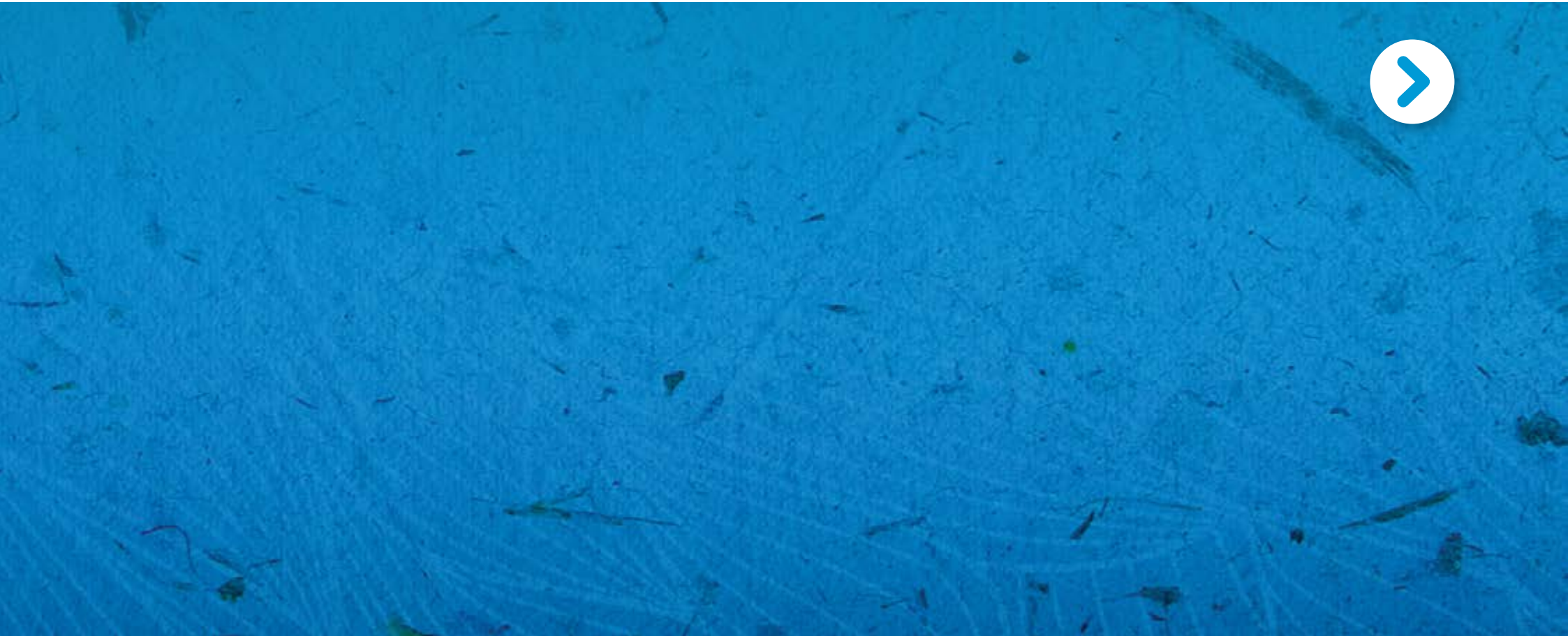
Government of **Western Australia**
Mental Health Commission

Mental Health Commission

2016/17 Annual Report



Statement of Compliance

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

Dear Minister

In accordance with section 63 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the annual report of the Mental Health Commission for the reporting period ended 30 June 2017.

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

Timothy Marney
COMMISSIONER
MENTAL HEALTH COMMISSION

6 September 2017

This annual report provides a review of the Mental Health Commission's (hereby referred to as the Commission) operations for the financial year ended 30 June 2017.

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

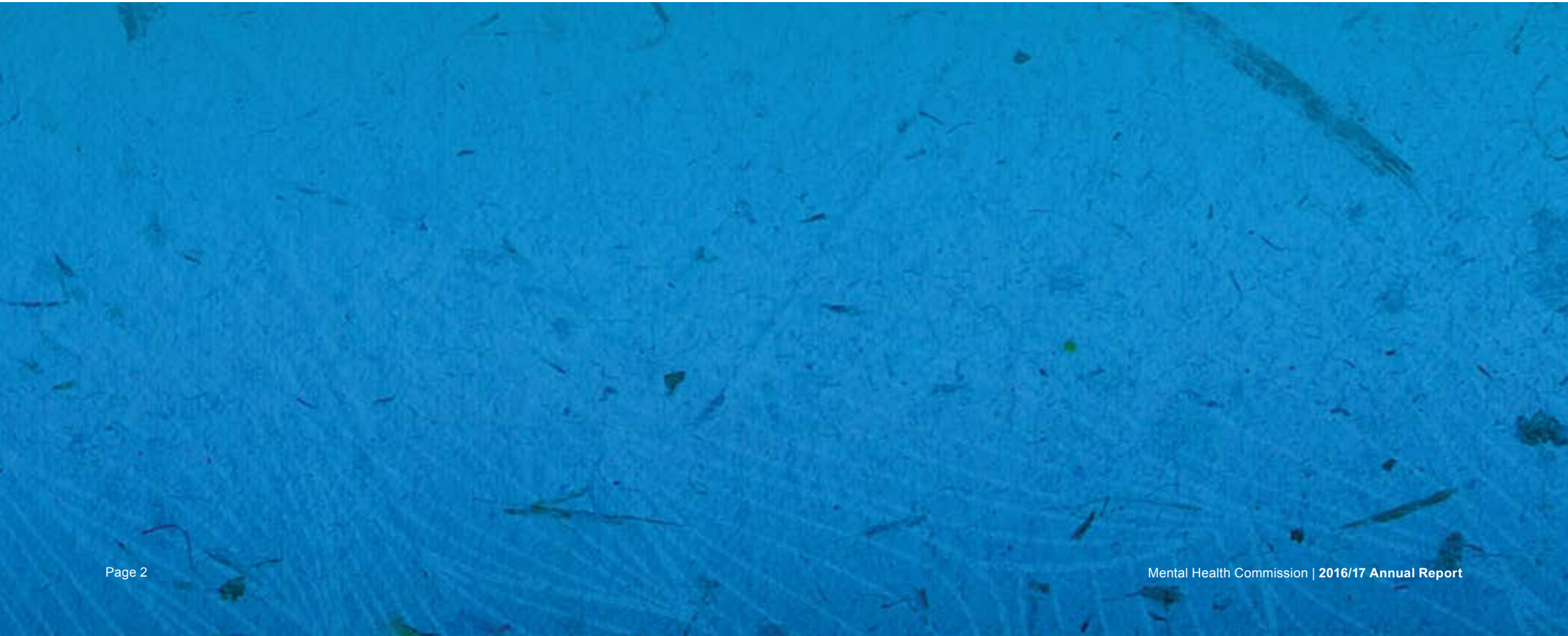
A full copy of this, and earlier annual reports, are available from the Commission's website at www.mhc.wa.gov.au

To make this annual report as accessible as possible, it is also provided as an interactive online PDF, which has links to other sections within the annual report as well as external links to content on the Commission's website and other external sites (excluding financial statements from pages 50 to 99). This annual report can also be made available in alternative formats upon request for those with visual or other impairments, including Word, audio, large print and Braille.

 ISSN 2208-4347

Contents

Overview

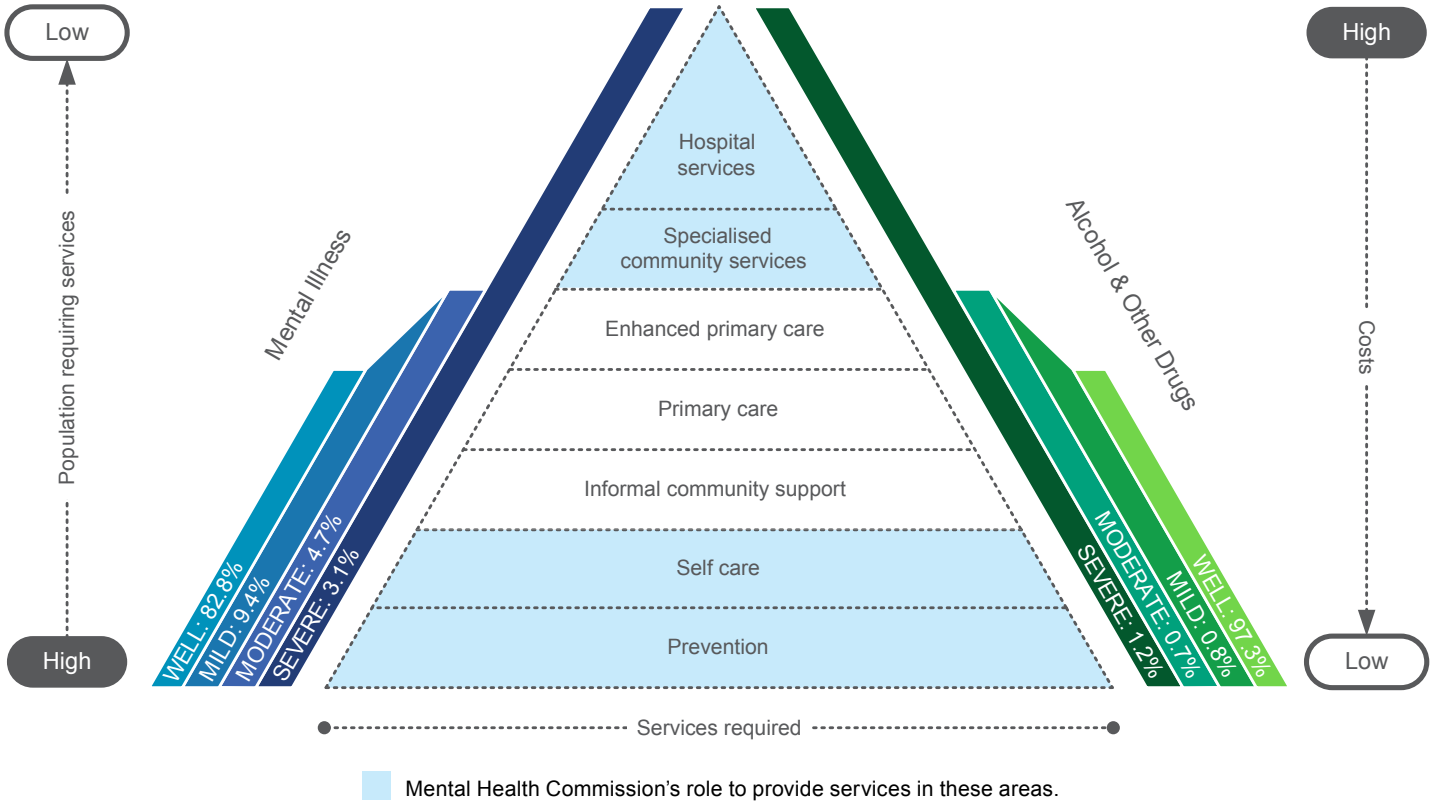


Vision And Mission

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

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

- prevention, promotion and early intervention programs;
- treatment, services and supports; and
- research, policy and system improvements.



Commissioner's Foreword

The Commission delivered a range of initiatives in 2016/17 to enhance the treatment, services and supports to people with mental health and/or AOD issues.

Guided by the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives, key initiatives included prevention campaigns, increases in hospital and community bed-based services, training and support to frontline workers, and growth in counselling through our helplines.

In 2016/17, we continued integration in addressing mental health and AOD issues, particularly through our prevention, promotion and purchasing activity. With up to 50% of people with mental health issues also experiencing problems with AOD use, an integrated approach within the Commission and across service providers is a major priority.

Prevention Services included:

- Strong Spirit Strong Mind Aboriginal Programs;
- Alcohol.Think Again and Drug Aware public education campaigns;
- Meth Can Take Control and Meth Helpline campaigns;
- a number of service and support lines, including the Meth Helpline (1800 874 878) which was launched on 12 September 2016; and
- a range of suicide prevention initiatives, including the establishment of Suicide Prevention Community Coordinators across the State.

Mental Health and AOD Services initiatives included:

- the development, consultation and release of the Commissioning Framework, which provides the foundation to purchasing services in line with evidence based decision making;
- the first bilateral agreements with the new Health Services Boards. These agreements adhere to the legal framework outlined in the *Health Services Act 2016* and provide a further mechanism to drive change and improvement in the public mental health system.
  The Commission continued to ensure that all funding provided by the Commission to Health Service Providers (HSPs) was spent on mental health services, by close monitoring of expenditure through special purpose accounts (which under the *Financial Management Act 2006* are subject to audit by the Auditor General) and improved monitoring of service performance;
- further development of a youth mental health stream in collaboration with the Department of Health and HSPs, with 12 dedicated youth beds opened in 2016/17, bringing the total number of public mental health beds for children, adolescents and youth to 39;
- various initiatives to expand AOD prevention, treatment and support services to address the use of methamphetamines. The number of residential rehabilitation and low medical withdrawal beds increased by almost 20% in 2016/17, up from 371 to 441;
- planning for the three new step up/step down services in Broome, Bunbury and Karratha. The Rockingham community mental health step up/step down service opened in October 2016, with a strong collaborative approach between the non-government service provider and the South Metropolitan Mental Health Service;
- establishment of the new Methamphetamine Clinic at Next Step Drug and Alcohol Services (Next Step);

- development of the Exposure Draft Compulsory Treatment (Alcohol and Other Drugs) Bill 2016 and an associated Summary Model of Service with input from a range of stakeholders. Consultation included contribution from the Compulsory Treatment Community Advisory Group and the release of online Discussion and Background Papers in September 2016, for public consultation and feedback; and
- the expansion of the ALIVE program for support services to individuals following discharge from hospital in the North Metropolitan area, and the establishment of a new ALIVE program in the South Metropolitan area.

This is a sample of our achievements in 2016/17, with a more expansive summary provided in the Key Achievements section at page 19.

Many of our achievements in the 2016/17 financial year were overseen by the former Minister for Mental Health, the Hon. Andrea Mitchell MLA, and I acknowledge her contribution.

The new Minister for Mental Health, the Hon. Roger Hugh Cook MLA, also Deputy Premier and Minister for Health, was sworn in on 17 March 2017. The Parliamentary Secretary to the Deputy Premier, Minister for Health and Mental Health, the Hon. Alanna Therese Clohesy MLC, assumed responsibility for assisting the Minister on that date. We have sought to maximise the benefit of having the portfolios of Health and Mental Health reporting to the same Minister and Parliamentary Secretary. At the same time, the retention of the Mental Health Commission as a separate entity has enabled a continued focus on the commissioning of both government and non-government community-based treatments, services and supports, and the ability for us to continue to build our engagement and empowerment of consumers and carers.

In this regard, the Commission's Consumer, Family, Carer and Community Paid Partnership Policy was co-designed with consumers and carers and implemented in 2016/17. This co-design approach is also being undertaken in the development of the Commission's Engagement Framework.

Internally, we worked across the Commission to develop and bring a shared understanding and ownership of our Values and the behaviours that are consistent with them. We further refined our corporate governance, including the introduction of a Reconciliation Committee, as a sub-committee of the Corporate Executive, chaired by myself.

We also focused on achieving internal efficiencies, particularly in our corporate services area, following the amalgamation of the Commission and the Drug and Alcohol Office in 2015/16. With our back office processing functions provided by Health Support Services, we sought to streamline our resourcing of the corporate services functions within the Commission.

I am pleased to present to you this annual report. I thank all those who have worked with us over the past year and I also extend my genuine thanks to everyone at the Commission for their efforts and achievements in 2016/17.

Timothy Marney
Mental Health Commissioner

Executive Summary

2016/17 Highlights

Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives.

$TOTAL

$863.1
million

$OUT

$20.6
million

Prevention

- established network of 10 new Suicide Prevention Community Coordinators
- Regional Men's Health Initiative to provide suicide prevention education to the farming industry
- Meth Can Take Control achieved greater awareness in its first year than any previous Drug Aware campaign
- 73% of Western Australians surveyed were aware of national low-risk drinking guidelines
- evaluation of Strong Spirit Strong Mind Metro Project campaign found 83% of young Aboriginal people were more aware of AOD harms
- funding provided to 21 NGO community-based prevention services. Eg: Lifeline WA; Act Belong Commit

$46.5
million

Community Support

- establishment of a two-year $282,100 pilot project purchased to provide support for regionally based lesbian, gay, bisexual, transgender and intersex youth
- funding of $192,745 for 10 Aboriginal specific peer support and mentoring grants
- an additional $47,299 in targeted peer support suicide prevention grants for three community initiatives
- funding provided to 97 NGO community support services. Eg: Even Keel Bipolar Disorder Support Association; Lamp

$OUT

$383.7 million

Community Treatment

- over 21,550 occasions of service through the Alcohol and Drug Support Service
- AOD treatment services to support the Alcohol Interlock Scheme
- new Next Step Methamphetamine Clinic established
- expansion of the ALIVE program to provide services for people at risk of suicide
- expansion of Community Alcohol and Drug Services across the State
- $321 million invested in public mental health non-admitted services
- new Child, Adolescent and Youth Psychiatrist service in the Kimberley

$44.6 million

Community Bed-Based Services

- additional 60 AOD rehabilitation and withdrawal beds established
- new 10 bed community mental health step up/step down service in Rockingham, with 69 admissions since it opened in October 2016
- Joondalup step up/step down had 312 admissions
- progressed development of step up/step down services in Karratha, Bunbury and Broome

$367.8 million

Hospital-Based Services

- $330 million in mental health inpatient services across Western Australia
- new contracts established with the five State Health Service Providers
- expansion of existing Next Step Drug and Alcohol Services clinical liaison inreach model into Rockingham Hospital
- 12 youth beds opened, bringing the total capacity of youth, child and adolescent beds across the system to 39

Operational Structure

Hon. Roger Hugh Cook MLA

Responsible Minister

The Commission is responsible to the Minister for Mental Health, the Hon. Roger Hugh Cook MLA, and is the government agency primarily assisting him in the administration of the mental health portfolio.
The Minister is supported by the Parliamentary Secretary to the Minister for Mental Health.

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

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

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

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

Accountable authority

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

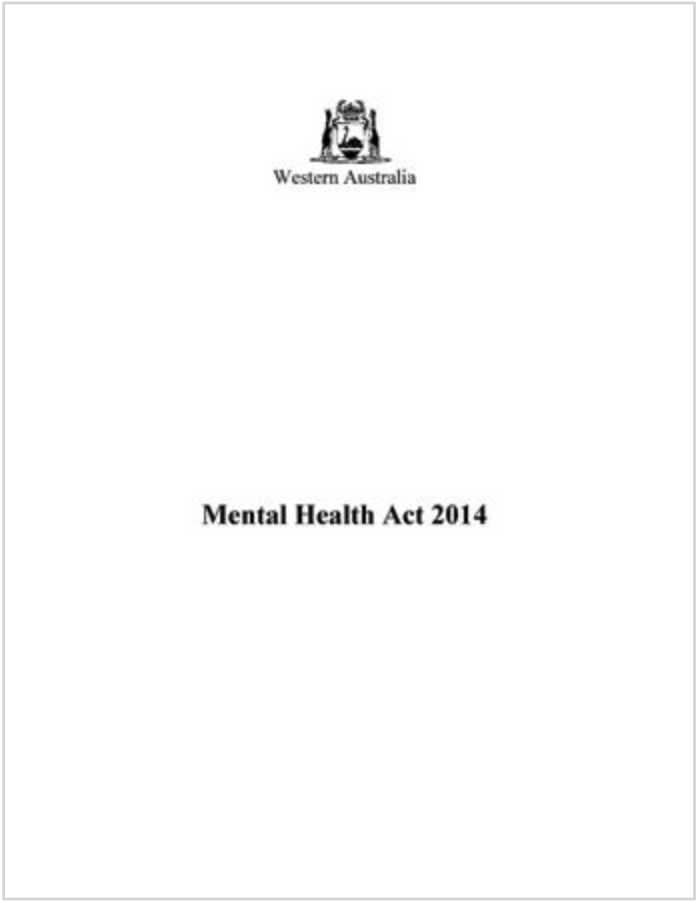
Administered legislation

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

Other key legislation

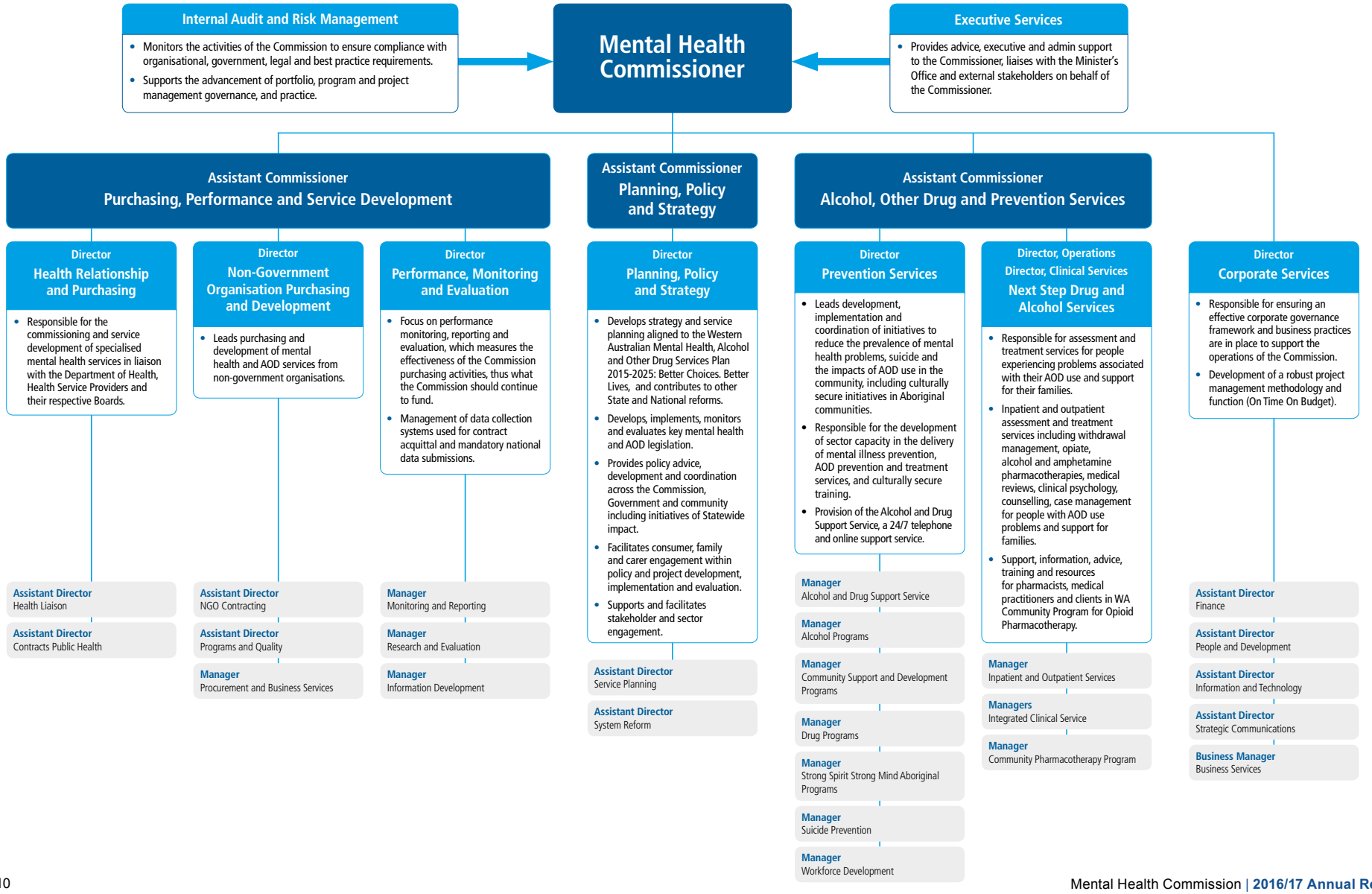
The Commission is required to comply with a range of laws including:

Auditor General Act 2006
Carers Recognition Act 2004
Corruption, Crime and Misconduct Act 2003
Disability Services Act 1993
Equal Opportunity Act 1984
Financial Management Act 2006
Freedom of Information Act 1992
Health and Disability Services (Complaints) Act 1995
Health Services Act 2016
Industrial Relations Act 1979
Minimum Conditions of Employment Act 1993
Occupational Safety and Health Act 1984
Private Hospitals and Health Services Act 1927
Public Interest Disclosure Act 2003
Public Sector Management Act 1994
Salaries and Allowances Act 1975
State Records Act 2000
State Superannuation Act 2000
State Supply Commission Act 1991
Workers' Compensation and Injury Management Act 1981


Western Australia

Mental Health Act 2014

Organisational Structure



Commissioner for Mental Health
Timothy Marney

Mr Marney was appointed as Mental Health Commissioner in February 2014. He joined the Western Australian Department of Treasury in 1993, where he held the position of Under Treasurer from 2005 to 2014. In this role, he gained an in-depth understanding of the health system and health reform initiatives, as well as government procurement policies and practices. As the Mental Health Commissioner, Mr Marney is responsible for planning and commissioning the State's mental health and AOD services. Mr Marney also has lived experience of mental health issues.

David Axworthy / Julia Knapton (Acting)
Assistant Commissioner, Planning, Policy and Strategy

This area develops strategy and service planning aligned to the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives, and contributes to other State and National strategies and reforms. It develops, implements, monitors and evaluates key mental health and AOD legislation and provides policy advice, development and coordination across the Commission, government and community, including initiatives of Statewide impact. This area also facilitates consumer, family and carer engagement within policy and project development, implementation and evaluation, and supports and facilitates stakeholder and sector engagement.

Elaine Paterson
Assistant Commissioner, Purchasing, Performance and Service Development

This area leads the contracts for commissioning and management of services purchased by the Commission. It is fundamental to the development, delivery and quality improvement of services. This area is responsible for contract governance, performance monitoring and evaluation. It drives improved service outcomes with an emphasis on integrated and person-centred approaches.

Sue Jones
Assistant Commissioner, Alcohol, Other Drug and Prevention Services

This area leads the provision of AOD support services, prevention and clinical services. It shapes the development and delivery of prevention services, and treatment for people experiencing problems with AOD use, and leads the implementation of the suicide prevention strategy – Suicide Prevention 2020: Together we can save lives.

Barry Thomas
Director, Corporate Services

This area is responsible for ensuring that effective and efficient corporate governance framework and business practices are in place to support the operations of the Commission. This area manages financial and staffing resources to ensure services are provided within budgetary, organisational and legislative constraints and in line with the Vision and Values of the Commission. Corporate services are also provided to the following independent entities – the Mental Health Tribunal, Mental Health Advocacy Service and the Office of the Chief Psychiatrist.

Agency Performance

Performance Summaries – Report On Operations

Summary of financial performance

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

FINANCIAL TARGET	2016/17 BUDGET $'000	2016/17 ACTUAL $'000	VARIATION $'000
Total cost of service (expense limit)	865,772	863,107	(2,665)
Net cost of services	683,050	694,582	11,532
Total equity	43,079	47,424	4,345
Net increase/(decrease) in cash held	(6,179)	(12)	6,167

STAFFING	2016/17 BUDGET	2016/17 ACTUAL	VARIATION
Approved full-time equivalent staff level (including independent entities)	304	303	-1

Working cash targets

	2016/17 AGREED LIMIT $'000	2016/17 TARGET / ACTUAL $'000	VARIATION $'000
Agreed Working Cash Limit (At Budget)	43,264	43,264	N/A
Agreed Working Cash Limit (At Actuals)	43,316	42,951	365

Summary of key effectiveness and efficiency indicators

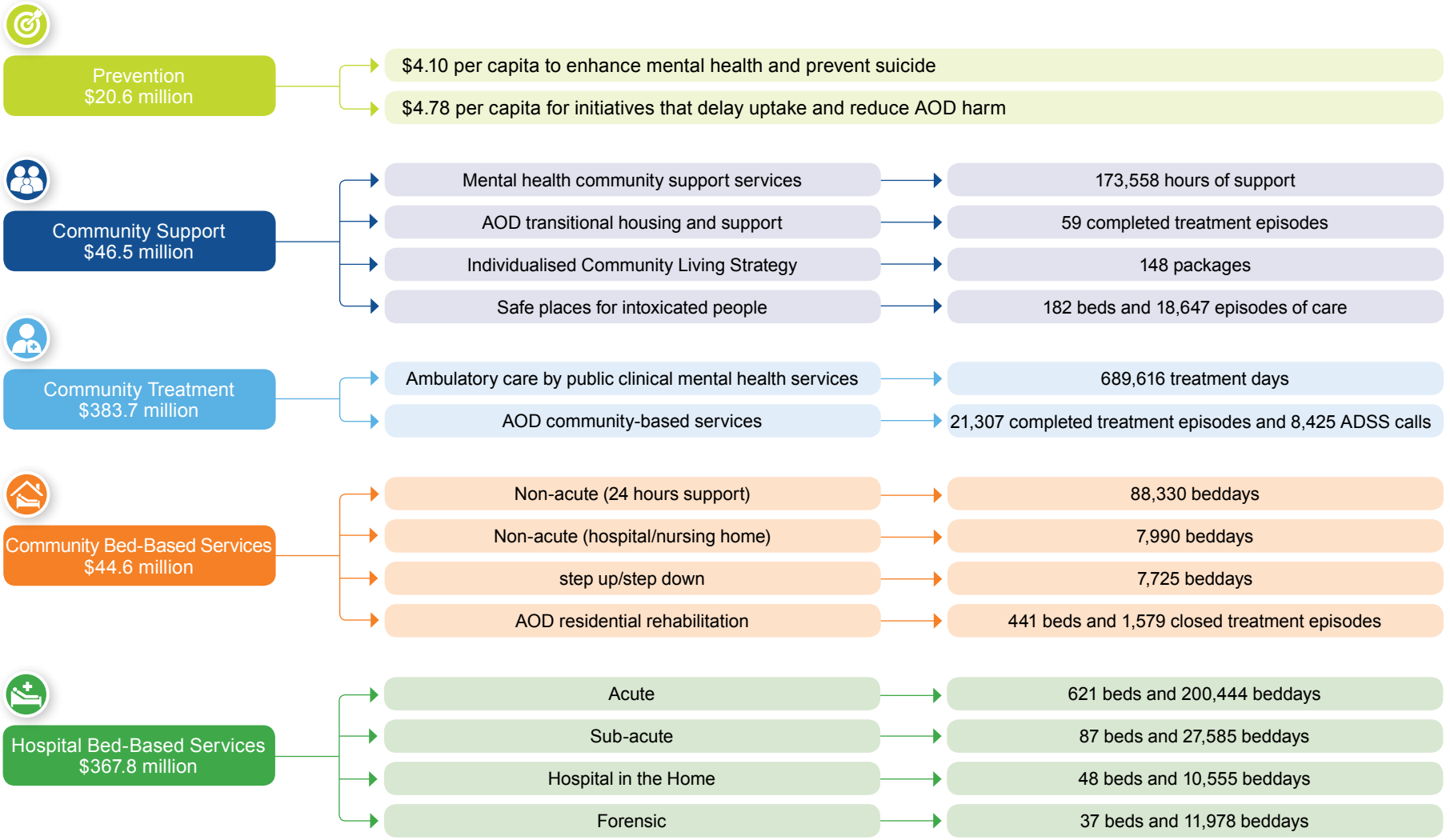
The Commission reports each year on efficiency and effectiveness indicators that contribute to its agency outcomes. A summary of its performance is provided in the table below. More detailed information and analysis of its efficiency and effectiveness indicators are provided in the Key Performance Indicators section from page 100.

KEY EFFECTIVENESS INDICATOR		2016/17 TARGET	2016/17 ACTUAL
Outcome 1 – Promote mental health and wellbeing			
1.1	Percentage of the Western Australian population with high or very high levels of psychological distress compared to the percentage reported nationally	-1.8%	-1.8%
Outcome 2 – Reduced incidence of use and harm associated with AOD use			
2.1	Percentage of the Western Australian population aged 14 years and over reporting recent use of illicit drugs and the percentage reporting use of alcohol at risky levels compared to the percentage reported nationally	Illicits +2.0% Alcohol +3.4%	Illicits +2.0% Alcohol +3.4%
2.2	Percentage of correct take out messages for AOD campaigns among target population	Alcohol 72.8% Meth 34.6%	Alcohol 39.2% Meth 38.2%
Outcome 3 – Accessible, high quality and appropriate mental health and AOD treatments and supports			
3.1	Re-admissions to hospital within 28 days of discharge from acute specialised mental health units (national indicator)	≤ 12.0%	17.1%
3.2	Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units (national indicator)	≥ 70.0%	64.1%
3.3	Percentage of closed AOD treatment episodes completed as planned	≥ 76.0%	73.5%
3.4	Percentage of non-government organisations contracted to provide mental health services that met the National Standards for Mental Health Services (2010) through independent evaluation	100.0%	77.8%
3.5	Percentage of the population receiving public clinical mental health care (national indicator)	≥ 2.2%	2.3%

KEY EFFICIENCY INDICATOR		2016/17 TARGET	2016/17 ACTUAL
Service 1 – Prevention			
1.1	Cost per capita to enhance mental health and wellbeing and prevent suicide (illness prevention, promotion and protection activities)	$4.44	$4.10
1.2	Cost per capita of the Western Australian population 14 years and above for initiatives that delay the uptake and reduce the harm associated with alcohol and other drugs	$3.57	$4.78
1.3	Cost per person of AOD campaign target groups who are aware of, and correctly recall, the main campaign messages	Alcohol $0.68 Meth $1.27	Alcohol $0.89 Meth $1.19
Service 2 – Hospital Bed-Based Services			
2.1	Average length of stay in purchased acute specialised mental health units	< 15.0 days	14.9 days
2.2	Average cost per purchased bedday in acute specialised mental health units	$1,441	$1,489
2.3	Average length of stay in purchased sub-acute specialised mental health units	< 103.0 days	105.8 days
2.4	Average cost per purchased bedday in sub-acute specialised mental health units	$1,383	$1,419
2.5	Average length of stay in purchased hospital in the home mental health units	< 22.0 days	23.7 days
2.6	Average cost per purchased bedday in hospital in the home mental health units	$1,393	$1,352
2.7	Average length of stay in purchased forensic mental health units	< 50.0 days	34.3 days
2.8	Average cost per purchased bedday in forensic mental health units	$1,310	$1,338

KEY EFFICIENCY INDICATOR		2016/17 TARGET	2016/17 ACTUAL
Service 3 – Community Bed-Based Services			
3.1	Average cost per purchased bedday in non-acute (24 hours support) community bed-based services	$240	$239
3.2	Average cost per purchased bedday in non-acute (hospital/nursing home) community bed-based units	$230	$213
3.3	Average cost per purchased bedday in step-up/step-down community bed-based units	$628	$643
3.4	Cost per completed treatment episode in AOD residential rehabilitation services	$9,291	$10,140
Service 4 – Community Treatment			
4.1	Average cost per purchased treatment day of ambulatory care provided by public clinical mental health services (national indicator)	$491	$470
4.2	Average treatment days per episode of ambulatory care provided by public clinical mental health services (national indicator)	< 5.00 days	4.87 days
4.3	Cost per completed treatment episode in community-based AOD services	$1,705	$1,680
Service 5 – Community Support			
5.1	Average cost per hour for community support provided to people with mental health problems	$130	$144
5.2	Average cost per episode of community support provided for AOD services	$9,277	$8,672
5.3	Average cost per package of care provided for the Individualised Community Living Strategy	$71,325	$42,150
5.4	Cost per episode of care in safe places for intoxicated people	$361	$342

Summary of specialised services and activity contracted by the Commission



Key Achievements

The development, implementation and evaluation of initiatives and programs that drive mental health and AOD system development has been the Commission's focus in 2016/17. During the year, the Commission was guided by the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives (the Plan) and worked to deliver high priority initiatives to achieve value for money for the community. The Plan sets out the optimal mix and level of services required to meet the needs of Western Australians.

The Commission partnered with 112 non-government organisations (NGOs) for the provision of services across the spectrum of care, and established contracts with each of the five public HSPs under the *Health Services Act 2016.*

In 2016/17, the Commission's spending on hospital bed-based services and community treatment services increased by 4.1% and 2.7% respectively to reach totals of $367.8 million and $383.7 million. These increases primarily supported HSPs to deliver public inpatient and non-admitted mental health services to meet the needs of the Western Australian population.

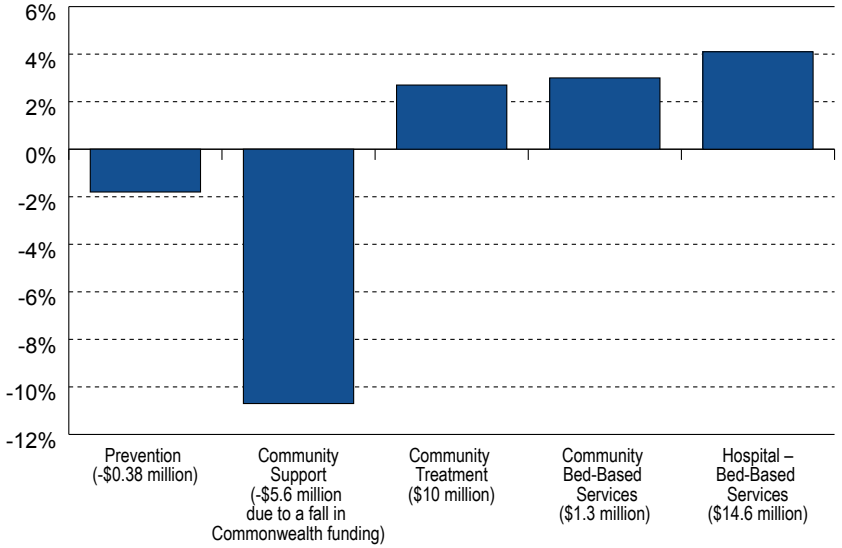
Community bed-based services spending increased by 3% to $44.6 million, due to the addition of 60 AOD withdrawal and residential rehabilitation beds by the Commission and the opening of a new community mental health step up/step down service at Rockingham.

The Commission's spend on community support services decreased by 10.7% to $46.5 million, as the Commonwealth funding for the National Partnership Agreement for Supporting Mental Health Reform ceased. The State's own funding for community support services remained steady at $39 million. Prevention services decreased slightly by 1.8% to $20.6 million.

In total, the Commission expended $863.1 million on mental health and AOD services in 2016/17, an increase of $19.9 million over the previous year.

These services cover the continuum of care, from prevention services, to community treatment and support services, community bed-based services and services delivered in hospitals.

Change in each service category since 2015/16



These services delivered:

- a 3% increase in AOD treatment episodes delivered in 2016/17, bringing the total to more than 22,900;
- 8,425 counselling-related calls to the Alcohol and Drug Support Service (ADSS);
- more than 18,600 episodes of care at sobering up centres;
- more than 173,500 community hours of support;
- more than 250,000 inpatient beddays and 689,600 community treatment days; and
- 148 individualised community living packages, to people across Western Australia.

Prevention

The Commission invested $20.6 million in prevention services during 2016/17, to assist Western Australians in improving mental health and reducing the risk of mental illness, suicide and AOD related harms.

The Commission established 10 new Suicide Prevention Community Coordinator positions across the State through purchasing from NGOs and the WA Country Health Service (WACHS). These positions act as the central point for communication, to assist services on the ground to work in partnership to improve support and care for those affected by suicide and intentional self-harm.

A new contract was established with the Aboriginal Health Council of Western Australia (AHCWA), the peak body for Aboriginal Medical Services in the State. AHCWA will deliver a social and emotional wellbeing training package for Aboriginal people across Western Australia, incorporating recommendations from the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project and the National Aboriginal Torres Strait Islander Suicide Prevention Strategy.

The Commission also contracted the Regional Men's Health Initiative as part of the Suicide Prevention 2020: Together we can save lives strategy, to provide mental health and wellbeing, and suicide prevention education to men in farming communities across Western Australia.

In 2016/17, the Commission continued to deliver its successful Statewide AOD public education campaigns *Drug Aware, Alcohol.Think Again* and *Strong Spirit Strong Mind Metro Project* that prevent and reduce harm attributable to AOD use. The campaigns include public awareness education and training, television advertisements, digital media, radio and outdoor media.

Highlights in 2016/17 included:

- the Drug Aware Meth Can Take Control campaign achieved greater awareness than any previous Drug Aware campaign in its first year, with 53% of the target group aware of the campaign, and 90% of those aware correctly understanding the campaign messages. This campaign was recognised at the 2017 Campaign Brief Awards, where its 'The Law' video won the 2016 Best Of The Year Creative Award for the Cinema/Television commercial category;

Meth Can Take Control campaign poster

- an independent post-campaign evaluation of 155 young Aboriginal people found 83% were more aware of AOD harms as a result of the Strong Spirit Strong Mind Metro Project campaign, and 73% were exposed to the campaign at least once;
- a 2017 National Health and Medical Research Council funded study by the Cancer Council Victoria identified the Commission's Alcohol.Think Again advertisements 'Cancer – Spread' and 'What you can't see', as the two most likely campaigns, worldwide, to motivate people to reduce the amount of alcohol they drink; and
- Western Australia recorded significantly greater awareness of the national low-risk drinking guidelines than other jurisdictions in the 2017 Foundation for Alcohol Research and Education (FARE) Annual Alcohol Poll, with 73% of participants in Western Australia aware of the guidelines (compared with the Australian average of 58%) and 85% of participants in Western Australia knowing that the safest option is to not drink any alcohol at all when pregnant (compared with an 80% Australian average).

The Commission invested $6.7 million in community-based prevention services provided by non-government organisations in 2016/17. These initiatives support promotion of mental health and work to reduce suicide and AOD harms in the community. Initiatives supported included:

- Mental Health Week 2016;
- MATES in Construction, which is a mental health initiative for the Western Australian building and construction industry;
- Act Belong Commit;
- beyondblue (please note Related Party Disclosures on page 165);
- Lifeline WA; and
- School Drug Education and Road Aware (SDERA) program.

The full list is available in Appendix One on page 169.

In 2016/17, the Commission supported the development and implementation of 32 Alcohol and Other Drug Management Plans (AODMPs) across Western Australia. Prevention Plans were developed and led by local service providers to prevent and reduce AOD related harms, with 31 plans developed regionally and one in the metropolitan area.

The Commission's Community Support and Development Programs (CSDP) team was engaged to assist with the development of five new AODMPs in 2016/17 to address local AOD harm. The CSDP team supported the review of a further four AODMPs and provided ongoing support in planning, development, implementation and review of the other AODMPs at a local level across Western Australia. This included:

- facilitation of planning meetings to identify issues and stakeholder roles;
- support with the development of AODMPs and strategies;
- targeted capacity building at a local, regional and State level for key community stakeholders and relevant service providers including 23 training sessions;
- providing support to local media and communications campaigns to reduce local AOD harm; and
- support with seeking funding for local activity.

The Commission also provided advice to community groups, government agencies and NGOs on policy-based actions that reduce alcohol-related harm. The Commission:

- monitored liquor licence applications across the State and investigated 209 matters regarding the potential for, and minimisation of, alcohol-related harm and ill-health;
- made 65 submissions to inform the Director of Liquor Licencing Authority about alcohol-related harm or ill-health matters associated with particular liquor licence applications;
- made two submissions to inquiries examining whether it was in the public interest to strengthen existing liquor restrictions to reduce alcohol-related harm in Kununurra, Wyndham and surrounding communities and in Port and South Hedland; and
- worked with the Western Australian Local Government Association on the development and training of the Local Government Town Planning Guideline for Alcohol Outlets.

The Commission commenced the development of a Mental Health Promotion, Mental Illness and Alcohol and Other Drug Prevention Plan (the Prevention Plan) in 2016/17. The aim of the Plan is to provide guidance in the recommended evidence-informed programs, strategies and initiatives to prevent and reduce harmful AOD use, and promote optimal mental health in the Western Australian community.

Community support, treatment and bed-based services

The Commission invested $474.7 million in public and non-government community services in 2016/17, an increase of 1.2% since 2015/16.

This included an extra $4.85 million to establish new community initiatives under the Western Australian Meth Strategy 2016 and additional funding through Suicide Prevention 2020: Together we can save lives. The full list of services funded is available at Appendix One. Achievements included:

- a new community mental health step up/step down service was opened in Rockingham in October 2016, providing an additional 10 beds.

Mind Australia was contracted to provide recovery-oriented support services in partnership with the South Metropolitan Health Service (SMHS), that was contracted to provide the clinical mental health in-reach service. The service had 69 admissions in its first nine months of operation;

- the State's first step up/step down service at Joondalup had 312 admissions (an average of 26 per month) in 2016/17. Of these, approximately 99% of people 'stepping up' were transitioned back into the community and did not require hospital admission (1% were admitted to an inpatient facility). At the end of 'stepping down', approximately 98% were transitioned to the community (2% returned to an inpatient facility);
- the Commission progressed projects to establish step up/step down services in Karratha (six beds), Bunbury (10 beds) and Broome (six beds), with extensive community consultation undertaken this financial year;
- a targeted round of suicide prevention grants totalling $239,000 was released in 2016/17, which resulted in funding for 14 community initiatives delivered to communities. Grant recipients are delivering peer support and/or mentoring projects for at-risk communities (Aboriginal people, youth, and the lesbian, gay, bisexual, transgender and intersex (LGBTI) community);
- the ALIVE postvention program was expanded through an enhanced contract with 360 Health, to provide additional services for people identified as being at risk of suicide following presentation to hospitals at Joondalup, and establish new services linked to Armadale, Fremantle and Rockingham hospitals;
- the Commission procured an additional 52 residential rehabilitation beds (ten beds in the North Metropolitan area, 14 beds in the South Metropolitan area and 28 regional beds) and eight low medical withdrawal beds (four metropolitan beds and four regional beds). These beds delivered an estimated 228 methamphetamine treatment episodes, in addition to the almost 1,300 already provided through existing services, which is an 18% increase;
- the Commission expanded existing Community Alcohol and Drug Services (CADS) across the state through an additional 13 community treatment full time positions to provide additional prevention and outpatient services, including for methamphetamine issues; and
- the Commission procured a Statewide network of treatment providers, in anticipation of referrals from the State Government's new mandatory performance-based Alcohol Interlock Scheme (the Scheme) to provide Alcohol Assessment and Treatment to road traffic offenders. The Commission's Alcohol and Drug Support Service database was also updated to support a centralised booking service to link Scheme participants with treatment providers.

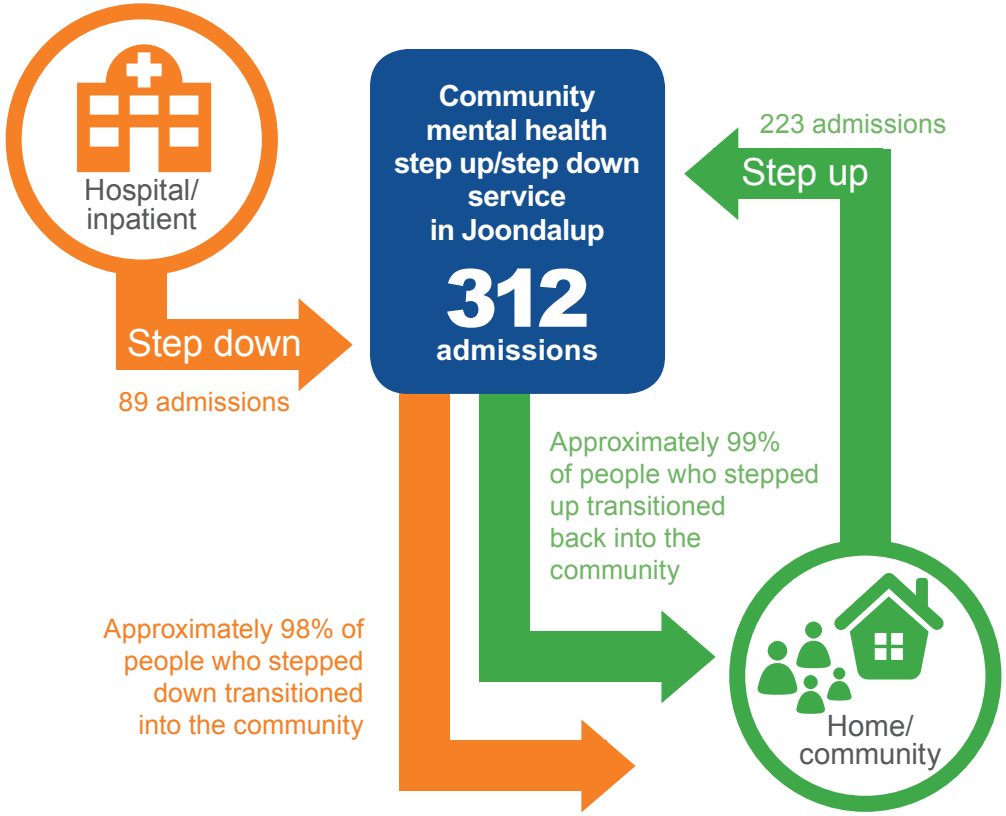
Community mental health step up/step down service in Rockingham

Step up/step down mental health services are delivered in the community, close to an individual's personal supports including family and friends.

Step up/step down services are staffed 24/7 and provide short term recovery-oriented care and residential support, following discharge from hospital or to those in the community who are experiencing a deterioration in their mental health but do not require hospitalisation. The model has been successfully implemented in Rockingham and Joondalup.

Although individuals can stay for up to 28 days, the average length of stay in a step up/step down service is 17 to 24 days. During their stay, support workers facilitate residents to engage in individual and group activities (including counselling) towards their mental health recovery. This is achieved by identifying the person's own strengths, values and goals, to increase personal autonomy, confidence and self-belief to live independently in their own community. Individuals also participate in a number of daily activities, which include preparing their own meals, yoga, arts and crafts, tennis and other recreational activities to support their recovery.

In 2016/17, the community mental health step up/step down service in Joondalup had 312 admissions. Of these, approximately 99% of people 'stepping up' were transitioned back into the community and did not require hospital admission (1% were admitted to an inpatient facility). At the end of 'stepping down', approximately 98% were transitioned to the community (2% returned to an inpatient facility)



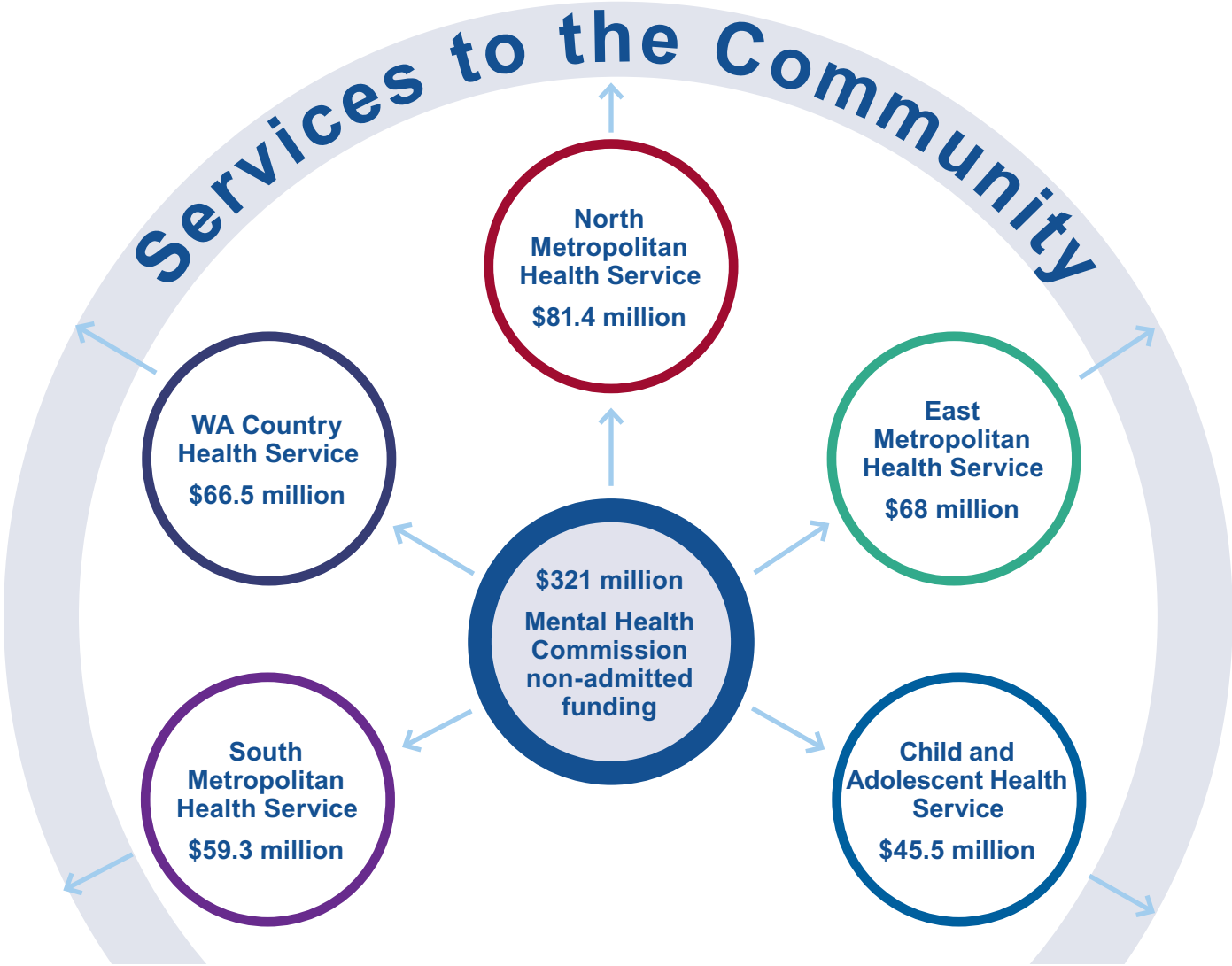
The Commission invested $321 million in public specialised mental health non-admitted services in the community in 2016/17, through contracts with each of the State's Health Service Providers (HSPs) – the Child and Adolescent Health Service (CAHS), North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS), East Metropolitan Health Service (EMHS) and WA Country Health Service (WACHS). More than 689,616 treatment days were provided by these services, which included core community services purchased by the Commission, and the following targeted initiatives:

- Statewide Specialist Aboriginal Mental Health Service;
- youth mental health services (including the regional Youth Mental Health Program purchased through the WACHS, and Youth Community Treatment at Fiona Stanley Hospital);
- WA Eating Disorder Outreach Consultation Service;
- Mental Health Court Diversion program;
- Mental Health and Police Co-Response Trial;
- Individualised Community Living Strategy;
- School Suicide Response;
- Gender Diversity Service;
- Mobile Clinical Outreach Team;
- regional Suicide Prevention Community Coordinators; and
- services to the Rockingham step up/step down service.

A new specialist Child, Adolescent and Youth Psychiatrist service was established in the Kimberley through the WACHS. This commenced in January 2017 and expands the clinical, supervisory and coordinating capacity of mental health services for children and young people in the Kimberley.

The adult component of the Mental Health Court Diversion program, the Start Court, is based within the Central Law Courts in the Perth CBD. It is operated by a dedicated multi-disciplinary team that includes mental health clinical support from the NMHS.

2016/17 expenditure on mental health non-admitted services provided by public Health Service Providers



The Commission also directly provided approximately $18 million worth of AOD treatment and support services to Western Australians. Highlights included:

- the Commission established and promoted the Meth Helpline to provide free specialist information, support, counselling and referral for individuals and families affected by methamphetamine use. The new Meth Helpline was promoted through television, radio, cinema, out-of-home and digital advertising. More than 1,500 calls were received to the Meth Helpline since it was launched on 12 September 2016;
- the Commission provided over 21,550 occasions-of-service to Western Australians through the four 24/7 telephone counselling, information, referral and support lines for AOD: the Parent and Family Drug Support line; Meth Helpline; Alcohol and Drug Support Line; and Working Away Alcohol and Drug Support Line. Of these, 21% of contacts mentioned alcohol as the primary drug of concern, 21% cannabis and 24% methamphetamine;
- the Commission established a specialist Methamphetamine Clinic in East Perth at Next Step to provide rapid assessment, early intervention and outpatient withdrawal for methamphetamine users. This model was replicated in Rockingham in May, with further expansion planned for other metropolitan Community Alcohol and Drug Services (CADS);
- Next Step managed a significant increase in the number of Hepatitis C clients referred, tested and treated by Direct Acting Antiviral medications since they were listed on the Pharmaceutical Benefits Scheme in March 2016; and
- there were 636 admissions to the Next Step Inpatient Withdrawal Unit. During 2016/17, 77% of closed treatment episodes were completed as planned.

Hospital-based services

In 2016/17 the Commission invested $330 million in public mental health inpatient services, through contracts with each of the State's HSPs – the CAHS, NMHS, SMHS, EMHS and WACHS. More than 250,000 inpatient beddays were provided to people across metropolitan and regional areas via these services and the Commission's high-medical AOD withdrawal service through Next Step.

The Commission worked with the CAHS and the SMHS to manage child, adolescent and youth mental health services, as ward movements occurred ahead of the future opening of the Perth Children's Hospital. Following the closure of eight beds at Princess Margaret Hospital in March 2016, which was unforeseen by the Commission, seven additional beds were opened at the Bentley Adolescent Unit site, for individuals up to the age of 16 and clinically appropriate 17 year olds. The remaining six beds at the Fiona Stanley Hospital youth unit, were also opened in November 2016 to further assist with the treatment of 16 and 17 year olds.

The Commission expanded its existing Next Step clinical liaison inreach model at Joondalup Health Campus, into Rockingham Hospital. A clinical nurse inreach service was also established to service Bunbury Hospital through the South West CADS. These specialist support services provide timely review, support, information and referral options to individuals, family members and hospital staff related to AOD issues including methamphetamine.

This resulted in increased AOD interventions for patients presenting at emergency departments and mental health services and increased referrals to CADS. This model received acknowledgement at the Australasian Professional Society on Alcohol and other Drugs (APSAD) national conference in November 2016.

SMHS mental health services, such as at Rockingham Hospital, are funded through the Commission

2016/17 expenditure on mental health inpatient services, provided by public Health Service Providers

Forensic services

The Commission enhanced specialised forensic community services in 2016/17. Highlights included:

- a dedicated stream for individuals with co-occurring AOD problems was introduced, to enable individuals to be assessed and referred to specialist AOD drug treatment providers from the Start Court;
- 385 referrals to the Start Court. Where clinical data was available, 89% of the cases that exited the program experienced improvement in their mental health and/or AOD issues;
- two additional consumer and carer representatives were recruited to the Start Court Operational Committee;
- the Links Clinical Assessment Team in the Children's Court provided advice, assessment or assistance in 466 cases during 2016/17 to young people appearing before the Children's Court;
- collaboration with the former Department of Corrective Services and the NMHS to develop and establish a new forensic mental health prison in-reach transition service from February 2017 across several metropolitan prisons. This service assists prisoners who experience severe and enduring mental illness with complex co-morbidity, in preparing for release. It also facilitates transitions between prison and community mental health services; and
- over 2,930 bookings Statewide, for WA Police and other diversionary programs including the Cannabis Intervention Requirement, Other Drug Requirement, and the Alcohol Assessment and Treatment component of the Alcohol Interlock Scheme.

System wide reform

Recovery-oriented practice

During 2016/17, the Commission and Self Management and Recovery Training (SMART) Recovery worked in partnership to provide facilitator training to Parents and Family Drug Support (PFDS) coordinators, and Alcohol and Drug Support Service staff and peer parent volunteers, to enable Be SMART recovery groups to be run by PFDS. SMART Recovery supports people with AOD issues in a recovery focused, goal orientated group process. The Be SMART groups are for parents, other family members and significant others impacted by the AOD issues of a loved one.

Consumer, carer and family engagement

The Commission strengthened engagement with consumers, families and carers in many areas of its work in 2016/17. Engagement has included:

- the development and implementation of its Consumer, Family, Carer and Community Paid Partnership Policy. The co-produced Policy adopts a tiered participation payment approach and has seen the Commission provide advice and support to a range of external stakeholders, around consumer, family and carer engagement in the health, disability and education sectors;
- a dedicated 12 person Community Advisory Group to guide the development of the Exposure Draft Compulsory Treatment (Alcohol and Other Drugs) Bill 2016;
- contribution from 25 active participants in an Accommodation and Support Strategy Consumer, Carer and Family Workshop;
- in partnership with Consumers of Mental Health WA, 20 students received scholarships to complete the Certificate IV Peer Work qualification through North Metropolitan TAFE;

- providing funding to the Health Consumers Council to progress AOD consumer involvement by developing a principles and strategies document;
- establishment of a trial, in partnership with Helping Minds, of the Practical Guide to Working with Carers for mental health services;
- the appointment of a Consumer Co-chair to the Next Step Consumer Involvement Committee and commencement of the development of a co-designed training package specific to AOD consumer representatives; and
- a steering committee was convened and co-chaired by a consumer/carer representative, to develop a Statewide engagement framework to ensure consumers, families, carers and community members actively and effectively participate in the Commission's work.

Bringing everyone together

The Mental Health Network, is a co-sponsored project between the Western Australian Department of Health and the Commission and comprises approximately 1,600 members, 10 steering groups and sub-networks.

The Network brings together NGO service providers, clinicians, consumers and carers from all areas across the mental health sector and community to collaboratively facilitate policy and increase coordination of care.

In the past year, four new sub-networks have been established to address specific issues relating to personality disorders, neuropsychiatry and developmental disability, multicultural mental health and older adult mental health. Over 30 priority projects that aim to improve outcomes for people with mental health conditions and reform the mental health sector are being progressed by the Mental Health Network.

Support to independent entities

The Commission provided corporate services to the Mental Health Advocacy Service, the Mental Health Tribunal and the Office of the Chief Psychiatrist. This included services and support in the areas of finance, human resources, information technology and facilities management.

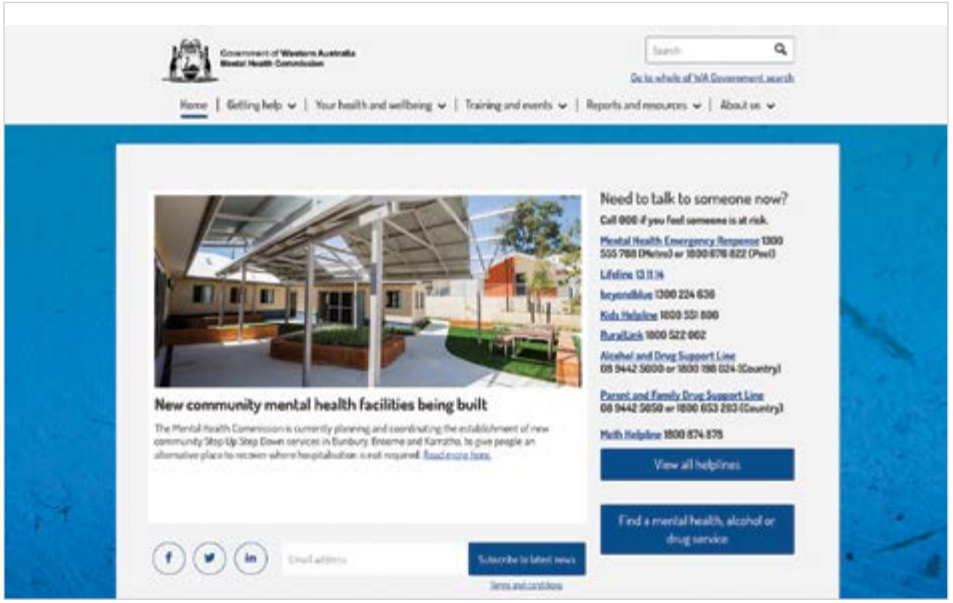
Aboriginal People

Please refer to the Workforce Development (page 35), Reconciliation Action Plan (page 165), Prevention (page 20) and Services in the community (page 22) sections for the range of programs undertaken by the Commission in 2016/17 in support of Aboriginal people and communities.

All services funded by the Commission are required to be able to demonstrate how they respond to cultural and social diversity, including for Aboriginal people, through the Commission's Quality Evaluation and Accreditation processes for mental health and AOD services. The *Mental Health Act 2014* also requires that assessment, examination and treatment for Aboriginal people should be in collaboration with Aboriginal mental health workers, their family and community, including elders and traditional healers, and cater for cultural and spiritual beliefs and practices, wherever appropriate.

System integration and navigation

The Commission is working with the Western Australian Primary Health Alliance (WAPHA) to co-plan and co-commission services where possible, with the aim that investment is coordinated and contributes to an effective and coherent system of services. One project that the WAPHA has been leading, supported by the Commission, is the development of a mental health and AOD Atlas of services in Western Australia. The aim of the Atlas is to provide a Statewide snapshot of the location and nature of mental health and AOD services across Western Australia. This will assist with the planning and commissioning of services, as well as providing the base information to contribute to initiatives to assist clinicians, consumers and carers in navigating the system.



New Mental Health Commission website

The Commission developed a new website at www.mhc.wa.gov.au in 2016/17 that provides an integrated and up-to-date source of information, for both the community, and the mental health and AOD sector. The website was launched in early 2017 and includes content on health and wellbeing; information and contact details for treatment and support services in Perth and regional areas; and information about the Commission and its role. The new website brings together mental health and AOD resources in one place.

Proposed compulsory alcohol and other drug treatment legislation

A Compulsory Alcohol and Other Drug Treatment Program was proposed for Western Australia in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives, to facilitate short-term compulsory treatment, stabilisation, care and support for people with a severe AOD problem.

In the 2016/17 financial year, the Commission developed an Exposure Draft Compulsory Treatment (Alcohol and Other Drugs) Bill 2016 (Exposure Draft Bill) and associated Summary Model of Service to enable input into the design of the proposed program.

Following substantial consultation on the Discussion and Background Papers, the Exposure Draft Bill and Summary Model of Service were released for public comment from December 2016 to January 2017.

Corrective Services e-learning

Collaboration between the Commission and the former Department of Corrective Services resulted in the development and roll-out of an online mental health and AOD awareness training package designed specifically for prison officers and other Corrections staff.

The Commission contributed funding to the cost of the training package, provided expert advice and facilitated stakeholder input into the content through the forensic sub-network of the Mental Health Network.

Approximately 3,000 Corrections staff have participated in the e-learning program, and those that have completed the training have gained increased awareness and understanding of mental health issues and enabling access to mental health supports and services for people in their care.

Department of Corrective Services e-learning program

Organisational effectiveness and efficiency

This financial year, the Commission developed and released the Commissioning Framework, which sets out the approach it adopts when commissioning services. The Framework outlines the full cycle of strategic planning, defining commissioning and decommissioning intentions, service design, procurement and contracting, and monitoring and evaluation.

Commissioning decisions and new service developments in mental health and AOD services throughout 2016/17 were guided by the priorities identified in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives.

The Commission has further improved its internal governance through the development of its Organisational Project Management Framework and System.

Strategic direction development

Stakeholder consultation to inform the development of a Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2017-2025 was undertaken through the financial year. The Strategy outlines a system-wide, multi-agency approach to addressing the accommodation and support needs of people with severe mental health or AOD related issues.

The Commission consulted with and received submissions from approximately 50 stakeholder organisations, convened two targeted workshops and established an Advisory Committee to guide its development.

The Drug and Alcohol Youth Service (DAYS) is one of the NGO services contracted by the Commission

The draft Western Australian Alcohol and Drug Interagency Strategy 2017-2021 was developed in 2016/17, by the Drug and Alcohol Strategic Senior Officers Group (DASSOG), which is chaired by the Commission and includes senior representatives from other key government departments involved in the response to reducing AOD related harms.

Advisory bodies

The Alcohol and Other Drugs Advisory Board (AODAB) provides advice to the Commission on matters relevant to section 11 functions of the *Alcohol and Other Drug Act 1974*. A complete list of members and their remuneration is provided in Appendix Two.

In 2016/17, the AODAB provided input into the draft Alcohol and Drug Interagency Strategy 2017-2021, consumer engagement in the AOD sector, proposed compulsory AOD treatment legislation and Summary Model of Service, and consideration of the implementation of the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives.

The Mental Health Advisory Council (MHAC) provides advice to the Commission regarding major issues affecting Western Australians with mental health issues, their carers and service providers. A complete list of members and their remuneration is provided in Appendix Two. In 2016/17, the MHAC provided advice to the Commission regarding: support services to assist prisoners to successfully transition from prison to the community; the Post Implementation Review of the *Mental Health Act 2014*; the Commission's approach to funding and contractual requirements for services commissioned from HSPs and how consumers, carers and families are included; and on the proposed compulsory AOD treatment program in Western Australia.

National and international partnerships

The Mental Health Commissioner represents Western Australia on the Mental Health, Drug and Alcohol Principal Committee (MHDAPC), a national committee that provides advice on mental health, tobacco and AOD issues to the Australian Health Ministers' Advisory Council.

In 2016/17, the Commission provided support and representation on programs and initiatives such as the:

- Mental Health Professional Online Development Program;
- National Mental Health Consumer and Carer Forum. The Commission continued to support Ms Lorraine Powell and Ms Debra Sobott as Western Australia's consumer and carer representatives on this forum;
- International Initiative of Mental Health Leadership (IIMHL) and the associated Leadership Exchange held in Sydney in February and March 2017;
- drafting of the Fifth National Mental Health and Suicide Prevention Plan;
- National Mental Health Commission's Advisory Group for Suicide Prevention;
- Mental Health Information Strategy Standing Committee;
- Safety and Quality Partnership Standing Committee; and
- drafting of the National Drug Strategy 2016-2025 as a member of the Inter-Governmental Committee on Drugs.

Through the Thinker in Residence program, the Commission continued its partnership with the Commissioner of Children and Young People to engage highly regarded specialists in the field of young people. The 2016/17 Thinker in Residence was Jane Burns, Professor of Innovation and Industry at The University of Sydney Faculty of Health Sciences. Professor Burns is nationally and internationally recognised for her work in suicide prevention research, translation, practice implementation and policy.

Funding was provided by the Commission to the World Health Organization (WHO) for the development of the QualityRights toolkit, which is used to assess and improve quality, and human rights conditions in mental health and related services.

Research and evaluation

In addition to monitoring and performance analysis, a range of evaluation and research projects were undertaken to inform policy development and support evidence-based commissioning. These included the:

- re-establishment of the Western Australian Coronial Suicide Information System (WACSIS) in conjunction with the Telethon Kids Institute, to provide an in-depth evidence-base on all suicides between 1986 and 2015;
- planning and commissioning of a major research project, The Research and Evaluation Services for the Fly-In Fly-Out Work Arrangements On Mental Health In The Resources Industry, in line with the recommendations of the Legislative Assembly Education and Health Standing Committee;
- implementation of the mental health *Your Experience of Service Survey* pilot program, with a wider roll-out of the survey to occur in 2017/18. This will capture feedback from consumers to support the commissioning of improved services;
- establishment of a contract with the University of Western Australia to mitigate mental ill-health and foster thriving workplaces;
- enhanced focus on non-admitted mental health services, including implementation of improved monitoring and analysis of service activity delivered by HSPs across the State; and focus on two key indicators with HSPs being:
  - monitoring the percentage of re-admissions to hospital within 28 days of discharge from acute specialised inpatient units; and
  - the percentage of contacts with community-based, public, non-admitted services, within seven days post discharge from public inpatient units.

Workforce development

The Commission continued to provide development opportunities to clinicians, frontline workers, volunteers and peer workers.
Key achievements included:

- leadership and support for undergraduate and post graduate addiction medicine training programs. Two Addiction Medicine Registrars completed the Next Step training to become Fellows of the Australasian Chapter of Addiction Medicine and a further two are currently in training;
- additional general practitioners trained and authorised as suboxone-only prescribers by Next Step, which enabled an expansion of community pharmacotherapy programs across Western Australia;
- the hosting of the Towards Elimination of Restrictive Practices national conference held in Perth in February 2017. The theme for the forum, ‘Working together, a culture of care’, was designed to bring improvements in policy and practice in mental health services. It provided an opportunity to reflect on current lessons, innovations and ideas that have arisen from practice and research around the world;
- funding for the WA Aids Council to develop and deliver the Peer Amphetamine Project: Rock Solid, to prevent and reduce methamphetamine-related harms for people who currently use or are at risk of using methamphetamine, by providing peer-based education. There have been 12 peer educators recruited;
- an amphetamine intoxication and toxicity, opioid overdose training resource package was developed, with training delivered to a total of 1,281 participants;

- a total of 221 evidence-based training events were delivered to 3,817 participants from a range of health, welfare, justice, AOD and mental health services, including educational training in regional areas of Western Australia; and
- more than 12,000 information resources were disseminated to support the workforce around the State.

Workforce Development at the Commission

Evaluation of training events demonstrated that training exceeded key performance indicators.

87% of training participants reported that they found the Commission's training had been 'a lot' to 'extremely' useful.

The Commission's Strong Spirit Strong Mind Aboriginal Programs delivered:

- Certificate III in Community Services and Certificate IV in Alcohol and other Drugs courses, with both qualifications customised to provide a culturally secure learning environment for Aboriginal workers in the specialist AOD and broader health sectors. Nineteen participants registered for the Certificate III and 14 graduates successfully completed the Certificate IV in May 2017. Participants were Aboriginal people from the Pilbara, East and West Kimberley regions, Mid West, Goldfields, Wheatbelt, Tjuntjunjarra (The Great Victoria Desert) and metropolitan Perth;
- three days of Ways of Working Part 1 training to 80 participants, and two days of training to 34 participants for Ways of Working Part 2. The training develops participants' knowledge, skills and understanding of Aboriginal culture in order to build better working relationships with Aboriginal clients and effect organisational change;
- three workshops about fetal alcohol spectrum disorders;
- blood-borne virus training for cultural ways of responding to injecting and other drug use in Aboriginal communities; and
- a Quitline Aboriginal Liaison Training (QALT) program that ensured the cultural security of Quitline services, promotion of Quitline services to Aboriginal people in Western Australia, and the provision of training resources and promotional materials. QALT delivered 12 training sessions, including eight community events, training 145 health professionals in 2016/17.

Strong Spirit Strong Mind Aboriginal Programs deliver training to participants from across Western Australia

"You can go and study anywhere but to have somewhere where there is a cultural focus and respect… I am grateful because it is in line with how we live.

It's made it achievable. These guys didn't judge me, they supported me and really did walk alongside me, which is our way.

Certificate III, invaluable. It made me able to do the work that I do, that I love.

It's been an incredible journey and I would recommend it to anyone."

– a recent Strong Spirit Strong Mind Aboriginal Program Certificate IV graduate

Commission employee development and wellness

In 2016/17 the Commission revised its Values. They are:

- respect for individuals and culture;
- working together and supporting each other;
- involving and engaging others;
- ownership, transparency and accountability;
- fair and ethical decisions; and
- improvement focus.

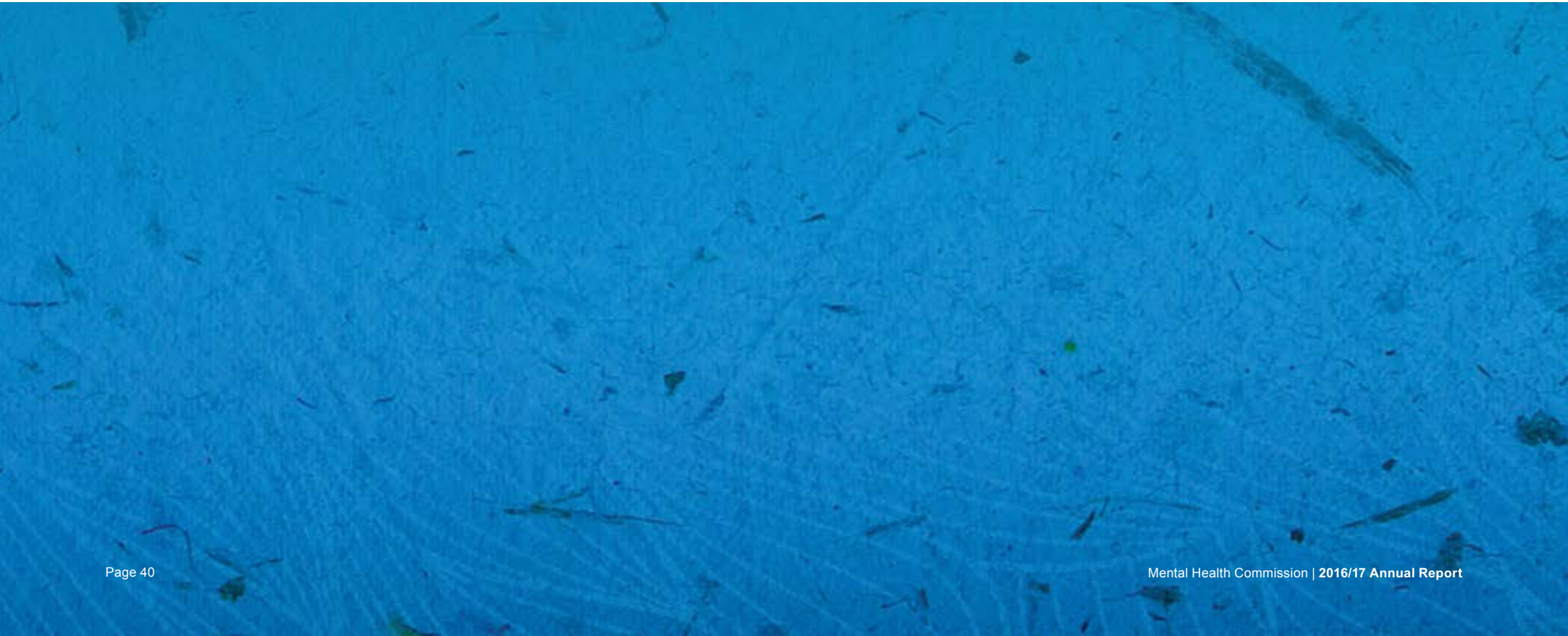
In alignment with its focus on respect, and working together and supporting each other, the Commission implemented professional and personal development initiatives to assist its employees to achieve both individually and as a team. These included:

- 'Behaviour Matters' workshops, delivered to 228 employees, which established a common understanding across the Commission, of the behaviours that are consistent with working in accordance with the Commission's new Values and Code of Conduct;
- 'Building and Leading High Performing Teams' training for supervisors, which provided an overview of the strategies necessary to lead a team successfully and maximise the performance of individual staff members;
- 'Mental Health First Aid' training;

- a new online learning management system, ELMO, to provide employees with a comprehensive library of online courses ranging from Accountable and Ethical Decision Making, Recordkeeping Awareness Training, Communication and Personal Development, Customer Service, Finance, Leadership and Management, Health Care/Clinical and Project and Business Management. ELMO also provides accurate, up-to-date data on employee training completion, enabling the Commission to improve its reporting capabilities and assist employees and supervisors with performance development; and
- as part of the Commission's commitment to providing employees with an environment that actively assists them to maximise their overall health and wellbeing, a Wellness program was launched, supported by the Wellness Committee. The program includes activities such as on-site fitness classes, toolbox sessions – on topics such as mindfulness, improved communication and relationships, financial health, and improved posture and resilience – corporate team challenges and free flu vaccinations.

Commission employees during 2016/17

Significant Issues



Significant Issues Impacting The Commission

On 1 July 2016, WA Health (the Department of Health and five HSPs), underwent significant reform with the commencement of the *Health Services Act 2016*. This required the Commission to enter into new bilateral agreements with the new Health Services Boards, which were progressed in 2016/17. These agreements adhere to the legal framework outlined in the *Health Services Act 2016* and provide a further mechanism for improvement and accountability in the delivery of public mental health services.

The amalgamation of the child and adolescent mental health inpatient facilities at Princess Margaret Hospital (PMH) and the Bentley Adolescent Unit (BAU) by the CAHS in March 2016, led to the closure of eight beds at PMH. This closure was unplanned by the Commission, but was implemented by the CAHS in the interests of safety and quality. The Commission closely monitored the impact, and sought and facilitated the opening of additional child and adolescent beds at the BAU to address the resultant increase in unmet demand following the PMH ward closure. To assist with the sustainability of child and adolescent mental health services and in preparation for the transfer of mental health inpatient beds to the Perth Children's Hospital, the Commission is working in collaboration with the CAHS and Department of Health on a review of child and adolescent inpatient mental health costs. This review will inform commissioning and ongoing service improvements.

The implementation of the Western Australian Meth Strategy 2016 and the Government's Methamphetamine Action Plan, has underpinned and expanded the Commission's work in the AOD sector, as part of an across government effort to reduce the supply, demand and harm of methamphetamine in Western Australia. The Commission has worked in 2016/17 to plan, deliver and evaluate initiatives across the spectrum of prevention, treatment, and community-based and bed-based rehabilitation services.

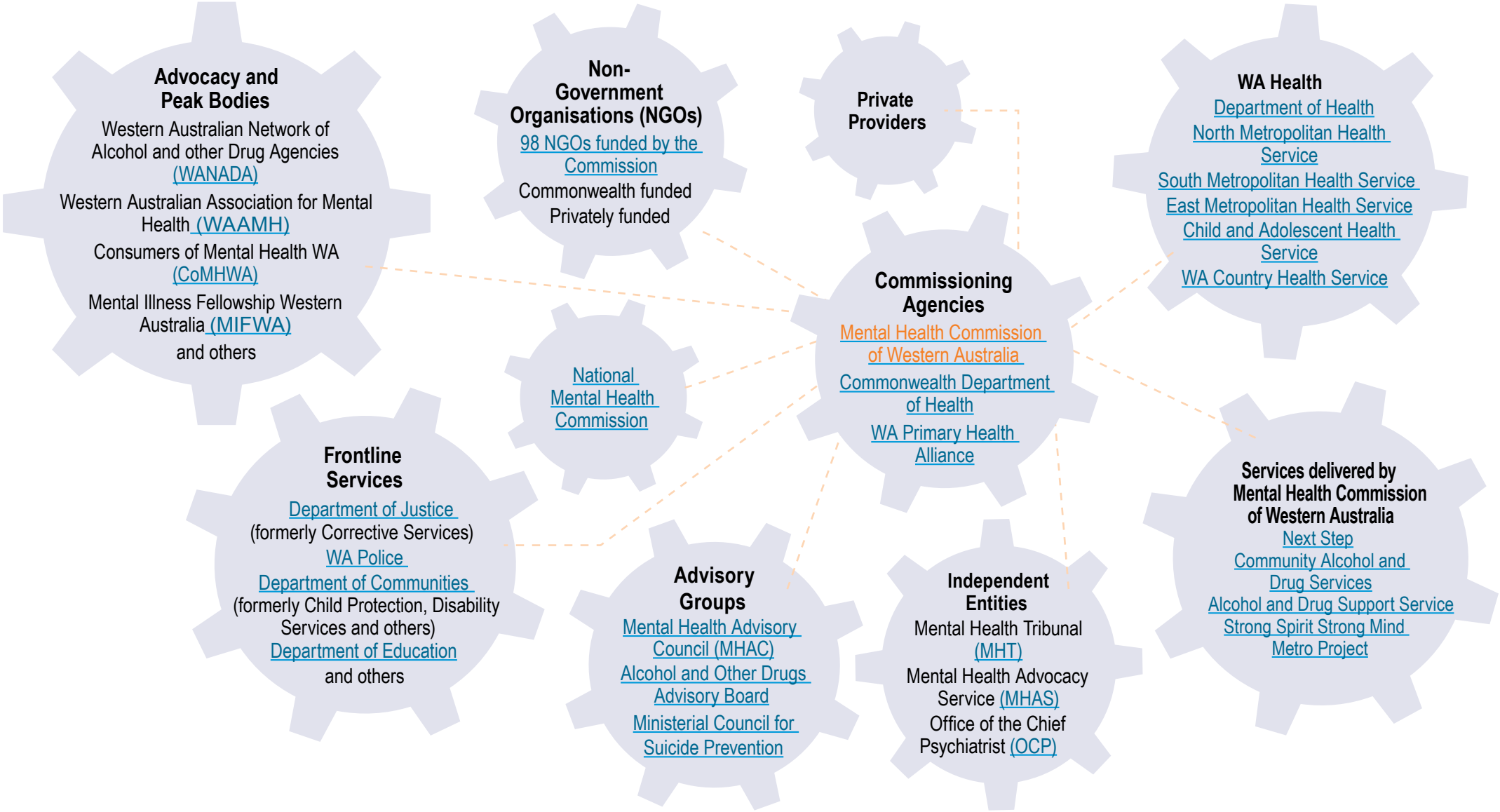
Development of the Fifth National Mental Health and Suicide Prevention Plan is being led by the Mental Health, Drug and Alcohol Principal Committee of the Australian Health Minister's Advisory Council, of which the Western Australian Mental Health Commissioner is a member. The National Drug Strategy 2017-2026 (NDS) was endorsed for release by the Ministerial Drug and Alcohol Forum on 29 May 2017. The NDS continues the strong partnership between health and law enforcement agencies with a commitment to harm minimisation and a comprehensive approach to AOD policy that focuses on reduction in supply, demand and harm.

The Mental Health Commission has been closely monitoring the implementation of the National Disability Insurance Scheme and working in partnership with the Department of Communities (former Disability Services Commission) and the National Disability Insurance Agency to include people with psychosocial disability within the Scheme. The Commission has not, and will not, reduce funding to mental health support services as a result of the Scheme.

The Commission continued to evaluate and prioritise the provision of services and initiatives in 2016/17 to ensure its resources are allocated both effectively and efficiently, to achieve maximum benefit to the community.

The 2017 State Election and the preceding caretaker period required a phase of transition. There were major legislative and planning decisions requiring assessment and review by the incoming government, and election commitments forming part of the Commission's planned scope of works. The Commission worked to comprehensively brief the incoming Minister for Mental Health and the new Parliamentary Secretary for Mental Health. It also conducted planning and detailed assessment of deliverables within the Mental Health portfolio, ahead of their future implementation.

Overview of the mental health and AOD sector in Western Australia



Disclosures and Legal Compliance

Certification of Financial Statements For the year ended 30 June 2017

The accompanying financial statements of the Mental Health Commission have been prepared in compliance with provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the financial year ended 30 June 2017 and the financial position as at 30 June 2017.

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.

Marie Falconer
Chief Financial Officer
Mental Health Commission

6 September 2017

Timothy Marney
Accountable Authority
Mental Health Commission

6 September 2017

Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

MENTAL HEALTH COMMISSION

Auditor General

Report on the Financial Statements

Opinion

I have audited the financial statements of the Mental Health Commission which comprise the Statement of Financial Position as at 30 June 2017, the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows, Schedule of Income and Expenses by Service, Schedule of Assets and Liabilities by Service, and Summary of Consolidated Account Appropriations and Income Estimates for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information, including Administered transactions and balances.

In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the Mental Health Commission for the year ended 30 June 2017 and the financial position at the end of that period. They are in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for Opinion

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

Responsibility of the Commissioner for the Financial Statements

The Commissioner is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions, and for such internal control as the Commissioner determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditor's Responsibility for the Audit of the Financial Statements

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

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

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

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

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

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

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

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

Report on Controls

Opinion

I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the Mental Health Commission. The controls exercised by the Commission are those policies and procedures established by the Commissioner to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions (the overall control objectives).

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

In my opinion, in all material respects, the controls exercised by the Mental Health Commission are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2017.

The Commissioner's Responsibilities

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

Auditor General's Responsibilities

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

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

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

Limitations of Controls

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

Report on the Key Performance Indicators

Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the Mental Health Commission for the year ended 30 June 2017. The key performance indicators are the key effectiveness indicators and the key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators of the Mental Health Commission are relevant and appropriate to assist users to assess the Commission's performance and fairly represent indicated performance for the year ended 30 June 2017.

The Commissioner's Responsibility for the Key Performance Indicators

The Commissioner is responsible for the preparation and fair presentation of the key performance indicators in accordance with the *Financial Management Act 2006* and the Treasurer's Instructions and for such internal control as the Commissioner determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

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

Auditor General's Responsibility

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

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

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

My Independence and Quality Control Relating to the Reports on Controls and Key Performance Indicators

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

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators

This auditor's report relates to the financial statements and key performance indicators of the Mental Health Commission for the year ended 30 June 2017 included on the Commission's website. The Commission's management is responsible for the integrity of the Commission's website. This audit does not provide assurance on the integrity of the Commission's website. The auditor's report refers only to the financial statements and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial statements and key performance indicators to confirm the information contained in this website version of the financial statements and key performance indicators.

SANDRA LABUSCHAGNE
ACTING DEPUTY AUDITOR GENERAL
Delegate of the Auditor General for Western Australia
Perth, Western Australia
7 September 2017

Financial Statements

Mental Health Commission
Statement of Comprehensive Income
For the year ended 30 June 2017

	Note	2017 $	2016 $
COST OF SERVICES			
Expenses			
Employee benefits expense	6	35,975,411	38,982,037
Service agreement - WA Health	8	670,265,489	643,885,694
Service agreement - non government and other organisations	9	139,015,908	137,109,599
Supplies and services	10	10,389,927	10,684,639
Grants and subsidies	11	2,864,341	6,642,853
Depreciation expense	12	473,756	455,123
Accommodation expense	13	2,249,106	1,023,150
Other expenses	14	1,873,235	4,431,291
Total cost of services		**863,107,173**	**843,214,386**
Income			
Revenue			
Commonwealth grants and contributions	16	163,338,110	173,026,975
Other grants and contributions	17	4,304,596	5,280,494
Other revenue	18	882,539	256,475
Total revenue		**168,525,245**	**178,563,944**
Total income other than income from State Government		**168,525,245**	**178,563,944**
NET COST OF SERVICES		**694,581,928**	**664,650,442**
Income from State Government			
Service appropriation	19	684,695,000	654,815,000
Services received free of charge	19	3,196,476	3,922,970
Royalties for Regions Fund	19	5,422,609	5,630,000
Total income from State Government		**693,314,085**	**664,367,970**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(1,267,843)**	**(282,472)**
OTHER COMPREHENSIVE INCOME		-	-
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(1,267,843)**	**(282,472)**

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

Financial Statements

Mental Health Commission
Statement of Financial Position
As at 30 June 2017

	Note	2017 $	2016 $
ASSETS			
Current Assets			
Cash and cash equivalents	31	24,611,247	25,951,257
Restricted cash and cash equivalents	20, 31	6,022,264	4,818,201
Receivables	21	490,446	564,893
Inventories	23	18,244	20,008
Other current assets	24	27,626	39,685
Total Current Assets		**31,169,827**	**31,394,044**
Non-Current Assets			
Restricted cash and cash equivalents	20, 31	123,552	-
Amounts receivable for services	22	5,486,123	5,145,123
Property, plant and equipment	25	22,426,272	22,571,657
Total Non-Current Assets		**28,035,947**	**27,716,780**
TOTAL ASSETS		**59,205,774**	**59,110,824**
LIABILITIES			
Current Liabilities			
Payables	28	4,331,079	3,897,124
Provisions	29	5,351,712	5,770,643
Total Current Liabilities		**9,682,791**	**9,667,767**
Non-Current Liabilities			
Provisions	29	2,098,539	1,860,770
Total Non-Current Liabilities		**2,098,539**	**1,860,770**
TOTAL LIABILITIES		**11,781,330**	**11,528,537**
NET ASSETS		**47,424,444**	**47,582,287**
EQUITY			
Contributed equity	30	32,135,558	31,025,558
Accumulated surplus	30	15,288,886	16,556,729
TOTAL EQUITY		**47,424,444**	**47,582,287**

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

Financial Statements

Mental Health Commission
Statement of Changes in Equity
For the year ended 30 June 2017

	Note	2017 $	2016 $
CONTRIBUTED EQUITY	30		
Balance at start of period		31,025,558	945,900
Transactions with owners in their capacity as owners:			
Other contribution by owners - Royalties for Region Fund		1,110,000	-
Contributions by owners		-	30,079,658
Balance at end of period		32,135,558	31,025,558
ACCUMULATED SURPLUS	30		
Balance at start of period		16,556,729	16,839,201
Surplus/(deficit) for the period		(1,267,843)	(282,472)
Balance at end of period		15,288,886	16,556,729
TOTAL EQUITY			
Balance at start of period		47,582,287	17,785,101
Total comprehensive income/(loss) for the period		(1,267,843)	(282,472)
Transactions with owners in their capacity as owners		1,110,000	30,079,658
Balance at end of period		**47,424,444**	**47,582,287**

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

Financial Statements

Mental Health Commission
Statement of Cash Flows
For the year ended 30 June 2017

	Note	2017 $ Inflows (Outflows)	2016 $ Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation	31	684,354,000	654,575,000
Royalties for Regions Fund - Capital	30	1,110,000	-
Royalties for Regions Fund - Recurrent	19	5,422,609	5,630,000
Net cash provided by State Government		**690,886,609**	**660,205,000**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits expense		(36,122,797)	(41,220,707)
Service agreement - WA Health		(670,265,489)	(644,092,337)
Service agreement - non government and other organisations		(139,086,788)	(137,797,069)
Supplies and services		(6,326,892)	(6,265,190)
Grants and subsidies		(3,193,909)	(6,349,005)
Accommodation expense		(2,025,210)	(1,072,650)
Other payments		(1,919,112)	(3,201,759)
Receipts			
Commonwealth grants and contributions		163,338,110	173,026,975
Other grants and contributions		4,304,596	5,280,494
Other receipts		643,244	189,943
Net cash used in operating activities	31	**(690,654,247)**	**(661,501,305)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets		(244,757)	(145,875)
Net cash used in investing activities		**(244,757)**	**(145,875)**
Net increase / (decrease) in cash and cash equivalents		(12,395)	(1,442,180)
Cash and cash equivalents at the beginning of the period		30,769,458	24,032,135
Cash and cash equivalents transferred from WA Alcohol & Drug Authority	30	-	8,179,503
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	31	**30,757,063**	**30,769,458**

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

Financial Statements

Mental Health Commission
Schedule of Income and Expenses by Service
For the year ended 30 June 2017

	Prevention		Hospital Bed Based Services		Community Bed Based Services		Community Treatment		Community Support		Total	
	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $
COST OF SERVICES												
Expenses												
Employee benefits expense	856,215	966,755	15,329,123	16,333,473	1,859,929	2,003,677	15,994,667	17,272,940	1,935,477	2,405,192	35,975,411	38,982,037
Service agreement - WA Health	15,952,319	15,968,365	285,600,125	269,788,106	34,652,726	33,095,725	298,000,036	285,305,751	36,060,283	39,727,747	670,265,489	643,885,694
Service agreement - non government and other organisations	3,308,579	3,400,318	59,234,678	57,448,922	7,187,122	7,047,433	61,806,473	60,753,263	7,479,056	8,459,663	139,015,908	137,109,599
Supplies and services	247,280	264,979	4,427,148	4,476,864	537,159	549,190	4,619,362	4,734,364	558,978	659,242	10,389,927	10,684,639
Grants and subsidies	68,171	164,743	1,220,496	2,783,355	148,086	341,443	1,273,486	2,943,448	154,102	409,864	2,864,341	6,642,853
Depreciation expense	11,275	11,287	201,867	190,697	24,493	23,393	210,633	201,665	25,488	28,081	473,756	455,123
Accommodation expense	53,529	25,374	958,344	428,700	116,279	52,590	999,952	453,358	121,002	63,128	2,249,106	1,023,150
Other expenses	44,583	109,896	798,185	1,856,711	96,846	227,768	832,840	1,963,505	100,781	273,411	1,873,235	4,431,291
Total cost of services	20,541,951	20,911,717	367,769,966	353,306,828	44,622,640	43,341,219	383,737,449	373,628,294	46,435,167	52,026,328	863,107,173	843,214,386
Income												
Commonwealth grants and contributions	336,000	181,000	96,549,948	99,219,612	-	-	66,270,402	68,411,749	181,760	5,214,614	163,338,110	173,026,975
Other grants and contributions	2,226,312	2,467,143	100,000	208,145	-	-	1,978,284	2,605,206	-	-	4,304,596	5,280,494
Other revenue	21,004	6,361	376,050	107,463	45,627	13,182	392,377	113,644	47,481	15,825	882,539	256,475
Total income other than income from State Government	2,583,316	2,654,504	97,025,998	99,535,220	45,627	13,182	68,641,063	71,130,599	229,241	5,230,439	168,525,245	178,563,944
NET COST OF SERVICES	17,958,635	18,257,213	270,743,968	253,771,608	44,577,013	43,328,037	315,096,386	302,497,695	46,205,926	46,795,889	694,581,928	664,650,442
Income from State Government												
Service appropriation	17,662,100	17,774,635	268,841,722	252,009,528	44,346,207	43,111,877	308,492,226	296,033,130	45,352,745	45,885,830	684,695,000	654,815,000
Services received free of charge	76,076	97,290	1,362,019	1,643,724	165,258	201,641	1,421,153	1,738,268	171,970	242,047	3,196,476	3,922,970
Royalties for Regions Fund	190,283	378,283	-	-	-	-	4,619,326	4,601,134	613,000	650,583	5,422,609	5,630,000
Total income from State Government	17,928,459	18,250,208	270,203,741	253,653,252	44,511,465	43,313,518	314,532,705	302,372,532	46,137,715	46,778,460	693,314,085	664,367,970
SURPLUS/(DEFICIT) FOR THE PERIOD	(30,176)	(7,005)	(540,227)	(118,356)	(65,548)	(14,519)	(563,681)	(125,163)	(68,211)	(17,429)	(1,267,843)	(282,472)

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

Financial Statements

Mental Health Commission
Schedule of Assets and Liabilities by Service
As at 30 June 2017

	Prevention		Hospital Bed Based Services		Community Bed Based Services		Community Treatment		Community Support		Total	
	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $	2017 $	2016 $
ASSETS												
Current assets	741,842	778,572	13,281,463	13,154,105	1,611,480	1,613,654	13,858,105	13,910,701	1,676,937	1,937,012	31,169,827	31,394,044
Non-current assets	667,256	687,376	11,946,117	11,613,331	1,449,458	1,424,642	12,464,782	12,281,305	1,508,334	1,710,126	28,035,947	27,716,780
Total Assets	1,409,098	1,465,948	25,227,580	24,767,436	3,060,938	3,038,296	26,322,887	26,192,006	3,185,271	3,647,138	59,205,774	59,110,824
LIABILITIES												
Current liabilities	230,450	239,761	4,125,837	4,050,794	500,600	496,923	4,304,970	4,283,788	520,934	596,501	9,682,791	9,667,767
Non-current liabilities	49,945	46,147	894,187	779,663	108,494	95,643	933,012	824,507	112,901	114,810	2,098,539	1,860,770
Total Liabilities	280,395	285,908	5,020,024	4,830,457	609,094	592,566	5,237,982	5,108,295	633,835	711,311	11,781,330	11,528,537
NET ASSETS	1,128,703	1,180,040	20,207,556	19,936,979	2,451,844	2,445,730	21,084,905	21,083,711	2,551,436	2,935,827	47,424,444	47,582,287

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

Financial Statements

Mental Health Commission
Summary of Consolidated Account Appropriations and Income Estimates
For the year ended 30 June 2017

	2017 Estimate $	2017 Actual $	Variance $	2017 Actual $	2016 Actual $	Variance $
Delivery of Services						
Item 43 Net amount appropriated to deliver services	668,680,000	683,886,000	15,206,000	683,886,000	657,798,000	26,088,000
Section 25 transfer of service appropriation						
Office of the Chief Psychiatrist	-	-	-	-	(921,000)	921,000
Mental Health Tribunal	-	-	-	-	(1,406,000)	1,406,000
Mental Health Advocacy Service	-	-	-	-	(1,439,000)	1,439,000
Amount Authorised by Other Statutes						
- *Salaries and Allowances Act 1975*	809,000	809,000	-	809,000	783,000	26,000
Total appropriations provided to deliver services	669,489,000	684,695,000	15,206,000	684,695,000	654,815,000	29,880,000
Administered Transactions						
Administered grants, subsidies and other transfer payments	7,569,000	7,569,000	-	7,569,000	4,520,000	3,049,000
Administered capital appropriations	-	-	-	-	-	-
Total administered transactions	7,569,000	7,569,000	-	7,569,000	4,520,000	3,049,000
GRAND TOTAL	677,058,000	692,264,000	15,206,000	692,264,000	659,335,000	32,929,000
Details of Expenses by Service						
Prevention	19,507,000	20,541,951	1,034,951	20,541,951	20,911,717	(369,766)
Hospital Bed Based Services	364,119,000	367,769,966	3,650,966	367,769,966	353,306,828	14,463,138
Community Bed Based Services	49,036,000	44,622,640	(4,413,360)	44,622,640	43,341,219	1,281,421
Community Treatment	381,704,000	383,737,449	2,033,449	383,737,449	373,628,294	10,109,155
Community Support	51,406,000	46,435,167	(4,970,833)	46,435,167	52,026,328	(5,591,161)
Total Cost of Services	865,772,000	863,107,173	(2,664,827)	863,107,173	843,214,386	19,892,787
Less Total income	(182,722,000)	(168,525,245)	14,196,755	(168,525,245)	(178,563,944)	10,038,699
Net Cost of Services	683,050,000	694,581,928	11,531,928	694,581,928	664,650,442	29,931,486
Adjustments (a)	(13,561,000)	(9,886,928)	3,674,072	(9,886,928)	(9,835,442)	(51,486)
Total appropriations provided to deliver services	669,489,000	684,695,000	15,206,000	684,695,000	654,815,000	29,880,000
Details of Income Estimates						
Income disclosed as Administered Income	7,569,000	8,649,914	1,080,914	8,649,914	5,058,418	3,591,496
	7,569,000	8,649,914	1,080,914	8,649,914	5,058,418	3,591,496

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

Note 42 'Explanatory statement' and note 43 'Explanatory statement for Administered Items' provide details of any significant variations between estimates and actual results for 2017 and between actual results for 2017 and 2016.

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 1 Australian Accounting Standards

General

The Commission's financial statements for the year ended 30 June 2017 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' includes Standards and Interpretations issued by the Australian Accounting Standards Board (AASB).

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

Early adoption of standards

The Commission cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 1101 '*Application of Australian Accounting Standards and Other Pronouncements*'. There has been no early adoption of any other Australian Accounting Standards that have been issued or amended (but not operative) by the Commission for the annual reporting period ended 30 June 2017.

Note 2 Summary of significant accounting policies

(a) General statement

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

The *Financial Management Act* 2006 and the Treasurer's Instructions impose legislative provisions that govern the preparation of financial statements and take precedence over the Australian Accounting Standards, the Framework, Statements 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, except for land and buildings which have been measured at fair value.

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.

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(c) Reporting entity

The reporting entity comprises the Commission only.

Mission

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

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

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

Services

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

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

Prevention

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

Hospital Bed Based Services

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

Community Bed Based Services

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

Community Treatment

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

Community Support

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

The Commission administers assets, liabilities, income and expenses on behalf of Government which are not controlled by, nor integral, to the function of the Commission. These administered balances and transactions are not recognised in the principal financial statements of the Commission but schedules are prepared using the same basis as the financial statements and are presented at Note 40 ‘Disclosure of administered income and expenses by service’ and Note 41 ‘Administered assets and liabilities’.

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(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 TI 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 30 'Equity'.

(e) Income

Revenue recognition

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

Sale of goods

Revenue is recognised from the sale of goods and disposal of other assets when the significant risks and rewards of ownership transfer to the purchaser and can be measured reliably.

Provision of services

Revenue is recognised by reference to the stage of completion of the transaction.

Interest

Revenue is recognised as the interest accrues.

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 or credited to the "Amounts receivable for the services" (holding account) held at Treasury. Refer to note 19 'Income from State Government' for further information.

Net appropriation determination

The Treasurer may make a determination providing for prescribed receipts to be retained for services under the control of the Commission. In accordance with the determination specified in the 2016-17 Budget Statements, the Commission retained $5,704,895 in 2017 ($12,943,584 in 2016) from the following:

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

In addition, Commonwealth revenue retained under the *National Health Funding Pool Act 2012* totals $162,820,350 in 2017 ($165,620,360 in 2016).

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(e) Income (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.

Royalties for Regions funds are recognised as revenue at fair value in the period in which the Commission obtains control over the funds. The Commission obtains control of the funds at the time the funds are deposited into the Commission's bank account.

Gains

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

(f) Property, plant and equipment

Capitalisation/expensing of assets

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

Initial recognition and measurement

Property, plant and equipment are initially recognised at cost.

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

Subsequent measurement

Subsequent to initial recognition as an asset, the revaluation model is used for the measurement of land and buildings and historical cost for all other property, plant and equipment. Land and buildings are carried at fair value less accumulated depreciation (buildings) and accumulated impairment losses. All other items of property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Where market-based evidence is available, the fair value of land and buildings (non-clinical sites) is determined on the basis of current market values determined by reference to recent market transactions.

In the absence of market-based evidence, fair value of land and buildings (clinical sites) is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use buildings is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the depreciated replacement cost. Fair value for restricted use land is determined by comparison with market evidence for land with similar approximate utility (high restricted use land) or market value of comparable unrestricted land (low restricted use land).

When buildings are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(f) Property, plant and equipment (continued)

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

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

See also note 25 'Property, plant and equipment' for further information on revaluation.

Derecognition

Upon disposal or derecognition of an item of property, plant and equipment, any revaluation surplus relating to that asset is retained in the asset revaluation reserve.

Asset revaluation surplus

The asset revaluation surplus is used to record increments and decrements on the revaluation of non-current assets as described in note 25 'Property, plant and equipment'.

Depreciation

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

In order to apply this policy, the following methods are utilised:
* Land - not depreciated
* Buildings, Plant and equipment - straight line

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

The assets' useful lives are reviewed, and adjusted if appropriate, annually. Estimated useful lives for each class of depreciable asset are:

Buildings	23 to 50 years
Computer equipment	4 years
Furniture and fittings	10 to 20 years
Medical equipment	10 years
Other plant and equipment	5 to 10 years

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

(g) Impairment of assets

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

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(g) Impairment of assets (continued)

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

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

Refer also to note 2(l) 'Receivables" and note 21 'Receivables' for impairment of receivables and note 27 'Impairment of assets'.

(h) 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. 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.

(i) Financial instruments

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

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

Financial instruments have been disaggregated into the following classes:

Financial Assets
- Cash and cash equivalents
- Restricted cash and cash equivalents
- Receivables
- Amounts receivable for services

Financial Liabilities
- Payables

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

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

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(j) Cash and cash equivalents

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

(k) Accrued salaries

Accrued salaries (see note 28 'Payables') represent the amount due to employees but unpaid at the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Commission considers the carrying amount of accrued salaries to be equivalent to its fair value.

The accrued salaries suspense account (see note 20 'Restricted cash and cash equivalents') consists of amounts paid annually into a suspense account over a period of 10 financial years to largely meet the additional cash outflow in each eleventh year when 27 pay days occur instead of the normal 26. No interest is received on this account.

(l) Receivables

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

Refer to note 2(i) 'Financial instruments' and note 21 'Receivables'.

Accounting procedure for Goods and Services Tax

Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for GST have been assigned to the 'Department of Health'. This accounting procedure was a result of application of the grouping provisions of “A New Tax System (Goods and Services Tax) Act 1999" whereby the Department of Health became the Nominated Group Representative (NGR) for the GST Group as from 1 July 2012. The entities in the GST group include the Department of Health, Mental Health Commission, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service, Health Support Services, WA Country Health Service, QE II Medical Centre Trust, and Health and Disability Services Complaints Office.

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

(m) Amounts receivable for services (holding account)

The Commission receives state appropriation funding from the State Government on an accural basis, partly in cash and partly as an asset (holding account receivable). The accrued amount receivable is accessible on the emergence of the cash funding requirement to cover leave entitlements and asset replacement.

See also note 19 'Income from State Government' and note 22 'Amounts receivable for services'.

(n) Inventories

Inventories are measured at the lower of cost and net realisable value. Costs are assigned on a weighted average cost basis.

Inventories not held for resale are measured at cost unless they are no longer required in which case they are measured at net realisable value. (See note 23 'Inventories')

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(o) Payables

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

Refer to note 2(i) 'Financial Instruments' and note 28 'Payables'.

(p) 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 the end of each reporting period.

Refer to note 29 '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

Annual leave is not expected to be settled wholly within 12 months after the end of the reporting period and is therefore considered to be 'other long-term employee benefits'. The annual leave liability is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

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

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

Long service leave

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

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

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

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(p) Provisions (continued)

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 Salary Scheme

The provision for deferred salary scheme relates to the Commission's employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. The provision recognises the value of salary set aside for employees to be used in the fifth year. This liability is measured on the same basis as annual leave. Deferred salary scheme is reported as a current provision as employees can leave the scheme at their discretion at any time.

Superannuation

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

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

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

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

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

The GESB makes all benefit payments in respect of the Pension Scheme and GSS, and is recouped from the Treasurer for the employer's share.

Refer to note 2(q) 'Superannuation expense'.

Employment on-costs

Employment on-costs (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 are not included as part of the Commission's 'Employee benefits expense'. Any related liability is included in 'Employment on-costs provision'.

Refer to note 14 'Other expenses' and note 29 'Provisions'.

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(q) Superannuation expense

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

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

Services received free of charge or for nominal cost, that the Commission would otherwise purchase if not donated, are recognised as income at the fair value of the services where they can be reliably measured. A corresponding expense is recognised for services received.

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

(s) Assets transferred between government agencies

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

(t) Comparative figures

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

Note 3 Judgements made by management in applying accounting policies

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

The judgements that have been made in the process of applying accounting policies that have the most significant effect on the amounts recognised in the financial statements include:

Buildings

A number of buildings that are located on the land of local government agencies have been recognised in the financial statements. The Commission believes that, based on past experience, its occupancy in these buildings will continue to the end of their useful lives.

Employee benefits provision

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

Operating lease commitments

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

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

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.

Buildings

In order to estimate fair value on the basis of existing use, the depreciated replacement costs are determined on the assumption that the buildings will be used for the same functions in the future. A major change in utilisation of the buildings may result in material adjustment to the carrying amounts.

Long Service Leave

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

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Commission has applied the following Australian Accounting Standards effective, or adopted, for annual reporting periods beginning on or after 1 July 2016 that impacted on the Commission.

AASB 1057 *Application of Australian Accounting Standard*

This Standard lists the application paragraphs for each other Standard (and Interpretation), grouped where they are the same. There is no financial impact.

AASB 2014-4 *Amendments to Australian Accounting Standards – Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 & 138]*

The adoption of this Standard has no financial impact for the Commission as depreciation and amortisation is not determined by reference to revenue generation, but by reference to consumption of future economic benefits.

AASB 2015-1 *Amendments to Australian Accounting Standards - Annual Improvements to Australian Accounting Standards 2012-2014 Cycle (AASB 1, 2, 3, 5, 7, 11, 110, 119, 121, 133, 134, 137 & 140)*

These amendments arise from the issuance of International Financial Reporting Standard Annual Improvements to IFRSs 2012-2014 Cycle in September 2014, and editorial corrections. The Commission has determined the application of the Standard has no financial impact.

AASB 2015-2 *Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 101 (AASB 7, 101, 134 & 1049)*

This Standard amends AASB 101 to provide clarification regarding the disclosure requirements in AASB 101. Specifically, the Standard proposes narrow-focus amendments to address some of the concerns expressed about existing presentation and disclosure requirements and to ensure entities are able to use judgement when applying a Standard in determining what information to disclose in their financial statements. There is no financial impact.

AASB 2015-6 *Amendments to Australian Accounting Standards - Extending Related Party Disclosures to Not-for-Profit Public Sector Entities (AASB 10, 124 & 1049)*

The amendments extend the scope of AASB 124 to include application by not-for-profit public sector entities. Implementation guidance is included to assist application of the Standard by not-for-profit public sector entities. There is no financial impact.

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

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

Title		Operative for reporting periods beginning on/after
AASB 9	*Financial Instruments* This Standard supersedes *AASB 139 Financial Instruments: Recognition and Measurement* , introducing a number of changes to accounting treatments. The mandatory application date of this Standard is currently 1 January 2018 after being amended by AASB 2012-6, AASB 2013-9 and AASB 2014-1 *Amendments to Australian Accounting Standards.* The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 15	*Revenue from Contracts with Customers* This Standard establishes the principles that the Commission shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from a contract with a customer. The Commission's income is principally derived from appropriations which will be measured under AASB 1058 *Income of Not-for-Profit Entities* and will be unaffected by this change. However, the Commission has not yet detremined the potential impact of the Standard on other revenues. In broad terms, it is anticipated that the terms and conditions attached to these revenues will defer revenue recognition until the Commission has discharged its performance obligations.	1 Jan 2019
AASB 16	*Leases* This Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. Whilst the impact of AASB 16 has not yet been quantified, the entity currently has operating lease commitments for $20,404,100. The Commission anticipates most of this amount will be brought onto the statement of financial position, excepting amounts pertinent to short term or low value leases. Interest and amortisation expenses will increase and rental expenses will decrease.	1 Jan 2019
AASB 1058	*Income of Not-for-Profit Entities* This Standard clarifies and simplifies the income recognition requirements that apply to not-for-profit (NFP) entites, more closely reflecting the economic reality of NFP entity transactions that are not contracts with customers. Timing of income recognition is dependent on whether such a transaction gives rise to a liability, a performance obligation (a promise to transfer a good or service), or, an obligation to acquire an asset. The commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2019

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

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

Future impact of Australian Accounting Standards not yet operative (continued)

Title		Operative for reporting periods beginning on/after
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The mandatory application date of this Standard has been amended by AASB 2012-6 and AASB 2014-1 to 1 January 2018. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-1	*Amendments to Australian Accounting Standards* Part E of this Standard makes amendments to AASB 9 and consequential amendments to other Standards. It has not yet been assessed by the Commission to determine the application or potential impact of the Standard.	1 Jan 2018
AASB 2014-5	*Amendments to Australian Accounting Standards arising from AASB 15* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 15. The mandatory application date of this Standard has been amended by AASB 2015-8 to 1 January 2018. The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 9 (December 2014). The Commission has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2015-8	*Amendments to Australian Accounting Standards - Effective Date of AASB 15* This Standard amends the mandatory effective date (application date) of AASB 15 *Revenue from Contracts with Customers* so that AASB15 is required to be applied for annual reporting periods beginning on or after 1 January 2018 instead of 1 January 2017. For Not-For-Profit entities, the mandatory effective date has subsequently been amended to 1 January 2019 by AASB 2016-7. The Commission has not yet determined the application or the potential impact of AASB 15.	1 Jan 2019

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

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

Future impact of Australian Accounting Standards not yet operative (continued)

Title		Operative for reporting periods beginning on/after
AASB 2016-2	*Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 107* The Standard amends AASB 107 *Statement of Cash Flows* (August 2015) to require disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. There is no financial impact.	1 Jan 2017
AASB 2016-3	*Amendments to Australian Accounting Standards - Clarifications to AASB 15* This Standard clarifies identifying performance obligations, principal versus agent considerations, timing of recognising revenue from granting a licence, and, provides further transitional provisions to AASB 15. The Commission has not yet determined the application or the potential impact.	1 Jan 2018
AASB 2016-4	*Amendments to Australia Accounting Standards - Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities.* This Standard clarifies that recoverable amount of primarily non-cash-generating assets of not-for-profit entities, which are typically specialised in nature and held for continuing use of their service capacity, is expected to be materially the same as fair value determined under AASB13 *Fair Value Measurement*. The Commission has not yet determined the application or the potential impact.	1 Jan 2017
AASB 2016-7	*Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not for Profit Entities* This Standard amends the mandatory effective date (application date) of AASB 15 and defers the consequential amendments that were originally set out in AASB 2014 5 Amendments to Australian Accounting Standards arising from AASB 15 for not for profit entities to annual reporting periods beginning on or after 1 January 2019, instead of 1 January 2018. There is no financial impact.	1 Jan 2017
AASB 2016-8	*Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not for Profit Entities* This Standard inserts Australian requirements and authoritative implementation guidance for not-for-profit entities into AASB 9 and AASB 15. This guidance assists not-for-profit entities in applying those Standards to particular transactions and other events. There is no financial impact.	1 Jan 2019

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

	2017	2016
	$	$
Note 6 Employee benefits expense		
Salaries and wages (a)	32,801,318	35,632,630
Superannuation - defined contribution plans (b)	3,174,093	3,349,407
	35,975,411	38,982,037

(a) Includes the value of the fringe benefit to the employees plus the fringe benefits tax component and the value of superannuation contribution component for leave entitlements.
(b) Defined contribution plans include West State, Gold State and GESB Super and other eligible funds. Super contribution paid to GESB for West State, Gold State and GESB Super is $2,892,957 (2015-16 $3,108,907).

Employment on-costs (workers' compensation insurance) are included at note 14 'Other expenses'.

Note 7 Compensation of Key Management Personnel

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

Total compensation for key management personnel, comprising senior officers of the Commission for the reporting period are presented within the following bands:

Compensation of Senior Officers Band ($)	**2017**	**2016**
480,001 - 490,000	-	1
410,001 - 420,000	1	-
390,001 - 400,000	-	1
330,001 - 340,000	1	-
230,001 - 240,000	1	-
210,001 - 220,000	-	1
200,001 - 210,000	3	1
190,001 - 200,000	2	1
180,001 - 190,000	-	2
160,001 - 170,000	2	2
140,001 - 150,000	-	2
130,001 - 140,000	1	-
120,001 - 130,000	1	1
80,001 - 90,000	1	-
70,001 - 80,000	-	1
60,001 - 70,000	1	-
40,001 - 50,000	1	-
20,001 - 30,000	1	-
	$	**$**
Short-term employee benefits	2,204,888	2,188,170
Post-employment benefits	281,574	283,394
Other long-term benefits	298,194	233,767
Total compensation of key management personnel	2,784,656	2,705,331

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

	2017	2016
	$	$
Note 8 Service agreement - WA Health		
Metropolitan Health Service	-	551,954,527
East Metropolitan Health Service	163,094,963	-
North Metropolitan Health Service	235,021,901	-
South Metropolitan Health Service	116,588,065	-
Child and Adolescent Health Service	59,464,397	-
WA Country Health Service	96,096,163	91,931,167
	670,265,489	643,885,694

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

Note 9 Service agreement - non government and other organisations		
Non-government and other organisations	139,015,908	137,109,599

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

Note 10 Supplies and services		
Specific project expenses - other government organisations (a)	529,976	247,086
Purchase of outsourced services (b)	4,074,044	3,665,055
Corporate support services (c)	3,188,663	3,917,088
Computer related services	240,336	272,780
Consulting fees (b)	1,336,746	1,364,281
Consumables	394,702	396,699
Equipment lease expenses	4,190	14,476
Communications	296,717	371,260
Printing and Stationery	281,739	382,736
Other	42,814	53,178
	10,389,927	10,684,639

(a) Department of Corrective Services $434,537 (2015-16 $247,086) and Western Australia Police Service $95,439 (2015-16 $0).
(b) Department of Finance $368,809 (2015-16 $284,750) and Western Australia Police Service $0 (2015-16 $146,000).
(c) Health Support Services, previously within Metropolitan Health Service, has provided supply services, IT services, human resource services, finance services to the Commission since 2010. Due to proclamation of Health service Act 2016, Metropolitan Health Service is abolished and new health services have been established including Health Support Services. Service provided is inclusive free of charge $3,095,2975 (2015-16 $3,791,791).

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

	2017	2016
Note 11 Grants and subsidies	**$**	**$**
Recurrent		
National Partnership Agreement - Improving public hospitals	-	1,900,000
Suicide Prevention Strategy	1,074,830	1,709,478
National Perinatal Depression Initiative	-	506,148
Prevention and Anti-Stigma	100,000	441,350
Crisis Accommodation Support	442,000	424,114
Alcohol Assessment and Treatment Services	608,310	-
Other grants	639,201	1,661,763
	2,864,341	6,642,853

Grants and subsidies include payment to Disability Services Commission $50,000 (2015-16 $50,000), Department for Child Protection $533,785 (2015-16 $424,114), refund to Road Safety Commission $608,310 (2015-16 $0), Department of Education $417,390 (2015-16 $486,998), Department of Housing 1,900,000 in 2015-16, Department of Health $110,113 in 2015-16 and WA Country Health Service $50,000 in 2015-16.

Note 12 Depreciation expense		
Buildings	422,267	428,845
Computer equipment	16,628	16,629
Furniture and fittings	-	391
Medical equipment	1,647	1,647
Other plant and equipment	33,214	7,611
	473,756	455,123
Note 13 Accommodation expense		
Office accommodation expenses	2,249,106	1,023,150

Expenses include Department of Finance $2,066,920 (2015-16 $420,395) and Health Support Services $408,597 in 2015-16.

Note 14 Other expenses		
Workers' compensation insurance (a) (b)	195,522	593,523
Other employee related expenses	361,973	496,148
Consumable equipment, repairs and maintenance (c)	433,678	1,053,043
Loss on revaluation of land	-	667,900
Loss on revaluation of buildings	69,801	240,389
Travel related expenses (d)	168,370	227,187
Audit fees (e)	124,887	345,710
Legal fees (f)	73,803	127,909
Administration	206,328	308,632
Advertising	66,677	93,426
Other insurance (b)	105,539	96,217
Disposal of non-current asset	4,299	31,389
Other (c)	62,358	149,818
	1,873,235	4,431,291

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 14 Other expenses (continued)

(a) The employment on-costs include workers' compensation insurance only. Any on-costs liability associated with the recognition of annual and long service leave liability is included at note 29 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.
(b) Include expense to Riskcover $311,507 (2015-16 $699,388).
(c) Include expense to Department of Finance $16,156 (2015-16 $83,418).
(d) Include expense to Statefleet $79,196 (2015-16 $120,730).
(e) Include expense to Office of Audit General $0 (2015-16 $258,927). In 2015-16 expense to Office of Audit General is inclusive of 2014-15 payment and accrued 2015-16 audit fee. In 2016-17, accrued 2015-16 fee is paid however no fee is accrued at the end of financial year 2016-17. So net expense to Office of Audit General is $0 in 2016-17.
(f) Include expense to State Solicitor's Office $72,701 (2015-16 $99,941).

Note 15 Related Party Transactions

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

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

Significant transactions with Government-related entities
Significant transactions include:
- service appropriation (Note 19);
- other contribution by owners (Note 30);
- services received free of charge from the other state government agencies (Note 19);
- grants and contribution received from other government agencies (Note 17).
- royalties for regions fund (Note 19 & 30);
- services agreement WA Health (Note 8);
- specific project expenses - Department of Corrective Services and Western Australia Police Service (Note 10);
- corporate support services - Health Support Services (prior year within Metropolitan Health Service) (Note 10);
- purchase of outsourced services - Western Australia Police Service (Note10);
- project management consultancies and other payments (Note 10), consumable and other payments (Note 14) to Department of Finance ;
- grants and subsidies payment to other government agencies (Note 11);
- lease rentals and accommodation related payments to the Department of Finance and Health Support Services (Note 13);
- workers' compensation and other insurance payment to Riskcover (Note 14);
- vehicle rental payments to Statefleet (Note 14);
- audit fees payments to Office of Audit General (Note 14);
- legal fees from State Solicitor's Office (Note 14); and
- services provided free of charge to the other state government agencies (Note 38);

Material transactions with related parties
The Mental Health Commissioner, Mr. Timothy Michael Marney, is the Deputy Chair of the Beyond Blue Ltd, Board of Directors. A not-for-profit organisation, Beyond Blue Ltd, focuses on raising awareness and understanding of anxiety and depression in Australia, and received $342,000 funding from the Commission in 2016/17. This funding, which commenced in 2000, predates the establishment of the Commission and has remained at approximately this level since 2005. The Commission's current contract with Beyond Blue Ltd is for five years contract total value of $1,710,000 from 2015 to 2020. This contract was awarded and approved by the Director, Non-Government Organisations Purchasing and Development in 2015. Funding decisions and contract managment is separted from the Commissioner to ensure there is no capicity to influence decisons.

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 15 Related Party Transactions (continued)

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

Material transactions with other related parties

- Superannuation payments to the Government Employees Superannuation Board (GESB) (Note 6).

Note 16 Commonwealth grants and contributions

	2017 $	2016 $
National Health Reform Agreement (a)	162,820,350	165,620,360
National Partnership Agreement:		
Supporting National Mental Health	-	7,004,000
Plan for Perinatal Depression	-	31,900
Pay Equity Funding	181,760	189,715
Indigenous Advancement Strategy	181,000	181,000
Cost Shared Funding Model (CSFM) Projects	155,000	-
	163,338,110	173,026,975

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

Note 17 Other grants and contributions

Department of Health	685,131	763,129
WA Country Health Service	1,129,745	1,154,745
Department for Child Protection and Family Support	706,000	706,000
Department of Education	155,296	152,850
WA Police	-	487,406
Road Safety Commission	600,000	773,066
Healthway	838,424	1,123,298
Department of Regional Development	90,000	-
Other	100,000	120,000
	4,304,596	5,280,494

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

	2017 $	2016 $
Note 18 Other revenue		
Refund of prior year's payment on contract for services (a)	360,919	8,616
Good Outcomes Award	-	36,364
Interest revenue	93,890	106,903
Services to external organisations	155,198	50,207
Asset revenue (b)	242,700	-
Other revenue	29,832	54,385
	882,539	256,475

(a) Refunds were received from non-government organisations in 2016/17 and 2015/16, as the funds paid in prior year were in excess of the requirement.
(b) Revenue is related to an increment in value of assets after revaluation. It is recognised as other revenue to the extent it reverses the loss on revaluation recognised as other expense in previous years. No revaluation surplus exists in previous year.

Note 19 Income from State Government		
Service appropriation received during the period:		
Amount appropriated to deliver services	683,886,000	654,032,000
Amount authorised by other statutes:		
Salaries and Allowances Act 1975	809,000	783,000
	684,695,000	654,815,000
Services received free of charge from other State government agencies during the period:		
State Solicitor's Office - legal advisory services	72,701	99,941
Department of Finance - office accommodation leasing services	28,478	29,389
Department of Health - human resource data service	-	1,849
Health Support Services (a)	3,095,297	3,791,791
	3,196,476	3,922,970

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

Royalties for Regions Fund		
Regional Community Services Account		
Regional Community Services Account - Northwest drug and alcohol support program	5,422,609	5,630,000

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

		2017	2016
Note 20	**Restricted cash and cash equivalents**	**$**	**$**
	Current		
	Commonwealth special purpose account (b)	4,723,793	4,622,341
	Royalties for Regions Fund (c)	1,298,471	195,860
		6,022,264	4,818,201
	Non-current		
	Accrued salaries suspense account (a)	123,552	-

(a) Funds held in the suspense account used only for the purpose of meeting the 27th pay in a financial year that occurs every 11 years. The 27th pay was paid in the 2015/16 financial year.

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

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

Note 21	**Receivables**		
	Current		
	Receivables	170,263	132,030
	Accrued revenue	109,563	119,119
	GST receivables	210,620	313,744
		490,446	564,893

Refer to note 2(l) 'Receivables' and note 44 'Financial instruments'.

Note 22	**Amounts receivable for services**		
	Non-current	5,486,123	5,145,123

Represents the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability. See note 2(m) 'Amounts receivable for services'.

Note 23	**Inventories**		
	Current		
	Pharmaceutical stores - at cost	18,244	20,008

See note 2(n) 'Inventories'.

Note 24	**Other current assets**		
	Prepayments	27,626	39,685

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 25 Property, plant and equipment	2017 $	2016 $
Land		
At fair value (a)	8,681,900	8,439,200
	8,681,900	8,439,200
Buildings		
At fair value (a) (b)	13,288,100	13,780,168
	13,288,100	13,780,168
Computer equipment		
At cost	49,886	49,886
Accumulated depreciation	(33,257)	(16,629)
	16,629	33,257
Furniture and fittings		
At cost	-	6,273
Accumulated depreciation	-	(1,974)
	-	4,299
Medical equipment		
At cost	167,819	14,819
Accumulated depreciation	(3,293)	(1,647)
	164,526	13,172
Other plant and equipment		
At cost	310,623	303,853
Accumulated depreciation	(47,506)	(14,292)
	263,117	289,561
Artworks		
At cost	12,000	12,000
	12,000	12,000
Total property, plant and equipment	22,426,272	22,571,657

(a) Land and buildings were revalued as at 1 July 2016 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2017 and recognised at 30 June 2017. In undertaking the revaluation, fair value was determined by reference to market values for land: $780,000 (2015/16 $1,035,000) and buildings $1,190,000 (2015/16 $1,325,000). For the remaining balance, fair value of buildings was determined on the basis of depreciated replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land). See also note 2 (f) 'Property, plant and equipment'.

(b) During 2016/17 financial year, the Commission reviewed the depreciation method of buildings and changed method from diminishing balance to straight-line, to bring it in line with other asset classes. It is also the method applied by Landgate Valuation Services to derive their depreciated replacement cost valuation for building assets. The impact of this change is increase in depreciation expense by $8,862 in 2016-17 and expected increase in depreciation expense by $7,865 each year from 2017-18 and onwards.

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

		2017	2016
Note 25	**Property, plant and equipment (continued)**	**$**	**$**
	Reconciliations		
	Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the reporting period are set out below.		
	Land		
	Carrying amount at start of period	8,439,200	-
	Transfer from WA Alcohol & Drug Authority	-	9,107,100
	Revaluation increments / (decrements)	242,700	(667,900)
	Carrying amount at end of period	8,681,900	8,439,200
	Buildings		
	Carrying amount at start of period	13,780,168	-
	Transfer from WA Alcohol & Drug Authority	-	14,292,000
	Transfer from Work in Progress	-	157,402
	Revaluation increments / (decrements)	(69,801)	(240,389)
	Depreciation	(422,267)	(428,845)
	Carrying amount at end of period	13,288,100	13,780,168
	Computer equipment		
	Carrying amount at start of period	33,257	-
	Transfer from WA Alcohol & Drug Authority	-	58,906
	Disposals	-	(9,020)
	Depreciation	(16,628)	(16,629)
	Carrying amount at end of period	16,629	33,257
	Furniture and fittings		
	Carrying amount at start of period	4,299	4,690
	Disposals	(4,299)	-
	Depreciation	-	(391)
	Carrying amount at end of period	-	4,299
	Medical equipment		
	Carrying amount at start of period	13,172	-
	Transfer from WA Alcohol & Drug Authority	-	14,819
	Additions	153,001	-
	Depreciation	(1,647)	(1,647)
	Carrying amount at end of period	164,526	13,172
	Other plant and equipment		
	Carrying amount at the start of year	289,561	22,896
	Transfer from WA Alcohol & Drug Authority	-	58,659
	Additions	6,770	237,986
	Disposals	-	(22,369)
	Depreciation	(33,214)	(7,611)
	Carrying amount at the end of year	263,117	289,561

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

	2017	2016
	$	$
Note 25 Property, plant and equipment (continued)		
Artworks		
Carrying amount at the start of year	12,000	12,000
Carrying amount at the end of year	12,000	12,000
Works in progress		
Carrying amount at the start of year	-	-
Transfer from WA Alcohol & Drug Authority	-	11,527
Additions	-	145,875
Capitalised to asset classes	-	(157,402)
Carrying amount at the end of year	-	-
Total property, plant and equipment		
Carrying amount at the start of year	22,571,657	39,586
Transfer from WA Alcohol & Drug Authority	-	23,543,011
Additions	159,771	383,861
Disposals	(4,299)	(31,389)
Revaluation increments/(decrements)	172,899	(908,289)
Depreciation	(473,756)	(455,123)
Carrying amount at the end of year	22,426,272	22,571,657

Note 26 Fair value measurements

Assets measured at fair value:	**Level 1**	**Level 2**	**Level 3**	**Fair Value At end of period**
2017	**$**	**$**	**$**	**$**
Land (Note 25)	-	780,000	7,901,900	8,681,900
Buildings (Note 25)	-	1,190,000	12,098,100	13,288,100
	-	1,970,000	20,000,000	21,970,000
2016				
Land (Note 25)	-	1,035,000	7,404,200	8,439,200
Buildings (Note 25)	-	1,325,000	12,455,168	13,780,168
	-	2,360,000	19,859,368	22,219,368

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

Valuation techniques to derive Level 2 fair values

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

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 26 Fair value measurements (continued)

Fair value measurements using significant unobservable inputs (Level 3)	Land	Buildings
2017	**$**	**$**
Fair value at start of period	7,404,200	12,455,168
Revaluation increments/(decrements) recognised in Profit or Loss	497,700	38,699
Depreciation expense	-	(395,767)
Fair value at end of period	7,901,900	12,098,100
2016		
Fair value at start of period	-	-
Transfer from work in progress	-	157,402
Transfer from WA Alcohol & Drug Authority	7,657,100	12,737,000
Revaluation increments/(decrements) recognised in Profit or Loss	(252,900)	(57,039)
Depreciation expense	-	(382,195)
Fair value at end of period	7,404,200	12,455,168

Valuation processes

There were no changes in valuation techniques during the period.

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

Land (Level 3 fair values)

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

Buildings (Level 3 fair values)

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

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

Basis of Valuation

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

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 27 Impairment of assets

There were no indications of impairment to property, plant and equipment at 30 June 2017. The Commission held no goodwill during the reporting period.

Note 28 Payables	**2017 $**	**2016 $**
Current		
Trade creditors (a)	1,469,249	1,513,337
Accrued salaries	421,544	328,984
Accrued expenses (a)	2,435,695	2,054,803
Other creditors	4,591	-
	4,331,079	3,897,124

(a) Includes expenses not paid yet to Department of Finance $384,504 (2015-16 $476,011), Office of Audit General 2015-16 $180,800, WA Police $95,439 (2015-16 $0) and Department of Child Protection $247,086 in 2015-16.

Refer to note 2(o) 'Payables' and note 44 'Financial instruments'.

Note 29 Provisions

Current		
Employee benefits provision		
Annual leave (a)	2,551,321	2,667,212
Long service leave (b)	2,589,029	2,787,059
Deferred salary scheme (c)	211,362	316,372
	5,351,712	5,770,643
Non-current		
Employee benefits provision		
Long service leave (b)	2,098,539	1,860,770
	7,450,251	7,631,413

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

Within 12 months of the end of the reporting period	1,792,352	1,862,002
More than 12 months after the end of the reporting period	758,969	805,210
	2,551,321	2,667,212

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

Within 12 months of the end of the reporting period	524,201	559,479
More than 12 months after the end of the reporting period	4,163,367	4,088,350
	4,687,568	4,647,829

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

Within 12 months of the end of the reporting period	103,065	151,765
More than 12 months after the end of the reporting period	108,297	164,607
	211,362	316,372

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 30 Equity

	2017 $	2016 $
The Western Australian Government holds the equity interest in the Commission on behalf of the community. Equity represents the residual interest in the net assets of the Commission.		
Contributed equity		
Balance at start of period	31,025,558	945,900
Contributions by owners (a)	-	30,079,658
Other contribution by owners - Royalties for Region Fund - Regional Community Services Account	1,110,000	-
Balance at end of period	32,135,558	31,025,558
(a) The Western Australian Alcohol and Drug Authority was abolished as a statutory authority and its functions were amalgamated into the Commission on 1 July 2015. In accordance with AASB 1004 'Contributions', the transfer of net assets to the Commission as a result of administrative arrangements has been accounted for as contributions by owners.		
Assets		
Cash and cash equivalents		8,179,503
Receivables		60,434
Inventories		23,632
Prepayments		35,074
Amounts receivable for services		4,905,123
Land		9,107,100
Buildings		14,292,000
Computer equipment		58,906
Medical equipment		14,819
Other plant and equipment		58,659
Works in progress		11,527
Total Assets		36,746,777
Liabilities		
Payables		(1,226,214)
Provisions		(5,440,905)
Total Liabilities		(6,667,119)
Net assets transferred from Western Australian Alcohol and Drug Authority		30,079,658
Accumulated surplus / (deficit)		
Balance at start of period	16,556,729	16,839,201
Result for the period	(1,267,843)	(282,472)
Balance at end of period	15,288,886	16,556,729
Total Equity at end of period	47,424,444	47,582,287

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

	2017 $	2016 $
Note 31 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	24,611,247	25,951,257
Restricted cash and cash equivalents (refer to note 20)	6,145,816	4,818,201
	30,757,063	30,769,458
Reconciliation of net cost of services to net cash flows provided by/(used in) operating activities		
Net cost of services (Statement of Comprehensive Income)	(694,581,928)	(664,650,442)
Non-cash items:		
Services received free of charge (refer to note 19)	3,196,476	3,922,970
Depreciation expense (refer to note 12)	473,756	455,123
Loss from disposal of non-current assets (refer to note 14)	4,299	31,389
Increment on revaluation of Land (refer to note 18)	(242,700)	-
Loss on revaluation of land (refer to note 14)	-	667,900
Loss on revaluation of buildings (refer to note 14)	69,801	240,389
(Increase)/decrease in assets:		
Current receivables	74,447	(317,437)
Inventories	1,764	(20,008)
Other current assets	12,059	(39,685)
Increase/(decrease) in liabilities:		
Current payables	518,941	262,258
Current provisions	(418,931)	3,164,370
Non-current provisions	237,769	1,329,847
Net liability transferred from WA Alcohol & Drug Authority	-	(6,547,979)
Net cash provided by/(used in) operating activities (Statement of Cash Flows)	(690,654,247)	(661,501,305)
Reconciliation of income from State Government to cash flows from State Government		
Service appropriations as per Statement of Comprehensive Income	684,695,000	654,815,000
Less: Non-cash items		
Accrual appropriations	(341,000)	(240,000)
Cash flows from State Government as per Statement of Cash Flows	684,354,000	654,575,000

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

	2017 $	2016 $
Note 32 Commitments		
The commitments below are inclusive of GST where relevant.		
Non-cancellable operating lease commitments		
Commitments for minimum lease payments are payable as follows:		
Within 1 year	2,648,809	2,493,399
Later than 1 year and not later than 5 years	10,090,779	10,225,143
Later than 5 years	7,664,512	11,299,056
	20,404,100	24,017,598
The leases are non-cancellable, with rent payable monthly in advance. Operating leases relating to buildings and office equipment do not have contingent rental obligations. There are no restrictions imposed by these leasing arrangements on other financing transactions.		
Contracts for the provision of mental health, alcohol and other drug services		
Expenditure commitments in relation to private hospitals and non-government organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:		
Within 1 year	150,124,573	121,218,073
Later than 1 year and not later than 5 years	45,493,204	37,974,975
Later than 5 years	-	6,619,454
	195,617,777	165,812,502
In addition, the 2017/18 service agreement between the Mental Health Commission, Department of Health and Area Health Services for the provision of mental health services in public hospitals was signed prior to 30 June 2017. The 2016/17 service agreement was not signed prior to 30 June 2016. The expenditure commitment is payable as follows:		
Within 1 year	692,116,136	-
Other expenditure commitments		
Other expenditure commitments contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:		
Within 1 year	6,995	42,642
Note 33 Remuneration of auditor		
Remuneration paid or payable to the Auditor General in respect of the audit for the current financial year is as follows:		
Auditing the accounts, controls, financial statements and key performance indicators	177,700	175,000
Note 34 Contingent liabilities and contingent assets		
The Commission is not aware of any contingent liabilities or contingent assets.		

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 35 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 36 Related bodies

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

The Commission had no related bodies during the financial year.

Note 37 Affiliated bodies

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

During the financial year the following affiliated bodies received the funding from the Commission:

	2017 $	2016 $
Albany Halfway House Association Incorporated	1,415,557	1,393,265
Australian Medical Procedures Research Foundation Limited	-	3,220,074
Consumers of Mental Health WA	341,650	389,247
Even Keel Bipolar Support Association Incorporated	126,505	124,513
Goldfields Rehabilitation Services Inc	-	724,519
Holyoake Australian Institute for Alcohol and Drug Addiction Resolution Inc	4,294,999	3,905,986
Home Health Pty Ltd (trading as Tender Care)	1,203,311	1,184,361
June O'Conner Centre Incorporated	1,924,506	1,894,199
Local Drug Action Groups Inc	1,189,047	629,751
Palmerston Association Inc	8,064,279	7,365,448
Pathways Southwest Inc.	752,883	741,027
Richmond Wellbeing Incorporated	10,304,424	10,611,039
St Vincent De Paul Society	743,917	-
WA Council on Addictions (trading as Cyrenian House)	8,411,784	7,487,671
	38,772,862	39,671,100

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

Mental Health Tribunal is a government administered body that received administrative support from, but is not subject to operational control by the Commission. It is funded by parliamentary appropriation of $2,653,000 for 2016/17 ($1,406,000 for 2015/16)

Mental Health Advocacy Service is a government administered body that received administrative support from, but is not subject to operational control by the Commission. It is funded by parliamentary appropriation of $2,654,000 for 2016/17 ($1,439,000 for 2015/16)

Office of Chief Psychiatrist is a government administered body that received administrative support from, but is not subject to operational control by the Commission. It is funded by parliamentary appropriation of $2,262,000 for 2016/17 ($1,675,000 for 2015/16)

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

		2017	2016
		$	$
Note 38	**Services provided free of charge**		
	Services provided free of charge to other agencies during the period:		
	Mental Health Tribunal - corporate services	312,110	168,804
	Mental Health Advocacy Service - corporate services	346,141	185,203
	Office of the Chief Psychiatrist - orporate services and accommodation	393,511	167,145
		1,051,762	521,152

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

Note 39 Special purpose accounts

State Managed Fund (Mental Health) Account

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

Balance at the start of period	-	-
Receipts:		
Service appropriations (State Government)	253,932,217	245,419,236
Commonwealth grants and contributions	73,699,322	73,579,896
	327,631,539	318,999,132
Payments:		
Block grant funding to local hospital networks in WA Health	(323,991,924)	(315,412,510)
Block grant funding to non-government organisation	(3,639,615)	(3,586,622)
Balance at the end of period	-	-

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 40 Disclosure of administered income and expenses by service

	2017 Hospital Bed Based Services $	2016 Hospital Bed Based Services $
Income		
Appropriations from Government for transfer to :		
Mental Health Tribunal (a)	2,653,000	1,406,000
Mental Health Advocacy Service (a)	2,654,000	1,439,000
Office of Chief Psychiatrist (a)	2,262,000	1,675,000
Service received free of charge (b)	1,080,044	537,840
Other revenue	870	578
Total administered income	8,649,914	5,058,418
Expenses		
Employee benefits expense (a)	6,638,163	3,627,125
Supplies and services (a)	1,226,585	703,186
Accommodation expense (a)	364,379	135,479
Other expenses (a)	245,072	176,764
Total administered expenses	8,474,199	4,642,554

(a) The Mental Health Act 2014 established the Mental Health Tribunal, Mental Health Advocacy Service, and Office of Chief Psychiatrist as administered affiliated bodies under the Mental Health Commission, effective in 2015/16 financial year.

(b) Service received free of charge in 2016 /17 includes $1,051,762 ($521,152 in 2015/16) from Mental Health Commission (refer to note 38 'Services provided free of charge'), $28,282 ($14,361 in 2015/16) from State Solicitor Office, and $2,327 in 2015/16 from Department of Finance.

Note 41 Disclosure of administered assets and liabilities

Current Assets		
Cash and cash equivalents	1,682,595	1,316,166
Receivables	73,811	3,150
Total Administered Current Assets	1,756,406	1,319,316
Total Administered Assets	**1,756,406**	**1,319,316**
Current Liabilities		
Payables	240,027	135,723
Provision	749,756	661,748
Total Administered Current Liabilities	989,783	797,471
Non-Current Liabilities		
Provision	175,046	105,981
Total Administered Non-Current Liabilities	175,046	105,981
Total Administered Liabilities	**1,164,829**	**903,452**

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

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 42 Explanatory statement (Statement of Comprehensive Income)

All variances between estimates (original budget) and actual results for 2017, and between the actual results for 2017 and 2016 are shown below. Narratives are provided for selected major variances, which are generally greater than:

5% and $16.9 million for the Statements of Comprehensive Income and Cash Flows; and 5% and $1.1 million for the Statements of Financial Position.

	Variance Note	Estimate 2017 $	Actual 2017 $	Actual 2016 $	Variance between estimate and actual $	Variance between actual results for 2017 and 2016 $
COST OF SERVICES						
Expenses						
Employee benefits expense		39,336,000	35,975,411	38,982,037	(3,360,589)	(3,006,626)
Service agreement - WA Health		660,066,000	670,265,489	643,885,694	10,199,489	26,379,795
Service agreement - non government and other organisations		150,360,000	139,015,908	137,109,599	(11,344,092)	1,906,309
Supplies and services		7,762,000	10,389,927	10,684,639	2,627,927	(294,712)
Grants and subsidies		3,063,000	2,864,341	6,642,853	(198,659)	(3,778,512)
Depreciation expense		341,000	473,756	455,123	132,756	18,633
Accommodation expense		2,396,000	2,249,106	1,023,150	(146,894)	1,225,956
Other expenses		2,448,000	1,873,235	4,431,291	(574,765)	(2,558,056)
Total cost of services		**865,772,000**	**863,107,173**	**843,214,386**	**(2,664,827)**	**19,892,787**
Income						
Revenue						
Commonwealth grants and contributions		172,551,000	163,338,110	173,026,975	(9,212,890)	(9,688,865)
Other grants and contributions		2,121,000	4,304,596	5,280,494	2,183,596	(975,898)
Other revenue		8,050,000	882,539	256,475	(7,167,461)	626,064
Total income other than income from State Government		**182,722,000**	**168,525,245**	**178,563,944**	**(14,196,755)**	**(10,038,699)**
NET COST OF SERVICES		**683,050,000**	**694,581,928**	**664,650,442**	**11,531,928**	**29,931,486**
Income from State Government						
Service appropriation		669,489,000	684,695,000	654,815,000	15,206,000	29,880,000
Services received free of charge			3,196,476	3,922,970	3,196,476	(726,494)
Royalties for Regions Fund		7,233,000	5,422,609	5,630,000	(1,810,391)	(207,391)
Total income from State Government		**676,722,000**	**693,314,085**	**664,367,970**	**16,592,085**	**28,946,115**
SURPLUS / (DEFICIT) FOR THE PERIOD		**(6,328,000)**	**(1,267,843)**	**(282,472)**	**5,060,157**	**(985,371)**
OTHER COMPREHENSIVE INCOME		-	-	-	-	-
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(6,328,000)**	**(1,267,843)**	**(282,472)**	**5,060,157**	**(985,371)**

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 42 Explanatory statement (Statement of Financial Position)

	Variance Note	Estimate 2017 $	Actual 2017 $	Actual 2016 $	Variance between estimate and actual $	Variance between actual results for 2017 and 2016 $
ASSETS						
Current Assets						
Cash and cash equivalents		12,834,000	24,611,247	25,951,257	11,777,247	(1,340,010)
Restricted cash and cash equivalents		4,775,000	6,022,264	4,818,201	1,247,264	1,204,063
Receivables		96,000	490,446	564,893	394,446	(74,447)
Inventories		43,000	18,244	20,008	(24,756)	(1,764)
Other current assets		35,000	27,626	39,685	(7,374)	(12,059)
Total Current Assets		**17,783,000**	**31,169,827**	**31,394,044**	**13,386,827**	**(224,217)**
Non-Current Assets						
Restricted cash and cash equivalents		-	123,552	-	123,552	123,552
Amounts receivable for services		5,582,000	5,486,123	5,145,123	(95,877)	341,000
Property, plant and equipment	1	31,820,000	22,426,272	22,571,657	(9,393,728)	(145,385)
Total Non-Current Assets		**37,402,000**	**28,035,947**	**27,716,780**	**(9,366,053)**	**319,167**
TOTAL ASSETS		**55,185,000**	**59,205,774**	**59,110,824**	**4,020,774**	**94,950**
LIABILITIES						
Current Liabilities						
Payables		3,022,000	4,331,079	3,897,124	1,309,079	433,955
Provisions	2	7,040,000	5,351,712	5,770,643	(1,688,288)	(418,931)
Total Current Liabilities		**10,062,000**	**9,682,791**	**9,667,767**	**(379,209)**	**15,024**
Non-Current Liabilities						
Provisions		2,044,000	2,098,539	1,860,770	54,539	237,769
Total Non-Current Liabilities		**2,044,000**	**2,098,539**	**1,860,770**	**54,539**	**237,769**
TOTAL LIABILITIES		**12,106,000**	**11,781,330**	**11,528,537**	**(324,670)**	**252,793**
NET ASSETS		**43,079,000**	**47,424,444**	**47,582,287**	**4,345,444**	**(157,843)**
EQUITY						
Contributed equity		33,141,000	32,135,558	31,025,558	(1,005,442)	1,110,000
Reserves		608,000	-	-	(608,000)	-
Accumulated surplus		9,330,000	15,288,886	16,556,729	5,958,886	(1,267,843)
TOTAL EQUITY		**43,079,000**	**47,424,444**	**47,582,287**	**4,345,444**	**(157,843)**

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 42 Explanatory statement (Statement of Cash Flows)

	Variance Note	Estimate 2017 $	Actual 2017 $	Actual 2016 $	Variance between estimate and actual $	Variance between actual results for 2017 and 2016 $
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation		669,148,000	684,354,000	654,575,000	15,206,000	29,779,000
Royalties for Regions Fund - Capital		10,400,000	1,110,000	-	(9,290,000)	1,110,000
Royalties for Regions Fund - Recurrent		7,233,000	5,422,609	5,630,000	(1,810,391)	(207,391)
Net cash provided by State Government		**686,781,000**	**690,886,609**	**660,205,000**	**4,105,609**	**30,681,609**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits expense		(39,187,000)	(36,122,797)	(41,220,707)	3,064,203	5,097,910
Service agreement - WA Health		(660,066,000)	(670,265,489)	(644,092,337)	(10,199,489)	(26,173,152)
Service agreement - non government and other organisations		(150,360,000)	(139,086,788)	(137,797,069)	11,273,212	(1,289,719)
Supplies and services		(7,762,000)	(6,326,892)	(6,265,190)	1,435,108	(61,702)
Grants and subsidies		(3,063,000)	(3,193,909)	(6,349,005)	(130,909)	3,155,096
Accommodation expense		(2,396,000)	(2,025,210)	(1,072,650)	370,790	(952,560)
Other payments		(2,448,000)	(1,919,112)	(3,201,759)	528,888	1,282,647
Receipts						
Commonwealth grants and contributions		172,551,000	163,338,110	173,026,975	(9,212,890)	(9,688,865)
Other grants and contributions		2,121,000	4,304,596	5,280,494	2,183,596	(975,898)
Other receipts		8,050,000	643,244	189,943	(7,406,756)	453,301
Net cash used in operating activities		**(682,560,000)**	**(690,654,247)**	**(661,501,305)**	**(8,094,247)**	**(29,152,942)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets		(10,400,000)	(244,757)	(145,875)	10,155,243	(98,882)
Net cash used in investing activities		**(10,400,000)**	**(244,757)**	**(145,875)**	**10,155,243**	**(98,882)**
Net increase / (decrease) in cash and cash equivalents		(6,179,000)	(12,395)	(1,442,180)	6,166,605	1,429,785
Cash and cash equivalents at the beginning of the period		23,788,000	30,769,458	24,032,135	6,981,458	6,737,323
Cash and cash equivalents transferred from WA Alcohol & Drug Authority			-	8,179,503	-	(8,179,503)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**17,609,000**	**30,757,063**	**30,769,458**	**13,148,063**	**(12,395)**

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 42 Explanatory statement (continued)

Major Estimate and Actual (2017) Variance Narratives for Controlled Operations

1 Property, plant and equipment decreased by $9.4 million (29.5%) mainly due to repositioning of $10.4 million capital expenditure for the Bunbury and Karratha step-up step-down facilities, partially offset by a higher than budgeted amount for land and buildings of $0.7 million.

2 Provisions decreased $1.7 million (24%) mainly due to leave provisions of $0.7 million for the affiliated entities now being recognised in the Administered operations, together with management and enforcement of the Commission's internal leave management policy.

Financial Statements

Mental Health Commission

Notes to the Financial Statements

For the year ended 30 June 2017

Note 43 Explanatory statement for Administered Items (Statement of Comprehensive Income)

All variances between estimates (original budget) and actual results for 2017, between the actual results for 2017 and 2016 are below. Narratives are provided for key major variances, which are generally greater than 5% and $101 thousand.

	Variance Note	Estimate 2017 $	Actual 2017 $	Actual 2016 $	Variance between estimate and actual $	Variance between actual results for 2017 and 2016 $
Income						
For transfer:						
Service appropriation						
Mental Health Tribunal	A	2,653,000	2,653,000	1,406,000	-	1,247,000
Mental Health Advocacy Service	A	2,654,000	2,654,000	1,439,000	-	1,215,000
Office of Chief Psychiatrist	A	2,262,000	2,262,000	1,675,000	-	587,000
Service received free of charge	1, B	-	1,080,044	537,840	1,080,044	542,204
Other revenue		-	870	578	870	292
Total administered income		**7,569,000**	**8,649,914**	**5,058,418**	**1,080,914**	**3,591,496**
Expenses						
Employee benefits expense		-	6,638,163	3,627,125	6,638,163	3,011,038
Supplies and services		7,569,000	1,226,585	703,186	(6,342,415)	523,399
Accommodation expense		-	364,379	135,479	364,379	228,900
Other expenses		-	245,072	176,764	245,072	68,308
Total administered expenses	2, C	**7,569,000**	**8,474,199**	**4,642,554**	**905,199**	**3,831,645**

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

Financial Statements

Mental Health Commission

Notes to the Financial Statements

For the year ended 30 June 2017

Note 43 Explanatory statement for Administered Items (Statement of Financial Position)

At the time of budget submission, it was estimated that there will not be any assets and liabilities. All variances between the actual results for 2017 and 2016 are below. Narratives are provided for key major variances, which are generally greater than 5%.

	Variance Note	Estimate 2017 $	Actual 2017 $	Actual 2016 $	Variance between estimate and actual $	Variance between actual results for 2017 and 2016 $
ASSETS						
Current Assets						
Cash and cash equivalents		-	1,682,595	1,316,166	1,682,595	366,429
Receivables		-	73,811	3,150	73,811	70,661
Total Administered Current Assets		**-**	**1,756,406**	**1,319,316**	**1,756,406**	**437,090**
TOTAL ADMINISTERED ASSETS		**-**	**1,756,406**	**1,319,316**	**1,756,406**	**437,090**
LIABILITIES						
Current Liabilities						
Payables		-	240,027	135,723	240,027	104,304
Provisions	D	-	749,756	661,748	749,756	88,008
Total Administered Current Liabilities		**-**	**989,783**	**797,471**	**989,783**	**192,312**
Non-Current Liabilities						
Provisions	D	-	175,046	105,981	175,046	69,065
Total Administered Non-Current Liabilities		**-**	**175,046**	**105,981**	**175,046**	**69,065**
TOTAL ADMINISTERED LIABILITIES		**-**	**1,164,829**	**903,452**	**1,164,829**	**261,377**

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

Financial Statements

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2017

Note 43 Explanatory statement for Administered Item (continued)

Major Estimate and Actual (2017) Variance Narratives

1 Increase in services received free of charge of $1.1 million (100%) is due to corporate services provide by the Commission for which no budget has been provided.

2 Increase in administered expenditure of of $0.9 million (12%) is mainly due to no budget provided for services received free of charge from the Commission. At the time of compilation of the 2016-17 Budget, administered expenditure was not disaggregated in to separate expense categories. Therefore a comparison of total 2016-17 budget with total actual 2016-17 expenditure is only available.

Major Actual (2017) and Comparative (2016) Variance Narratives

A Increase in Administered approriation of $3 million (67.5%) is due to a full year operation of the Administered entities compared to a part year in 2015-16. The Administered entities were established following proclamation of the *Mental Health Act 2014* on 30 November 2015.

B Increase in services received free of charge of $0.5 million (100.8%) is due to a full year of support provided by the Commission to the Administered entities compared to a part year in 2015-16.

C Increase in administered expenditure of $3.8 million (82.5%) is due to a full year operation of the Administered entities compared to a part year in 2015-16.

D Increase in provisions of $0.2 million (20.5%) is mainly due to increases in the number of employees and associated value of leave balances transferred in for new employees.

Financial Statements

Mental Health Commission

Notes to the Financial Statements
For the year ended 30 June 2017

Note 44 Financial instruments

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

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

Credit risk

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

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment, as shown in the table at note 44(c) 'Financial Instruments Disclosures' and note 21 'Receivables'.

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

Liquidity risk

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

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

Market risk

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

b) **Categories of financial instruments**

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

	2017 $	2016 $
Financial Assets		
Cash and cash equivalents	24,611,247	25,951,257
Restricted cash and cash equivalents	6,145,816	4,818,201
Receivables (a)	279,826	251,149
Amounts receivable for services	5,486,123	5,145,123
Financial Liabilities		
Financial liabilities measured at amortised cost	4,331,079	3,897,124

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

Financial Statements

Mental Health Commission

Notes to the Financial Statements

For the year ended 30 June 2017

Note 44 Financial instruments (continued)

c) **Financial instrument disclosures**

Credit risk

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

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

Aged analysis of financial assets

			Past due but not impaired				
	Carrying amount	Not past due and not impaired	up to 1 month	1 - 3 months	3 months to 1 year	1 - 5 years	Impaired financial assets
	$	$	$	$	$	$	$
2017							
Cash and cash equivalents	24,611,247	24,611,247	-	-	-	-	-
Restricted cash and cash equivalents	6,145,816	6,145,816	-	-	-	-	-
Receivables (a)	279,826	175,829	38,283	8,324	10,723	46,667	-
Amounts receivable for services	5,486,123	5,486,123	-	-	-	-	-
	36,523,012	36,419,015	38,283	8,324	10,723	46,667	-
2016							
Cash and cash equivalents	25,951,257	25,951,257	-	-	-	-	-
Restricted cash and cash equivalents	4,818,201	4,818,201	-	-	-	-	-
Receivables (a)	251,149	198,522	4,099	1,186	4,292	43,050	-
Amounts receivable for services	5,145,123	5,145,123	-	-	-	-	-
	36,165,730	36,113,103	4,099	1,186	4,292	43,050	-

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

Financial Statements

Mental Health Commission

Notes to the Financial Statements

For the year ended 30 June 2017

Note 44 Financial instruments (continued)

c) **Financial instrument disclosures (continued)**

Liquidity risk and interest rate exposure

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

Interest rate exposure and maturity analysis of financial assets and financial liablities

		Interest rate exposure					Maturity Dates				
	Weighted average effective interest rate %	Carrying amount $	Fixed interest rate $	Variable interest rate $	Non-interest bearing $	Nominal Amount $	Up to 1 month $	1 - 3 months $	3 months to 1 year $	1 - 5 years $	More than 5 year $
2017											
Financial Assets											
Cash and cash equivalents	-	24,611,247	-	-	24,611,247	24,611,247	24,611,247	-	-	-	-
Restricted cash and cash equivalents	2.0%	6,145,816	-	4,723,793	1,422,023	6,145,816	6,145,816	-	-	-	-
Receivables (a)	-	279,826	-	-	279,826	279,826	279,826	-	-	-	-
Amounts receivable for services	-	5,486,123	-	-	5,486,123	5,486,123	-	-	-	-	5,486,123
		36,523,012	-	4,723,793	31,799,219	36,523,012	31,036,889	-	-	-	5,486,123
Financial Liabilites											
Payables	-	4,331,079	-	-	4,331,079	4,331,079	4,331,079	-	-	-	-
		4,331,079	-	-	4,331,079	4,331,079	4,331,079	-	-	-	-
2016											
Financial Assets											
Cash and cash equivalents	-	25,951,257	-	-	25,951,257	25,951,257	25,951,257	-	-	-	-
Restricted cash and cash equivalents	2.3%	4,818,201	-	4,622,341	195,860	4,818,201	4,818,201	-	-	-	-
Receivables (a)	-	251,149	-	-	251,149	251,149	251,149	-	-	-	-
Amounts receivable for services	-	5,145,123	-	-	5,145,123	5,145,123	-	-	-	-	5,145,123
		36,165,730	-	4,622,341	31,543,389	36,165,730	31,020,607	-	-	-	5,145,123
Financial Liabilites											
Payables	-	3,897,124	-	-	3,897,124	3,897,124	3,897,124	-	-	-	-
		3,897,124	-	-	3,897,124	3,897,124	3,897,124	-	-	-	-

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

Financial Statements

Mental Health Commission

Notes to the Financial Statements

For the year ended 30 June 2017

Note 44 Financial instruments (continued)

c) **Financial instrument disclosures (continued)**

Interest rate sensitivity analysis

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

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

		-100 basis points		+100 basis points	
	Carrying amount	Surplus	Equity	Surplus	Equity
	$	$	$	$	$
2016					
Financial Assets					
Restricted cash and cash equivalents	4,622,341	(46,223)	(46,223)	46,223	46,223
Total Increase/(Decrease)		(46,223)	(46,223)	46,223	46,223

Fair values

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

Key Performance Indicators

Certification of Key Performance Indicators for the year ended 30 June 2017

I hereby certify that key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the Mental Health Commission and fairly represent the performance of the Mental Health Commission for the financial year ended 30 June 2017.

Timothy Marney
Commissioner
Mental Health Commission
Accountable Authority

6 September 2017

Mental Health Commission:
Performance Management Framework 2016/17 – Outcome Based Management Framework

This Framework did not change during 2016/17 and the Commission did not share any responsibilities with other agencies

Strategic Outcomes

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

Agency Level Outcomes

Outcome 1	Outcome 2	Outcome 3
Promote mental health and wellbeing	Reduced incidence of use and harm associated with AOD use	Accessible, high quality and appropriate mental health and AOD treatments and supports

Key Effectiveness Indicators

Outcome 1	Outcome 2	Outcome 3
1.1 Percentage of the WA population with high or very high levels of psychological distress compared to the percentage reported nationally	**2.1** Percentage of the WA population aged 14 years and over reporting recent use of illicit drugs and the percentage reporting use of alcohol at risky levels compared to the percentage reported nationally **2.2** Percentage of correct take out messages for AOD campaigns among target population	**3.1** Re-admissions to hospital within 28 days of discharge from acute specialised mental health inpatient units (national indicator) **3.2** Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units (national indicator) **3.3** Percentage of closed AOD treatment episodes completed as planned **3.4** Percentage of non-government organisations contracted to provide mental health services that met the National Standards for Mental Health Services (2010) through independent evaluation **3.5** Percentage of the population receiving public clinical mental health care (national indicator)

Mental Health Commission:
Performance Management Framework 2016/17 – Outcome Based Management Framework

This Framework did not change during 2016/17 and the Commission did not share any responsibilities with other agencies

Services	Service 1 Prevention	Service 2 Hospital Bed-Based Services	Service 3 Community Bed-Based Services	Service 4 Community Treatment	Service 5 Community Support
Key Efficiency Indicators	**1.1** Cost per capita to enhance mental health and wellbeing and prevent suicide (illness prevention promotion and protection activities) **1.2** Cost per capita of the WA population 14 years and above for initiatives that delay the uptake and reduce the harm associated with alcohol and other drugs **1.3** Cost per person of AOD campaign target groups who are aware of, and correctly recall, the main campaign messages	**Acute** **2.1** Average length of stay in purchased acute specialised mental health units **2.2** Average cost per purchased bedday in acute specialised mental health units **Sub-acute** **2.3** Average length of stay in purchased sub-acute specialised mental health units **2.4** Average cost per purchased bedday in sub-acute specialised mental health units **Hospital in the Home** **2.5** Average length of stay in purchased hospital in the home mental health units **2.6** Average cost per purchased bedday in hospital in the home mental health units **Forensic** **2.7** Average length of stay in purchased forensic mental health units **2.8** Average cost per purchased bedday in forensic mental health units	**3.1** Average cost per purchased bedday in non-acute (24 hours support) community bed-based services **3.2** Average cost per purchased bedday in non-acute (hospital/ nursing home) community bed-based units **3.3** Average cost per purchased bedday in step up/step down community bed-based units **3.4** Cost per completed treatment episode in AOD residential rehabilitation services	**4.1** Average cost per purchased treatment day of ambulatory care provided by public clinical mental health services (national indicator) **4.2** Average treatment days per episode of ambulatory care provided by public clinical mental health services **4.3** Cost per completed treatment episode in community -based AOD services	**5.1** Average cost per hour of community support provided to people with mental health problems **5.2** Average cost per episode of community support provided for AOD services **5.3** Average cost per package of care provided for the Individualised Community Living Strategy **5.4** Cost per episode of care in safe places for intoxicated people

Key Effectiveness Indicators

Outcome one
Promote mental health and wellbeing

Description:

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

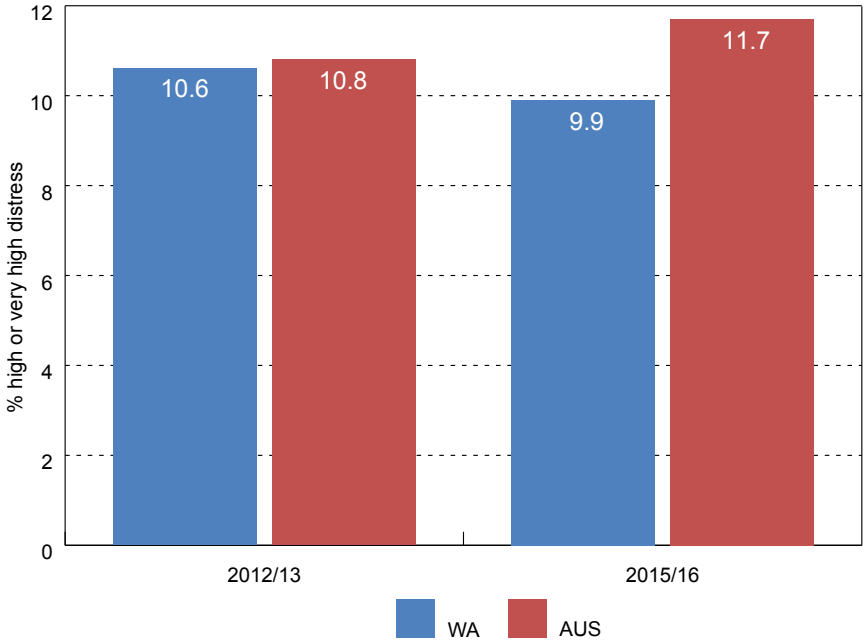
Rationale:

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

Results:

The most recent survey (2015/16) stated that the proportion of the Western Australian population with high or very high levels of psychological distress (9.9 per cent) was 1.8 percentage points lower than the proportion reported nationally (11.7 per cent). The next survey's results will be available in 2018/19.

1.1: Percentage of the Western Australian population with high or very high levels of psychological distress compared to the percentage reported nationally



Note: The Kessler Psychological Distress Scale (K10) is scored from 10 to 50, with higher scores indicating a higher level of distress, a score of 22 and above indicates high or very high distress.

Data Source: Australian Bureau of Statistics (ABS) – National Health Survey, 2011/12 and 2014/15. The 2014/15 survey was conducted in all states and territories and across urban, rural and remote areas of Australia (other than very remote areas), and included around 19,000 people in nearly 15,000 private dwellings.

Time Period: The National Health Survey is only conducted every three years. The 2011/12 results were published in 2012/13 and the 2014/15 results were published in 2015/16. The next survey will be conducted in 2017/18 and published in 2018/19, so no results are available for 2016/17.

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

1.8 percentage points lower

than the national average

Key Effectiveness Indicators

Outcome two
Reduce incidence of use and harm with AOD use

Description:

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

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

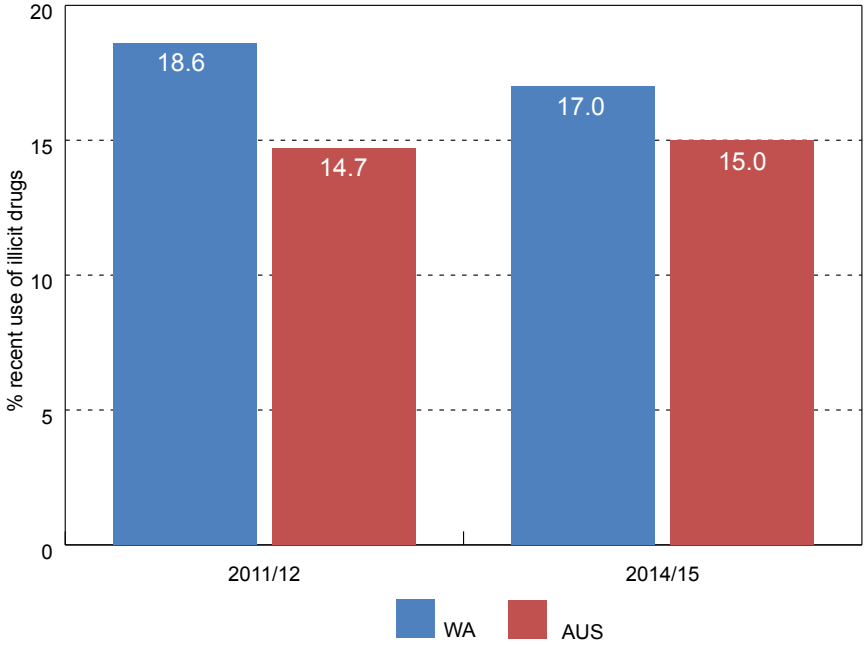
Rationale:

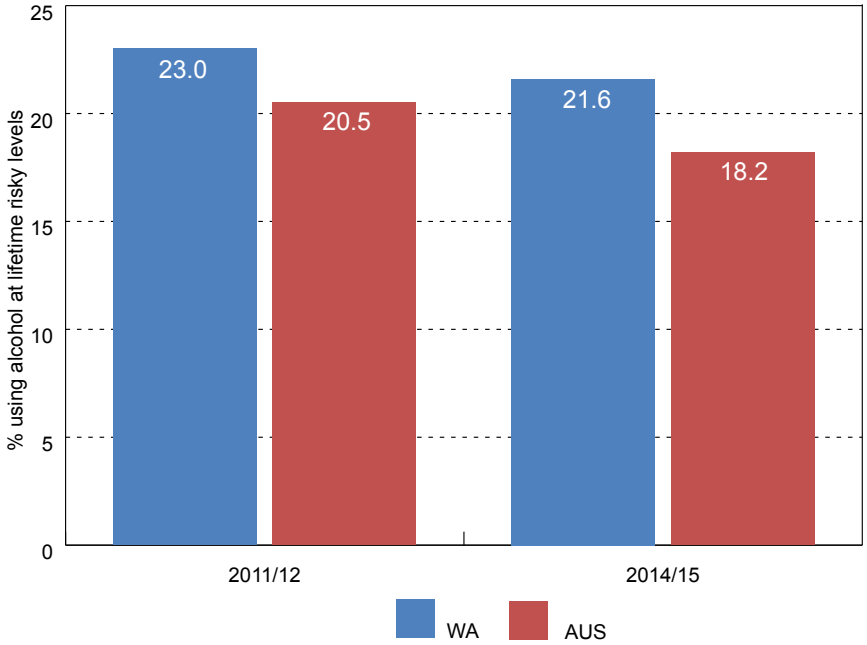
Preventing or delaying the onset of risky alcohol consumption and preventing illicit drug use reduces the impact of short-term risk and contributes to the prevention of long-term health related harm. This indicator is strategic, measurable and comparable to other jurisdictions. It uses information from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

Results:

The most recent survey (2014/15) stated that the proportion of the Western Australian population aged 14 years and over reporting recent use of illicit drugs (17.0 per cent) was two percentage points higher than the proportion reported nationally (15.0 per cent). The proportion of the Western Australian population aged 14 years and over reporting use of alcohol at lifetime risky levels (21.6 per cent) was 3.4 percentage points higher than the proportion reported nationally (18.2 per cent). The next survey's results will be available in 2017/18.

2.1: Percentage of the Western Australian population aged 14 years and over reporting recent use of illicit drugs and the percentage reporting use of alcohol at risky levels compared to the percentage reported nationally





Data Source: Australian Institute of Health and Wellbeing (AIHW) – National Drug Strategy Household Survey (NDSHS), 2010 and 2013. The 2013 survey collected data from nearly 24,000 people across Australia. Households were selected by a multistage, stratified area random sample design.

Time Period: The NDSHS is only conducted every three years. The 2010 results were published in 2011/12 and the 2013 results were published in 2014/15. The next survey is in progress (2016) and will be published in 2017/18, so no results are available for 2016/17.

Key Effectiveness Indicators

Outcome two
Reduce incidence of use and harm with AOD use

Description:

This indicator reports on the percentage "correct" take out messages for AOD campaigns, which are social marketing programs aimed at raising awareness of the risk of AOD-related harms.

An alcohol or other drug prevention advertisement is presented to a panel of individuals recruited by a marketing company. The individuals represent the age and/or gender demographic that the campaign intends to target. The panel members participate in a post-evaluation campaign session which collects data relating to awareness and correct recall of the campaign messages. These statistics are then applied to the corresponding Western Australian population figures for that targeted age and/or gender demographic.

An adjustment factor was applied to approximate a correct message recall rate amongst the target population. The factor used was 80% and has been recommended by experts at TNS.

Rationale:

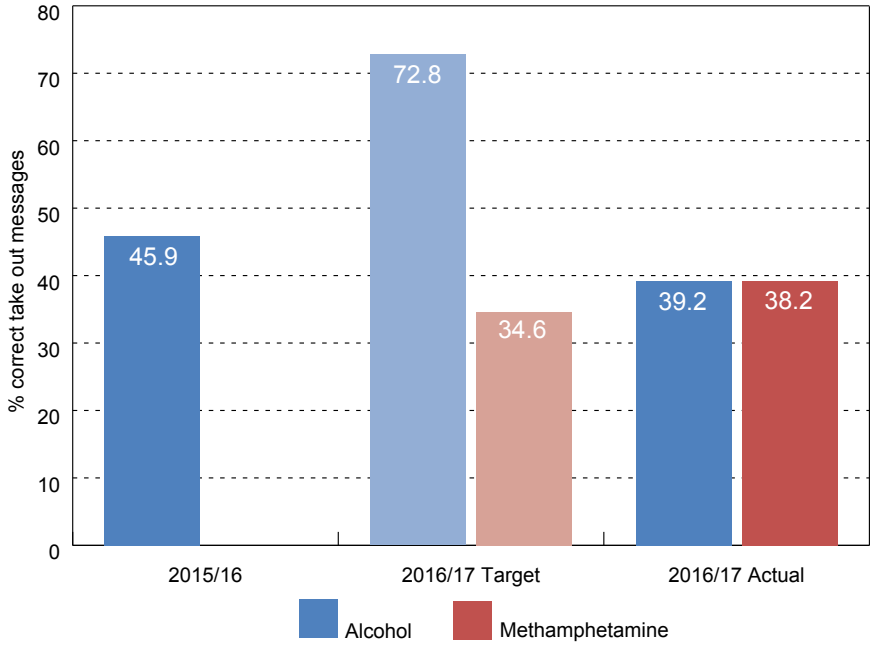
This indicator measures success of public education and social marketing campaigns to reduce the social acceptability of risky AOD use and increase the awareness of associated harm. The campaigns aim to build awareness and understanding of the risks and harms associated with AOD use. This indicator provides a measure of how many people aware of the campaign correctly understood the message(s) (i.e. correct take out) presented by the campaign, which provides an indication of how effective the campaign was in delivering the message(s) to the target population to reduce the incidence of use and harm associated with AODs. A range of other prevention activities are undertaken within the Western Australian community and linked explicitly to the key campaign messages: Alcohol.Think Again and Drug Aware.

Results:

In 2016/17, the correct message take out for the "Alcohol. Think Again" health campaign was 39.2 per cent. This result is lower than the 2016/17 target of 72.8 per cent due to the implementation of a refined methodology used to calculate campaign correct message takeout which was not available at the time of target development. This methodology uses both correct recall and correct message takeout. If the old methodology was used the campaign correct message take out amongst the target population would be 78.4%, indicating the campaign was above target.

The correct message take out for the Drug Aware "Meth Can Take Control" campaign (38.2 per cent) was 3.6 percentage points higher than the 2016/17 target of 34.6 per cent. As this is the first time Drug Aware "Meth Can Take Control" campaign results have been presented using this methodology the target is not effected by the change.

2.2: Percentage of correct take out messages for AOD campaigns among target population



Data Source – Alcohol: TNS Global social marketing company. The total sample size was 402 and was weighted by gender within age and by location to approximate the Western Australian population of individuals aged 25 to 54 years. The response rate was 76%. The confidence interval is 95% and the standard error rate is 4.59%.

Data Source – Methamphetamine: TNS Global social marketing company. The total sample size was 401 and was weighted by gender within age and by location to approximate the Western Australian population of individuals aged 14 to 29 years. The response rate was 25%. The confidence interval is 95% and the standard error rate is 4.99%.

Time Period: The data is for the financial year.

During 2016/17 a new online tool was launched as part of the Alcohol.Think Again campaign

Key Effectiveness Indicators

Outcome three
Accessible, high quality and appropriate mental health and AOD treatments and supports

Description:

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

Rationale:

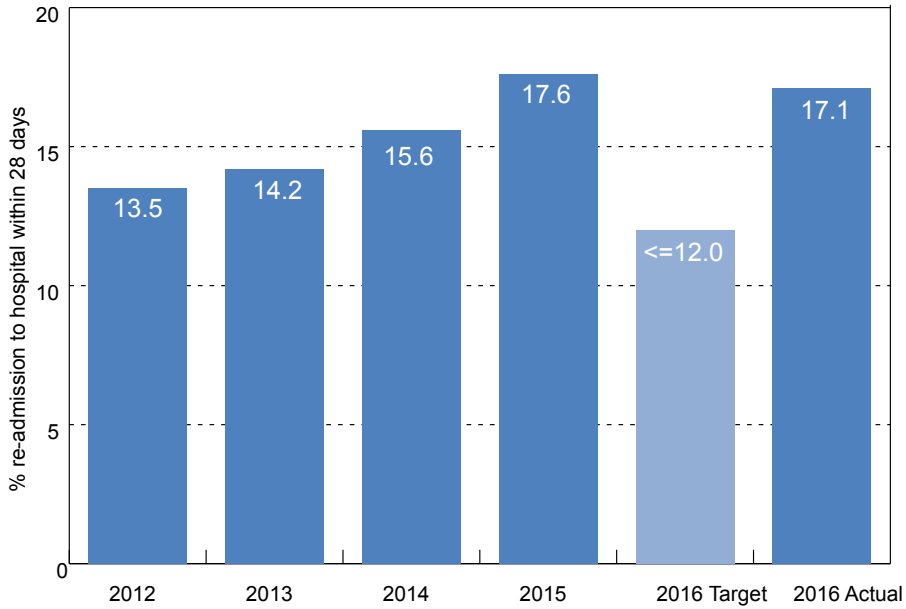
This indicator measures the appropriateness and quality of care provided by mental health services. The re-admission rate is an indicator of the objective to provide effective care and continuity of care in the delivery of mental health services. This indicator is a nationally endorsed and widely reported indicator, considered to be a global performance measure as it potentially points to deficiencies in the functioning of the overall mental health care system. Admissions to a specialised mental health inpatient unit following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inappropriate or inadequate to maintain the person out of hospital.

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

Results:

In 2016, the re-admission rate to acute mental health inpatient facilities within 28 days of discharge was 17.1 per cent. This result is lower than the 2015 result of 17.6 per cent but above the nationally set target of less than or equal to 12.0 per cent. Since 2014, re-admission rates have been impacted by the introduction of new models of care such as hospital in the home and data recording and reporting practices. The Commission has implemented a monitoring program for this key effectiveness measure and is regularly reviewing current results with Western Australian Department of Health to further improve performance and enhance data capture.

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



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

Data Source: Mental Health Information System, Department of Health.

Time Period: The data is for the calendar year.

A community support system for people who are discharged from hospital after an acute psychiatric episode is essential to maintain clinical and functional stability and to minimise the need for hospital re-admission.

Key Effectiveness Indicators

Outcome three
Accessible, high quality and appropriate mental health and AOD treatments and supports

Description:

The proportion of overnight separations from public mental health inpatient units where a first contact with a community-based public mental health non-admitted service occurred within seven days following discharge. 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.

Rationale:

This indicator measures the quality of care provided by mental health services. It is an indicator of the objective to provide continuity of care in the delivery of mental health services. A large proportion of people with a mental health problem have a chronic or recurrent type illness that results in only partial recovery between acute episodes and deterioration in functioning that can lead to problems in living an independent life. As a result, hospitalisation may be required on more than one occasion each year with the need for ongoing community-based support.

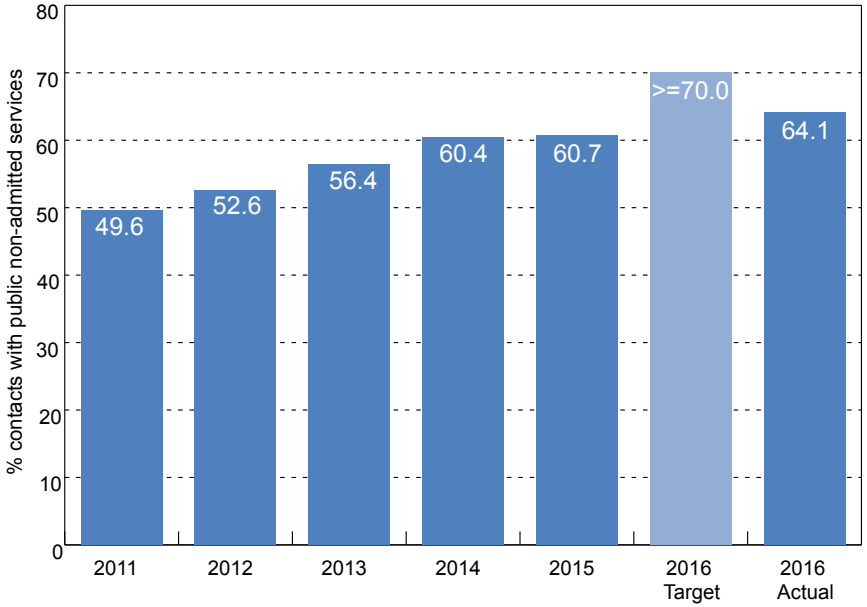
A responsive and high quality community support system will assist people who have experienced an acute psychiatric episode requiring hospitalisation in maintaining clinical and functional stability to minimise their need for a hospital re-admission. Patients leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with public community-based services and supports, are less likely to need inappropriate re-admission.

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.

Results:

In 2016, 64.1 per cent of patients had contact with a community-based public mental health service within seven days post discharge from a public mental health inpatient unit. This result is higher than the 2015 result of 60.7 per cent but below the nationally set target of greater than or equal to 70 per cent. As seen over the six year period, the Commission is continuing to work towards the national target.

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



Note: This indicator includes follow up by public mental health non-admitted services only. Follow up by other providers, including private psychiatrists, GPs or community managed (non-government) services are not included.

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

Time Period: The data is for the calendar year.

In 2016/17 the Commission funded community-based public mental health non-admitted services, such as the Youth Community Treatment service at Fiona Stanley Hospital

Key Effectiveness Indicators

Outcome three
Accessible, high quality and appropriate mental health and AOD treatments and supports

Description:

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

Unplanned exits occur if the client ceased to participate against advice, ceased to participate (non-compliance), ceased to participate without notice, died, sanctioned by drug court or court diversion service back to jail, and imprisoned (other than drug court sanctioned).

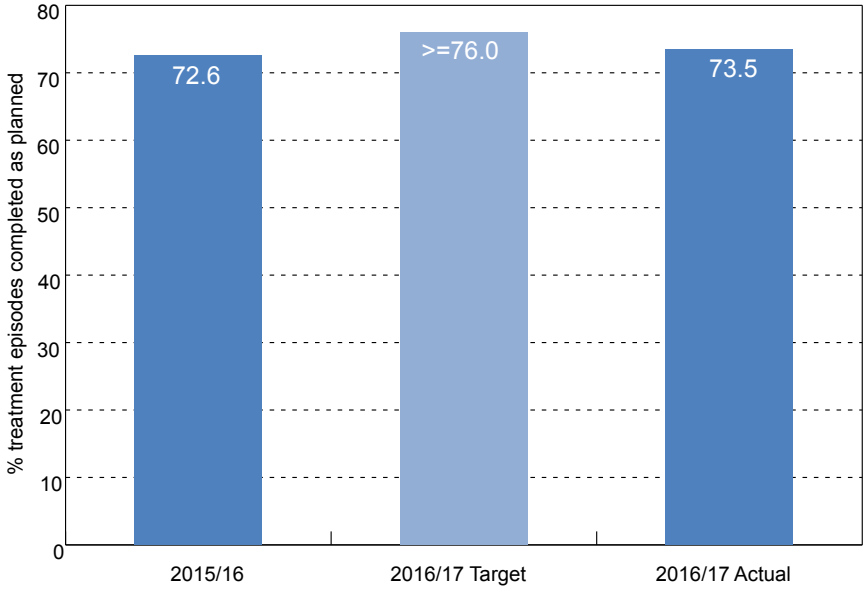
Rationale:

This indicator measures the quality of AOD treatment and supports. International literature identifies that treatment outcomes for people with alcohol and drug-related problems are significantly enhanced if they remain in treatment until the program is completed or they leave with the agreement of their clinician. Treatment episodes that are completed as planned are indicative of effective outcomes. This indicator provides an indication of the extent of which treatment objectives are likely to be achieved (i.e., a planned outcome). A high percentage of closed AOD treatment episodes completed as planned is indicative of high quality and appropriate care in AOD treatment and support.

Results:

In 2016/17, the percentage of closed treatment episodes that were completed as planned was 73.5 per cent. This result is higher than the 2015/16 result of 72.6 per cent but below the 2016/17 target of greater than or equal to 76.0 per cent. The Commission is continuing to work towards the target to ensure high quality and appropriate care.

3.3: Percentage of closed AOD treatment episodes completed as planned



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

Time Period: Data is for the April 2016 to March 2017 time period to allow for a three month lag for coding and auditing purposes.

In 2016/17, the percentage of closed treatment episodes that were completed as planned was 73.5 per cent

Key Effectiveness Indicators

Outcome three
Accessible, high quality and appropriate mental health and AOD treatments and supports

Description:

Monitoring the non-government organisations contracted by the Mental Health Commission to provide mental health services and supports against national standards for care will enable the Commission to be confident that it is investing in services that are providing appropriate and quality care to individuals in the community. Revised National Standards for Mental Health Services (NSMHS) were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. These standards can apply to non-government community mental health services as well as specialised public mental health services. This indicator measures the proportion of organisations that have been through an independent evaluation that achieved at least eight of the ten standards.

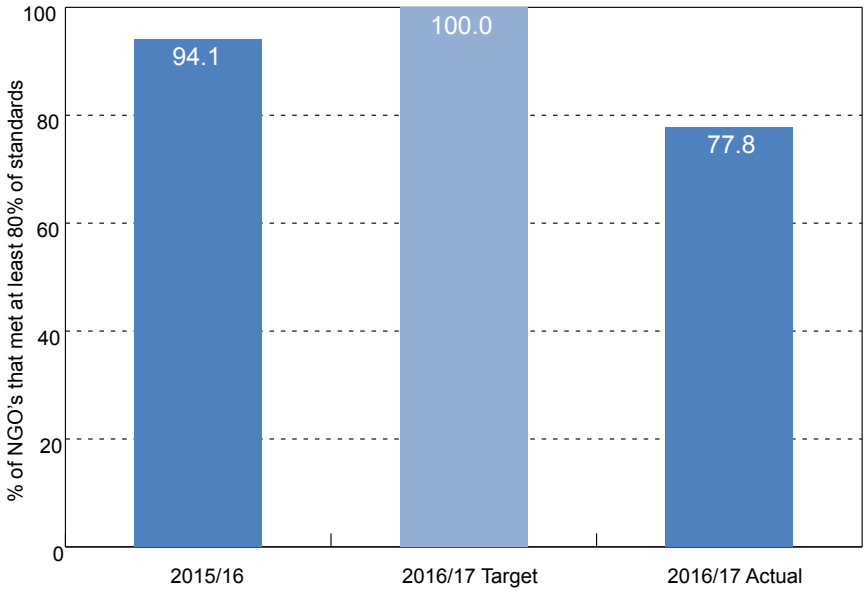
Rationale:

This indicator measures the appropriateness and quality of mental health services provided by non-government organisations contracted by the Commission against the NSMHS. All Commission funded organisations are required to meet the NSMHS and these are evaluated through Independent Quality Evaluations in addition to an annual self-assessment. The intent of Independent Quality Evaluations is to focus on how an organisation is continuously improving its services, supporting individuals to meet their individual goals (Outcomes) and meeting the Standards. A key component of the Quality Evaluations is identifying the satisfaction people (individuals, families and carers) have experienced accessing the services including their perception and confidence in how the organisation is meeting their needs. Having an independent team of evaluators look at an organisation's services and speak to the people accessing them in a confidential manner can provide the opportunity for continuous improvement activities that otherwise may not be identified.

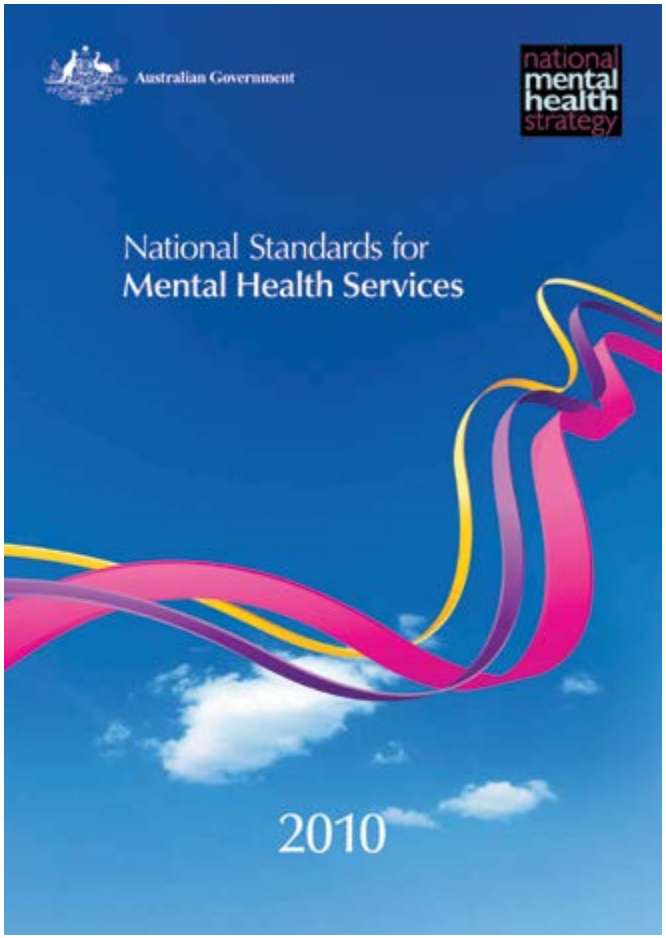
Results:

In 2016/17, the percentage of non-government organisations contracted to provide mental health services that met at least eight of the ten NSMHS standards was 77.8 per cent. This is lower than the 2016/15 result of 94.1 per cent and the 2016/17 target of 100 per cent. The 2016/17 result relates to four of the eighteen service providers audited in 2016/17 failing to meet at least eight of the standards. These service providers have required actions identified that must be implemented within a set timeframe and provide evidence to the Commission that these have been implemented in order to bring their services in line with the Standards.

3.4: Percentage of non-government organisations contracted to provide mental health services that met the National Standards for Mental Health Services (2010) through independent evaluation



Data Source: The Commission, Sector and Quality Evaluation Management.
Time Period: Data is for the financial year.



Key Effectiveness Indicators

Outcome three
Accessible, high quality and appropriate mental health and AOD treatments and supports

Description:

This indicator reports on the proportion of the Western Australian population using a specialised public mental health service. This indicator measures the accessibility of public mental health services.

Rationale:

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

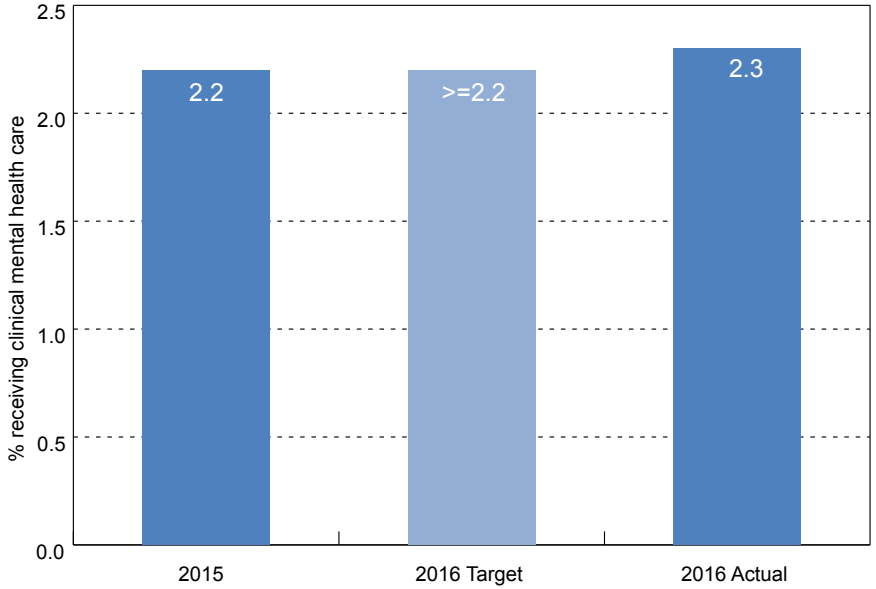
The issue of unmet need has become prominent at a national level since the National Survey of Mental Health and Wellbeing indicated that a majority of people affected by a mental disorder do not receive treatment.

While not all people affected by a mental disorder require treatment, and while some will only receive treatment from sources other than specialised public mental health services (such as primary care from GPs, treatment in private hospitals or supports from non-government organisations), this indicator enables the Commission to monitor the accessibility of public mental health services, which currently account for more than 78% of the Commission's funding. Severe mental health disorders are experienced by approximately 3% of the Australian population (National Action Plan for Mental Health 2006-2011: Fourth Progress Report; Council of Australian Governments). A higher percentage is indicative of greater accessibility to mental health services by those in need.

Results:

In 2016, the percentage of the Western Australian population receiving public mental health care was 2.3 per cent. This result is higher than the 2015 result (2.2 per cent) and met the 2016/17 target of greater than or equal to 2.2 per cent. It should be noted that although the result of 2.3 per cent is below the estimated population prevalence of severe mental health disorders (3.0 per cent), many individuals receive treatment through the private sector and are therefore not captured in this indicator.

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



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

Time Period: The population receiving public clinical mental health care data is for the calendar year, the population data is a June 2016 population estimate calculated by the ABS in December 2016, the latest estimate available.

NMHS public mental health services, such as those at Graylands Hospital, are funded through the Commission

Key Efficiency Indicators

Service one
Prevention

Description:

This indicator is calculated by dividing total Commission expenditure on mental health illness prevention, promotion and protection activities by the total Western Australian estimated resident population. Mental health 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.

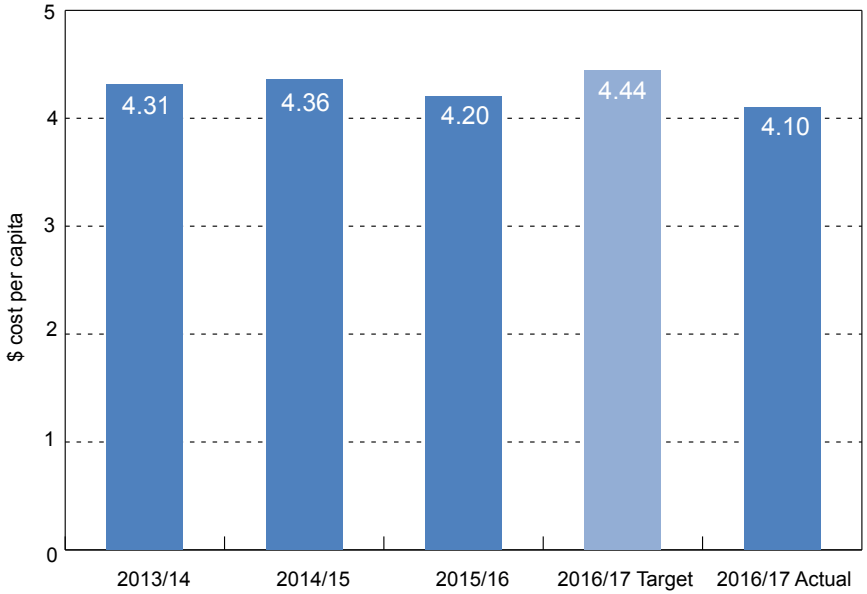
Rationale:

This indicator measures the cost per capita of mental health promotion, illness prevention, protection and related activities. It monitors the investment by the Mental Health Commission in activities that aim to eliminate or reduce modifiable risk factors associated with individual, social and environmental health determinants to enhance mental health and wellbeing and prevent mental illnesses before they develop. This investment applies to the population as a whole in the context of their everyday lives. This indicator also seeks to address the policy question regarding how well mental health prevention services use their resources (inputs) to produce outputs, that is, whether prevention programs are delivered in the most efficient manner.

Results:

In 2016/17, the cost per capita to provide prevention, promotion, protection and related activities to enhance mental health wellbeing was $4.10. The result is lower than the 2015/16 result of $4.20 and below the 2016/17 target of $4.44. This is because not all the budgeted funds were expended during 2016/17 due to the delayed commencement of some projects (such as the Aboriginal Family Wellbeing Pilot Project and the Mental Health and Wellbeing Education for Men in Regional and Remote Farming Communities).

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



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

Time Period: The population data is a June 2016 population estimate calculated by the ABS in December 2016, the latest estimate available. Cost data is presented by financial year.

In 2016/17, the cost per capita to provide prevention, promotion, protection and related activities to enhance mental health wellbeing was $4.10

Key Efficiency Indicators

Service one
Prevention

Description:

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

The Commission supports local service providers to prevent AOD use and related problems through activities such as a Statewide network of local drug action groups that deliver preventative activities and education for youth and support for families, and school drug education through the state, Catholic and independent school sectors. The Commission provides a range of prevention and early intervention programs and services that prevent and delay the onset of AOD use, support environments that discourage harmful use, enhance healthy community attitudes and skills to avoid harmful use, support and enhance the community's capacity to address AOD problems and support initiatives that discourage inappropriate supply of alcohol and other drugs.

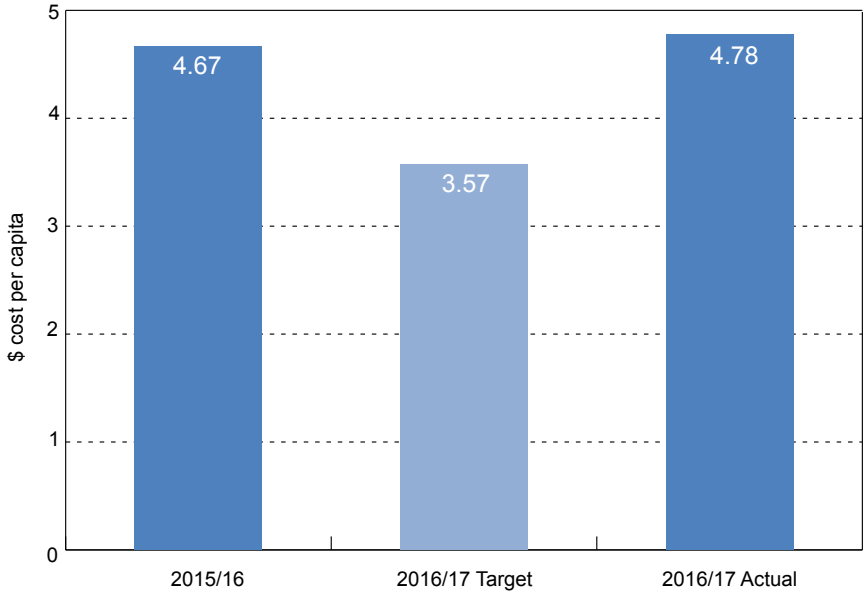
Rationale:

This indicator measures the cost per capita of AOD related initiatives that delay uptake and reduce harmful alcohol use as well as preventing illicit drug use. Key outcomes include: a community with better knowledge and skills to prevent AOD problems and reduce associated harms; prevention programs that build the resilience and protective factors targeted at children and young people; and a positive culture in Western Australia that is consistent with decreasing illicit drug use and harmful alcohol consumption. This investment applies to the population as a whole in the context of their everyday lives. The aim is to increase the proportional investment in the prevention service and gain a return in health, economic and social benefits for the Western Australian community.This indicator also seeks to address the policy question regarding how well AOD prevention services use their resources (inputs) to produce outputs, that is, whether AOD prevention programs are delivered in the most efficient manner.

Results:

In 2016/17, the cost per capita for initiatives that delay the uptake and reduce the harm associated with alcohol and other drugs was $4.78. This result is substantially above the 2016/17 target of $3.57 but only slightly higher than the 2015/16 result of $4.67. The variation between the 2016/17 actual and the 2016/17 target reflects the inclusion in the cost of service of previous Commonwealth and other grant funding for Drug and Alcohol Services. This was not included in the budget target because confirmation of Commonwealth and other grant funding had not been received at the time.

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



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

Time Period: The population data is a June 2016 population estimate calculated by the ABS in December 2016, the latest estimate available. Cost data is presented by financial year.

Alcohol.Think Again campaign poster during 2016/17

Key Efficiency Indicators

Service one
Prevention

Description:

The Commission delivers public health campaigns and initiatives to reduce harmful alcohol use and prevent illicit drug use. These include the Alcohol.Think Again and Drug Aware Prevention Campaigns. Online post-campaign surveys are conducted with a cohort of individuals representing the age and/or gender of the campaign target group. The surveys collect data on campaign awareness and correct message recall. As advised by TNS Social Research, an adjustment factor of 80% is applied to the correct message recall rate. This figure is then multiplied by the WA population figures for the campaign target group, which is divided by the average cost of a campaign burst in the financial year.

Rationale:

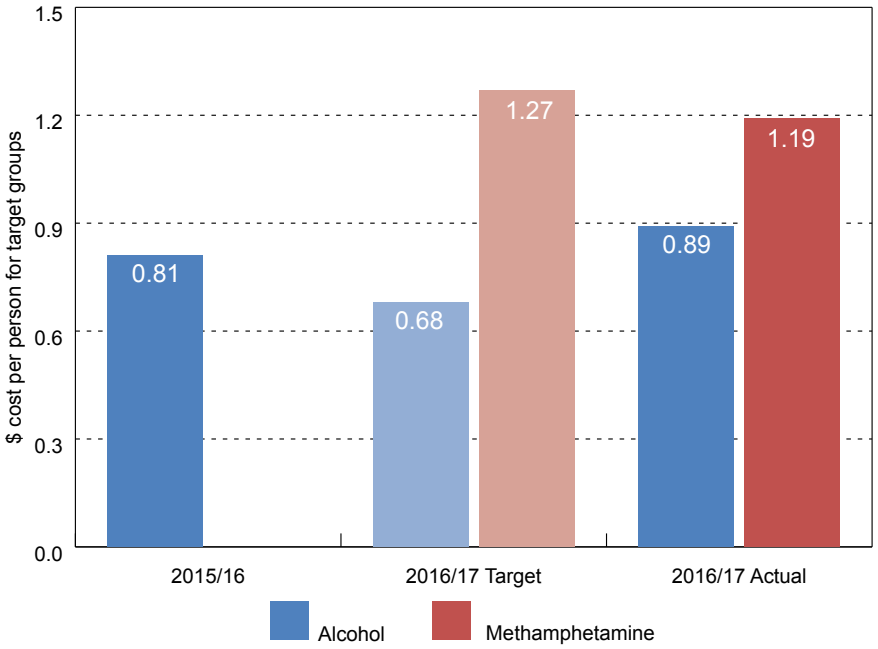
This indicator monitors the cost efficiency of key social marketing programs in terms of the target population‘s awareness of the campaign and recall of main messages in post-campaign evaluation. Separate targets are set for each campaign undergoing evaluation. Costs include direct media scheduling costs, production, evaluation and other campaign associated costs. The campaigns aim to build awareness and understanding of the risks and harms associated with AOD use. This indicator provides a measure of how much it costs to reach each person aware of the campaign and who correctly understood the message(s) presented by the campaign. This provides an indication of how cost efficient the campaign was in delivering the message(s) intended by the campaign to the target population.

Results:

In 2016/17 the cost per person of the “Alcohol.Think Again” health campaign target group who was aware of, and could correctly recall, the main campaign message was $0.89. This is higher than the 2016/17 target of $0.68 and slightly higher than the 2015/16 result of $0.81 due to the implementation of a refined methodology used to calculate campaign correct message takeout which was not available at the time of target development.

In 2016/17 the cost per person of the Drug Aware “Meth Can Take Control” campaign target group who was aware of, and could correctly recall, the main campaign message was $1.19, slightly lower than the 2016/17 target of $1.27. The cost per person for the methamphetamine campaign was higher than for the alcohol campaign as the target population is almost half that of the alcohol campaign and delivered in a more targeted manner than the alcohol campaign.

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



Data Source – Alcohol: The Commission's Prevention Branch – Total cost of the campaign. TNS Global – percentage of target group who were 'aware' and 'correctly' identified campaign message. The total sample size was 402 and was weighted by gender within age and by location to approximate the Western Australian population of individuals aged 25 to 54 years. The response rate was 76%. The confidence interval is 95% and the standard error rate is 4.59%. Population figures – ABS time series workbook 3101.0 Population by age and sex, Australian States and Territories, Western Australia.

Data Source – Methamphetamine: The Commission's Prevention Branch – Total cost of the campaign. TNS-Global – percentage of target group who were 'aware' and 'correctly' identified campaign message. The total sample size was 401 and was weighted by gender within age and by location to approximate the Western Australian population of individuals aged 14 to 29 years. The response rate was 25%. The confidence interval is 95% and the standard error rate is 4.99%. Population figures – ABS time series workbook 3101.0 Population by age and sex, Australian States and Territories, Western Australia.

Time Period: Population data is a June 2016 population estimate calculated by the ABS in December 2016, the latest estimate available. Cost data is for the financial year.

Key Efficiency Indicators

Service two
Hospital Bed-Based Services

Description:

Acute hospital beds provide inpatient assessment and treatment services for people experiencing severe episodes of mental illness who cannot be adequately treated in a less restrictive environment. Average length of stay is defined as the number of inpatient patient days divided by the number of separations in the reference period — data are disaggregated by inpatient target population (acute units only). Acute inpatient services include the Next Step and DAYS inpatient withdrawal units.

Rationale:

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

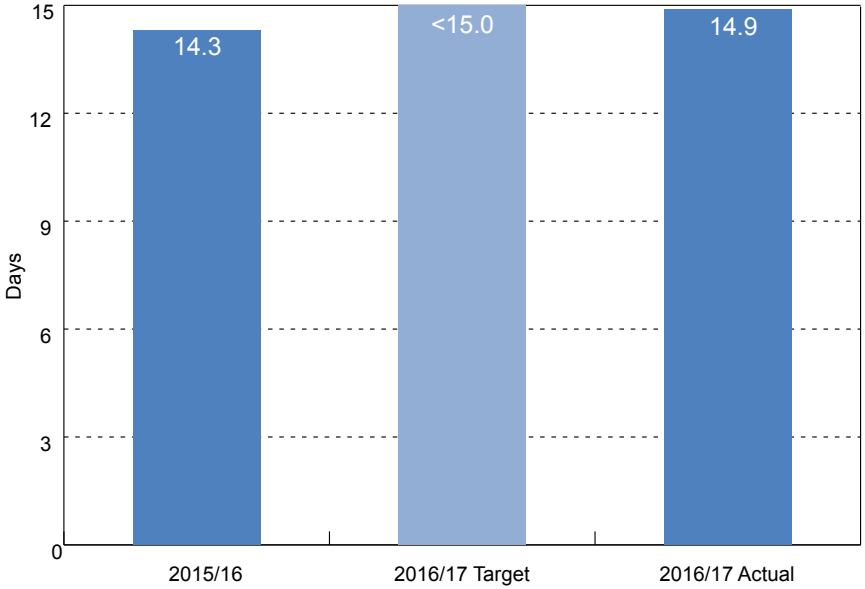
The purpose of this indicator is to better understand underlying factors which cause variation in acute specialised mental health care costs. It may also demonstrate the degrees of accessibility to acute specialised mental health units. The length of stay indicates the relative volume of care provided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

Results:

In 2016/17, the average length of stay in purchased acute specialised units was 14.9 days.

This result is marginally lower than the 2016/17 target of less than 15.0 days and slightly higher than the 2015/16 result of 14.3 days.

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



Data Source: Hospital Morbidity Data Collection, Department of Health. Drug and Alcohol Youth Service (DAYS) and Next Step data extracted from the Commission's De-identified Treatment Agency Database.

Time Period: Data is for the April 2016 to March 2017 time period to allow for a three month lag for coding and auditing purposes.

In 2016/17, the average length of stay in purchased acute specialised units was 14.9 days

Key Efficiency Indicators

Service two
Hospital Bed-Based Services

Description:

As outlined in the Plan, acute hospital beds provide hospital based inpatient assessment and treatment services for people experiencing severe episodes of mental illness who cannot be adequately treated in a less restrictive environment. Cost per inpatient bedday is defined as expenditure on inpatient services divided by the number of inpatient beddays — data are disaggregated by care type (acute units). Acute inpatient services include the Next Step and DAYS inpatient withdrawal units.

Rationale:

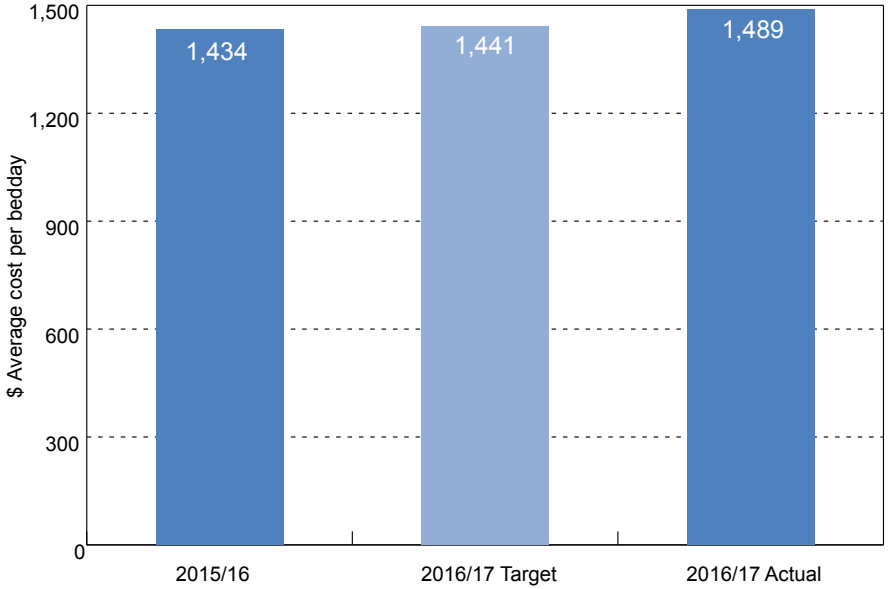
A key objective of the Plan is the realignment of bed-based services to ensure that beds of the right type are in the right places, in the right quantity, and delivered at an efficient price. This efficiency indicator aligns with the key hospital based bed types identified in the Plan, and reflects key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

In order to ensure quality care and cost effectiveness, it is important to monitor the unit cost of admitted patient care in acute specialised mental health units. Minimising the costs of providing inpatient mental health care may enable the reallocation of funds to alternative non-admitted care.

Results:

In 2016/17, the average cost per bedday in acute specialised units was $1,489. This result is higher than the 2016/17 target of $1,441 and the recasted 2015/16 result of $1,434. This indicator is impacted by a number of factors, including demand for services which affects the overall volume of beddays as well as changes which occur year to year to the underlying national funding model.

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



Note: In 2016/17, a newly established mental health treatment model has been developed. This changes the service cost classification, which means the prior year figure is no longer comparable. The prior year figure has been recasted from $1,384 to $1,434.

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

Time Period: Data is for the financial year.

In Western Australia in 2016/17 the cost per day for a mental health bed was:

$1,489

in acute specialised mental health units

Compared to:

$643

in step up/step down community bed-based units (see 3.3)

Key Efficiency Indicators

Service two
Hospital Bed-Based Services

Description:

Sub-acute hospital short stay provides hospital based treatment and support in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their receiving treatment in a less restrictive environment. This service provides for adults, older adults and a selected number of young people with special needs. Average length of stay is defined as the number of inpatient patient days divided by the number of separations in the reference period — data are disaggregated by inpatient target population (sub-acute units only).

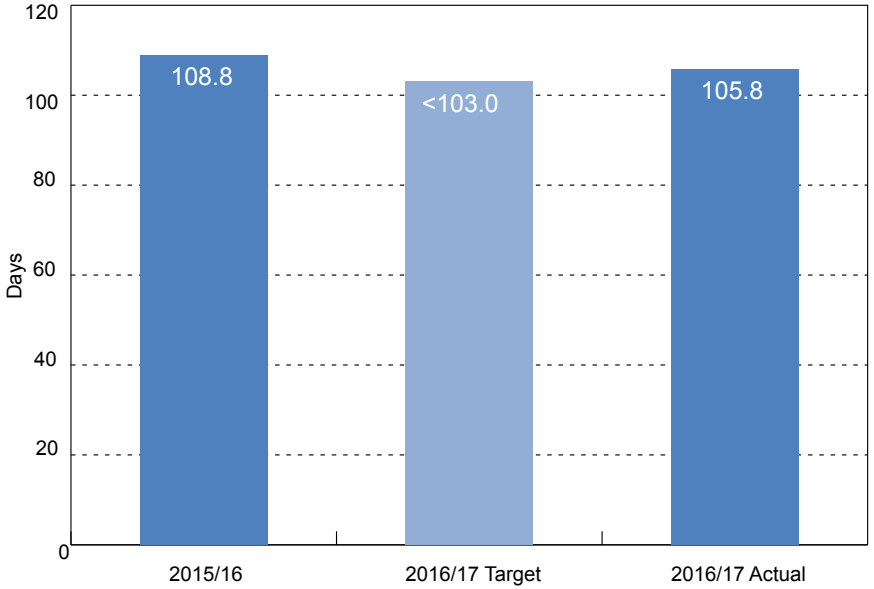
Rationale:

Average length of stay is included to present a more meaningful picture of the efficiency of each bed type. In national reports, such as the Report on Government Services, average length of stay is commonly reported together with cost per inpatient bedday to provide an overall picture of the cost of inpatient care. The purpose of this indicator is to better understand underlying factors which cause variation in sub-acute specialised mental health care costs. It may also demonstrate the degrees of accessibility to sub-acute specialised mental health units. The length of stay indicates the relative volume of care provided to people in sub-acute units and is the main driver of variation in costs. Inclusion of this indicator also provides a basis for understanding utilisation of services.

Results:

In 2016/17, the average length of stay in purchased sub-acute specialised mental health units was 105.8 days. This result is not significantly different to either the 2016/17 target or the 2015/16 result.

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



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

Time Period: Data is for the April 2016 to March 2017 time period to allow for a three month lag for coding and auditing purposes.

Sub-acute hospital short stay provides hospital based treatment and support in a safe, structured environment

Key Efficiency Indicators

Service two
Hospital Bed-Based Services

Description:

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

Rationale:

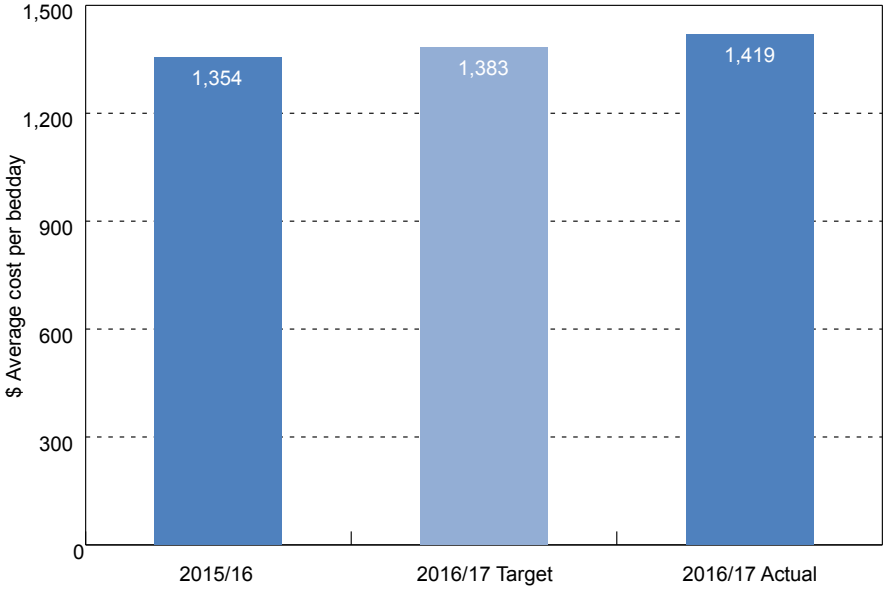
A key objective of the Plan is the realignment of bed-based services to ensure that beds of the right type are in the right places, in the right quantity, and delivered at an efficient price. This efficiency indicator aligns with the key hospital based bed types identified in the Plan, and reflects key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

In order to ensure quality care and cost effectiveness, it is important to monitor the unit cost of admitted patient care in sub-acute specialised mental health units. Minimising the costs of providing inpatient mental health care may enable the reallocation of funds to alternative non-admitted care.

Results:

In 2016/17, the average cost per bedday in sub-acute specialised units was $1,419. This result is higher than the 2016/17 target of $1,383 and the 2015/16 result of $1,354. This indicator is impacted by a number of factors, including demand for services which affects the overall volume of beddays as well as changes which occur year to year to the underlying national funding model. The increased cost per bedday in 2016/17 is due to a slightly lower number of beddays and increased cost.

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



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

Time Period: Data is for the financial year.

In 2016/17, the average cost per bedday in sub-acute specialised units was $1,419

Key Efficiency Indicators

Service two
Hospital Bed-Based Services

Description:

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

Rationale:

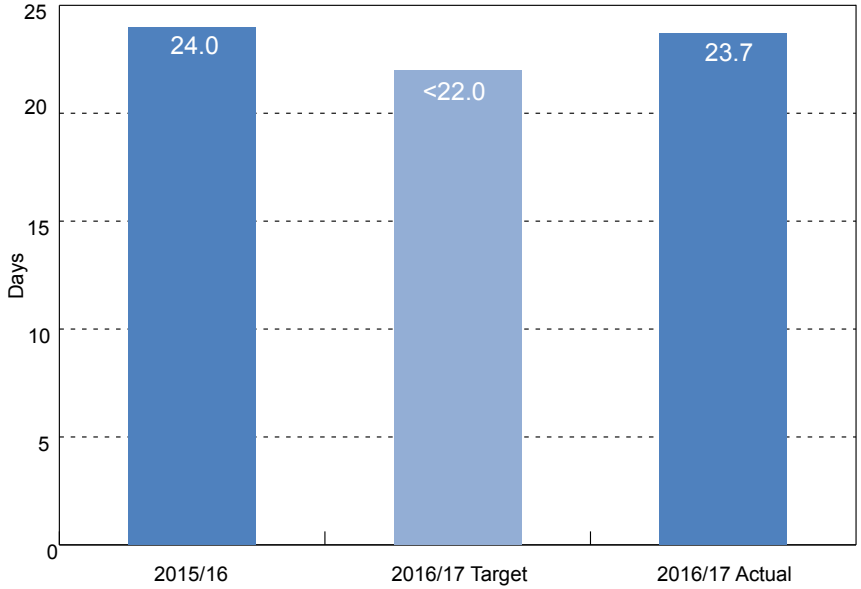
Average length of stay is included to present a more meaningful picture of the efficiency of each bed type. In national reports, such as the Report on Government Services, average length of stay is commonly reported together with cost per inpatient bedday to provide an overall picture of the cost of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

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

Results:

In 2016/17, the average length of stay in purchased hospital in the home mental health units was 23.7 days. This result is slightly higher than the 2016/17 target of less than 22 days and similar to the 2015/16 result of 24.0 days.

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



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

Time Period: Time Period: Data is for the April 2016 to March 2017 time period to allow for a three month lag for coding and auditing purposes.

The mental health Hospital in the Home program offers individuals the opportunity to receive hospital level treatment delivered in their home, where clinically appropriate.

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

Key Efficiency Indicators

Service two
Hospital Bed-Based Services

Description:

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

Rationale:

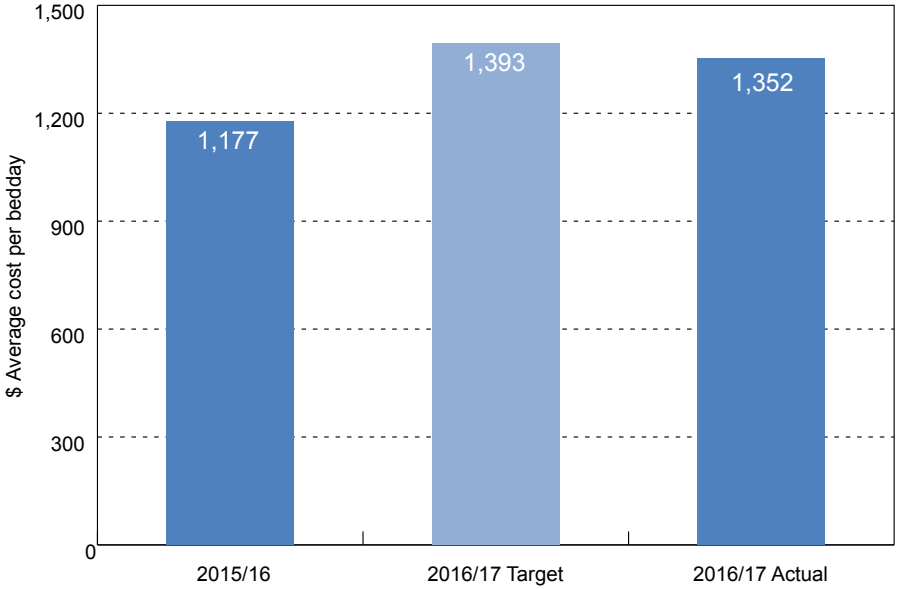
A key objective of the Plan is the realignment of bed-based services to ensure that beds of the right type are in the right places, in the right quantity, and delivered at an efficient price. This efficiency indicator aligns with the key hospital based bed types identified in the Plan, and reflects key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

In order to ensure quality care and cost effectiveness, it is important to monitor the unit cost of admitted patient care in HITH specialised mental health units. Minimising the costs of providing inpatient mental health care may enable the reallocation of funds to alternative non-admitted care.

Results:

In 2016/17, the average cost per bedday in Hospital in the Home mental health units was $1,352. This result is lower than the 2016/17 target of $1,393. The 2016/17 result was higher than the recasted 2015/16 result of $1,177. This indicator is impacted by a number of factors, including demand for services which affects the overall volume of beddays as well as changes which occur year to year to the underlying national funding model. The increased cost per bedday in 2016/17 compared to 2015/16 is due to a an increased allocation of funding to HITH beds. Accordingly, bedday activity increased 5% from 2015/16.

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



Note: In 2016/17, a newly established mental health treatment model has been developed. This changes the service cost classification, which means the prior year figure is no longer comparable. The prior year figure has been recasted from $2,170 to $1,177.

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

Time Period: Data is for the financial year.

City West older Adult Mental Health Service Hospital in the Home

Key Efficiency Indicators

Service two
Hospital Bed-Based Services

Description:

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

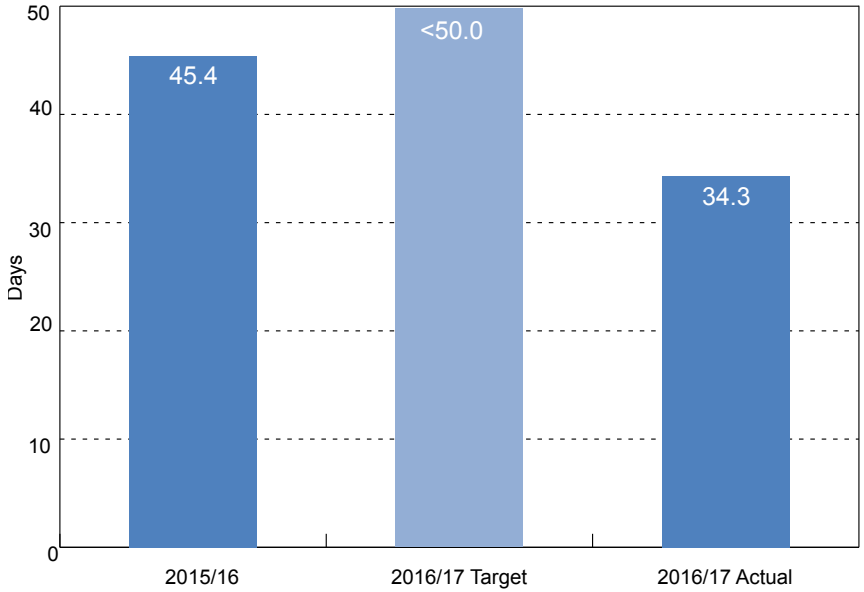
Rationale:

Average length of stay is included to present a more meaningful picture of the efficiency of each bed type. In national reports, such as the Report on Government Services, average length of stay is commonly reported together with cost per inpatient bedday to provide an overall picture of the cost of inpatient care. The purpose of this indicator is to better understand underlying factors which cause variation in forensic mental health care costs. It may also demonstrate the degrees of accessibility to forensic mental health units. The length of stay indicates the relative volume of care provided to people in forensic units and is the main driver of variation in costs. Inclusion of this indicator also provides a basis for understanding utilisation of services.

Results:

In 2016/17, the average length of stay in purchased forensic mental health units was 34.3 days. This result is substantially lower than the 2016/17 target of less than 50 days and the 2015/16 result of 45.4 days. This is likely due to high demand for limited capacity, in part leading to shorter lengths of stay to accomodate a larger number of people.

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



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

Time Period: Data is for the April 2016 to March 2017 time period to allow for a three month lag for coding and auditing purposes.

Compared to the general community, the prevalence of mental health issues is higher at every stage of the criminal justice process.

Forensic inpatient services provide specialist multidisciplinary mental health care to patients within the criminal justice system

Key Efficiency Indicators

Service two
Hospital Bed-Based Services

Description:

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

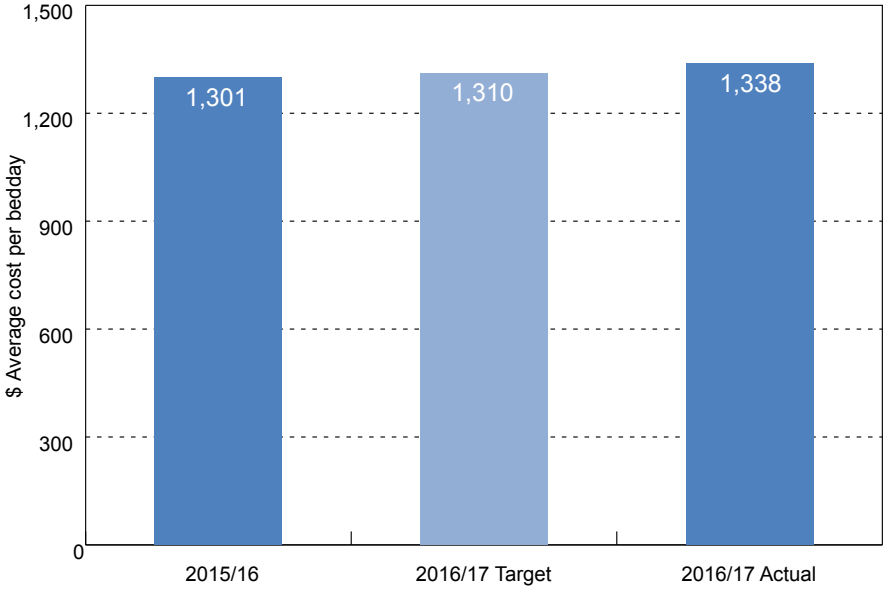
Rationale:

A key objective of the Plan is the realignment of bed-based services to ensure that beds of the right type are in the right places, in the right quantity, and delivered at an efficient price. This efficiency indicator aligns with the key hospital based bed types identified in the Plan, and reflects key indicators identified in the Plan's Evaluation Framework. This indicator will enable greater transparency of services in the context of the developing Activity Based Funding environment, and over time will enable monitoring of progress towards the targets and goals identified in the Plan. In order to ensure quality care and cost effectiveness, it is important to monitor the unit cost of admitted patient care in forensic specialised mental health units. Minimising the costs of providing inpatient mental health care may enable the reallocation of funds to alternative non-admitted care.

Results:

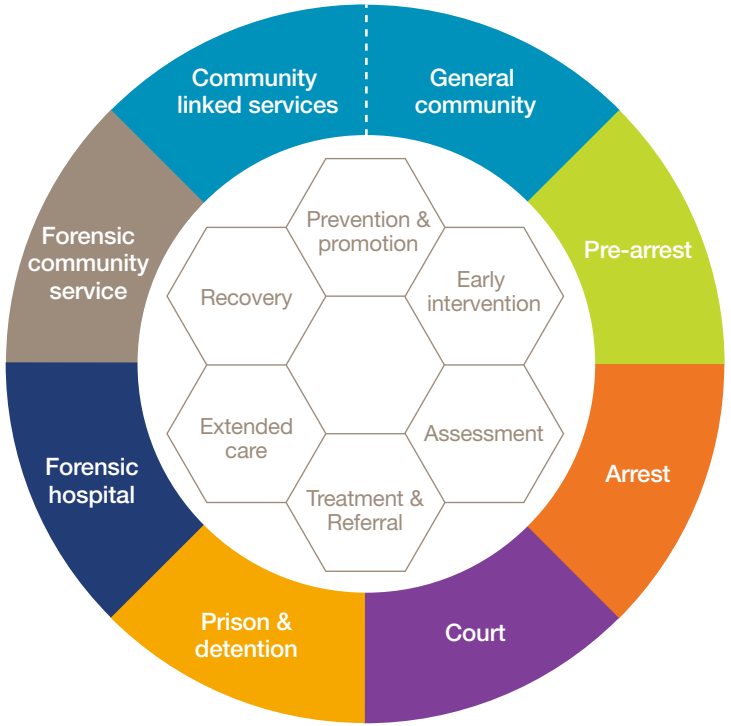
In 2016/17, the average cost per bedday in forensic units was $1,338. This result is marginally higher than the 2016/17 target of $1,310 and the 2015/16 result of $1,301.

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



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

Time Period: Data is for the financial year.



Range of forensic settings in Western Australia

Key Efficiency Indicators

Service three
Community Bed-Based Services

Description:

Non-government organisations provide accommodation in residential units for people affected by mental illness who require support to live in the community. Non-acute (24 hours support) residential care facilities provide support with self-management of personal care and daily living activities as well as initiate appropriate treatment and rehabilitation to improve the quality of life. This care is intended to be short to medium term (up to twelve months) in duration. This accommodation support is available to people with a mental illness, including older persons with complex mental health issues and significant behavioural problems. They are unable to live independently in the community without support and care.

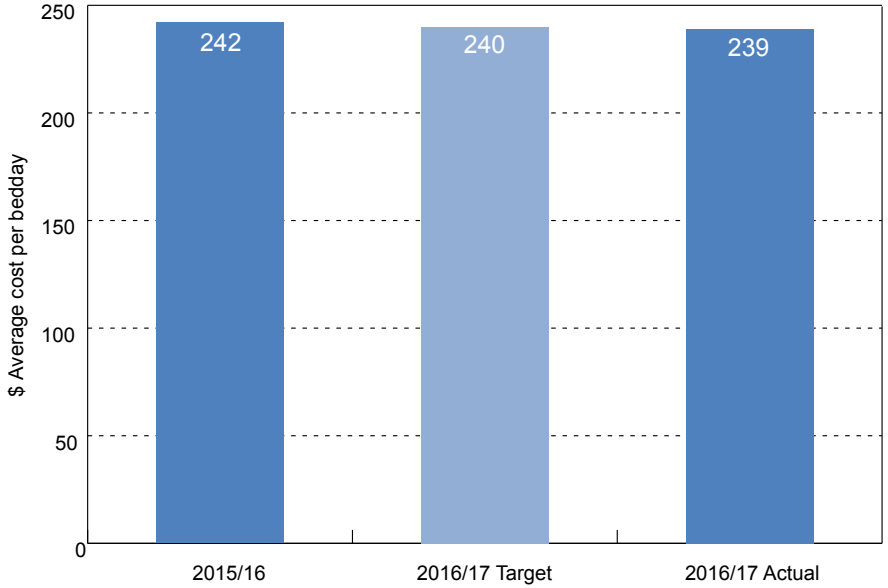
Rationale:

This indicator enables assessment of the efficiency of non-acute (24 hours support) community bed-based services both over time and relative to other services.

Results:

In 2016/17, the average cost per purchased bedday in non-acute (24 hours support) community bed-based services was $239, in line with the 2016/17 target of $240 and the 2015/16 result.

3.1: Average cost per purchased bedday in non-acute (24 hours support) community bed-based services



Data Source: The Commission's Financial Systems. The Commission's Non-government Organisation Establishment State Data Collection. Activity data for 6 months extrapolated to 12 months.

Time Period: Data is for the financial year.

St Bartholomew's House Inc, Bentley Villas, Community Supported Residential Units (CSRU's).

Key Efficiency Indicators

Service three
Community Bed-Based Services

Description:

Non-government organisations provide accommodation in residential units for people affected by mental illness who require long term support to live in the community. Services are specifically designed for older adults who have severe and persistent symptoms of mental illness, and who have support and care needs above those provided for in mainstream aged care settings. The services provide assessment, ongoing treatment, rehabilitation and residential support for consumers. Community long-stay services provide a more home-like environment compared to hospital services and can reduce the inappropriate use of hospital-based older adult services.

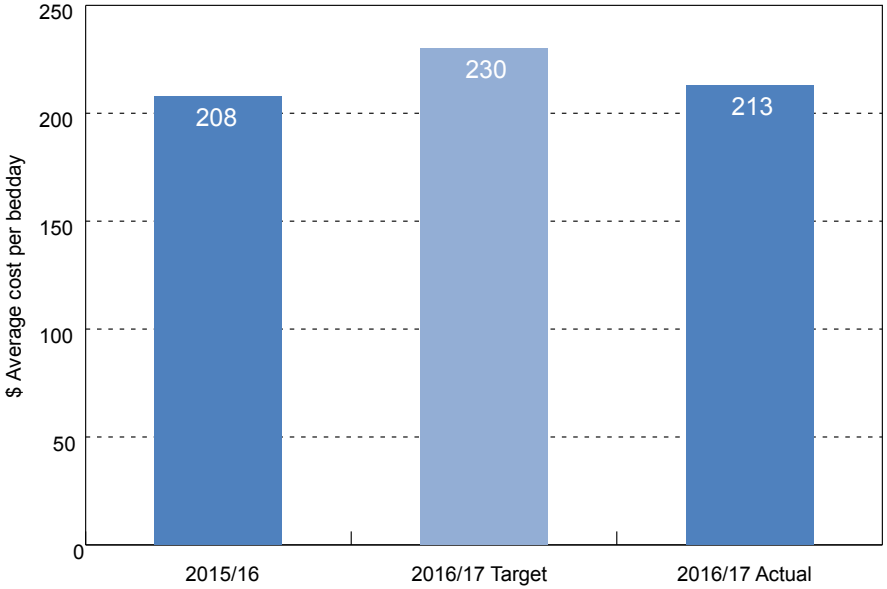
Rationale:

This indicator enables assessment of the efficiency of non-acute (Hospital/Nursing Home) community bed-based services both over time and relative to other services.

Results:

In 2016/17, the average cost per purchased bedday in non-acute (Hospital/Nursing Home) community bed-based services was $213. This is lower than the 2016/17 target of $230 and only slightly higher than the 2015/16 result of $208.

3.2: Average cost per purchased bedday in non-acute (hospital/nursing home) community bed-based units



Data Source: The Commission's Financial Systems. The Commission's Non-government Organisation Establishment State Data Collection. Activity data for 6 months extrapolated to 12 months.

Time Period: Data is for the financial year.

With our growing ageing population, the provision of appropriate services for older adults across the service spectrum is essential

Key Efficiency Indicators

Service three
Community Bed-Based Services

Description:

The Mental Health step-up/step-down service is a new initiative in Western Australia that provides short term mental health care, in a residential setting, that promotes recovery and reduces the disability associated with mental illness. These are comprehensive services designed to deliver support to individuals that is aimed at improving symptoms, encouraging the use of functional abilities and assists in facilitating a return to the usual environment. This is achieved within a framework of recovery and rehabilitation, and is delivered predominantly through non-clinical activities.

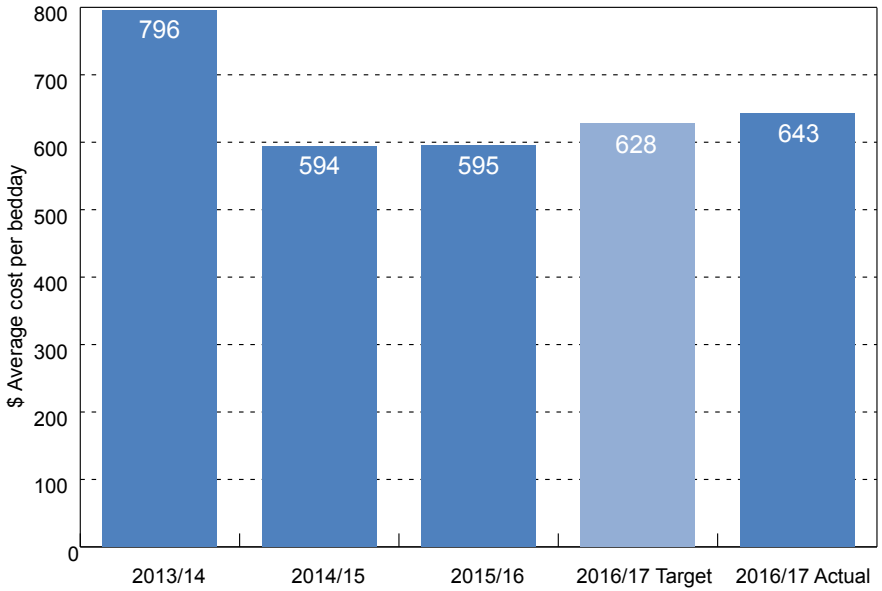
Rationale:

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

Results:

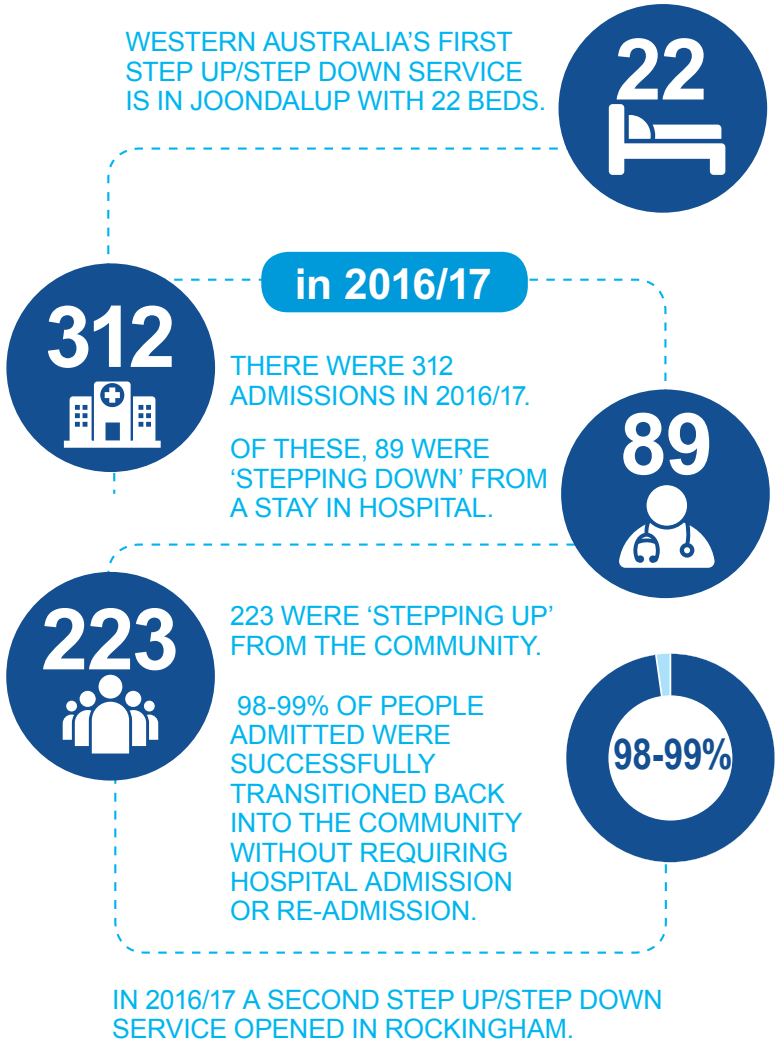
In 2016/17, the average cost per purchased bedday in step-up/step-down community bed-based units was $643. This is slightly higher than the 2016/17 target of $628. Fluctuation in the average cost per purchased bedday across years may be attributable to variability in the number of occupied beddays. The increase in 2016/17 is due to service development costs associated with the setting up of additional step up/step down bed capacity in Rockingham.

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



Data Source: The Commission's Financial Systems. The Commission's Non-government Organisation Establishment State Data Collection. Activity data for 6 months extrapolated to 12 months.

Time Period: Data is for the financial year.



Key Efficiency Indicators

Service three
Community Bed-Based Services

Description:

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

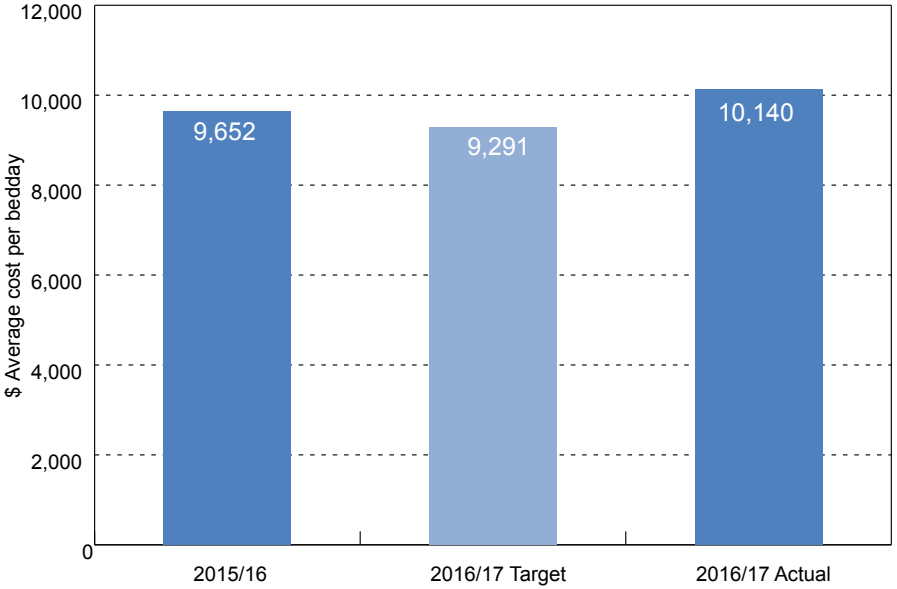
Rationale:

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

Results:

In 2016/17, the average cost per completed treatment episode in AOD residential rehabilitation services was $10,140. This result is higher than the 2016/17 target of $9,291 and the 2015/16 result of $9,652. The increase in 2016/17 is due to service development costs associated with the setting up of substantial additional residential rehabilitation bed capacity.

3.4: Cost per completed treatment episode in AOD residential rehabilitation services



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

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

Rick Hammersley Therapeutic Community run by Cyrenian House

Key Efficiency Indicators

Service four
Community Treatment

Description:

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

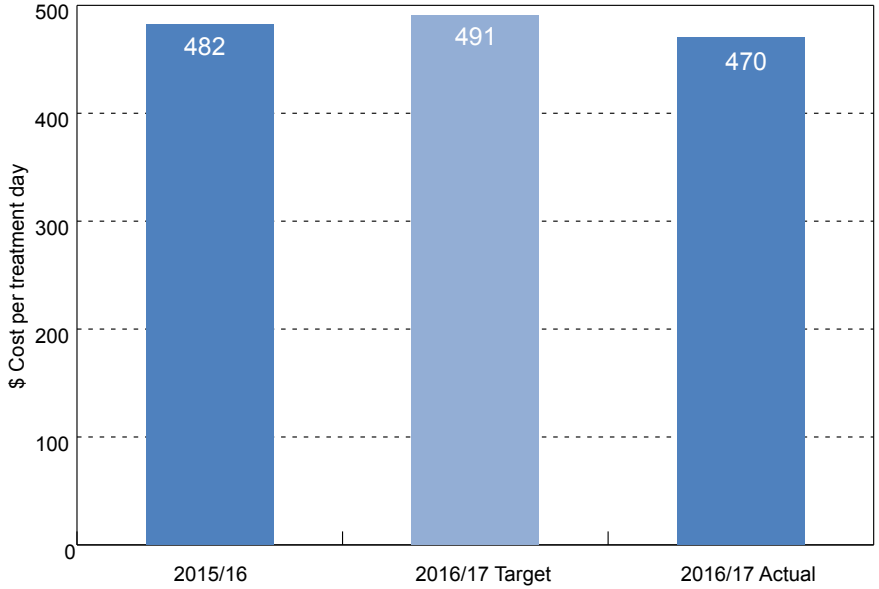
Rationale:

This indicator enables assessment of the efficiency of public clinical ambulatory mental health services both over time and relative to other services.

Results:

In 2016/17, the average cost per purchased treatment day of ambulatory care provided by public clinical mental health services was $470. This is slightly lower than both the 2016/17 target of $491 and the 2015/16 result of $482.

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



Data Source: The Commission's Financial Systems. Mental Health Information System (MHIS), Department of Health. The Commission's Non-government Organisation Establishment State Data Collection. Non-government organisation activity data for 6 months extrapolated to 12 months.

Time Period: Data is for the financial year.

Efficient functioning of public community mental health services is critical to ensure that finite funds are used effectively to deliver maximum community benefit

Key Efficiency Indicators

Service four
Community Treatment

Description:

An ambulatory mental health care service is a specialised mental health organisation that provides services to people who are not currently admitted to a mental health inpatient or residential service. Services are delivered by health professionals with specialist mental health qualifications or training. This indicator is the number of community treatment days provided by ambulatory mental health services divided by the number of ambulatory care statistical episodes (three month periods) treated by ambulatory mental health services.

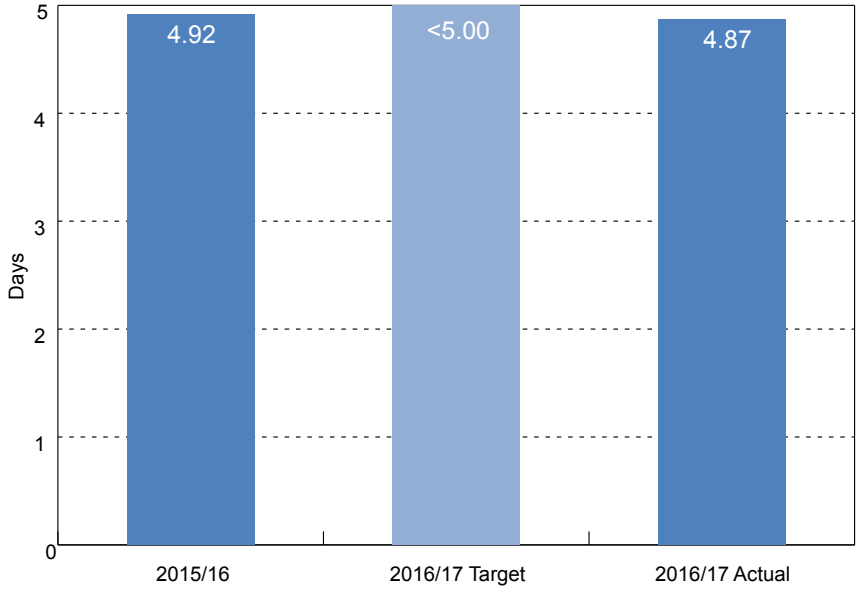
Rationale:

The purpose of this indicator is to better understand underlying factors which cause variation in community care costs. It may also demonstrate the accessibility to public sector community mental health services. The number of treatment days is the community treatment equivalent to length of stay and it indicates the relative volume of care provided. Frequency of servicing is the main driver of variation in community care costs and may reflect differences between health service organisation practices. This indicator provides an understanding of the extent or duration of community care treatment.

Results:

In 2016/17, the average treatment days per episode of ambulatory care provided by public clinical mental health services was 4.87 days. This result is in line with both the 2016/17 target and the 2015/16 result.

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



Data Source: Mental Health Information System (MHIS), Department of Health.
Time Period: Data is for the financial year.

An ambulatory mental health care service is a specialised mental health organisation that provides services to people who are not currently admitted to a mental health inpatient or residential service

Key Efficiency Indicators

Service four
Community Treatment

Description:

The Commission supports a comprehensive range of outpatient counselling, pharmacotherapy and support and case management services, including specialist youth, women's and family services, which are provided primarily by non-government agencies. The Western Australian Diversion Program aims to reduce crime by diverting offenders with drug use problems away from the criminal justice system and into treatment to break the cycle of offending and address their drug use. The Alcohol and Drug Support Service (ADSS) is a 24-hour, Statewide, confidential telephone service providing information, advice, counselling and referral to anyone concerned about their own or another person's AOD use. Callers have the option of talking to a professional counsellor, a volunteer parent or both. This indicator is the cost for these community-based services divided by the number of treatment episodes provided and the number of ADSS contacts answered with an outcome of counselling (excluding tobacco-related contacts). A treatment episode is the period of care between the start and end of treament, whereas for ADSS this refers to a single contact (e.g. a phone call).

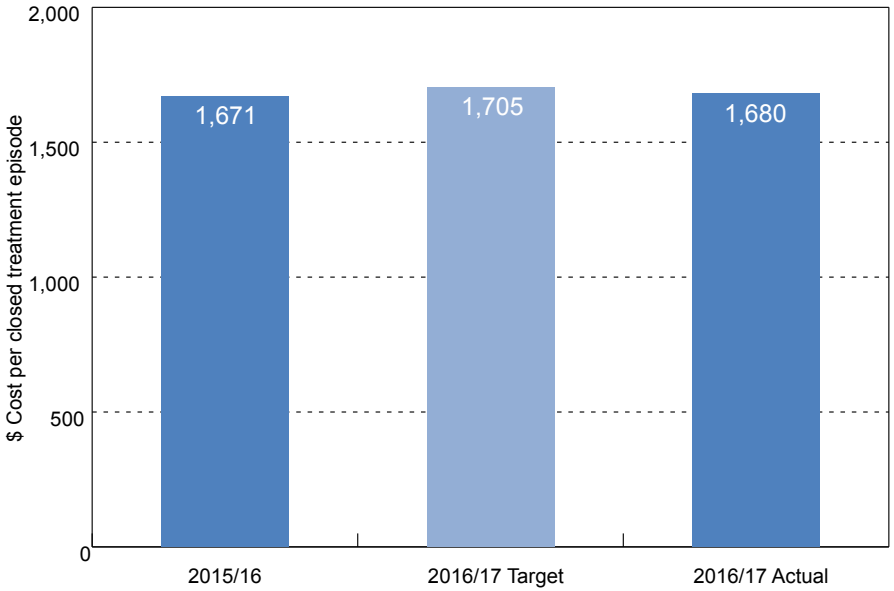
Rationale:

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

Results:

In 2016/17, the average cost of a completed treatment episode in community-based AOD services was $1,680. This is in line with both the 2016/17 target and the 2015/16 result.

4.3: Cost per completed treatment episode in community-based AOD services



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

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

In 2016/17, the average cost of a completed treatment episode in community-based AOD services was $1,680

Key Efficiency Indicators

Service five
Community Support

Description:

Community-based support programs support people with mental health problems to develop/maintain skills required for daily living, improve personal and social interaction, and increase participation in community life and activities. They also aim to decrease the burden of care for carers. These services primarily are provided in the person's home or in the local community. The range of services provided is determined by the needs and goals of the individual.

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

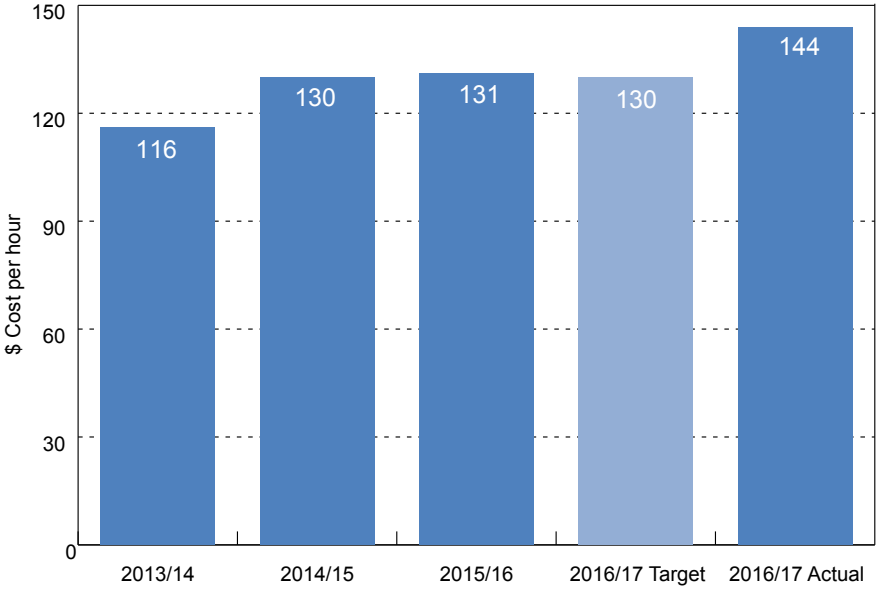
Rationale:

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

Results:

In 2016/17, the average cost per hour of community support provided to people with mental health problems was $144. This result is higher than the 2016/17 target of $130 and the previous years' results. This is due to refinements in data capture and validation processes. Delays in staff recruitment and higher than normal staff turnover in some non-government community support service providers, which has caused increased cost of services.

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



Data Source: The Commission's Financial Systems and the Non-government Organisation Establishment State Data Collection. Activity data for 6 months extrapolated to 12 months.

Time Period: Data is for the financial year.

South Metropolitan Community Alcohol and Drug Support Service

Key Efficiency Indicators

Service five
Community Support

Description:

The Transitional Housing and Support Program (THASP) provide in-reach community support for people staying in short-term accommodation following residential AOD treatment. There are currently 12 THASP houses operational across Western Australia. A 2013 evaluation of the program has demonstrated a range of positive outcomes including reductions in relapse rates, improvements in wellbeing, increased life and independent living skills and reduced levels of homelessness. This indicator is calculated by dividing the overall cost of THASP services by the number of closed treatment episodes. A treatment episode is the period of care between the start and end of treament.

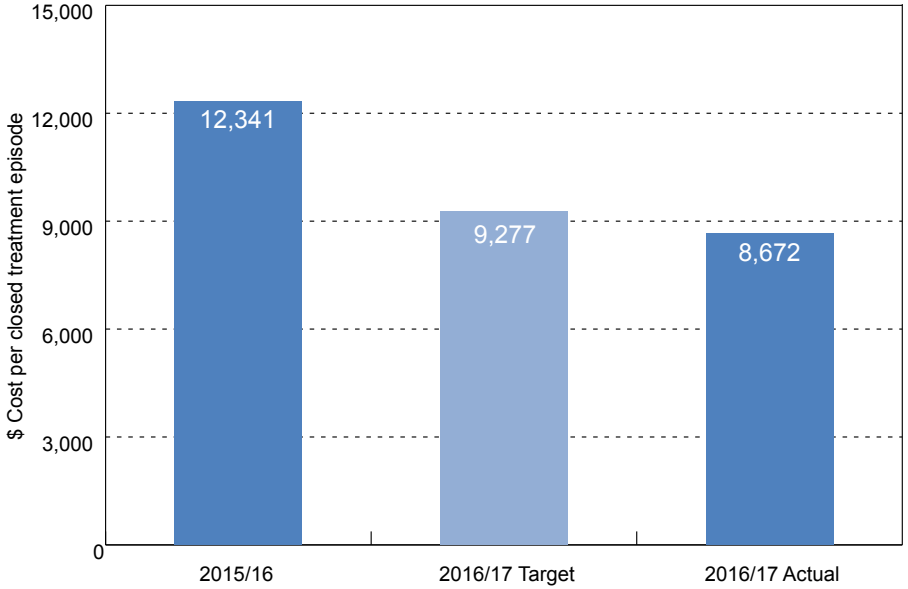
Rationale:

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

Results:

In 2016/17, the average cost per completed episode of community support provided for AOD services was $8,672, lower than the 2016/17 target of $9,277 and substantially lower than the 2015/16 result. This is due to a 44% increase in the number of closed treatment episodes in 2016/17 (59) as compared to 2015/16 (41). The difference in the number of closed treatment episodes between the 2016/17 actual (59) and 2016/17 target (55) was much less pronounced. Due to the long term nature of this service, there is a small volume of cases which can result in high variability in cost over the reporting periods.

5.2: Average cost per episode of community support provided for AOD services



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

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

Cyrenian House offers a transitional housing program to assist people who have completed a rehabilitation program to re-enter the community

Key Efficiency Indicators

Service five
Community Support

Description:

The ICLS provides coordinated clinical and psychosocial support to assist individuals to achieve their recovery goals and live well in the community. ICLS supports people to live in their own home in the community with the principles of choice, personalised planning, self-direction and portability of funding. A significant emphasis is placed on planning processes that will focus on the development and achievement of each person's individual recovery goals. Prior to any service commencing, individual plans are completed by the service provider in conjunction with the individual and any other related parties and submitted to the Commission for review. Individuals accessing ICLS can expect to: have an increasing ability to fully participate in their ongoing clinical and psychosocial support needs; develop and sustain meaningful social connections and relationships; participate and contribute to their community and relationships in personally meaningful ways; have an increasing ability to participate in educational, vocational and/or employment activities; develop their skills to self-manage their lifestyle and well-being; demonstrate an increasing ability to maintain and sustain their housing tenancy; and improve their quality of life. The target group includes individuals that have a range of complexities and challenges and there is a mix of individuals requiring low, medium, high and very high levels of support. Individuals have a severe mental illness and can only access the service by being nominated by a public mental health service Case Manager or Psychiatrist.

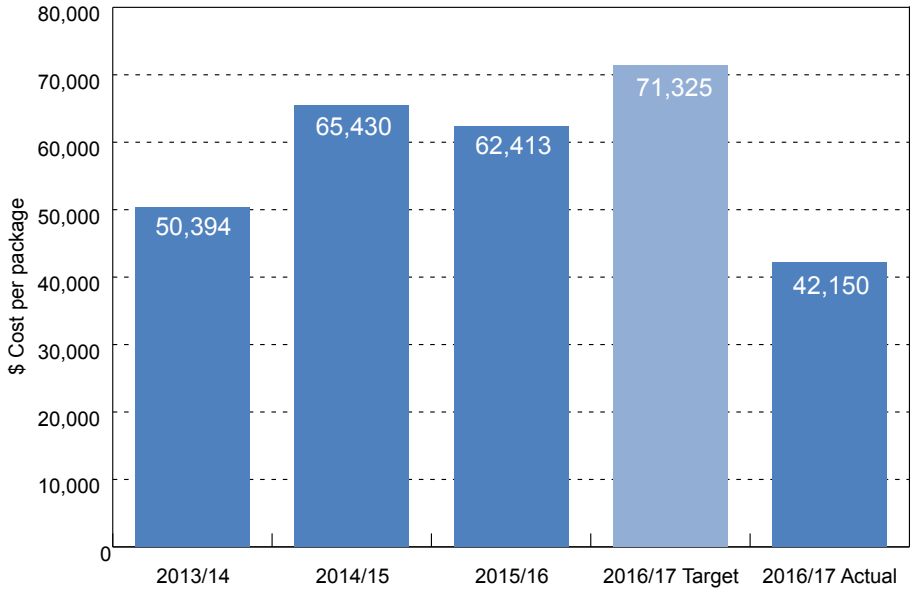
Rationale:

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

Results:

The 2016-17 cost of $42,150 was significantly lower than the 2016/17 target of $71,325 and previous years' results. In part, this is because support packages are allocated and commence at staggered times throughout the financial year and therefore include part payments that are not reflective of the full year costs for an individual. There are also lead times for the development of support packages for new entrants when backfilling client vacancies. In addition, the purpose of the ICLS is to provide coordinated clinical and psychosocial supports to assist eligible individual's to achieve their recovery goals and live well in the community. Therefore it is expected that the average cost per package would decline due to the individuals level of need for recovery focused supports also decreasing. Although there is the expectation that the average cost per package will decrease, it is hard to predict or estimate by how much due to the nature of the ICLS program being based on individualised support needs. The decline in funding is a positive outcome of the ICLS program and demonstrates program success by supporting individuals to maximise their recovery and maintain independent living in the community.

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



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

Time Period: Data is for the financial year.

ICLS supports people to live in their own home in the community with the principles of choice, personalised planning, self-direction and portability of funding.

Key Efficiency Indicators

Service five
Community Support

Description:

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

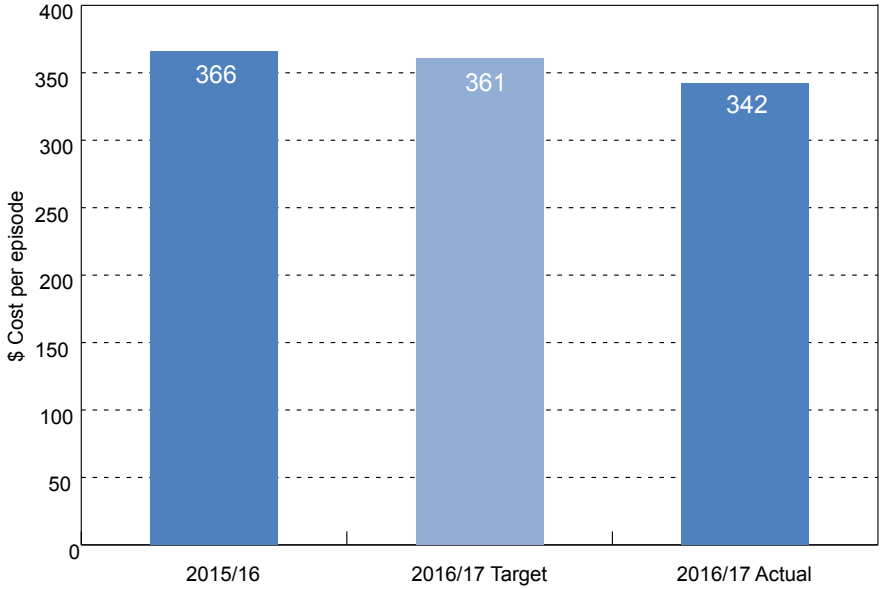
Rationale:

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

Results:

In 2016/17, the average cost per episode of care in safe places for intoxicated people was $342, slightly lower than both the 2016/17 target and the 2015/16 result.

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



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

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

There are ten sobering up centres in Western Australia providing a safe, care-oriented environment in which people found intoxicated in public may sober up.

Sobering up centres help to reduce the harm associated with intoxication for the individual, their families and the broader community

Other Legal And Government Policy Requirements And Financial Disclosures

Ministerial directives

Treasurer's Instruction 903 (12) requires the Commission to disclose information on any Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financial activities. No such directives were issued by the Minister with portfolio responsibility for the Commission during 2016/17.

Compliance with Public Sector Standards and ethical codes

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

The Commission's Code of Conduct (the Code) and organisational values were reviewed during the year. The Code interprets the Commission's organisational values into behaviours, which focus on working relationships, to ensure there is respect and that diversity is valued in the workplace. It outlines clear expectations on fair, ethical and accountable decisions. In 2016/17, 64% of employees attended the 'Behaviour Matters' training on the new Values, this established a common understanding of the standards of behaviours expected by all Commission employees.

In 2016/17, the Commission continued to promote compliance with public sector standards and ethical codes. The introduction of a new online learning management system in April 2017, ELMO, improved the Commission's ability to promote, record and track employee completion of its Accountable and Ethical Decision Making course. Since rolling out ELMO, 91% of employees have completed the course.

Personal expenditure

In accordance with section 903(13)(iv) of the Treasurer's Instructions, the following personal expenditure was incurred on a Western Australian Government Purchasing Card during the reporting period:

Number of instances the Purchasing Card has been used for Personal Use	1
Aggregate amount	$149.40
Aggregate amount settled by due date	$149.40
Aggregate amount settled after due date	–
Aggregate amount outstanding	–
Number of referrals for disciplinary action	–

Board and committee remuneration reporting

A number of advisory committees were established by the Commission outside of the Cabinet process as they were required to support specific projects such as the development of the Exposure Draft Compulsory Treatment (Alcohol and Other Drugs) Bill 2016, Accommodation Advisory Committee and the Engagement Framework Steering Committee. Some of these members were remunerated in accordance with the Commission's Consumer, Family, Carer and Community Paid Partnership Policy.

Contracts with senior officers

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

As per Related Party Disclosures (AASP124), conflicts of interest have been identified in relation to the Mental Health Commissioner. The Commissioner is:

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

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

Compliance with Electoral Act advertising

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

EXPENDITURE CLASS	NAME OF AGENCY	AMOUNT 2016/17	TOTAL
Advertising agencies:	Carat Australia Media Services Pty Ltd	$6,372.19	$33,090.71
	The Brand Agency	$11,618.00	
	Seek Limited	$540.00	
	Adcorp	$5,490.52	
	Timeline Productions	$9,050.00	
Market research organisations:	La Trobe University	$71,050.00	$358,094.32
	Miles Morgan Australia	$46,244.32	
	Taylor Nelson Sofres	$240,800.00	
Polling organisations:	Nil	Nil	Nil
Direct mail organisations:	Nil	Nil	Nil
Media advertising organisations:	The Brand Agency via Curtin University*	$2,876,052.00	$2,934,196.59
	Alucinor	$56,600.00	
	Facebook	$1,544.57	
		$3,325,361.60	**$3,325,361.60**

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

Disability Access and Inclusion Plan

In early 2017, the Commission launched its new Disability Access and Inclusion Plan (DAIP) for 2017–2021. The new DAIP builds on the achievements and experiences from the previous plan and demonstrates the Commission's commitment to proactively removing any barriers that may exclude people from accessing information, services, facilities, events and employment opportunities with the Commission. The DAIP is available on the Commission's website.

Reconciliation Action Plan

In March 2017, the Commission formed the Reconciliation Committee as a Corporate Executive subcommittee, chaired by the Commissioner.

The Committee is responsible for ensuring the Commission is achieving its vision for reconciliation, improving organisational awareness of the needs of Aboriginal people and progressing actions that will create opportunities to build relationships and grow respect for and with Aboriginal people.

To achieve this, the Committee oversees the implementation of the 2015-2017 Reconciliation Action Plan (RAP) and the development of a new RAP for 2017-2019.

Commission employees took part in cultural tours as part of Reconciliation Week 2017

Occupational safety, health and injury management

The following table details the Commission's 2016/17 key performance indicators against occupational safety and health and injury management measures:

INDICATOR	ACTUAL 2016/17
Number of Workers Compensation Claims received	4
Number of fatalities	0
Lost time injury/disease incidence rate	0.6%
Lost time injury severity rate	0
Percentage of injured workers returned to work within 13 weeks	100%
Percentage of injured workers returned to work within 26 weeks	100%
Percentage of managers trained in occupational safety, health and injury management responsibilities	88%*
Percentage of employees trained in Mental Health First Aid	16%*

**approximate figure*

Recordkeeping plans

The *State Records Act 2000* (the Act) was established to standardise statutory record keeping practices for every government agency.

Government agency practice is subject to the provisions of the Act and the standards and policies of the State Records Commission. The Commission established a formal Recordkeeping Plan to ensure compliance with these requirements.

Following the amalgamation of the Mental Health Commission and the Drug and Alcohol Office in 2015/16, the Commission undertook a complete review of its Business Classification Scheme to capture the functions and activities from mental health and AOD related information management.

The Commission also participated in the delivery of the first Western Australian Sector Disposal Authority (SDA) for Mental Health Services. This SDA will be used in combination with the State Records Office publication General Disposal Authority for State Government Information, collectively defining appropriate disposal schedules of records relating to mental health related activities and functions, general administration, financial management and accounting, and human resource management at the Commission.

The Commission has also continued to shift to a greater electronic records management operation, significantly improving compliance with the Act.

In 2016/17, 88% of Commission employees completed the Recordkeeping Awareness Training. This training provides an understanding of the fundamentals of recordkeeping and employee responsibilities in creating, managing and protecting records.

Appendices

Appendix One: Non-Government Organisations Funded Through Service Agreements 2016/17*

SERVICE PROVIDER	SERVICE TYPE	AREA
360 Health and Community	Counselling – Face to Face	Metropolitan
55 Central	Personalised Support – Other	North Metropolitan
Aboriginal Alcohol and Drug Service	AOD Community Treatment	Metropolitan
	AOD Diversion Community Treatment	Metropolitan
	AOD Cannabis Community Treatment	Metropolitan
	AOD Community Prevention	Metropolitan
Access Housing Australia	Personalised Support – Linked to Housing	South Metropolitan
Albany Halfway House	Personalised Support – Linked to Housing	Great Southern
	Staffed Residential Services	Great Southern
	Personalised Support – Other	Great Southern
Amana Living	Staffed Residential Services	Metropolitan
Association For Services To Torture and Trauma Survivors	Counselling – Face to Face	Metropolitan
Australian Medical Procedures Research Foundation	AOD Community Treatment	Metropolitan
	AOD Community Bed-Based	Metropolitan
	AOD Community Support	Metropolitan
Avivo	Personalised Support – Linked to Housing	Statewide
	Personalised Support – Other	Metropolitan
	Family and Carer Support	Metropolitan
Bay of Isles Community Outreach	Personalised Support – Other	Goldfields
Bega Garnbirringu Health Services	AOD Community Support Sobering Up	Goldfields

SERVICE PROVIDER	SERVICE TYPE	AREA
Beyond Blue	Mental Illness Prevention	Statewide
Black Swan Health	Counselling – Face to Face	South Metropolitan
Bloodwood Tree Association	AOD Community Support Sobering Up	Pilbara
	AOD Community Treatment	Pilbara
BP Luxury Care	Personalised Support – Other	South Metropolitan
Burswood Care Pty Ltd	Staffed Residential Service – Personal Care Support	South Metropolitan
Carers Association of Western Australia	Individual Advocacy	Statewide
	Sector Development and Representation	Statewide
Carnarvon Family Support Service	AOD Community Support Sobering Up	Mid West
Casson Homes	Staffed Residential Service – Personal Care Support	North Metropolitan
Catholic Education Office of WA	AOD Prevention	Statewide
Centrecare	Counselling – Face to Face	Goldfields
	Personalised Support – Other	Goldfields
	Personalised Support – Linked to Housing	Goldfields
	Family and Carer Support	Goldfields
Collie Family Centre	Counselling – Face to Face	South West
Community First International	Personalised Support – Linked to Housing	Statewide
Connect Groups Support Groups Association WA	Sector Development and Representation	Metropolitan
Consumers of Mental Health WA (CoMHWA)	Sector Development and Representation	Statewide
Curtin University of Technology	AOD Prevention	Statewide
Curtin University of Technology (Aussie Optimism)	Mental Illness Prevention	Metropolitan

SERVICE PROVIDER	SERVICE TYPE	AREA
Curtin University of Technology (Mentally Healthy WA)	Mental Health Promotion	Statewide
Devenish Lodge	Personal Care Subsidy	South Metropolitan
Disability in the Arts Australia (DADAA)	Group Support Activities	North Metropolitan
Even Keel Bipolar Disorder Support Association	Mutual Support and Self Help	Metropolitan
Foundation Housing	Personalised Support – Linked to Housing	North Metropolitan
Franciscan House	Personal Care Subsidy	South Metropolitan
Fremantle Multicultural Centre	Individual Advocacy	Metropolitan
Fremantle Women's Health Centre	Counselling – Face to Face	South Metropolitan
Fusion Australia	Staffed Residential Services	Mid West
Garl Garl Walbu Aboriginal Corporation	AOD Community Support Sobering Up	Kimberley
Goldfields Rehabilitation Services	AOD Community Bed-Based	Goldfields
	AOD Community Support	Goldfields
Gosnells Women's Health Service	Counselling – Face to Face	South Metropolitan
Great Southern Community Housing Association	Personalised Support – Linked to Housing	Great Southern
GROW	Mutual Support and Self Help	Statewide
	Mental Health Promotion	Statewide
Helping Minds	Mental Health Promotion	Metropolitan
	Individual Advocacy	Statewide
	Family and Carer Support	Statewide

SERVICE PROVIDER	SERVICE TYPE	AREA
Holyoake Australian Institute for Alcohol and Drug Addiction Resolution	AOD Community Treatment	Metropolitan Wheatbelt
	AOD Diversion Community Treatment	Metropolitan Wheatbelt
	AOD Cannabis Community Treatment	North East Metropolitan Wheatbelt
Home Health (trading as Tendercare)	Personalised Support – Other	North Metropolitan Wheatbelt South West
	Family and Carer Support	North Metropolitan Wheatbelt South West
Honeybrook Lodge	Personal Care Subsidy	North Metropolitan
Hope Community Services	AOD Community Bed-Based	Mid West
	AOD Diversion Community Bed-Based	Mid West
	AOD Community Support	Mid West
	AOD Community Treatment	Goldfields
	AOD Diversion Community Treatment	Goldfields
	AOD Cannabis Community Treatment	Goldfields
	AOD Community Support Sobering Up	Mid West
Ishar Multicultural Women's Health Centre	Family and Carer Support	Metropolitan
Jennie Bertram & Associates	Personalised Support – Other	Metropolitan
June O'Connor Centre	Group Support Activities	Metropolitan
	Personalised Support – Other	Metropolitan

SERVICE PROVIDER	SERVICE TYPE	AREA
Kununurra Waringarri Aboriginal Corporation	AOD Community Support Sobering Up	Kimberley
Lamp	Personalised Support – Other	South West
	Family and Carer Support	South West
	Personalised Support – Linked to Housing	South West
Life Without Barriers	Personalised Support – Linked to Housing	Statewide
	Staffed Residential Services	South Metropolitan
Lifeline WA (The Living Stone Foundation)	Counselling, Support, Information and Referral – Telephone	Statewide
Local Drug Action Groups	AOD Prevention	Statewide
Mental Health Law Centre	Individual Advocacy	Statewide
Mental Illness Fellowship of WA	Personalised Support – Other	Metropolitan
	Family and Carer Support	Statewide
	Mental Health Promotion	Statewide
	Group Support Activities	Metropolitan
Midland Women's Health Care Place	Counselling – Face to Face	North Metropolitan
Milliya Rumurra Aboriginal Corporation	AOD Community Treatment	Kimberley
	AOD Diversion Community Treatment	Kimberley
	AOD Community Support	Kimberley
	AOD Community Support Sobering Up	Kimberley
Mind Australia	Staffed Residential Services	Metropolitan

SERVICE PROVIDER	SERVICE TYPE	AREA
Mission Australia	Family and Carer Support	Metropolitan
	AOD Community Bed-Based	Metropolitan
	AOD Diversion Community Bed-Based	Metropolitan
	AOD Community Support	Metropolitan
	AOD Cannabis Community Treatment	Metropolitan Pilbara
	AOD Community Treatment	Metropolitan Pilbara
	AOD Diversion Community Treatment	Pilbara
Neami	Personalised Support – Linked to Housing	Statewide
	Staffed Residential Services	Metropolitan
Ngaanyatjarra Health Service Aboriginal Corporation	AOD Community Treatment	Goldfields
Ngangganawili Aboriginal Community Controlled Health & Medical	AOD Community Support	Goldfields
Ngnowar Aerwah Aboriginal Corporation	AOD Community Treatment	Kimberley
	AOD Diversion Community Treatment	Kimberley
	AOD Community Support Sobering Up	Kimberley
Nindillingarri Cultural Health Services	AOD Community Treatment	Kimberley
Nyoongar Patrol System	AOD Community Support	Metropolitan
Outcare	Personalised Support – Other	Metropolitan

SERVICE PROVIDER	SERVICE TYPE	AREA
Palmerston Association	AOD Community Treatment	Metropolitan Great Southern
	AOD Diversion Community Treatment	Metropolitan Great Southern
	AOD Community Bed-Based	Metropolitan
	AOD Diversion Community Bed-Based	Metropolitan
	AOD Community Support	Metropolitan
	AOD Cannabis Community Treatment	South Metropolitan Great Southern
Pathways South West	Personalised Support – Other	South West
	Personalised Support – Linked to Housing	South West
	Family and Carer Support	South West
Perth Inner City Youth Service	Personalised Support – Other	Metropolitan
Richmond Wellbeing	Personalised Support – Linked to Housing	Statewide (ICLS only) South Metropolitan
	Personalised Support – Other	Statewide
	Staffed Residential Services	Statewide
	Mutual Support and Self Help	Metropolitan
	Group Support Activities	Great Southern

SERVICE PROVIDER	SERVICE TYPE	AREA
Rise Network	Personalised Support – Linked to Housing	Statewide (ICLS only) North Metropolitan Wheatbelt
	Personalised Support – Other	North Metropolitan
	Individual Advocacy	North Metropolitan
Romily House	Personal Care Subsidy	North Metropolitan
Ruah Community Services	Personalised Support – Linked to Housing	Statewide (ICLS only) South Metropolitan Mid West
	Personalised Support – Other	Metropolitan Great Southern Mid West
	Education, Employment and Training	Metropolitan
	AOD Community Treatment	Metropolitan
	Staffed Residential Services	Mid West
Salisbury Home	Personal Care Subsidy	North Metropolitan
Share & Care Community Services Group	Personalised Support – Other	Wheatbelt
	Family and Carer Support	Wheatbelt
Silver Chain Group	Personalised Support – Other	Pilbara
	Family and Carer Support	Pilbara
South Coastal Women's Health Services Association	Counselling – Face to Face	South Metropolitan
Southern Cross Care (WA)	Staffed Residential Services	Metropolitan
	Personalised Support – Other	Metropolitan
	Family and Carer Support	Metropolitan

SERVICE PROVIDER	SERVICE TYPE	AREA
Spirit of the Street Choir	Group Support Activities	Metropolitan
St Bartholomew's House	Staffed Residential Services	Metropolitan
	Personalised Support – Linked to Housing	South Metropolitan
St John of God Health Care	Clinical Treatment and Care – Admitted	Metropolitan
	AOD Community Bed-Based	Metropolitan
	AOD Diversion Community Bed-Based	Metropolitan
St John of God Hospital Bunbury	AOD Community Treatment	South West
	AOD Diversion Community Treatment	South West
	AOD Cannabis Community Treatment	South West
	AOD Community Bed-Based	South West
St Jude's Hostel (Pu-Fam Pty Ltd)	Personal Care Subsidy	North Metropolitan
St Patrick's Community Support Centre	Group Support Activities	Metropolitan
	AOD Community Treatment	Metropolitan
St. Vincent De Paul Society (WA)	Staffed Residential Service – Personal Care Support	North Metropolitan
Teen Challenge Perth	AOD Community Bed-Based	Statewide
The Salvation Army Western Australia Property Trust	Personalised Support – Other	North Metropolitan
	AOD Community Bed-Based	Metropolitan
	AOD Diversion Community Bed-Based	Metropolitan
	AOD Community Support	Metropolitan
	AOD Community Support Sobering Up	Metropolitan
	AOD Community Treatment	Metropolitan

SERVICE PROVIDER	SERVICE TYPE	AREA
The Samaritans	Counselling – Face to Face	Statewide
	Counselling, Support, Information and Referral – Telephone	Statewide
	Mental Health Promotion	Statewide
UnitingCare West	Personalised Support – Linked to Housing	North Metropolitan
	AOD Community Treatment	East Metropolitan
WA Council on Addictions T/A Cyrenian House	AOD Community Treatment	Metropolitan Kimberley
	AOD Diversion Community Treatment	Metropolitan
	AOD Community Bed-Based	Metropolitan
	AOD Diversion Community Bed-Based	Metropolitan
	AOD Community Support	Metropolitan
	AOD Community Support	Metropolitan
	AOD Cannabis Community Treatment	North Metropolitan
WA Network of Alcohol & Other Drug Agencies	AOD Community Treatment	Statewide
Wanslea Family Services	Family and Carer Support	South Metropolitan
Warmun Community (Turkey Creek)	AOD Community Treatment	Kimberley
Western Australian AIDS Council	Mental Illness Prevention	Statewide
	Mental Health Promotion	Statewide

SERVICE PROVIDER	SERVICE TYPE	AREA
Western Australian Association for Mental Health	Mental Health Promotion	Statewide
	Sector Development and Representation	Statewide
	Workforce Development	Statewide
	Education, Employment and Training	Statewide
Western Australian Substance Users Association	AOD Community Treatment	Metropolitan
Women's Healthcare Association	Counselling – Face to Face	North Metropolitan
	Group Support Activities	North Metropolitan
	Mutual Support and Self Help	Metropolitan
	AOD Community Treatment	Metropolitan
	AOD Diversion Community Treatment	Metropolitan
Yaandina Family Centre	AOD Community Support Sobering Up	Pilbara
	AOD Community Bed-Based	Pilbara
Youth Focus	Counselling – Face to Face	Metropolitan

**This list does not include grants*

Glossary Of Service Types: Appendix One

SERVICE TYPE	DESCRIPTION
AOD Cannabis Community Treatment	These services provide Cannabis Intervention Sessions for people issued with a Cannabis Infringement Requirement by WA Police for low level cannabis related offences under the *Cannabis Law Reform Act 2010.*
AOD Community Bed-Based	These services include residential rehabilitation and low medical withdrawal services which provide 24 hour, seven days per week recovery-orientated treatment in a residential setting to people with AOD problems.
AOD Community Prevention	These include a range of programs, initiatives and strategies that aim to delay the uptake and reduce the harm associated with AOD use in the community. Initiatives can be targeted at the whole population or specific to a target group.
AOD Community Support	These services provide individuals with access to the help and support they need to participate in the community and reduce the harm associated with their AOD use. They include needle and syringe provision, overdose prevention, patrol services and safe places for intoxicated people (sobering up centres). AOD Community Support programs also include the Transitional Housing and Support Program, which provides supported accommodation for people exiting residential rehabilitation treatment.
AOD Community Support Sobering Up	This is a dedicated category for sobering-up centres. These centres provide a safe, supervised place for intoxicated people to be cared for overnight. Clients are also offered access to treatment through in-reach or referral to other services.
AOD Community Treatment	These services provide non-residential clinical care in the community to help people reduce the harms associated with AOD use. They include screening and assessment, individual and group counselling for families and carers and pharmacotherapy programs.
AOD Diversion Community Bed-Based	The WA Diversion Programs include a range of voluntary and pre-sentence programs for youth and adults that offer clients the opportunity to engage in treatment programs prior to sentencing. Programs are available in non-residential and residential (bed-based) settings.
AOD Diversion Community Treatment	WA Diversion Programs include a range of voluntary and pre-sentence programs for youth and adults that offer clients the opportunity to engage in treatment programs prior to sentencing. This category is for treatment services such as counselling, provided in the community.
Clinical Treatment and Care – Admitted	Hospital-based services provide treatment and support to help people with mental health issues in a recovery-oriented environment. These services provide individualised, multi-disciplinary treatment delivered in a safe and structured environment.

SERVICE TYPE	DESCRIPTION
Counselling – Face to Face	Face to Face Counselling is a structured process where a counsellor works on an individual basis with the client to address and resolve specific problems, make decisions, work through feelings and inner conflicts, or improve relationships with others. Counselling facilitates personal growth, development, self-understanding and the adoption of constructive life practices.
Counselling, Support, Information and Referral – Telephone	Mental health support, information and referral telephone services are those that provide support for people experiencing mental illness and which offer reliable referrals, information and selfhelp resources to empower people to take steps towards maintaining mental health and emotional wellbeing.
Education, Employment and Training	This category includes services where the principal function is to provide or support people with lived experience of mental illness, in gaining education, employment and/or training.
Family and Carer Support	Family and carer support services provide families and carers of people living with a mental illness support, information, education and skill development opportunities to fulfil their caring role, while maintaining their own health and wellbeing.
Group Support Activities	Group support activities include services that aim to improve the quality of life and psychosocial functioning of mental health consumers, through the provision of group-based social, recreational or pre-vocational activities. In contrast to services in the Mutual Support and Self Help service type, group support activities are led by a staff member of the NGO providing the service.
Individual Advocacy	These services seek to represent the rights and interests of people with a mental illness, on a one-to-one basis, by addressing instances of discrimination, abuse and neglect. Individual advocates work with people with mental illness on either a short-term or issue specific basis.
Mental Health Promotion	These services aim to raise awareness of mental health issues, improve mental health literacy, reduce stigma and discrimination and maximise the population's mental health and wellbeing. Mental Health Promotion may include programs targeted to population segments, based on age (e.g. early childhood) or setting (e.g. school or workplace), as well as initiatives to educate the general population.
Mental Illness Prevention	These services work to prevent the onset of mental disorders, in order to reduce the incidence and prevalence of mental illness in the community. Mental Illness Prevention activities are directed at reducing known risk factors and/or preventing people that display early signs of mental illness from developing a diagnosable mental illness. These activities can be either population-wide or targeted at vulnerable segments of the community. In contrast to Mental Health Promotion, which seeks to enhance the population's mental health, Mental Illness Prevention aims to prevent the development of mental illness.

SERVICE TYPE	DESCRIPTION
Mutual Support and Self Help	These services provide information and peer support to people with a lived experience of mental illness. People meet to discuss shared experiences, coping strategies and to provide information and referrals. Self Help groups are usually formed by peers who have come together for mutual support and to accomplish a specific purpose.
Personal Care Subsidy	These services provide assistance to residents residing in large congregate care hostels. The intention of personal care support is to encourage and maintain the current skills of individuals, to increase autonomy and self-management and to improve the quality of life for residents. The amount of subsidy paid to each Hostel is based on the level of support required by each individual to meet their personal care needs.
Personalised Support – Linked to Housing	These are flexible services tailored to a mental health consumer's individual and changing needs to assist people maintain their tenancy and to support them to live independently.
Personalised Support – Other	These are flexible services tailored to a mental health consumer's individual and changing needs to support them in their recovery journey. They include a range of one-on-one activities and psychosocial support provided by a support worker directly to mental health consumers in their homes or local communities.
Sector Development and Representation	Mental health sector development and representation services engage with a wide variety of issues regarding the sustainability and development of the mental health sector. This includes information dissemination, advocacy, policy analysis, program development and sector capacity building.
Staffed Residential Services Staffed Residential Service – Personal Care Support	Staffed residential services provide overnight accommodation in a domestic style environment, with on-site support workers. Accommodation may be provided on a short, medium or long term basis for people with severe and persistent mental health problems.
Workforce Development	These are structured education and training programs designed to enhance the capacity of workers to work with people with mental health or AOD problems. Programs may also aim to develop the capability of the broader health and human services workforce to contribute to preventing mental illness and to meet the needs of people with mental health or AOD problems.

Appendix Two: Board And Committee Remuneration

Alcohol and Other Drugs Advisory Board

POSITION	MEMBERS NAME	TYPE OF REMUNERATION	PERIOD OF MEMBERSHIP	GROSS REMUNERATION 2016/17 FINANCIAL YEAR
Chair	Prof Colleen Hayward	Annual	1 July 2016 – 30 June 2017	$31,744.61
Deputy Chair	Mr Barry Mackinnon AM	Annual	1 July 2016 – 30 June 2017	$26,142.04
Member	Ms Judith Alcock	Sessional	1 July 2016 – 30 June 2017	$3,938.72
Member	Prof Rosanna Capolingua	Sessional	1 July 2016 – 30 June 2017	$3,938.73
Member	Dr John Edwards	Sessional	1 July 2016 – 30 June 2017	$5,012.92
				$70,777.02

Mental Health Advisory Council

POSITION	MEMBERS NAME	TYPE OF REMUNERATION	PERIOD OF MEMBERSHIP	GROSS REMUNERATION 2016/17 FINANCIAL YEAR
Chair	Mr Barry Mackinnon AM	Annual	1 July 2016 – 30 June 2017	$15,872.31
Deputy Chair	Hon. Eric Ripper AM	Annual	19 September 2016 – 30 June 2017	$8,714.02
Member	Mr Rodney Astbury	Sessional	1 July 2016 – 30 June 2017	$5,233.05
Member	Ms Margaret Doherty	Sessional	1 July 2016 – 30 June 2017	$4,158.85
Member	Dr John Edwards	Sessional	1 July 2016 – 30 June 2017	$3,800.78
Member	Ms Pamela Gardner	Sessional	1 July 2016 – 30 June 2017	$4,158.85
Member – Ex Officio*	Ms Aimee Sinclair	Sessional	1 July 2016 – 30 June 2017	$716.13
Member	Mr Lindsay Smoker	Sessional	1 July 2016 – 30 June 2017	$3,800.78
Member	Dr Bernadette Wright	Sessional	1 July 2016 – 30 June 2017	$3,608.04
				$50,062.81

** Ex Officio: Due to role held as CoMHWA representative*

Ministerial Council for Suicide Prevention

POSITION	NAME	TYPE OF REMUNERATION	PERIOD OF MEMBERSHIP	GROSS REMUNERATION 2016/17 FINANCIAL YEAR
Chair	Dr Neale Fong	Annual	1 July 2016 – 30 June 2017	$24,341.58
Deputy Chair	Mr Glenn Pearson	Annual	7 December 2016 – 30 June 2017	$9,903.92
Member	Ms Jenny Allen	Sessional	1 July 2016 – 30 June 2017	$1,489.20
Member	Ms Tamisha King	Sessional	1 July 2016 – 30 June 2017	$657.00
Member	Ms Delys Mouritz	Sessional	1 July 2016 – 30 June 2017	$3,985.80
Member	Ms Anne Richards	Sessional	1 July 2016 – 30 June 2017	$985.50
Member	Prof Cobie Rudd	Sessional	1 July 2016 – 30 June 2017	$3,985.80
Member	Ms Donna Cole	Sessional	1 July 2016 – 30 June 2017	$1,385.20
Member	Dani Wright Toussaint	Sessional	1 July 2016 – 30 June 2017	$1,971.00
Member	Ms Alison Xamon	Sessional	1 July 2016 – 30 June 2017	$2,671.80
Member – Ex Officio*	Mr Timothy Marney	N/A	1 July 2016 – 30 June 2017	$0
Member – Ex Officio*	Mr Chris Gostelow	N/A	1 July 2016 – 30 June 2017	$0
				$51,376.80

** Ex Officio: Due to role held as State Government representative*

Mental Health Tribunal

In the interests of security and sensitivity, the names and details of the Mental Health Tribunal members have been excluded from this report. However, gross remuneration for the President, and averages for the Tribunal members, for the 2016/17 financial year is as follows:

President:	$ 181,013.00
Member (high):	$ 111,232.29
Member (average):	$ 28,101.73
Member (low):	$ 382.16

Government of **Western Australia**
Mental Health Commission

Mental Health Commission
Levels 1 and 2, 1 Nash Street, PERTH WA 6000
PO Box X2299, Perth Business Centre, PERTH WA 6849
T: 6553 0600
E: ContactUs@mhc.wa.gov.au
www.mhc.wa.gov.au

@mentalhealthwa
@mentalhealthwa
Mental Health Commission of Western Australia
Mental Health Commission of Western Australia