar year of 2010.

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

Percent of contacts with community based public mental health non admitted services within seven days prior to admission to a public mental health inpatient unit

Rationale

A large proportion of people with a mental health problem may have a chronic or recurrent illness that results in only partial recovery between acute episodes and deterioration in functioning that can lead to challenges 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.

Access to community based mental health services may assist with improving the management of or alleviate the need for admissions to inpatient care. Many consumers admitted to public sector mental health acute inpatient units are known to public sector community mental health services and it is reasonable to expect that community services should be involved in preadmission care.

The time period of seven days was recommended nationally as an indicative measure for contact with public community based non admitted services prior to admission to public mental health inpatient units.

Results

In 2010/11, 62% of patients had contact with a community based public mental health service within seven days prior to being admitted to a public mental health inpatient unit. The target has been increased from 60% in previous years to be equal to or greater than 70% in 2010/11 to be in line with the national target. This is an aspirational target and it may take some time to achieve. Public community mental health services continue to ensure contact occurs prior to admission wherever possible.

Percent of patients that had contact with a community based service within seven days prior to admission to an inpatient unit.

	2010/11	Target
Percent of patients that had contact with a community based service within seven days prior to admission	62%	>=70%

Data sources

Mental Health Information System, Department of Health.

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

Average cost per bedday in specialised mental health units

Rationale

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

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

Results

In 2010/11 the average cost per bedday in a specialised mental health inpatient unit was $1 086. This result is slightly higher than the target. See note below.

Average cost per bedday in a specialised mental health unit.

	2010/11	Target
Average cost per bedday	$1,086	$1,071

Data sources

Mental Health Commission Financial System.

BedState, Department of Health.

Notes

This indicator is reported at a statewide level based on funding provided to the Department of Health for the first time this year. The unit cost reflects a 'purchased' bedday cost and includes a proportion of Mental Health Commission overheads.

This indicator measures the average cost per bedday in authorised (capacity to provide care to patients under the Mental Health Act 1996) and designated facilities (no capacity to provide care to patients under the Mental Health Act 1996) in Western Australia.

The target has been revised as there was a decrease in the 2010/11 Mental Health Commission budget (set in March 2010) to actual. The Estimated Actual figure published in the 2011/12 Budget Papers was used as the revised target.

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

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

Rationale

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

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

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

Results

In 2010/11, the cost per capita to provide prevention, promotion and protection activities to enhance mental health and wellbeing was $7. This figure is the same as the 2009/10 figure and $1 above the target.

Cost per capita of providing activities to enhance mental health and wellbeing.

	2009/10	2010/11	Target
Cost per capita of providing activities to enhance mental health and wellbeing	$7	$7	$6

Data sources

Mental Health Commission General Ledger.

Australian Bureau of Statistics December 2010 population for Western Australia (2,317,100).

The target has been revised as there was a decrease in the 2010/11 Mental Health Commission budget (set in March 2010) to actual. The Estimated Actual figure published in the 2011/12 Budget Papers was used as the revised target.

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

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

Rationale

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

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

Results

In 2010/11 the average cost per hour to provide community support to an individual with mental health problems was approximately $67. This result is less than the target as more hours of service were provided than was estimated as well as redistribution of overheads.

Average cost per hour for community support provided by nongovernment organisations to people with mental health problems.

	2007/08	2008/09	2009/10	2010/11	Target
Average cost per hour for community support	$57.92	$60.98	$61.27	$67.35	$74

Data sources

Nongovernment mental health service activity 6 monthly reports extrapolated for the full 12 months.

Mental Health Commission General Ledger.

Note

The target has been revised as there was a decrease in the 2010/11 Mental Health Commission budget (set in March 2010) to actual. The Estimated Actual figure published in the 2011/12 Budget Papers was used as the revised target.

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

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

Rationale

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

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

Results

In 2010/11 the average subsidy per bedday was $168. This result is lower than the target due to more beddays being reported than was estimated as well as redistribution of overheads.

Average subsidy per bedday to support people living in community residential accommodation provided by nongovernment organisations.

	2007/08	2008/09	2009/10	2010/11	Target
Average subsidy per bedday	$148	$164	$156	$168	$218

Data sources

Nongovernment mental health service activity six monthly reports extrapolated for the full 12 months.

Mental Health Commission General Ledger.

Note

The target has been revised as there was a decrease in the 2010/11 Mental Health Commission budget (set in March 2010) to actual. The Estimated Actual figure published in the 2011/12 Budget Papers was used as the revised target.

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

Average subsidy per person to support residents in metropolitan licensed private psychiatric hostels

Rationale

Private licensed psychiatric hostels provide personal support services to residents with mental health problems to assist them to maintain and further develop their current skills, autonomy and self management in the area of personal care in order to improve their overall quality of life.

Without subsidised care in licensed private psychiatric hostels many people with mental health problems would not be able to live relatively independent lives in a supported environment and their quality of life would be diminished.

Results

The actual subsidy per person for eligible residents in metropolitan licensed private psychiatric hostels for 2010/11 was $6,836. This result is less than the target due to redistribution of overheads.

Average subsidy per person to support residents in metropolitan licensed private psychiatric hostels.

	2008/09	2009/10	2010/11	Target
Average subsidy per person	$5,889	$6,583	$6,836	$8,530

Data sources

Mental Health Commission General Ledger.
Mental Health Information System, Department of Health.

Note

The target has been revised as there was a decrease in the 2010/11 Mental Health Commission budget (set in March 2010) to actual. The Estimated Actual figure published in the 2011/12 Budget Papers was used as the revised target.

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

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

Rationale

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

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

Results

In 2010/11, the average cost per three month episode of community care provided by public mental health services was $1 809. This result is slightly higher than the target as fewer episodes of care were delivered than estimated.

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

	2010/11	Target
Average cost per three month episode of community care	$1,809	$1,792

Data sources

Mental Health Commission Financial System.

Mental Health Information System, Department of Health.

Notes

This indicator is reported at a statewide level based on funding provided to the Department of Health for the first time this year. The unit cost reflects a 'purchased' cost per three month episode of community care and includes a proportion of Mental Health Commission overheads.

An episode of community care is defined as each three month period of care with one or more service contacts for an individual.

The target has been revised as there was a decrease in the 2010/11 Mental Health Commission budget (set in March 2010) to actual. The Estimated Actual figure published in the 2011/12 Budget Papers was used as the revised target.

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

Other disclosures

Ministerial directives

Treasurer's Instruction 903 (12) requires the Mental Health Commission to disclose information on any Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financial activities. No such directives were issued by the Ministers with portfolio responsibility for the Mental Health Commission during 2010/11.

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 Mental Health Commission.

Other legal requirements

Compliance with Public Sector Standards and Ethical Codes

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

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

During the year the Mental Health Commission undertook a range of activities to promote compliance with public sector standards and ethical codes including development of the Mental Health Commission Code of Conduct and the roll out of structured training for staff on ethical and accountable decision making.

The Mental Health Commission Corporate Governance Charter was launched in October 2010. The charter, based on the former Office of the Public Sector Standards Good Governance Guide, assists the Mental Health Commission and staff in complying with the standards as well as general governance, administration and management reporting requirements. It provides a framework for the proper management of the Mental Health Commission and helps the Mental Health Commission meet the accountability requirements of government. The Charter specifically addresses the following public sector good governance principles:

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

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

Disability access and inclusion plan

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

During the year work progressed on the Mental Health Commission's Disability Access and Inclusion Plan 2011-2016, due to be submitted to the Disability Services Commission in December 2011. The draft plan is currently going through detailed consultation processes with appropriate stakeholders to ensure that the initiatives developed will be successful in addressing statutory requirements and achieving the following desired six outcomes:

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

Until the new plan is finalised, the Mental Health Commission continues to operate under the Disability Access and Inclusion Plan of the Department of Health.

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

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

Advertising agencies	
AdCorp Australia Limited	$17,919

Recordkeeping plans

The *State Records Act 2000* was established to mandate standardised statutory record keeping practices for every government agency including records creation policy, record security and the responsibilities of all staff. Government agency practice is subject to the provisions of the Act and the standards and policies, and government agencies are subject to scrutiny by the State Records Commission.

The Mental Health Commission operates under an addendum to the Department of Health's record keeping plan which was approved by State Records Commissioner in September 2010. The plan is due for review and renewal in 2012 and a report of the review will be submitted to the State Records Office.

Training in the use of the Mental Health Commission's current record management system is provided to staff as part of our induction process and is also available to individual staff when required. During 2011/12 the Mental Health Commission will be reviewing the efficiency and effectiveness of record keeping training for all staff.

DISCLOSURES AND LEGAL COMPLIANCE

Key performance indicators continued

Government policy requirements

Occupational safety, health and injury management

The Mental Health Commission is committed to providing and maintaining a safe and healthy work environment and promoting the health and wellbeing of all employees. The Mental Health Commission acknowledges its responsibilities under the *Occupational Safety and Health Act 1984* and the *Workers Compensation and Injury Management Act 1981.* For 2010/11 the Mental Health Commission continued to operate under the umbrella of the Department of Health's occupational safety and health policies and procedures.

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

During the year the following initiatives were progressed:

- Continued the roll out of structured training for managers and supervisors in occupational safety, health and injury management responsibilities.
- Called for expressions of interest for safety representatives and provision of required training.
- Commenced monthly work place inspections.
- Quarterly reporting on incidents/accidents within the workplace.
- Developed and implemented occupational safety, health and injury management requirements as part of the Mental Health Commission's induction manual for all new employees.
- Provided an ergonomic assessment for employees on request.
- Continued to provide access to an employee assistance program.
- Provided employees with annual flu injections.
- Continued to support the Mental Health Commission's Wellbeing Team in their efforts to promote the health and wellbeing of employees.

The following table details our 2010/11 key performance indicators against the following targets:

Indicator	Actual 2010/11	Target 2010/11
Number of fatalities	Zero	Zero
Lost time injury/disease incidence rate	Zero	Zero
Lost time injury severity rate	Zero	Zero
% of injured workers returned to work within 28 weeks	N/A	N/A
% managers trained in occupational safety, health and injury management responsibilities	68%	Greater than or equal to 50%

DISCLOSURES AND LEGAL COMPLIANCE

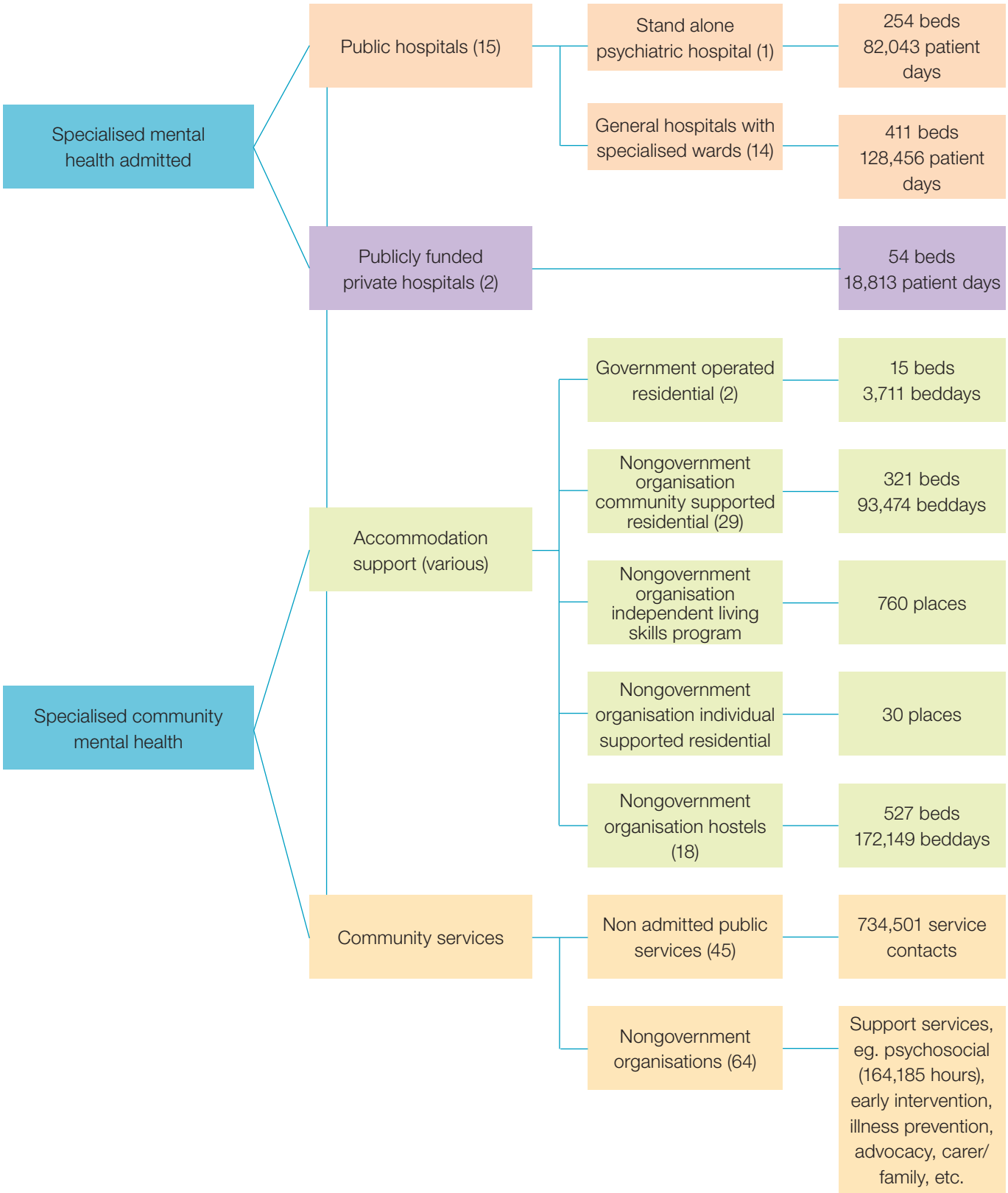
Key performance indicators continued

To continue to achieve our high standards the Mental Health Commission will be undertaking a review of occupational safety and health management systems during 2011/12. The Mental Health Commission will also incorporate internal mechanisms that will continue to:

- promote a culture that emphasises safety as a core value in all aspects of work
- train and develop employees in their duty of care through induction process and ongoing training and development sessions
- empower employees through communication media on the importance of personal safety of themselves and others within the workplace
- conduct monthly work place inspections to identify hazards, assess risks and implement controls
- promote hazard identification as a positive initiative and empower employees and management to report as they are recognised
- ensure hazard/risk is assessed as soon as practicable
- investigate all incidents/accidents to prevent reoccurrence.

APPENDIX ONE

Summary of the specialised mental health services and activity contracted by the Mental Health Commission in 2010/11.



APPENDIX TWO

Members of the Mental Health Advisory Council

Mr Barry MacKinnon AM (Chair). Mr MacKinnon has extensive experience in community service, politics and the corporate sector. He is currently president of the Deafness Council Western Australia and chairperson of the Western Australian Centre for Public Health Consultative Committee.

Dr Judy Edwards (Deputy Chair). Dr Edwards is the executive manager of the McCusker Alzheimer's Research Foundation Inc. She is currently a board member of Durham Road School and brings considerable experience in medicine, politics, advocacy, cross agency partnerships, social justice and community engagement.

Mr Joe Calleja. Mr Calleja is chief executive officer of the Richmond Fellowship of Western Australia, one of Australia's leading nongovernment mental health agencies. He is currently on the Board of the Western Australian Association for Mental Health.

Mr Geoff Diver. Mr Diver is a consulting scientist who works primarily in sustainable development. He lives in Port Hedland and brings a rural perspective to the work of the Council.

Ms Margaret Doherty. Ms Doherty is the convenor of Mental Health Matters 2. She is a member of the Western Australian Collaboration for Substance Use and Mental Health Workforce Development Working Group, the Alcohol and Other Drugs Council of Australian Families and Community Working Group and board member of the Western Australian Association for Mental Health.

Dr John Edwards. Dr Edwards is a general practitioner and is a foundation fellow of the College of Physicians Chapter of Addiction Medicine. He set up his own addiction medicine clinic, and chairs the Opioid Pharmacotherapy Advisory Committee. Dr Edwards is chairman of the board of Abbotsford Private Psychiatric Hospital.

Ms Pam Gardner. Ms Gardner is chair of Bay of Isles Community Outreach Inc and is closely involved in developing support services in the southeast Goldfields. She is a board member of the Western Australian Association of Mental Health and has extensive experience in planning strategies, managing businesses, developing projects and improving workforce capacity.

Ms Katherine Hams. Ms Hams is the executive manager of the Regional Social Emotional Wellbeing Workforce Support Unit for the Kimberley Aboriginal Medical Service Council. She is an Indigenous mental health professional and is a member of the Kimberley Aboriginal Mental Health Planning Forum and the National Advisory Committee for Aboriginal Mental Health First Aid.

Mr John Hesketh. John is currently the Area Manager of Student Services for the Department of Education based in Cannington, a position that he has occupied for twelve years. John is the representative for the Department of Education on the Pilot Youth Justice Initiative and a member of the Youth Justice Steering Group, both of which are multi agency task forces to reduce recidivism and incarcerations among youth, especially the Indigenous population.

Mr Lindsay Smoker. Mr Smoker is currently a member of the Local Health Advisory Group for the Corrigin Hospital and is an executive committee member of Farmsafe Alliance Western Australia. He brings an insight into what matters to people living in regional areas and how to tailor mental health strategies for rural communities.

Dr Alexandra Welborn. Dr Welborn is the chair of the Western Australian branch of the Royal Australian and New Zealand College of Psychiatrists. She works with the Consultation Liaison Team at Royal Perth Hospital providing psychiatric consultation to patients in the emergency departments and medical and surgical wards.

Dr Bernadette Wright. Dr Wright is a specialist clinical psychologist with extensive experience in migrant and refugee settlement, services and disability. She is the adjunct professor at the School of Psychology at the Curtin University of Technology and secretary of the Ethnic Disability Advocacy Centre Board of Management.

Prof Dianne Wynaden. Professor Wynaden is a credentialed mental health nurse with the Australian College of Mental Health Nurses. She is a professor (mental health) at the School of Nursing and Midwifery and the Curtin Health Innovation Research Institute. She is the chief investigator on the National Health and Medical Research Council capacity building grant in Indigenous mental health. She also chairs the Western Australian Mental Health Nursing Leadership Collaboration.

APPENDIX THREE

Good Outcomes Award winners

Award	Winner
GESB government organisations award	Growing Towards Wellness – South West Regional College of TAFE partnering with South West Horticultural Therapy and Training
St John of God Health Care nongovernment organisations award	Mental Health Law Centre Western Australia
Western Australian Equal Opportunity Commission human rights award for consumers	Lorraine Powell
John Da Silva carers award	Jan Harvey
Freehills Mental Health employee award	Dena Lawrence – Hollywood Private Hospital
Edith Cowan University mental health promotion and mental illness prevention award	Music to Open Your Mind – South Metropolitan Area Health Service, Mental Health
Curtin University of Technology mental health research and education award	Child Health Promotion Research Centre – Edith Cowan University
Maitri Aboriginal and culturally and linguistically diverse mental health award	Ethnic Disability Advocacy Centre
Sonshine FM media achievement award	Anthony DeCeglie, 'My Post Natal Battle', The Sunday Times
The University of Western Australia Dr Mark Rooney award for improved outcomes in child and youth mental health	Grant Wheatley – Department of Education, Hospital School Services
The Hollywood Private Hospital Leanne Wood award for excellence	Ann White – Western Australian Association for Mental Health

APPENDIX FOUR

Community sector organisations funded by the Mental Health Commission

Service provider	Service type
55 Central	Independent living skills support
56 Central	Psychosocial support
Access Housing Association	Supportive landlord services
Albany Halfway House Association	Community supported residential units
Albany Halfway House Association	Independent living skills support
Albany Halfway House Association	Intermediate care accommodation
Albany Halfway House Association	Psychosocial support
Albany Halfway House Association	Recreation
Amana Living	Specialist residential services
ARAFMI Mental Health Carers and Friends Association	Carer/family support – education/information and skill development
ARAFMI Mental Health Carers and Friends Association	Individual advocacy
ARAFMI Mental Health Carers and Friends Association	Mental health promotion
ARAFMI Mental Health Carers and Friends Association	Recreation
Association for Services to Torture and Trauma Survivors	Early intervention – general
Australian Association for Infant Mental Health WA	Workforce development
Baptistcare	Crisis/respite accommodation
Baptistcare	Independent living skills support
Baptistcare	Psychosocial support
Baptistcare	Supportive landlord services
Bay of Isles Community Outreach	Psychosocial support
Beyondblue	Mental illness prevention
BP Luxury Care	Psychosocial support
Bunbury Pathways '92	Carer/family support – admitted respite
Bunbury Pathways '93	Carer/family support – education/information and skill development
Bunbury Pathways '94	Independent living skills support
Bunbury Pathways '95	Psychosocial support
Bunbury Pathways '96	Supportive landlord services
Burswood Psychiatric Hostel	Personal care support
Carers Association of WA	Systemic advocacy
Casson House	Personal care support
Centrecare	Carer/family support – education/information and skill development
Centrecare	Early intervention – general
Centrecare	Independent living skills support

APPENDIX FOUR CONTINUED

Service provider	Service type
Centrecare	Mental illness prevention
Centrecare	Psychosocial support
Centrecare	Supportive landlord services
Clifford Beers Foundation	Mental illness prevention
Collie Family Centre	Early intervention – general
Curtin University of Technology	Mental health promotion
Curtin University of Technology	Mental illness prevention
Devenish Lodge	Personal care support
Disability in the Arts, Disadvantage in the Arts (WA)	Recreation
Even Keel (Bipolar Disorder Support Association)	Psychosocial support
Foundation Housing Association	Supportive landlord services
Franciscan House	Personal care support
Fremantle GP Network	Early intervention – general
Fremantle Multicultural Centre	Individual advocacy
Fremantle Women's Health Centre	Perinatal mental health service
Fusion Australia	Community supported residential units
Gosnells Women's Health Service	Perinatal mental health service
Great Southern Community Housing Association	Supportive landlord services
GROW (WA)	Psychosocial support
Headwest	Research and evaluation
Hills Community Support Group	Individual advocacy
Hills Community Support Group	Psychosocial support
Hills Community Support Group	Supportive landlord services
Honeybrook Lodge	Personal care support
Huntington's WA	Mental illness prevention
ISHAR Multicultural Centre for Women's Health	Carer/family support – education/information and skill development
June O'Connor Centre	Recreation
Kimberley Aboriginal Medical Services Council	Mental illness prevention
Kinway	Mental illness prevention
LAMP	Carer/family support – education/information and skill development
LAMP	Independent living skills support
LAMP	Psychosocial support
LAMP	Recreation

APPENDIX FOUR CONTINUED

Service provider	Service type
Life Without Barriers	Psychosocial support
Life Without Barriers	Supported accommodation for homeless youth
Lifeline WA	Mental health promotion
Mental Health Law Centre	Individual advocacy
Mental Health Law Centre	Research and evaluation
Mental Illness Fellowship of WA	Carer/family support – education/information and skill development
Mental Illness Fellowship of WA	Independent living skills support
Mental Illness Fellowship of WA	Mental health promotion
Mental Illness Fellowship of WA	Psychosocial support
Mental Illness Fellowship of WA	Recreation
Mercy Hospital	Clinical treatment and care – admitted
Midland Women's Health Care Place	Perinatal mental health service
Midwest Community Living Association	Recreation
PDLE	Pre-vocational training
Perth Home Care Services	Carer/family support – non admitted respite
Perth Home Care Services	Psychosocial support
Perth Inner City Youth Service	Psychosocial support
Perth Primary Care Network	Clinical treatment and care – non admitted
Pilbara and Kimberley Care	Carer/family support – non admitted respite
Pilbara and Kimberley Care	Independent living skills support
Pilbara and Kimberley Care	Psychosocial support
Pilbara and Kimberley Care	Recreation
Richmond Fellowship of WA	Community options
Richmond Fellowship of WA	Community supported residential units
Richmond Fellowship of WA	Crisis/respite accommodation
Richmond Fellowship of WA	Independent living skills support
Richmond Fellowship of WA	Intermediate care accommodation
Richmond Fellowship of WA	Long-term supported accommodation
Richmond Fellowship of WA	Psychosocial support
Richmond Fellowship of WA	Supported accommodation for homeless adults
Richmond Fellowship of WA	Workforce development
Romily House	Personal care support
Rosedale Lodge	Personal care support

APPENDIX FOUR CONTINUED

Service provider	Service type
Ruah Community Services	Carer/family support – education/information and skill development
Ruah Community Services	Mental health promotion
Ruah Community Services	Psychosocial support
Salisbury Home	Personal care support
Samaritan Befrienders of Albany	Early intervention – telephone services
Schizophrenia Fellowship Albany and Districts	Independent living skills support
Schizophrenia Fellowship Albany and Districts	Psychosocial support
Schizophrenia Fellowship Albany and Districts	Recreation
Share and Care Community Services Group	Carer/family support – non admitted respite
Share and Care Community Services Group	Independent living skills support
Share and Care Community Services Group	Psychosocial support
Share and Care Community Services Group	Recreation
Silver Chain Nursing Association	Carer/family support – education/information and skill development
Silver Chain Nursing Association	Workforce development
South Australian Postgraduate Medical Educations Association	Mental health promotion
South Coastal Women's Health Services Association	Perinatal mental health service
Southern Cross Care (WA)	Carer/family support – non admitted respite
Southern Cross Care (WA)	Community options
Southern Cross Care (WA)	Independent living skills support
Southern Cross Care (WA)	Psychosocial support
Southern Cross Care (WA)	Specialist residential services
St Bartholomew's House	Community supported residential units
St Bartholomew's House	Crisis/respite accommodation
St Bartholomew's House	Supportive landlord services
St Jude's Hostel	Personal care support
St Patrick's Community Support Centre	Mental illness prevention
Support In-Site	Recreation
Telethon Institute for Child Health Research	Mental illness prevention
Tender Care	Carer/family support – non admitted respite
Tender Care	Independent living skills support
Tender Care	Psychosocial support
Tender Care	Recreation
The Salvation Army (WA)	Independent living skills support

APPENDIX FOUR CONTINUED

Service provider	Service type
The Salvation Army (WA)	Psychosocial support
The Samaritans	Early intervention – general
The Samaritans	Early intervention – telephone services
UnitingCare West	Supportive landlord services
University of Western Australia (School of Psychiatry and Neuroclinical Sciences)	Mental health promotion
University of Western Australia (School of Psychiatry and Neuroclinical Sciences)	Research and evaluation
University of Western Australia (School of Psychiatry and Neuroclinical Sciences)	Workforce development
University of Western Australia (School of Psychology)	Research and evaluation
University of Western Australia (School of Psychology)	Workforce development
Vincentcare	Personal care support
Vincentcare	Psychosocial support
WA AIDS Council	Early intervention – general
WA Association for Mental Health	Mental health promotion
WA Association for Mental Health	Systemic advocacy
WA Association for Mental Health	Workforce development
WA Music Industry Association	Mental health promotion
WA Primary Care Network	Workforce development
Wanslea Family Services	Carer/family support – education/information and skill development
Women's Health Care Association	Clinical treatment and care – non admitted
Women's Health Care Association	Perinatal mental health service
Women's Health Care Association	Psychosocial support
Women's Healthworks	Psychosocial support
Woodville House	Personal care support
Youth Focus	Early intervention – general