Government of **Western Australia**
Mental Health Commission

Mental Health Commission

ANNUAL REPORT

2021-22

Acknowledgement of Country

We acknowledge the Traditional Custodians of our State and its waters and wish to pay our respects to Elders past and present. We extend this to all Aboriginal and Torres Strait Islander peoples seeing this message.

We acknowledge the individual and collective expertise of those with a living or lived experience of mental health, alcohol and other drug issues. We recognise their vital contribution at all levels and value the courage of those who share this unique perspective for the purpose of learning and growing together to achieve better outcomes for all.

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About this Report

Thank you for taking the time to read this year's Annual Report.

Its function is to inform our stakeholders about who we are as an organisation, our performance in the commissioning of mental health and alcohol and other drug (AOD) services over the past year, and our strategic direction and commissioning priorities looking forward.

Our challenges and achievements are reported against the *WA State Priorities Mental Health, Alcohol and Other Drugs 2020-24* which also informs our functions and operations. This report provides a comprehensive account of the Mental Health Commission's investment in mental health and AOD services across its five service streams for the 2021-22 financial year.

You can access this and our previous annual reports on our website at www.mhc.wa.gov.au. It can be made available in alternative formats including audio and Braille on request.

Statement of Compliance

The Hon. Amber Jade Sanderson, MLA
Minister for Mental Health

Dear Minister,

In accordance with section 63 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the annual report of the Mental Health Commission for the financial year ended 30 June 2022.

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

Kim Lazenby
A/Commissioner
Mental Health Commission

16 September 2022

Contents

Overview

Our Vision

A Western Australian community that experiences minimal alcohol and other drug-related harms and optimal mental health

Our Mission

We strive 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.

Our Values

We value:

- Respect for individuals and culture
- Working together and supporting each other
- Involving and engaging others
- Ownership, transparency and accountability
- Fair and ethical decisions

About the Mental Health Commission

The Commission is a Western Australian (WA) Government commissioning agency that facilitates delivery of more than $1 billion per annum of critical alcohol and other drug and mental health services, while leading the transformation required across the system to better meet the needs of the community into the future.

We are committed to improving outcomes for all Western Australians affected or impacted by mental health issues or problematic use of alcohol and other drugs. Our vision is to achieve a Western Australian community that experiences minimal alcohol and other drug-related harms and optimal mental health.

As a commissioning agency we purchase services for the State from a range of providers including public Health Sector Providers (HSPs), non-government organisations (NGOs) and the private sector. We deliver a small number of services primarily providing public-sector alcohol and drug treatment and support in WA.

As system stewards we recognise that mental health is a key driver of economic participation and productivity. We acknowledge that the wide-ranging reform of the system we are leading will produce significant benefits socially and economically, through the provision of person-centred, well-connected, properly resourced services that limit the need for clinical intervention.

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*. The accountable authority of the Commission is the Mental Health Commissioner, Ms Jennifer McGrath.

We are guided by the *WA State Priorities for Mental Health, Alcohol and Other Drugs 2020-2024* (State Priorities), and the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*.

Our activity is governed by the Mental Health Executive Committee (MHEC) and Community Mental Health, Alcohol and Other Drug Council (CMC), both established in 2020 to oversee and drive system transformation.

A snapshot of our year

2021-22

In 2021-22 we invested a total of $1,118.8 million on mental health and AOD services, across five service streams: Prevention, Community Support Services, Community Treatment Services, Community Bed-Based Services and Hospital-Based Services. This was an increase of 11% on the previous year. The Commission also undertook significant work to lead the transformation of the mental health and AOD sector in Western Australia. The Commission's key achievements in these areas for 2021-22 are outlined on the following pages.

How did we do?

The Your Experience of Service (YES) Survey is a nationally developed consumer feedback survey designed for public mental health services. It gathers information from consumers about their experiences of care. The information helps mental health services and consumers work together to improve services. The 2021 snapshot took place over 10 weeks, from 10 October to 17 December 2021 and all Health Service Providers participated.

During the snapshot, consumers aged 11 years and over who had contact with a public mental health service (inpatient and community services) were offered a survey, with 1,211 surveys completed. Across WA, 70% of respondents were highly satisfied with the service and 81% of respondents said they would recommend the service to others. The highest rated domain of experience was Showing Respect, suggesting respondents felt their service provided a welcoming environment where they were recognised, valued and treated with dignity. More information on the YES survey snapshots and published results from 2018 onwards are available on the YES survey page mhc.wa.gov.au/yes-survey-2021

70% highly satisfied

81% would recommend

Mental Health Funding

Prevention	$12.1 million
Hospital Bed Based	$469.4 million
Community Bed Based Services	$53.0 million
Community Treatment	$422.3 million
Community Support	$50.1 million
TOTAL	**$1,006.9 million**

Alcohol and Other Drug Funding

Prevention	$14.6 million
Hospital Bed Based	$5.0 million
Community Bed Based Services	$27.4 million
Community Treatment	$56.6 million
Community Support	$8.3 million
TOTAL	**$111.9 million**

EDNA Project

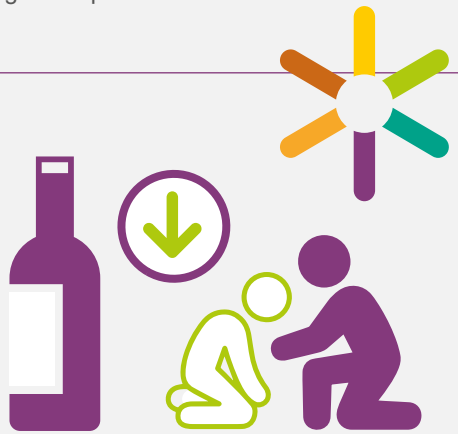
A wider variety of unusual or novel psychoactive substances (NPS) and harms associated with acute toxicity has recently been detected in WA. This year we partnered with the Department of Health to invest $482,000 over five years for the Centre for Clinical Research in Emergency Medicine at Royal Perth Hospital (RPH) to help fund the **Emerging Drugs Network of Australia (EDNA) project**.

This WA initiative brings together emergency physicians, toxicologists, forensic laboratories and health authorities to **improve detection of emerging drug issues using clinical and toxicological evidence at a national level**. Currently, there is no formal process in WA to alert medical staff about new and highly toxic agents circulating in the community, or to facilitate timely information sharing between health authorities. As part of the EDNA, **a State-wide Toxicological Alert Reporting System (STARS) has been established to facilitate the communication of alerts between health authorities about emerging drugs of concern**.

STARS will form part of a coordinated interagency Early Warning System to respond to new and emerging drugs of concern in WA, currently being led by the Commission.

Esther House

In May 2022 Cyrenian House took over operation of the facility previously occupied by Esther Foundation after it entered administration. **The Commission and Department of Communities have been working together to plan the transition of the service, and ongoing support and treatment for existing Esther House residents**. Following allegations of resident mistreatment, the WA Government launched the Education Health Standing Committee on Esther House and unregulated private health facilities.

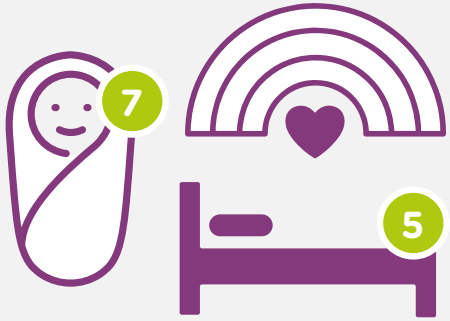


Reducing harm

The locally developed **Alcohol.Think Again 'Spread' campaign received international recognition**, identified by Victorian researchers as the campaign most likely to motive adults to reduce their alcohol use. National evaluation results of the campaign adapted for use in the ACT show substantial increases in awareness about the link between alcohol and specific types of cancer.

Pilot projects

We successfully trialled **10 innovative projects**, including seven perinatal mental health projects; support groups for LGBTIQA+ youth in Bunbury, Kalgoorlie and Geraldton; and five additional beds at Tenacious House for people who have a primary mental health diagnosis with alcohol and drug comorbidities. The funding has been continued for 2022-23.



Supporting vulnerable groups during COVID-19

In 2022 projections for very high caseload settings sparked a raft of measures to support vulnerable groups. We stood up a Coordination and Communications Centre to implement a range of strategies to **support 31 licenced psychiatric hostels keep their 703 residents safe**, **and reduce pressure on emergency departments and inpatient units**. We also distributed 284,400 items of Personal Protective Equipment (PPE) including masks, gowns and face shields, and 136,790 Rapid Antigen Tests to service providers. For the full suite of COVID-19 supports we provided this year please go to the Significant Issues Impacting the Agency section.

512 thousand

site searches

Service directory hits

Our online community services directory My Services **provides a list of current mental health and AOD treatment, support and advocacy services** that can be searched by issue of concern, service, organisation or geographic location. The directory is used in conjunction with our phone help line services and this year saw:

- **512,856** site searches
- **188,024** click throughs to individual listings
- **142,127** unique users.

Here For You

Launched in April 2022, this **State-wide confidential telephone line provided 765 instances of one-to-one support** to people experiencing mental health or other drug issues, or their loved ones, by qualified counsellors in just four months. Available 7am-10pm every day on 1800 here4u (1800 437 348).

Clinical excellence award

Our specialist Drug and Alcohol Clinical Advisory Service (DACAS) won the Capacity and Capability Building category at the 2021 WA Alcohol and Other Drug Excellence Awards.

DACAS is a specialist telephone consultancy program that provides clinical advice to health professionals on all issues relating to patient management of AOD use. A recent evaluation by Edith Cowan University described DACAS as a valuable service that builds health system capacity and supports clinicians to provide care to those with AOD issues in the community.

DACAS has supported hundreds of health practitioners across WA by providing an addiction medicine specialist they can speak to for leading treatment advice and receive follow up information via email. The service is helping improve clinician confidence to appropriately manage AOD issues. Building capacity and capabilities of GPs and other medical professionals means that treatment of patients with AOD issues can be safely managed in the community, improving health outcomes and reducing pressure on Emergency Departments and the hospital system.

Commissioner's foreword

Jennifer McGrath
Mental Health Commissioner

In a year that has seen the most significant impact of COVID-19 on the health and wellbeing of Western Australians, the Mental Health Commission (the Commission) effectively diversified and adapted its business model to help keep some of the most vulnerable people in our community safe, while starting to deliver the true reform needed to achieve better outcomes for all.

As a commissioning agency, our primary business is buying the most appropriate mental health and alcohol and other drug (AOD) services for the State, based on community need. As a leader in the sector our key focus is driving the very significant reform of our systems and processes to make sure every dollar spent procuring these much-needed services is an investment in a more efficient, sustainable, recovery-focused and consumer-led system. This means placing people at the heart of everything we do.

On the back of this year's record $1.118 billion dollar State Budget investment, we successfully delivered on a number of important commitments to optimise wellbeing and minimise the harm caused by mental health and AOD issues across a range of services, especially those for priority populations.

Improving outcomes for Aboriginal people is a key priority for the WA Government. This year it was extremely gratifying to award the Aboriginal Health Council of WA $17.6 million to deliver a culturally secure Social and Emotional Wellbeing Model of Service pilot program for Aboriginal people of all ages in the Kimberley, Pilbara, Midwest, Goldfields and South West regions. This complements the WA Government's work in progressing towards the National Agreement on Closing the Gap, which aims to reduce deaths by suicide and enhance the social and emotional wellbeing of all Aboriginal people.

I was immensely proud of the work we did to support the Ministerial Taskforce into Public Specialist Mental Health Services for Infants, Children and Adolescents aged 0 – 18 years in Western Australia, which published its Final Report in March. The heightened focus on this area of mental health will continue to grow following the State Government's $47.3 million response to address immediate Taskforce recommendations. As with the sector more broadly, the scale of reform needed here is wide-ranging and will take some years to achieve but it is critical to our goal of ensuring all children and their families and carers can access the help they need, when and where they need it.

Our vision for transforming the system is clear. The potential is exciting, but there is considerable work to be done before we start to realise the benefits of such wide-spread and deep systemic change. We need to manage

expectations because such reform cannot be achieved quickly. Outcomes from systemic change take years to realise, but we are committed to working across governments and alongside key stakeholders in the sector including consumers, carers, families and service providers to address immediate gaps while planning for sustainable longer-term improvements.

A particular highlight for me this year came – unexpectedly – from within the Commission itself as we paused some areas of business to divert staff and resources to supporting some of the most vulnerable people in our community during this year's high caseload COVID-19 settings. We stood up a COVID-19 Coordination and Communications Centre (CC Centre) to support 31 private psychiatric hostels to maintain the wellbeing of more than 700 residents within their home-like environment wherever possible during periods of COVID-19 positive cases; a factor critical to minimising avoidable presentations to hospitals. The hostels accommodate people with severe co-occurring physical and mental health conditions associated with significant psychosocial disability. Hostels are high-risk environments in a pandemic and the workforce traditionally has limited clinical staffing.

For almost a quarter of our year, initiatives we led helped people stay well, and significantly mitigated impact on emergency departments and inpatient hospital beds. I would like to sincerely thank my staff and those organisations who worked with us during this extraordinary time to achieve such a successful outcome.

I would like to acknowledge the invaluable contribution that people with a Living or Lived Experience of mental health and AOD issues make to the work we do. Including the individual and collective expertise of people with Lived Experience provides a unique perspective that is key to creating better outcomes through the co-design of pathways to better health and wellbeing.

I would especially like to thank the many individuals and organisations who have collaborated with the Commission throughout the year – our staff, service providers and their staff, peak bodies, governance groups and partner agencies who work tirelessly to support improved health and wellbeing outcomes for our community. Achieving our goal of a Western Australian community that experiences minimal alcohol and other drug-related harms and optimal mental health requires a united effort. I look forward to your support as we continue the journey together.

Jennifer McGrath
Mental Health Commissioner

Operational Structure

The Agency is led by a Commissioner, supported by the following Divisions:

Office of the Chief Medical Officer, Mental Health

- Works closely with the Commissioner, leadership team and mental health and AOD stakeholders to ensure system-level clinical advice on mental health and AOD issues is an integral consideration in strategic planning and policy development, to support system reform, strengthen consumer and community-focussed care and support system integration.

System Development

- Supports development of new and enhanced services while working to align stakeholders across the system.
- Manages policy for mental health and AOD, driving ongoing implementation and evaluation of the WA *Mental Health Act 2014*.
- Works closely with the Chief Medical Officer Mental Health to strategically influence development of policies, regulations, laws and government approaches in relation to mental health and AOD.

Operations – Prevention, Treatment and Community Support Services

- Manages provider relations to ensure delivery of high quality and well-integrated prevention, treatment and community support services into the WA community.
- Reviews vendor performance, assures and improves quality of services provision, owns the development of new services and contracting of new service providers.
- Ensures we are commissioning the right services that are system leading and filling gaps in current provider offerings by:
  - Managing the facilitation of service delivery in all areas of business, and
  - Managing the delivery of treatment services in the Next Step & Integrated Clinical Services, and delivery of support services through the programs we operate.

Governance and Corporate Services

- Manages delivery of functional expertise, consolidated business support services, and business planning and improvement.
- Provides procurement expertise to internal stakeholders, efficiently adding value to all stakeholder interactions.

The Mental Health Commission implemented its final structure in October 2021 following an Operating Model Review which reflected significant employee feedback regarding the effectiveness of the interim structure. It is envisaged the final structure will be critical to achieving the Government's State Priorities and enabling the Commission to build on its leadership role across the mental health and AOD sector to lead system-wide focus and reform.

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

Our Senior Executive Group

The Senior Executive Group at the Mental Health Commission is responsible for the strategic management and all aspects of operations at the Commission.

Jennifer McGrath
Mental Health Commissioner

Jennifer McGrath was appointed Commissioner of the Mental Health Commission in September 2020, after acting in the position since June 2019.

Before joining the Commission, Jennifer held the position of Deputy Director General, Education Business Services at the Department of Education and has worked in the Western Australian public sector for 17 years, holding senior executive positions in the Departments of the Premier and Cabinet and Finance, as well as the former Department of Child Protection.

Ms McGrath holds a Bachelor of Commerce and has a passion for delivering effective and efficient services to vulnerable people via social service systems. Ms McGrath, in many of her roles, has worked to deliver a better Western Australia for children and young people.

Jennifer believes all children and young people, no matter their background, have the right to access the level of care they require, when they need it, and continues to work tirelessly to make this effective change across all types of services.

Dr Sophie Davison
Chief Medical Officer – Mental Health

Dr Sophie Davison joined the Commission in 2020 as the inaugural Chief Medical Officer – Mental Health. Her qualifications include Consultant Forensic Psychiatrist. BA, MA(Cantab), MBBChir, DFP, MPhil, FRCPsych, FRANZCP, AFRACMA.

Prior to joining the Commission Sophie was Deputy Chief Psychiatrist of WA and Consultant, State Forensic Mental Health Service providing in-reach at Bandyup Women's Prison. She is currently adjunct Senior Lecturer at UWA and UNSW.

Sophie has been a Consultant Psychiatrist for more than 20 years and committed to improving services for people with mental health and AOD issues through training, research, quality improvement and working for the Commission. She is a passionate advocate for forensic mental health, in particular women's forensic mental health; integrated partnerships working to provide holistic care; and engagement of frontline staff and consumers and carers in system improvements.

Sophie is a Member of the WA RANZCP Forensic Faculty subcommittee.

Lindsay Hale

Deputy Commissioner Operations

Lindsay Hale joined the Commission in October 2021 after a period of leading service delivery at the Department of Communities. Prior to that he held State-wide delivery and State-wide services executive roles in the Department of Education, always with a keen interest in student wellbeing as well as learning. Lindsay holds a BA, DipEd and MEdAdmin.

Supporting vulnerable people, strengthening regional services and the advancement of Aboriginal people have been consistent themes throughout his career.

Lindsay is a staunch advocate for services that are person-centred, place-based, trauma-informed and culturally responsive.

Kim Lazenby

Deputy Commissioner System Development

Kim joined the Mental Health Commission in July 2020 and was appointed to lead the newly formed System Development division shortly after. Prior to joining the Commission she was Director of the Social Policy Unit at the Department of the Premier and Cabinet.

During her time at DPC, Kim led work of direct relevance to the mental health and alcohol and other drug systems, including in the areas of child protection, family and domestic violence, justice and juvenile justice, and responding to the harms caused by methamphetamine and other drug and alcohol abuse.

Kim has over 30 years' experience in the public sector, working in senior roles at both the State and national levels, in Western Australia and other states and territories. Throughout her career, Kim has worked to promote social justice and redress disadvantage. In 2020, Kim was awarded the Institute of Public Administration award as Policy Practitioner of the Year.

Kim holds a Masters of Assessment and Evaluation from the University of Melbourne, and post-graduate qualifications in social policy and accounting.

Alison Skeen

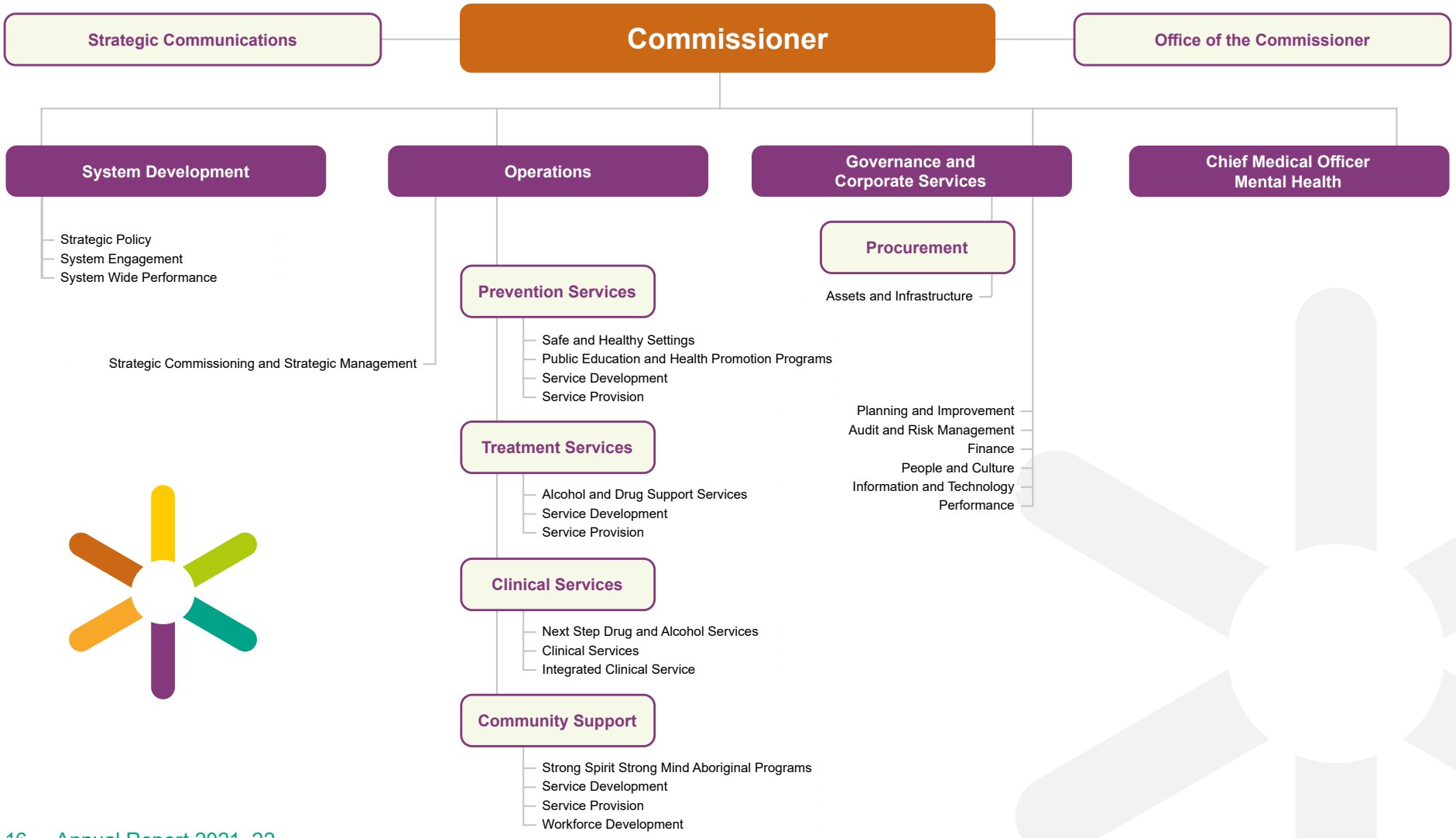
Executive Director Governance and Corporate Services

Alison Skeen was seconded to the Commission in August 2020, from her role leading the Business and Customer Services function at the Department of Education.

Prior to that Alison held finance and corporate services executive civil service roles in the UK. Alison is a qualified accountant and a Fellow of the Chartered Institute of Finance and Accountancy (FCIPFA) and has a passion for public service in making a difference to lives of the communities served.

Expiry of present term: 17 June 2022

Organisation structure



Agency Performance

Performance Management Framework

Government Goals

State Government organisations work together to achieve specific high-level goals that support the Western Australian Government's desired outcomes.

The Mental Health Commission's outcomes-based management framework was developed to help monitor and assess the agency's performance against the specific goal of achieving **STRONG COMMUNITIES**.

The following tables show summaries of:

1. the relationship between this Whole-of-Government goal, key outcomes the Commission seeks, how those outcomes are measured and how we performed this year; and
2. how effective and efficient the types of services we commission are in contributing to that goal.

Treasury exempted Key Efficiency Indicators

On the 24th of June 2022, the Under Treasurer approved a temporary exemption from the requirement to disclose several Key Efficiency Indicators under paragraph (4)(i) of Treasurer's Instruction 904. The necessity for the partial exemption is due to the impact of the COVID-19 pandemic, which prevented the independent verification of data from service providers within the required timeframe. The unaudited results of these Key Efficiency Indicators for 2021-22 are separately reported in the annual report for information only.

The Key Efficiency Indicators for which a temporary exemption has been approved are as follows:

- Average cost per purchased bed-day in mental health 24-hour and non-24-hour staffed community bed-based services (KPI 3.1)
- Average cost per bed-day in mental health step up/ step down community bed-based units (KPI 3.2)
- Average cost per closed treatment episode in alcohol and other drug residential rehabilitation and low medical withdrawal services (KPI 3.3)

Whole of Government Goal

Strong Communities
Safe communities and supported families

- Average cost per purchased treatment day of ambulatory care provided by public clinical mental health services (KPI 4.1)
- Average cost per closed treatment episode in community treatment-based alcohol and other drug services (KPI 4.2)
- Average cost per hour for community support provided to people with mental health issues (KPI 5.1)
- Average cost per episode of care in safe places for intoxicated people (KPI 5.2).

These unaudited KEIs can be found in the section starting on page 158.

Agency Level Government Desired Outcomes and Key Effectiveness Indicators

Desired Outcomes	Improved mental health and wellbeing	Reduced incidence of use and harm associated with alcohol and other drug use	Accessible, high quality and appropriate mental health and alcohol and other drug treatments and supports
Key Effectiveness Indicators	**1.1** Percentage of the population with high or very high levels of psychological distress	**2.1** Percentage of the population aged 14 years and over reporting recent use of alcohol at a level placing them at risk of lifetime harm	**3.1** Readmissions to hospital within 28 days of discharge from acute specialised mental health units
		**2.2** Percentage of the population aged 14 years and over reporting recent use of illicit drugs	**3.2** Percentage of contacts with community-based public mental health non-admitted services within 7 days post discharge from public mental health inpatient units
		2.3 Rate of hospitalisation for alcohol and other drug use	**3.3** Percentage of contracted non-government mental health or alcohol and other drug services that met an approved standard
			3.4 Percentage of the population receiving public clinical mental health care or alcohol and other drug treatment

Services and Key Efficiency Indicators

Services	Prevention	Hospital Bed Based Services	Community Bed Based Services	Community Treatment	Community Support
Key Efficiency Indicator	**1.1** Cost per capita spent on mental health and alcohol and other drug prevention, promotion and protection activities	**2.1** Average cost per purchased bedday in specialised mental health units	**3.1** Average cost per purchased bedday in mental health 24 hour and non-24 hour staffed community bed based services	**4.1** Average cost per purchased treatment day of ambulatory care provided by public clinical mental health services	**5.1** Average cost per hour of community support provided to people with mental health issues
		2.2 Average cost per purchased bedday in Hospital in the Home mental health units	**3.2** Average cost per bedday in step up/step down community bed based units	**4.2** Average cost per closed treatment episode in community treatment based alcohol and other drug services	**5.2** Average cost per episode of care in safe places for intoxicated people
		2.3 Average cost per purchased bedday in forensic mental health units	**3.3** Average cost per closed treatment episode in alcohol and other drug residential rehabilitation and low medical withdrawal services		

Performance Summaries - Report on Operations

Summary of financial performance

Financial target	2021-22 Budget $'000	2021-22 Actual $'000	Variation $'000
Total cost of service (expense limit)	1,114,246	1,118,757	(4,511)
Net cost of services	1,113,618	1,116,684	(3,066)
Total equity	57,205	80,718	23,513
Net increase/decrease in cash held	(6,196)	29,918	36,114*

** The increase in cash held is due to an increase in Commonwealth funding which resulted in less State funding being utilised. For further information, please refer to the Financial Statements and the associated explanatory statement.*

Working cash targets

	2021-22 Agreed Limit $'000	2021-22 Target/ Actual $'000	Variation $'000
Agreed Working Cash Limit (at Budget)	55,473	55,809	(336)
Agreed Working Cash Limit (at Actuals)	55,674	55,809	(135)

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

Key Performance Indicator (KPI) results against targets

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 tables below. More detailed information and analysis of its efficiency and effectiveness indicators are provided in the Key Performance Indicators section.

Indicator		2021-22 Target	2021-22 Actual
Key Effectiveness Indicators			
Outcome 1: Improved mental health and wellbeing			
1.1	Percentage of the population with high or very high levels of psychological distress	≤12.2%	12.2%
Outcome 2: Reduced incidence of use and harm associated with alcohol and other drug use			
2.1	Percentage of the population aged 14 years and over reporting recent use of alcohol at a level placing them at risk of lifetime harm	≤17.2%	17.2%
2.2	Percentage of the population aged 14 years and over reporting recent use of illicit drugs	≤15.6%	15.6%
2.3	Rate of hospitalisation for alcohol and other drug use (per 100,000 population)	<965.4	969.5
Outcome 3: Accessible, high quality and appropriate mental health and alcohol and other drug treatments and supports			
3.1	Readmissions to hospital within 28 days of discharge from acute specialised mental health units	≤12%	14.5%
3.2	Percentage of contacts with community-based public mental health non-admitted services within 7 days post discharge from public mental health inpatient units	≥75%	85.7%
3.3	Percentage of closed alcohol and other drug treatment episodes completed as planned	≥76%	76.0%
3.4	Percentage of contracted non-government mental health or alcohol and other drug services that met an approved standard	100%	100%
3.5	Percentage of the population receiving public clinical mental health care or alcohol and other drug treatment	≥3.3%	3.0%

Indicator		2021-22 Target	2021-22 Actual
Key Efficiency Indicators			
Service 1: Prevention			
1.1	Cost per capita spent on mental health and alcohol and other drug prevention, promotion and protection activities	$9.89	$10.67
Service 2: Hospital Bed-Based Services			
2.1	Average cost per purchased bedday in specialised mental health units	$1,673	$1,820
2.2	Average cost per purchased bedday in Hospital in the Home mental health units	$1,456	$1,677
2.3	Average cost per purchased bedday in forensic mental health units	$1,445	$1,492
Service 3: Community Bed-Based Services			
3.1	Average cost per purchased bedday in mental health 24 hour and non-24 hour staffed community bed-based services	$285	$295*
3.2	Average cost per bedday in mental health step up/ step down community bed-based units	$759	$895*
3.3	Average cost per closed treatment episode in alcohol and other drug residential rehabilitation and low medical withdrawal services	$17,133	$15,346*
Service 4: Community Treatment			
4.1	Average cost per purchased treatment day of ambulatory care provided by public clinical mental health services	$496	$532*
4.2	Average cost per closed treatment episode in community treatment based alcohol and other drug services	$2,079	$2,482*
Service 5: Community Support			
5.1	Average cost per hour for community support provided to people with mental health issues	$154	$157*
5.2	Average cost per episode of care in safe places for intoxicated people	$467	$605*

** The Commission was granted an exemption on the reporting of results for these key efficiency indicators due to COVID-19 related issues which prevented the independent verification of data from service providers within the required timeframe. The unaudited results of these KPIs are published for information only.*

WA State Priorities Mental Health, Alcohol and Other Drugs 2020–2024

Prevention	Community support	Community accommodation	Treatment services	Sector development	System supports and processes
Suicide prevention	Alternatives to EDs	Community beds for high needs	Suicide intervention and postvention	Critical skill shortages	Streamline inpatient documentation
Mental health prevention	Expansion of supported accommodation	Expansion of community supported beds	Diversion programs	Contemporary patient care	Mental health accommodation vacancy system
Alcohol reduction strategies	Step up/ step downs	Contemporary bed based models	Non-admitted community treatment	Consortiums and partnerships	Flow and transition between services
Local government health plans (illicit drugs)	Recovery college	AOD transition housing	Hospital beds (secure/open)	Peer workers across the sector	Navigation of services
Real time prescription monitoring			Forensic services	Safety and support for staff	Delivering consumer outcomes
Illicit drugs at high risk events					

Priority Groups

Aboriginal people	Infants, children and adolescents	Young people

Key Achievements

Priority groups

Aboriginal people

Aboriginal people are a key priority for the Commission with cultural security underpinning our values. We are committed to working across government and in partnership with Aboriginal Community Controlled Organisations and the Aboriginal community to make changes and improve the lives of Aboriginal people and their communities.

We invest in a range of specific prevention and treatment programs to support Aboriginal people and communities. Key initiatives implemented this year include:

Social and Emotional Wellbeing (SEWB) Model of Service Pilot

The SEWB is a regional pilot program to increase access to social and emotional wellbeing and healthcare services for Aboriginal people of all ages in the five pilot sites in the Kimberley, Pilbara, Midwest, Goldfields and South West Health Regions of WA.

- Local Aboriginal Community Controlled Health Services will run the program in their communities. The pilot is expected to improve quality of life for Aboriginal people through culturally secure prevention and community development, psychosocial support, targeted interventions, coordinated care by multidisciplinary teams.
- We will work closely with the Aboriginal Health Council of Western Australia and The University of Western Australia to support the governance and evaluation of the pilot.

Wama Wangka

This is a pilot program for Martu Aboriginal people living in Newman and in remote communities of Jigalong, Parnngurr, Punmu and Kunawarritji. Wama Wangka ("Talking about alcohol") is a program specifically developed and led by Martu people and encompasses Martu concepts of health, healing and wellbeing that immediately resonates with Martu people. Addressing the underlying issues that lead to alcohol-related harm in a way that is consistent with the Martu world view, the program:

- Acknowledges social, emotional and cultural wellbeing as a significant contributor to the prevention of alcohol-related harm and mental health issues.
- Aims to address the physical, mental, emotional and spiritual issues that impact on an individual's wellbeing, family unity and community harmony through building capacity within the Martu Aboriginal communities to change one's life.
- Is based on a combination of education, experience, group support, discussion and life choices through cultural engagement and learning and focusing on building personal and community resilience.
- Involves taking Martu people onto country to talk about issues such as alcohol and other drug use, suicide, depression, self-harm, family conflict and violence.
- Will be evaluated through thematic analysis, shown to be a useful way to draw out the intrinsic cultural values that are embedded in such a program.

Youth Project community grants

13 Aboriginal Community Controlled Organisations/Aboriginal owned not-for-profit organisations were successful in applying for grant funding worth a total of $278,450 to host culturally secure initiatives, events or programs aimed at Aboriginal youth aged 12-25 years.

- Purpose is development of culturally secure programs and activities that improve the social and emotional wellbeing of Aboriginal youth and increase their awareness and knowledge of the risks associated with AOD use.
- Grants are part of Royalties For Regions funding provided for the expansion of the Strong Spirit Strong Mind Metro Project, now known as Strong Spirit Strong Mind Youth Project.

The Commission leads and coordinates progression of the State Government's response to the Commitment to Aboriginal Youth Wellbeing (the Commitment)

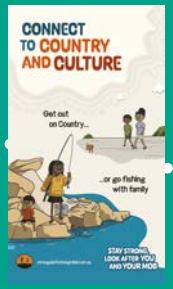
Commitment to Aboriginal Youth Wellbeing

The Commission leads and coordinates progression of the State Government's response to the Commitment to Aboriginal Youth Wellbeing (the Commitment). The Commitment outlines how the Government proposes to work towards addressing the 86 recommendations from the State Coroner's Inquest into the deaths of 13 children and young persons in the Kimberley Region, and the 2016 Parliamentary Inquiry, *Learnings from the Message Stick: the report of the Inquiry into Aboriginal youth suicide in remote areas*.

- We recognise the principles of working with Aboriginal communities as outlined in the National Agreement and the Aboriginal Empowerment Strategy and identify the need to engage with Aboriginal communities to deliver an appropriate response that is place-based, community led and also supports the development of genuine partnerships between the State Government, Aboriginal Community Controlled Organisations (ACCO's) and Aboriginal communities.
- To ensure these principles guide the work we undertake, the Kimberley Aboriginal Youth Wellbeing Steering Committee (the Steering Committee) was developed, which includes representatives from the Kimberley Aboriginal Regional Governance Group (ARGG) and Directors General of State Government agencies. The purpose of the Steering Committee is to bring together all relevant State Government agencies and Kimberley Aboriginal Community Controlled Organisations to support and enable Aboriginal community-led solutions to improve Aboriginal youth wellbeing outcomes in the Kimberley.
- In September 2021, the Commission released the annual progress report for 2021 which provided whole-of-government input on the initiatives progressed since March 2020 which support the Commitment. The annual progress report draws information from the Commitment itself, publicly available sources and information provided by senior government officers.

Stay Strong, Look After You and Your Mob

Social and Emotional Wellbeing (SEWB) Campaign



Aboriginal people prefer to use the culturally defined term 'social and emotional wellbeing' (SEWB), which is a holistic term that encompasses multiple facets of health. It is not referring to the individual but rather encompasses the social, emotional and cultural wellbeing of the whole community.

- The campaign promoted practical, evidence-based strategies to improve and protect the SEWB of Aboriginal and Torres Strait Islander peoples, at a time of heightened community concern associated with COVID-19 in WA.
- Launched State-wide in May 2022 for an initial six-month period across mass reach channels, including radio, out-of-home, digital and social media. Radio advertising has been adapted to several local languages across the Pilbara and Kimberley.
- The overarching message is to 'Stay Strong, Look After You and Your Mob'. Paid advertising is supported by a suite of resources available in the Community Toolkit to support local communities to extend the reach of the messaging.

Strong Spirit Strong Mind Aboriginal Programs (SSSMAP)

Part of the Commission's Community Support Services Directorate, SSSMAP promotes the uniqueness of Aboriginal culture as a central strength in guiding efforts to manage and reduce AOD-related harm in Aboriginal communities. SSSMAP guides cultural security and is the key concept and program underpinning the Commission's significant work in this area.

Training

SSSMAP operates as a Registered Training Organisation, delivering two culturally secure, nationally recognised training programs: CHC32015 Certificate III in Community Services; and CHC43215 Certificate IV in Alcohol and Other Drugs. Delivering these courses aligns to key priorities of:

- Aboriginal empowerment
- Increasing Commission capability
- Supporting development of a skilled Aboriginal workforce within the AOD and broader human services sector
- Responding to the needs of Aboriginal individuals, families and communities experiencing harm relating to problematic AOD use and issues around social and emotional wellbeing.

These nationally accredited courses further support the provision of culturally secure consultancy, support and advice within the Commission and broader human services sector to help address key policy and strategic initiatives relating to Aboriginal individuals, families and communities in WA.

Notwithstanding the workforce challenges exacerbated by COVID-19 experienced by all agencies, training for Aboriginal people has been especially difficult this year. The pandemic has and is still creating issues for Aboriginal student welfare and safety.

There are more than 200 remote Aboriginal communities across WA which have been subject to strict travel restrictions over much of the year. Such restrictions can impact regional and remote students travelling from and returning to communities while undertaking studies, as happened in 2021. A sudden lockdown required five students to travel home immediately, however, until travel could be approved students were confined to their accommodation location in Perth for several days. This caused social and emotional wellbeing issues for some participants and incurred additional travel and accommodation costs for the Commission. Student departures and arrivals this year were routinely disrupted by flight cancellations and delays.

Despite these challenges, this year:

- 16 participants received qualifications for Certificate IV in Alcohol and Other Drugs; and
- 16 people enrolled to participate in the next Intake 1 Certificate III in Community Services.

SSSMAP also delivers cultural awareness training for staff internally and those in our mental health and AOD sector partner agencies. The two-part Ways of Working with Aboriginal People training consists of:

- Part 1 - A whole day program focussing on introducing participants to working with Aboriginal people. Covering the exploration of Aboriginal peoples' lives before, during and after colonisation; developing cultural competencies, understanding oppression and how to challenge it; and how to support and build a stronger future for Aboriginal peoples.
- Part 2 - Provides a skills-based training approach, exploring culturally secure models and concepts, developing empathy and working in empowering ways with Aboriginal families, individuals and communities.

This year 82 people completed Part 1 and 16 people completed Part 2, resulting in:

- More training and workforce development initiatives that meet the needs of the AOD and broader human services sector
- Increased capacity of non-Aboriginal workers to work in culturally secure ways within the AOD and broader health services sector
- Increased capacity to work in culturally appropriate ways with Aboriginal people, inclusive of Aboriginal workers
- Better understanding of more effective ways of working with Aboriginal people within the broader community.

82 people

were introduced to Ways of Working with Aboriginal People, covering the exploration of Aboriginal peoples' lives before, during and after colonisation

Inside the commission: Commitment to conciliation

Aboriginal Advisory Group:

- The SSSMAP team coordinates our Aboriginal Advisory Group, which provides culturally secure advice on programs, resources, campaigns, workforce development initiatives, evaluation and research produced by the Commission.
- Established as part of our first Conciliation Action Plan (2018-2021) to demonstrate our commitment to relationship-building with Aboriginal and Torres Strait Islander people.
- SSSMAP works alongside the Aboriginal Advisory Group to ensure culturally secure practices throughout the Commission and support cultural guidance and advice from the Commission's Aboriginal Elders in Residence program.

Conciliation Action Plan:

- Our Conciliation Action Plan (2018-2021) was developed with input from across the agency, and in consultation with Reconciliation Australia and our own Aboriginal Advisory Group. Guided by our Elders in Residence, we adopted the term 'conciliation' in preference to the often used 'reconciliation'. Conciliation acknowledges Aboriginal and non-Aboriginal people are often working together for the first time as genuinely equal partners in a shared future.
- Work is underway to develop our future plan to improve the way we work with Aboriginal people and close the gap in social and emotional wellbeing of Aboriginal people in our community.

Aboriginal Elders in Residence Program

Noongar Elders Uncle Charlie Kickett and Aunty Helen Kickett have been part of our Aboriginal Elders In Residence Program since 2017. The program aimed to increase staff awareness of Aboriginal and Torres Strait Islander mental health issues through direct engagement with Aboriginal Elders who, in this instance, have Lived Experience as part of Australia's Stolen Generation. Our Elders act as Cultural Consultants, providing advice and support to guide improved outcomes in the commissioning of mental health, alcohol and other drug services to Aboriginal people.

The program has been supported through a five-year Looking Forward – Moving Forward project grant agreement which concluded this year. An evaluation of the program to inform next steps is underway.

Infants, children and adolescents

The increased incidence, complexity and early onset of mental ill-health in children is a challenge societies face world-wide. Working across government, the sector and with stakeholders to develop a contemporary, evidence-informed model of service and models of care for mental health services that meet the needs of children in WA from the day they're born until their 18th birthdays is one of the Commission's top priorities.

Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 years in WA

A Ministerial Taskforce was established to develop a whole-of-system plan for State Government funded specialist infant, child and adolescent (ICA) mental health services provided by Western Australian health service providers (HSPs). The Commission has worked with Taskforce to bring together leaders from across the ICA mental health system, as well as consumers, their families and carers to create a vision for the future: to ensure that despite pressures and demands on the State's mental health system children receive the treatment and care they need, when they need it.

This year:

- ICA Taskforce Final Report was released in March 2022 with a Government commitment to implement all 32 recommendations and to the State-wide, system-wide reform of ICA mental health services.
- The scale of reform is wide-ranging and will take several years to achieve, prompting Taskforce to recommend a phased approach to implementation.
- The Final Report provides the framework to transform the ICA mental health system into a contemporary, evidence-informed model of service with models of care that meet the needs of children in WA from the day they are born through to their 18th birthday.
- Taskforce was led by independent chair, Dr Robyn Kruk AO, and has actively engaged children, young people, families, clinicians, support providers, and other key stakeholders in the future design of public specialist child and adolescent mental health services for infants, children and adolescents that fit the unique metropolitan, regional, rural and remote circumstances of WA.
- Taskforce was guided by more than 100 members across three advisory groups: Lived Experience, Clinical, Interagency.
- Implementation of priority actions commenced.

Priority actions:

In May 2022, $47.2 million was allocated to respond to immediate recommendations from Taskforce's Final Report, including:

- $18.5 million to expand the Child and Adolescent Mental Health Service (CAMHS) frontline workforce across seven regions by 11.6 FTE;
- $12.9 million for additional Peer Support Workers;
- $10.5 million to deliver a two-year virtual support service for at-risk children;
- $4 million for Service Model Design and Implementation; and
- $1.3 million for mental health workforce development initiatives.

$18.5 million

to expand the Child and Adolescent Mental Health Service frontline workforce across seven regions by 11.6 FTE

In July 2021, seven service providers were awarded grants totalling $1.17 million to provide perinatal mental health pilot programs in the Perth metropolitan and South West regions, to support the mental health of vulnerable parents.

- Pilots will be tailored to specific community need helping to address current identified service gaps, including:
  - services for women experiencing co-occurring complexities such as history of trauma, family and domestic violence; and
  - a new Dads Program to help break down barriers for fathers accessing supports.
- Service providers awarded pilot grants were:
  - Gosnells Women's Health Services;
  - South Coastal Health and Community Services;
  - Fremantle Women's Health Centre;
  - Midland Women's Health Care Place;
  - Women's Healthcare Association;
  - Australian Association for Infant Mental Health WA; and
  - The Radiance Network South West.

Perinatal mental health services are important to promote confidence and emotional wellbeing for both new and experienced parents around the time of the birth of a new child. The first years of parenthood can be tough. These pilot programs aim to increase mental health support for mums and dads, reduce psychological distress and promote good mental health outcomes for parents and infants.

Young people

Our vision is that young people are healthy and have fulfilling lives, where young people can learn, grow and contribute to society as they set up life within the community. Most importantly we want young people to be well and stay well.

Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025 (YPPA)

Top Priorities

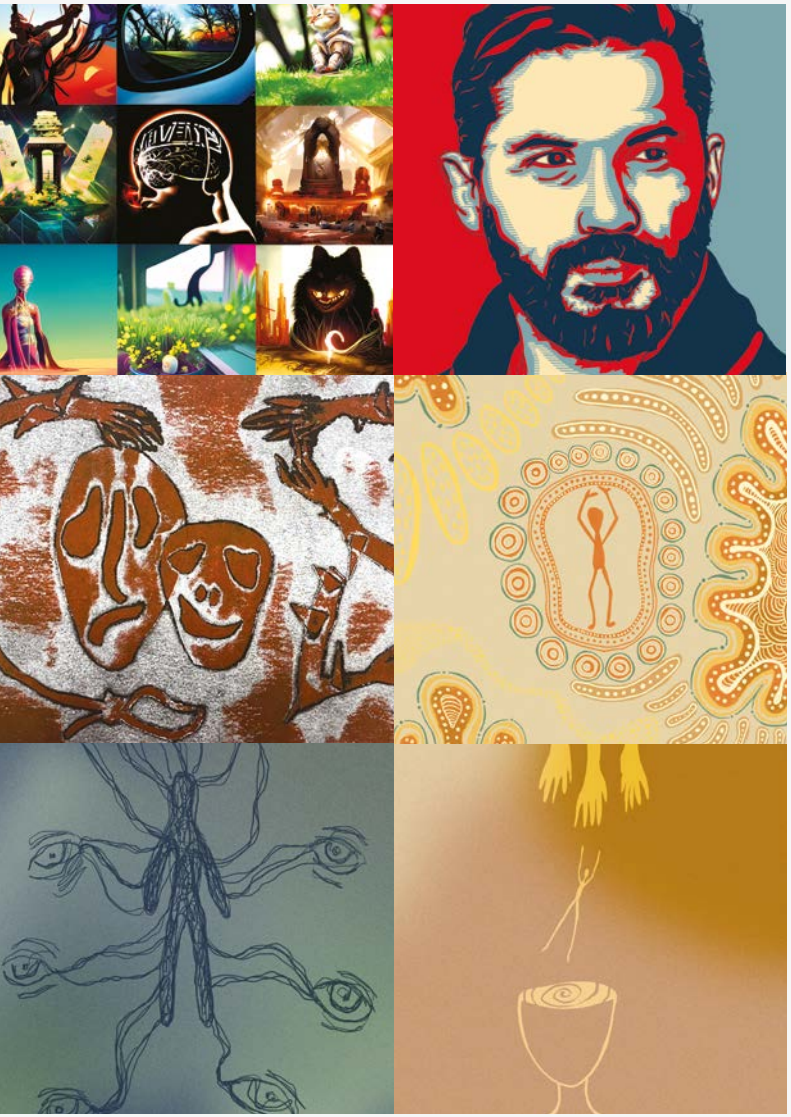
Top Priority actions are those deemed as the first priorities for implementation should additional funding become available. A significant investment was made in key initiatives for young people including:

- $9.5 million over three years for Psychosocial Support Packages for Young People.
- $18.2 million over four years for the Youth Long Term Housing and Support Program.
- $10.6 million over four years to establish a Youth Mental Health and AOD Step Up/Step Down service.
- $9.8 million for Youth Alcohol and Other Drug Workers in Youth Accommodation and Support Services on an ongoing basis.
- $9.2 million over the next four years to extend the Strong Spirit Strong Mind Public Education Campaign.
- $12.6 million has been allocated to establish a new Child, Adolescent and Youth Forensic Outreach Service on an ongoing basis.
- $10 million over four years for the expansion of youth mental health community treatments services - Youth Axis, YouthLink and YouthReach South.
- $0.4 million to continue the peer-based support and education for LGBTQIA+ youth.
- $35.3 million over four years for the expansion of the Youth Community Assessment and Treatment Teams.

YPPA Report on Implementation

This year we doubled down on our efforts to make sure young people continue to inform strategies designed to respond to their mental health and AOD needs.

- The Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025 (YPPA) guides government agencies, the mental health and AOD sector and community stakeholders in supporting and responding to the mental health and AOD needs of young people aged 12 to 24 years.
- This year we released the YPPA Report on Implementation (the Report), updating progress made since the launch of the YPPA in 2020.
- It reports against six key strategies identified by young people and sector stakeholders as priority areas for change and provides information on the implementation of agreed initiatives.



- Extensive stakeholder engagement was undertaken to develop the Report, including with young people.
- We partnered with the Youth Mental Health Sub Network and the Youth Affairs Council of Western Australia (YACWA) to help ensure young people had a range of ways they could choose to be represented, engaged, and involved, including:
  - Establishing a time-limited, 10-member Youth Steering Group to guide those events where young people and other key stakeholders came together to provide their advice.
- The Report provides an overview of these engagement activities and outlines ongoing governance and reporting arrangements.
- The Report was released alongside a public art exhibition called Project Elevation featuring artwork from young artists on the theme of mental health.
- Some of this artwork was included within the Report, together with works by Western Australian high school students and an Aboriginal trainee from the Commission.
- We developed the Report in collaboration with the Departments of Health, Education, Communities, Justice, Treasury, Local Government, Sport and Cultural Industries, Training and Workforce Development, the Premier and Cabinet, and the Western Australia Police Force.
- A shorter version entitled Our Future, Our Priorities: Young People's Priorities for Action 2021 Implementation Update was released to highlight:
  - some of the key YPPA initiatives identified by young people and
  - contact details for free support services young people, families and carers can access.

Drug Education Support Services for youth in crisis

Expansion of the Youth AOD Education and Support Program is an election commitment which will improve support for young people who are experiencing or are at risk of homelessness, to address their AOD issues in a safe and supportive environment. We're funding 17 full-time Drug Education and Support Service (DESS) Workers to deliver the AOD Education and Support Program at Department of Communities-funded youth accommodation support services around WA.

This year we:

- Developed an 11-week core training program for DESS workers employed in YASS. The DESS Worker Program includes online, face-to-face and webinar training. An online portal was also developed for the DESS workers providing a central source of information, communication, tools and resources for DESS Workers.
- Undertook an extensive consultation process across WA with consumers, other stakeholders and service providers to develop the service model.
- Delivered a transparent and collaborative procurement process with service providers to progressively begin services from 1 July 2022.
- Additionally, a Community of Practice will form a part of the DESS Worker Program which is ready to commence from 1 July 2022.

LGBTIQA+ regional grants

This year we invested an additional $500,000 to deliver counselling services for young people in regional WA who identify as LGBTIQA+ that also aim to build community capacity to support gender and sexually diverse groups. Three regional hubs in Geraldton, Bunbury and Kalgoorlie-Boulder were nominated to host pilot programs to be run by WAAC, formerly the WA AIDS Council.

- WAAC is a not-for-profit organisation that welcomes and supports people from all walks of life and aims to build healthy, inclusive, connected communities. It focuses on optimising the health, sexual health and wellbeing of LGBTIQA+ people through reducing stigma and discrimination and improving access to health services and information.
- The needs of LGBTIQA+ youth in regional and rural areas are complex and while they have similarities, each region requires a tailored approach. This funding provides:
  - direct support to young people
  - explores the broader issues they face
  - workshops and information to school students, educators, healthcare professionals, care-givers and parents.

Key Achievements

Prevention

Prevention initiatives aim to reduce the incidence and prevalence of mental health and AOD issues. Preventing suicide and reducing suicidal behaviour in Western Australia is one of the Commission's key priorities, understanding that suicide is a complex whole-of-community issue that will take time to address.

In 2021-22 we invested:

- **$12.1 million** in mental health services
- **$14.6 million** in AOD services

Challenges:

- Timely access to data and research that identifies emerging issues and evidence-based strategies or responses underpins best practice. Developing innovative solutions to capture real-time issues and prevalence and strengthening relationships with experts and research institutions to guide program development and delivery are key focus areas for the Commission going forward.

Suicide prevention

In 2021-22 we:

- Supported 10 regional Aboriginal suicide prevention plans, which are community-led and endorsed plans that prioritise a culturally secure Social and Emotional Wellbeing approach to suicide prevention activities.
- Assisted Suicide Prevention Coordinators, Alcohol and Other Drug Prevention Officers and Aboriginal Community Liaison Officers during COVID-19 by delivering online facilitation skills training and providing increased resources where needed.
- Delivered 39 workshops and trained 528 people in the Gatekeeper Suicide Prevention Training Program.
    - Workshops have been delivered across a range of services in the metropolitan and regional areas, including for the Department of Justice, the Department of Fire and Emergency Services, St John Ambulance, Murdoch University Clinical Psychology Masters program, as well as for health and welfare workers in the Wheatbelt, Midwest, South West and Perth region.
    - The Gatekeeper Training Calendar began in February 2022 with two training sessions delivered in this reporting period.
    - Two Train-the-Trainer workshops were completed, representing initial training for new facilitators. Each potential facilitator is required to complete two observed workshops satisfactorily to complete the accreditation process.
        - Of 14 potential facilitators trained, approximately half will deliver workshops within their workplace. The rest will be available to deliver workshops on a more flexible basis.
    - An external consultant was commissioned to review the Gatekeeper Suicide Prevention Training Program, to ascertain how well it remains linked to its stated aims. The final report has been provided and is being reviewed.
- Supported a review of the Suicide Prevention Coordinator Prevention Plans across the regions to ensure evidence-based, localised strategies are in place to prevent suicide, and improve postvention and mental health outcomes for the community.
- Supported delivery of the Busselton Service Provider Workshop, held in August 2021 and attended by the former Minister for Mental Health the Hon. Stephen Dawson MLC, this event brought key stakeholders together to enhance existing suicide prevention partnerships, provide collaboration opportunities and identify regional service

provision gaps.

- Consolidated our successful working relationship with StandBy National which is now located in all regions of WA, to provide a postvention service for people bereaved by a death from suicide. Meetings were held with StandBy to agree how Suicide Prevention Coordinators and StandBy postvention staff will work together to support each community.

Preventing Fetal Alcohol Spectrum Disorder (FASD) Project

2021-22 saw us:

- Continue delivery of the State-wide Alcohol.Think Again 'One Drink' public education campaign. Evaluation data has shown that the campaign has increased community awareness, concern and belief about the harmful and lifelong impacts associated with alcohol use in pregnancy and resulted in more women committing to alcohol-free pregnancies.
- Deliver Valuable Conversations training across the State, providing attendees with the skills to facilitate more meaningful conversations with their clients in the community about alcohol and FASD:
  - 10 two-day training events with 91 participants were achieved this year.
  - Training events were delivered in the Midwest, South West, Kimberley, Metro/Peel, Pilbara and Goldfields.
  - Data from pre and post evaluations demonstrated most participants reported increased knowledge about FASD and opportunities for local prevention initiatives, and increased confidence in their ability to apply reflective practice, trauma-informed care and practice, motivational interviewing and brief intervention skills. alcoholthinkagain.com.au/resources/resources-for-health-professionals/valuable-conversations-training-resources/.
- Provide funding to WACHS Midwest and Kanyirninpa Jukurrpa to deliver FASD prevention projects in Meekatharra and Newman. These services will work closely with key local stakeholders and community to co-design strategies for inclusion in a FASD Community Action Plan that aims to address alcohol use through targeted community action initiatives.

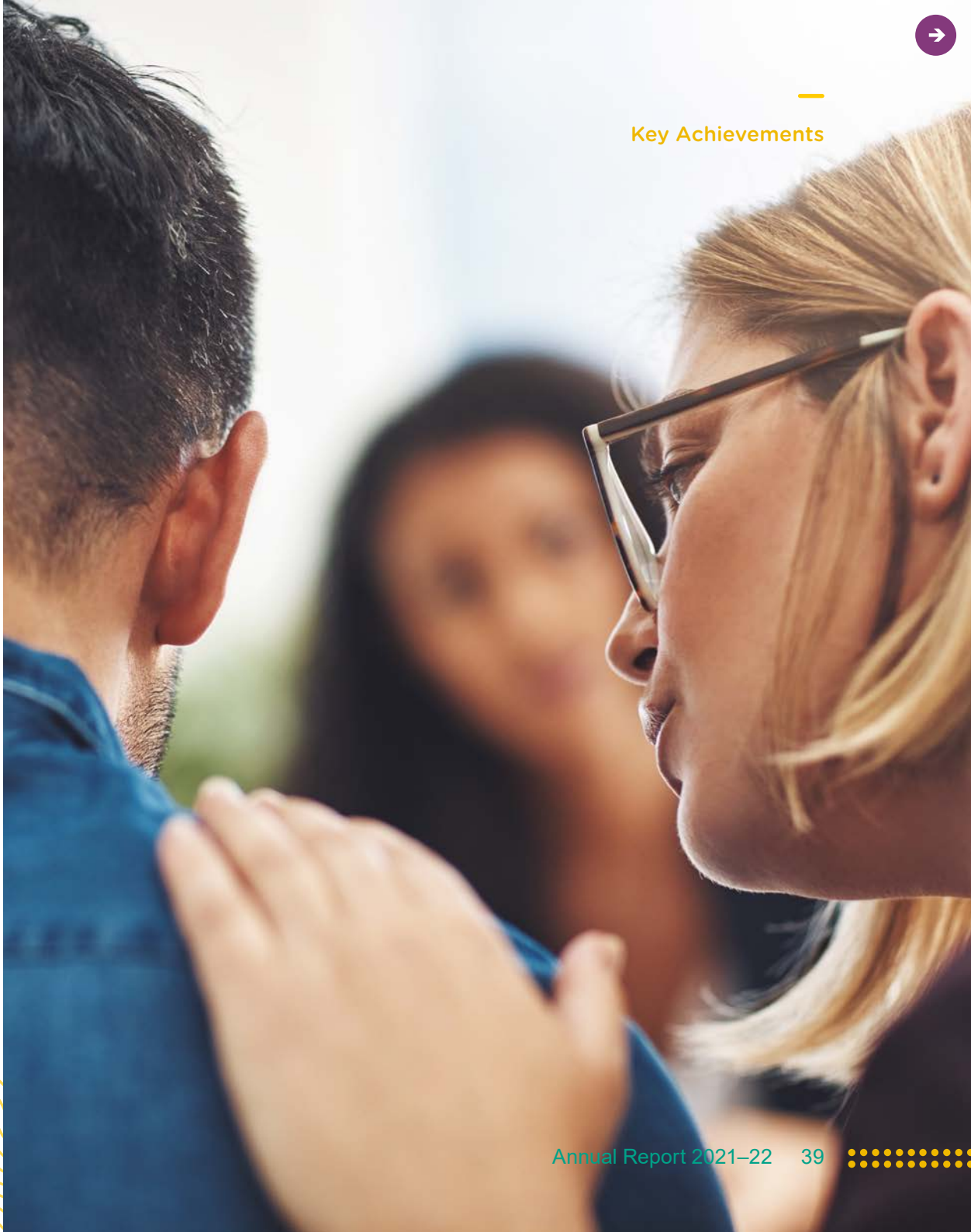
An evaluation of the Preventing FASD Project has demonstrated significant public health outcomes, in addition to conservative modelling* estimating financial savings of $24 million.

*Modelling undertaken by MHC, based on estimated lifetime cost of supporting one person with FASD; live births in WA; estimated FASD prevalence in WA; and independent campaign evaluation data. Unpublished 2021.

AOD and mental health strategies

In 2021-22 we:

- Supported 33 regional Alcohol and Other Drug Management and Community Wellness Plans. These plans facilitate partnerships between community members, service providers, local governments and non-government organisations to identify and address local issues and concerns. The plans support broader population approaches and are a tool to coordinate, implement and evaluate evidence-based community prevention approaches.
- Partnered with the Departments of Mines, Industry, Regulation and Safety, and Communities, and the Equal Opportunity Commission to address safety, mental health, and AOD issues in the mining industry as part of the Mental Awareness, Respect and Safety (MARS) Program.
- Funded Sportwest to develop and pilot mental health and wellbeing resources and training for the community sporting sector aligned with the industry-led Mental Health and Wellbeing Community Sport Framework. The Framework and resources respond to calls from the community sport sector for help to identify best practice approaches to mental health and wellbeing for community sporting clubs. The resources will assist clubs to apply the Framework with a focus on preventing mental health issues and promoting wellbeing.



Key Achievements

- Assisted the Chief Health Officer in his statutory role in the *Liquor Control Act 1998*, reviewing 97 liquor licence applications resulting in 21 submissions to the licensing authority seeking to minimise harm or ill-health associated with the applications. A key focus area for submissions was separating alcohol from child-focused activities.
    - Of 19 decisions, 12 were consistent with recommendations made in our submissions, two were partially consistent, three were not. Two applications did not proceed on public interest grounds.
- Helped keep WA Leavers safe during their South West celebrations post Year 12, as part of our collaboration with WA Police Force (WAPF), South West WACHS, and other organisations involved in delivery of the WA Leavers Strategy. Our contribution included:
    - Developing and delivering two targeted social media-led campaigns in the lead up to and throughout Leavers week.
        - » The Alcohol.Think Again Leavers campaign reminded teens that not using alcohol is the safest choice and provided strategies they could implement to reduce their risk of harm if they did choose to drink alcohol.
        - » The Drug Aware Party Smarter campaign was adapted for Leavers to reduce the risk of harm from MDMA use. It encouraged the use of harm minimisation strategies and referral to support services if young people were experiencing known life-threatening symptoms.
        - » To support campaign messaging, a pocket-sized resource featuring key AOD harm minimisation information was developed and distributed by organisations engaging with Leavers throughout the week.
    - Informing the structural set up of the Leavers Entertainment 'Zone' by providing advice on best practice strategies that could be implemented to reduce AOD-related harm, including providing chill out zones, adequately trained medical staff and peer workers, and easy access to water.
    - Delivering a tailored training package for all stakeholders involved to equip staff and volunteers with the knowledge and skills to prevent AOD-related harm, and to respond appropriately and efficiently to AOD use issues among those attending events.
        - » In the lead up to Leavers, we delivered training to more than 240 people across multiple sessions in the metropolitan and South West regions. Participants included paramedics, hospital ED staff, WA Police Force staff and Leavers service provider personnel and volunteers.

In the lead up to Leavers, we delivered training to more than 240 people across multiple sessions in the metropolitan and South West regions

Other prevention strategies

Naloxone

As part of our commitment to a Western Australian community that experiences minimal alcohol and other drug-related harms and optimum mental health, the Commission convenes the Overdose Strategy Group (OSG) comprised of key stakeholders including hospital emergency departments, needle and syringe programs, first responder services, peer services, sexual health and blood borne virus programs. The OSG aims to reduce opioid overdose related harms and deaths in the WA community by implementing targeted strategies, including WA Naloxone Programs.

We have co-ordinated the WA Naloxone Program since 2013 and provide training and information sessions in recognising and responding to opioid overdose, and how to administer and supply naloxone to clients/patients to reverse opioid overdose. We provide training and support to WAPF in delivering the WA Police Force Naloxone Pilot and support to St John Ambulance WA to deliver a State-wide Take Home Naloxone Program.

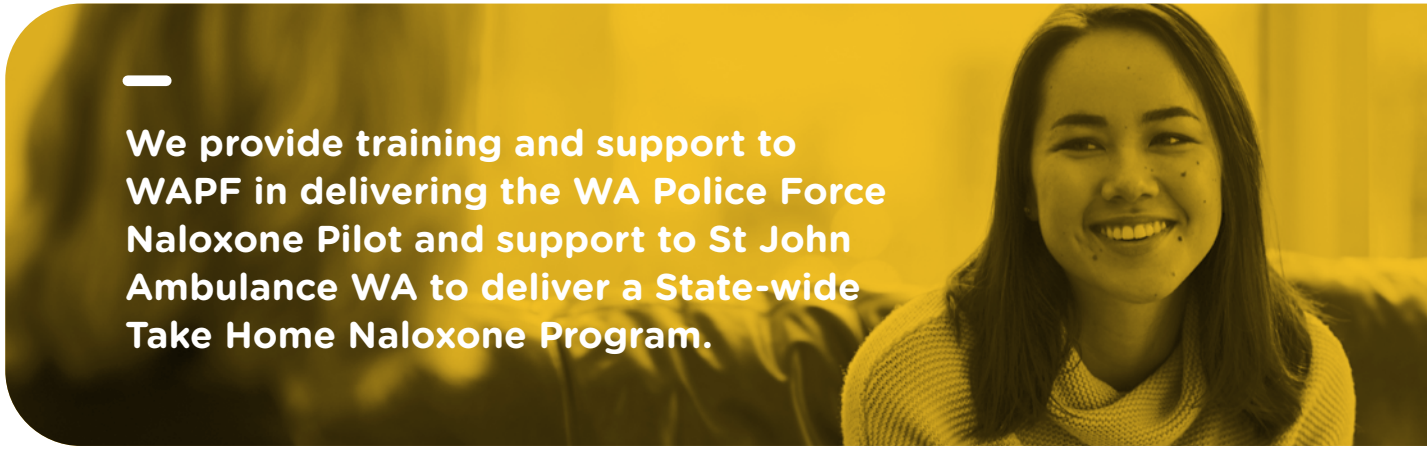
In 2021-22:

- The WAPF Naloxone Pilot and St John Ambulance (SJA) Take Home Naloxone Program continued to expand.
- 373 WAPF officers have been trained across five metropolitan and two regional locations.
- WAPF officers deployed naloxone on 19 occasions this year.
- All 566 SJA fleet vehicles now carry free naloxone to give to people who refuse transport after an overdose.
- Paramedics have left take home naloxone at the scene on 62 occasions. This allows paramedics to build a safety-net around patients who refuse transport to hospital post management of opioid toxicity.

Future focus on wellbeing

To inform development of the **Mental Health Guidelines (the Guidelines)** we commissioned a literature review and undertook State-wide consultation in October and November 2021. The Guidelines are being developed based on the outcomes of this work to ensure it reflects the views of the Western Australian community and the broader evidence base.

The Guidelines will inform future implementation and investment of evidence-based primary prevention and wellbeing activities in the Western Australian community.



Key Achievements

Community accommodation and support

In 2021-22 we invested:

- **$103.1 million** for mental health services
- **$35.7 million** for AOD services

Ensuring people have a safe place to live is essential to enabling their recovery or managing their mental health or AOD issues. Accommodation services and related mental health and AOD community supports enable people to recover in a safe and appropriate environment.

Challenges:

- While we have strong relationships with partner agencies there is a recognised need to better operationalise them to enable more innovative, effective commissioning of services. We are currently negotiating with the National Disability Insurance Agency (NDIA) and other government agencies to better coordinate mental health services funding outcomes.
- Lack of affordable accommodation is an ongoing concern. This year, working closely with the Department of Communities, we were able to secure agreement that allows greater flexibility in the categorisation of properties, resulting in more timely allocation of vacant properties.

Alternatives to EDs

In 2021-22 we:

- Began planning for a $74.1 million investment in more appropriate forms of care for long-stay hospital patients, part of the $252 million multi-agency Emergency Department Reform Package announced in May 2022, comprising 17 initiatives to improve hospital emergency capacity and address ambulance ramping.
- We also helped ease pressure on hospital beds by:
    - Working with the Departments of Health and Communities to drive cross-agency solutions to support the discharge of patients who have no medical or clinical reason to be in hospital. The cross-agency focus has supported the discharge of some of the longest stay patients in the health system.

Planning for a

$74.1 million

investment in more appropriate forms of care for long-stay hospital patients

Helplines

As part of our commitment to support people concerned about mental health and / or problematic AOD, we provided ongoing funding this year to:

- Lifeline 13 11 14 Crisis Telephone service: $732,326 for delivery of the crisis phone service from WA providing access to crisis support, suicide prevention, mental health support services and to create opportunities for emotional wellbeing
- Beyond Blue: $347,027 for mental health promotion services through campaigns, communications, resources and programs that inform, connect and support people to achieve their best possible mental health and access support when needed throughout WA.

We also fund and manage specific WA-focussed helplines at a cost this year of $2.98 million.

In 2021-22 we:

- Provided 20,000 occasions-of-service to Western Australians through the **Alcohol and Drug Support Line**, the **Parent and Family Drug Support Line**, and the **Meth Helpline**. A further 744 contacts were received by the National AOD Hotline (Federally funded and jurisdictionally delivered):
  - Contacts were made using the free 24/7 telephone counselling, information, support and referral support lines, live chat and email.
  - Of these, 44.5% identified alcohol as the primary drug of concern (an increase of 6.5% from last year) and 9.3% identified methamphetamine as the primary drug of concern (a decrease of 2.5% from last year).
- Launched a new State-wide telephone line providing support to Western Australians concerned about their own or another person's mental health issues and/or alcohol and other drug use.
  - Here For You provides accessible and immediate mental health and AOD support with the option of talking with a qualified counsellor or peer practitioner.
  - Operating from 7am to 10pm every day, the service provides emotional support, information, coping and relapse prevention strategies and helps people to navigate both mental health and AOD services.
  - Since launch, we provided 765 occasions-of-support.
  - Of these, 30% identified mental health issues as their primary reason for calling, with 14% noting social supports or isolation/grief as the secondary reason for calling. 11% noted co-occurring mental health and alcohol and other drug issues.

20 thousand

occasions-of-service to Western Australians through the Alcohol and Drug Support Line, the Parent and Family Drug Support Line, and the Meth Helpline

Here For You is part of the Immediate Drug Assistance Coordination Centre (IDACC)

Overall:

- 40% of all calls received help navigating both mental health and AOD services
- 31% of calls were referred to non-government organisational (NGO) mental health services
- 20% of calls were referred to their GP
- 13% of calls were referred to other services (e.g. grassroot supports in their local area).
- 6.5% of calls were referred to NGO AOD services
- 3% of calls were referred to public and private mental health clinics
- 1.5% of calls were advised to attend to a hospital ED
- Here For You is part of the Immediate Drug Assistance Coordination Centre (IDACC) initiative being developed in WA to help people experiencing a crisis involving problematic AOD use access immediate care and support in a coordinated, seamless way.

Beds for high needs

In 2021-22 we:

- Opened Momentum QP, an eight-bed interim Mental Health Alcohol and Other Drugs Youth Homelessness service, in February 2022. The service supports the rehabilitation and recovery of young people with complex mental health issues, who may also have AOD issues, and are experiencing homelessness or are at risk of doing so. The service supports young people to transition from homelessness to more independent living by working with them to improve functioning, reduce barriers to their independence, and assist them to obtain suitable, stable accommodation in the community. The service is operated by Richmond Wellbeing in partnership with EMHS, Anglicare WA and Cyrenian House.
- Opened Living Well, the first Community Care Unit in WA. This 20-bed service provides intensive, transitional support for people with complex mental health issues who have primarily been long-term inpatients in hospital. The service is set in a homelike environment that supports residents' rehabilitation and recovery. The service is operated by Richmond Wellbeing in partnership with SMHS and Cyrenian House. A long-term residential service is currently in the planning stage.
- Funded the Individualised Community Living

Consulted with young people, families, carers, services providers, Government agencies, peak bodies and other stakeholders to design three new community support and accommodation services for young people, including a Youth Step Up/Step Down

Strategy (ICLS) to purchase two additional properties for eligible participants to access, with recovery-focused community supports. ICLS is an innovative and collaborative approach between the Commission, HSPs, NGOs, Community Housing Organisations and the Department of Communities. ICLS provides coordinated clinical and psychosocial support to help eligible individuals achieve their recovery goals and live well in the community. Individualised supports are identified through a personalised planning process to meet someone's unique circumstances and, where relevant, their families and carers. This year:

- 4 ICLS participants successfully transitioned to further independent living
- 13 new participants were determined to be eligible for the ICLS program.

Supported bed expansion

In 2021-22 we:

- Provided grant funding to Life Without Barriers and Brightwater to enable 10 long-stay inpatients in public hospitals to transition to community-based supported accommodation while they undergo assessment for a long-term funding support plan through the National Disability Insurance Scheme.

Step up/Step down

In 2021-22 we:

- Completed consultation with young people, families, carers, services providers, government agencies, peak bodies and other stakeholders to design three new community support and accommodation services for young people, including a Youth Step Up/Step Down. Other services are a Youth Long-term Housing and Support Program, and Youth Psychosocial Support Packages.
  - Consultations included 97 written submissions/surveys, three sector workshops with 105 participants, three sector focus groups with 34 participants, and three youth focus groups with 25 participants.
  - With the Final Consultation Report to guide us we have started developing the models of service, with the first model for Youth Psychosocial Support Packages endorsed by our Executive Leadership Group in June.

We also:

- Progressed a Request for Tender for Group Support Services to improve the quality of life and psychosocial functioning of mental health and AOD consumers through the provision of group-based social, recreational and prevocational activities. Procurement is underway.
- Commenced an Expression of Interest from Registered Aboriginal Businesses and/or Aboriginal community-controlled services for a Pilot Grants Program for Group Support Services to improve life outcomes experienced by Indigenous Australians and to build the capacity and sustainability of the Aboriginal community-controlled sector. Procurement is underway.
- Progressed expansion of the Parent and Family Drug Support program, providing additional support groups and courses in Fremantle and online. This expansion will continue in 2022-23.

Mental Health Inpatient Snapshot Survey

The Mental Health Inpatient Snapshot Survey (MHISS) is conducted annually across all publicly-funded, specialised mental health inpatient facilities in WA. The purpose is to provide a point-in-time, State-wide snapshot of the number of mental health inpatients who could be discharged if appropriate accommodation, treatment and support services were available, and the types and intensity of services required. The results of the MHISS 2021 were published in September 2021 and provide important evidence for decision-making in relation to the planning of hospital-based, and community-based accommodation, and mental health treatment and support services.

Of all in-scope mental health inpatient beds, 96% were occupied on the census date. Of these clients, 23.5% (152) could have been discharged if the appropriate accommodation and/or treatment and support services were available. 88% of these inpatients (134) required accommodation with mental health treatment or support in order to be discharged. Of the inpatients needing both accommodation and mental health support, four in five did not have a fixed address to return to and half had co-occurring AOD issues.

This information is used to support initiatives to help reduce pressure on emergency departments and inpatient beds, such as the Long Stay Patient Project, Active Recovery Teams, Step Up/Step Down and Independent Community Living Strategy. These initiatives, informed by the MHISS, are all actively working to support relieving immediate pressures and other medium to long term projects that will lead to system reform. More information on the MHISS, previous results and initiatives to reduce pressures on inpatient beds can be found on the MHISS webpage: www.mhc.wa.gov.au/reports-and-resources/reports/mental-health-inpatient-snapshot-survey/.

Key Achievements

Treatment services

Treatment services provide clinical care to people with mental health or AOD issues. They include counselling services in the community, hospital services and services for people in the justice system (forensic services).

In 2021-22 we invested:

- **$891.7 million** for mental health services.
  - This includes $464.7 million for public mental health inpatient hospital beds which is managed 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).
- **$61.6 million** for AOD services.

Challenges:

- Uplifting existing services and establishing new services delivered by HSPs and NGOs has been impacted by a lack of accommodation needed for staff and clients, particularly in regional and remote areas. We continue to work with service providers and our wider networks to address this issue however some timeframes for expanded service delivery have increased.
- We recognise and acknowledge that the complexity of issues our clients experience is increasing. Ensuring our procurement processes consider capacity building within organisations, including training and workforce development and the importance of peer workers and Aboriginal health workers, are some ways we are seeking to address this.

Community treatment services

In 2021-22 we:

- Consolidated Active Recovery Teams (ART) in seven sites across HSPs in the metropolitan area as part of a pilot project. The teams are a partnership between HSPs and NGOs to provide a model of service that engages and supports individuals and families with complex needs in recovering from an acute or crisis episode through a combination of clinical and peer-based care. The provision of timely, high quality recovery planning and crisis response for individuals with complex needs recovering from an acute or crisis episode is helping people to maintain their recovery trajectory after the 90-day period. This may minimise future presentations to EDs and prolonged inpatient stays.
- Expanded operation of the Youth Community Assessment and Treatment Teams (YCATT). YCATT is a community outreach service that uses a client-centred, recovery-focused approach to youth mental health. The model includes a consultant psychiatrist, psychiatric registrars, mental health nurses, a social worker and a clinical psychologist. It provides community-based assessment and intensive case management for up to 90 days. This year we funded expansion of the SMHS service which commenced operation in May, and the establishment of a new EMHS service which opened in April. The NMHS has commenced recruitment of YCATT staff ready for service commencement in 2022-23.
- Allocated more than $1.295 million to EMHS and NMHS to continue providing Psychiatric Hostel Clinical In-reach to hostel residents. This funding allowed services to focus on optimising residents' physical and mental health outcomes, including employing multidisciplinary project teams to assist.
- Funded SMHS for an Eating Disorder Intensive Outpatient Service where people with eating disorders can receive some clinical intervention. Further expansions to Eating Disorder services will occur in the next financial year.

This year we funded expansion of the SMHS service which commenced operation in May, and the establishment of a new EMHS service which opened in April

Key Achievements

- Started research and consultation on the Body Esteem Project, an expansion of the Women's Health and Family Services program for eating disorders. The service is to be extended to support youth aged 16+, be inclusive of all genders and provide additional support to family and regional WA through online supports. A pilot is expected to commence in 2023.
- Successfully realigned governance of the Youth Reach South service to where services are needed and provided, from NMHS to SMHS, in June 2022. The service provides counselling, therapy and case management to young people aged 13 to 24 years with mental health issues who live in the south metropolitan area and experience barriers to accessing mainstream services.

AOD treatment services

In 2021-22 we:

- Completed community consultation for all 13 State-wide Community Alcohol and Drug Services (CADS) in September 2021. CADS provide non-residential alcohol and drug treatment and prevention services. Following recommendations arising from consultation we undertook an open tender process for the eight regional CADS services, worth approximately $111 million over seven years, with new service agreements to commence in the next financial year. The new agreements require services to be provided to people over 12 years, an increased emphasis on a peer and Aboriginal workforce, and capacity to provide services for people with mental health comorbidities.
- Finalised the IDACC Service Model in June 2022, following additional targeted consultation with key stakeholders. The IDACC will be a first for WA – helping to address the gap in AOD short-term crisis intervention services identified by families in the Methamphetamine Action Plan Taskforce Report. It also aligns with recommendations from the AOD Crisis Intervention Service System community consultation completed in 2020. The Commission undertook additional consultation to ensure the IDACC will effectively meet the needs of individuals in AOD crisis. Consultation involved significant engagement with government agencies, service providers, potential referrers, consumers, families and carers to seek their views on how the draft Model of Service could be improved to better meet the needs of people in AOD crisis, as well as families and carers. Procurement will commence next financial year.

IDACC a first for WA

helping to address the gap in AOD short-term crisis intervention services identified by families in the Methamphetamine Action Plan Taskforce Report

Next Step Drug and Alcohol Services

In 2021-22 we:

Next Step is funded and run by the Commission to provide a range of treatment services for people experiencing problems associated with their alcohol and other drug use, as well as support for families. Services include:

- Outpatient services at East Perth and via integrated Community Alcohol and Drug Services at six metropolitan locations
- The Inpatient Withdrawal Unit at East Perth
- Outpatient and medical support for young people via the integrated Drug and Alcohol Youth Service
- Community Pharmacotherapy Program for opioid dependence

Treatment Episodes*		
Primary Drug	**Outpatient CADS (including East Perth & DAYS)**	**NS Inpatient Unit**
Alcohol	699	481
Opioids	604	35
Cannabinoids	75	25
Benzodiazepines	46	21
Methamphetamine	42	10
Other	14	3
Amphetamine	11	7
TOTAL	**1491**	**582**

** Episodes defined as "The period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers in which there is no change in the main treatment type or the principal drug of concern, and there has not been a non-planned absence of contact for greater than three months." AIHW METEOR Metadata Online Registry Episode of treatment for alcohol and other drugs—treatment type (aihw.gov.au)*

Community Pharmacotherapy Program	
APPLICATIONS	
Community	754
Prison	254
Temporary Transfer	20
TOTAL	**1028**
OF THESE	
Prison release	153
S8 applications*	Supported 38, not supported 5
POD T	Renewals 20, new applications 5
New pharmacies	10
COVID third party/pharmacy delivery	98
New records made	981 (Not including renewals)
Records sent offsite	662

** S8 application to prescribe opioid substitution treatment*

The Community Pharmacotherapy Program also provides training and resources to medical practitioners and pharmacists who are, or wish to become, authorised to provide methadone and buprenorphine treatment.

We also:

- Commenced service delivery against a key election commitment to expand AOD treatment services in to the Peel region via the establishment of both community and hospital based AOD specialist treatment services. By expanding access to addiction medicine specialists and outpatient treatment services for people with AOD issues in the Peel area, Next Step is working to address the significantly unmet need in south metro WA.
  - An in-reach AOD specialist service into acute medicine and mental health has commenced at the Peel Health Campus
  - Additional in-reach services at Rockingham General Hospital and a fully integrated outpatient Next Step Drug and Alcohol Service in Mandurah are being finalised and expected to commence in the next financial year.
- This service achievement delivers on a number of key government objectives – the provision of addiction specialists into Western Australian hospitals, in particular Rockingham and Peel; reduction in risk and increase in safety for hospital staff; provision of methamphetamine community and hospital-based services; and the provision of locally accessible AOD treatment services for people in the Peel area. It also demonstrates Next Step's collaborative, partnered approach to service development with the SMHS, Peel Health Campus and NGOs working together to ensure that services are delivered effectively to the community of Peel and Rockingham.

Diversion programs

In 2021-22 we:

- Expanded the Mental Health Co-Response program to Geraldton in September 2021. The Geraldton model includes an Aboriginal mental health worker who provides culturally appropriate input and care, as well as a mental health practitioner. The Co-Response Geraldton model is the first of its kind in regional WA, with training for the Program also delivered by the Commission. We will continue to work with WAPF and HSPs to progress the overall expansion of the service both in the metropolitan area and into the regions. We have also been working with WAPF to develop the service model to provide a senior Aboriginal mental health worker and two AOD workers at the Perth Watch House. These additional staff will work in a team with the authorised Mental Health Practitioner to help manage people who have been detained and who are experiencing mental health and/or AOD issues.
- Monitored the Commission's revised Adult Model of Service for pre-sentence in Court Diversion – Alcohol and Other Drug Diversion Program which was implemented in January 2021. The program was developed in partnership with the Department of Justice and offers Magistrates a pre-sentence option for eligible adults who are in court and who are experiencing alcohol and other drug issues, to break the cycle of offending through specialist assessment and referral to treatment to address AOD use, addiction and related harm.
    - Since implementation there has been an increase in Aboriginal and Torres Strait Islanders who have commenced treatment at a specialist AOD treatment service as part of their court proceedings under the Alcohol and Other Drug Diversion Program, with new treatment episodes increasing 54% from 183 in 2020 to 283 in 2021.

Key Achievements

Sector development

There are more than 750 mental health and AOD services provided by five public health service providers (HSPs) and more than 100 community-based service providers across WA. The attraction, retention, continued growth and development of an appropriately skilled workforce is critical to achieving our vision of a Western Australian community that experiences minimal alcohol and other drug-related harms and optimum mental health.

Challenges:

- Attracting and retaining staff across all areas of health and human services currently is challenging and requires an innovative and collaborative approach. At the Commission we provide specialised training focussed on AOD-related issues including trauma-informed care, prevention, *Mental Health Act* online training, and we coordinate the Gatekeeper Suicide Prevention Training Program, adding significant value to workforce capacity building across the sector. We actively work with representatives from peak bodies who provide a voice for people with mental health, alcohol or other drug problems, their family and carers, including addiction medicine specialists to support the development of the workforce in a way that can sustainably meet current and predicted service demands.
- Peer workers are recognised as highly valuable in providing person-centred, recovery-focused services and are essential to enhancing care across the sector but the biggest risk to successfully embedding them in any system is organisations not being prepared. Peer workers may feel isolated, undervalued and not integrated, while clinicians may experience confusion about the role and concerned about peer work intervention. These issues can escalate to workplace stress and tension, absenteeism, wellbeing issues and ultimately the failure of the program. To mitigate these risks and ensure program viability the Commission is leading a range of initiatives to build and support a Lived Experience (Peer) Workforce in the mental health and AOD sector.

Workforce

This year we worked closely with the Department of Health across multiple levels to ensure a cohesive approach to workforce planning. The Commission's Chief Medical Officer, Mental Health participates in the Chiefs Forum and is a member of the newly formed Mental Health Workforce Planning Project Program Control Group along with member of the Commission's workforce team, to support the development and implementation of a cohesive, system-wide public mental health workforce plan. The purpose of the Program Control Group is to develop a network of expertise to collectively:

- identify and address the immediate, and impending, workforce needs of the mental health system, and
- support mental health workforce reform through innovative, responsive and data-driven planning.

The Project Control Group's first deliverable is an interprofessional Mental Health Workforce Action Plan to address current mental health clinical workforce shortages, and to ensure an adequate and sustainable mental health clinical workforce supply to support delivery of existing mental health services in WA, and their scheduled expansion.

Recognising the need to guide growth and development of an appropriately skilled and qualified workforce that provides high quality mental health and AOD services to the community, the Commission developed its Workforce Strategic Framework 2020-25 outlining priority areas for workforce planning and development, and principles to guide that. Building on that work, last year we developed an Implementation Plan to harness the success of achievements from within the Commission, including by our the Recognised Training Organisation SSSM which delivers certified qualifications in community services and AOD for the Aboriginal workforce; as well as a dedicated Workforce Development Team that provides tailored face-to-face and online programs for human services providers on

AOD-related issues including Trauma Informed Care and Practice, Volunteer AOD Counsellors Training Program, and foundational training for workers starting in the sector.

In 2021-22 our Workforce Development Team:

- Delivered 91 training events to 1,285 participants, totalling 612 hours of training. COVID-19 restrictions, lockdown and illness have had an impact on the numbers of events that were delivered as well as the number of participants that were able to attend training. On average participants evaluated training as follows:
  - 92.46% participants found the training 'a lot' to 'extremely' useful in relation to their work or study
  - 83.16% participants found their knowledge increased 'a lot' to 'extremely'
  - 79.69% participants felt that their confidence had increased 'a lot' to 'extremely'
  - 80.65% participants felt that their competence had increased 'a lot' to 'extremely'

Online learning

- 1,908 participants accessed our Workforce Development Alcohol and Other Drug online learning platform. eLearning programs developed during this period include the 'Alcohol and Other Drug Withdrawal' program and 'Opioid Overdose and the Use of Naloxone' program.
- This year digital portals were created to support Drug Education Support Service (DESS) workers and the 2022 Volunteer Drug and Alcohol Counsellors' Training Program intake. The portals house customised eLearning modules, online discussions and resources to complement participant face-to-face training.

1,908 participants

accessed our Workforce Development Alcohol and Other Drug online learning platform

Establishment of the Senior Organisational Consultant – eLearning position

- The Senior Organisational Consultant – eLearning position commenced at the Commission (Workforce Development) in March 2022. The objective of this role is to support digital learning initiatives across the Commission. This includes facilitating the creation, implementation, support and evaluation of digital learning material (e.g. eLearning modules) to assist the development of an appropriately skilled workforce.

AOD FDV cross sector capacity building WANADA

- In May 2022 Workforce Development delivered one day of AOD training to people working in the Men's Behaviour Change and Women's Refuge sectors as part of the Western Australian Network of Alcohol and other Drug Agencies (WANADA) AOD and Family and Domestic Violence Cross-Sector Capacity Building Project. All participants complete the MHC Introduction to Alcohol and Other Drugs – Part 1 online learning packages. Both the online learning and face-to-face training were well received.

Regional Frontline Worker training (MAPT)

- Workforce Development delivered regional Frontline Worker training on recognising and responding to methamphetamine and opioid use, throughout WA. Four events, with a total of 47 participants, were delivered this year. This number is down on previous years due to the impact of COVID-19 – previously we have held 12 events attended by on average 200 participants.

13,602 resources

produced by Workforce Development were disseminated to stakeholders in Western Australia during 2021/2022

Resource redevelopment

- The Here's to your Health resource, which provides information and strategies for people who wish to reduced harms from their alcohol use, was redeveloped during 2021/2022 to incorporate the updated Australian Guidelines to Reduce Health Risks from Drinking Alcohol released in 2020.
- The Alcohol and other drug (AOD) Terminology guide (2022), which provides information on stigma and non-stigmatising language in relation to alcohol and other drugs was released on the Mental Health Commission's website as an electronic resource.
- A total of 13,602 resources produced by Workforce Development were disseminated to stakeholders in Western Australia during 2021/2022.

Volunteer AOD Counsellors' Training Program

- The Volunteer AOD Counsellors' Training Program is a significant AOD sector capacity building program that has been delivered for more than 30 years.
- Throughout this year, adaptations were made to delivery of the training to ensure its continuation during COVID-19 restrictions, including the use of webinars and eLearning.
    - The 2021 MHC Volunteer AOD Counsellors' Training Program concluded at the end of October with the final weekend held at Muresk Campus in Northam.
    - A total of 20 participants completed the training program and commenced their 12-month placements as a Volunteer Alcohol and Other Drug Counsellor at a non-government alcohol and other drug agency.
- The 2022 intake of the Volunteer AOD Counsellors' Training Program commenced recruitment in March 2022; 23 people were offered a place in the program, with 22 commencing the course at the beginning of June.

In 2021-22 we also:

- Recruited two new Peer Practitioners to provide peer-based support to individuals calling the Here For You support line.

Peer Workforce

WA Lived Experience (Peer) Workforce Project

This year we've done considerable work leading the Lived Experience (Peer) Workforce Project (Project). In partnership with key stakeholders we are developing a co-designed framework that aims to guide the establishment of a thriving State-wide consumer, family and carer Lived Experience (Peer) Workforce across the mental health (including suicide prevention) and AOD sector. The Project includes developing:

- a Lived Experience (Peer) Workforces Framework, and
- strategies to build capacity of the peer workforces.

The soon to be published Lived Experience (Peer) Workforce Framework will be a practical guide for organisations who employ or are looking to employ, retain and make the most of their peer workers; and people who wish to become peer workers. The Framework will also be a useful resource for HSPs to enhance understanding of the value of peer workers and lived experience across their system.

- It encompasses the Personal Lived Experience (Consumer) and Family/ Significant Other workforces, noting there are commonalities and unique differences between these workforces which are detailed in the Framework.
- These roles may be combined within mentor roles in the Aboriginal workforce.
- The Framework covers the mental health, alcohol and other drug and suicide prevention sectors and both paid and volunteer roles.
- It's recognised these workforces across the sector may have different role types and practise distinct ways of working.
- These workforces are collectively referred to in the Framework as the Lived Experience (Peer) Workforces.
- Implementation strategies to support the outcomes are underway and include:
    - the scoping of a Lived Experience (Peer) Association
    - additional Certificate IV Mental Health Peer Work scholarships and support in partnership with Consumers of Mental Health WA (CoMHWA), the Australian Medical Association (AMA) and North Metropolitan TAFE
    - delivery of Mental Health Peer Work skill set
    - the development of Lived Experience (Peer) reflective practice supervision training
    - organisational readiness training.

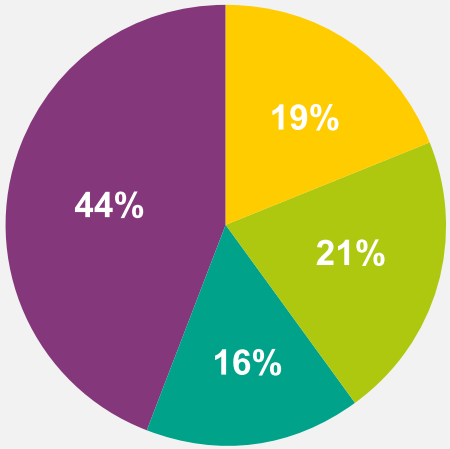
The Project has been informed by existing work including peer workforce reports, studies and guidelines, and aims to be consistent with the National Lived Experience Peer Workforce Guidelines. Engagement with more than 200 stakeholders using co-design principles took place in late 2021. Representatives from HSPs were briefed in June 2022 on work being undertaken to support implementing a peer workforce across the sector, including establishing Peer Work Coordinator Positions in HSPs. These roles will focus on preparing their organisations to understand, embrace and embed peer workers prior to recruitment.

Workshop success

More than 160 people took part in an interactive Lived Experience (Peer) Workforces Framework 'All of Stakeholder Workshop' in November 2021. Co-designed through seven exploratory, smaller in-person and online workshops with consumers, families, carers and service providers the purpose was to gain a greater understanding of peer services from the people who use them, the people who work in them and the organisations that offer them. Their contributions informed the Lived Experience (Peer) Workforce Project (Project) and Framework. Diversity of participants can be seen here:

Seven Pre-Design Workshops

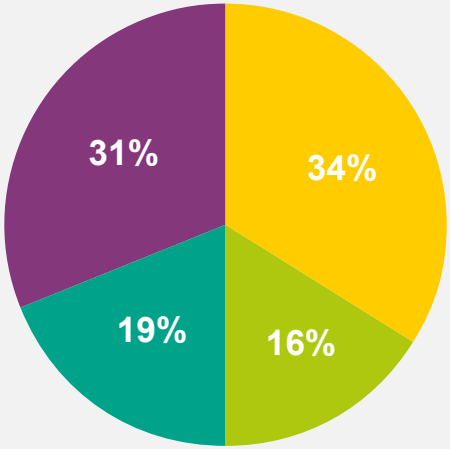
- Consumers and Lived Experience
- Family/Carer
- Service Providers
- Peer Worker



All of Stakeholder Workshop

- Consumers and Lived Experience
- Family/Carer
- Service Providers
- Peer Worker

- *160 participants - 31% AOD and 69% Mental Health*
- *4% identified as Aboriginal/ Torres Strait Islander, 4% as CaLD/ELD and 8% from the LGBTIQA+ community*



Participant Feedback

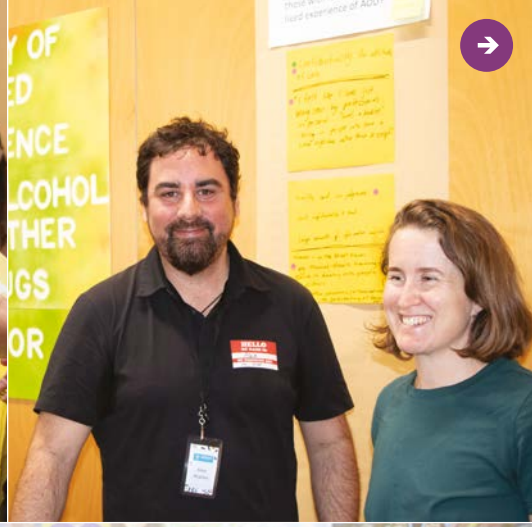
"Being able to interact with and meet so many people from mental health, alcohol and other drug and lived experience organisations was fantastic."

"So great to see how gender inclusive the event was - something I've only ever experienced at burlesque or drag shows! It was really great to see in a more professional context."

"Exceptional production delivery. Excellent participation from key stakeholders. Easy to participate. Great networking opportunity with peers sector-wide."

Held in a large open-planned gallery, participants interacted with people at themed tables that included:

- lived experience in the alcohol and other drug sector;
- family, carers and supporters;
- diversity of lived experience peer roles;
- organisational readiness;
- a peer association;
- lived experience peer leadership and principles.



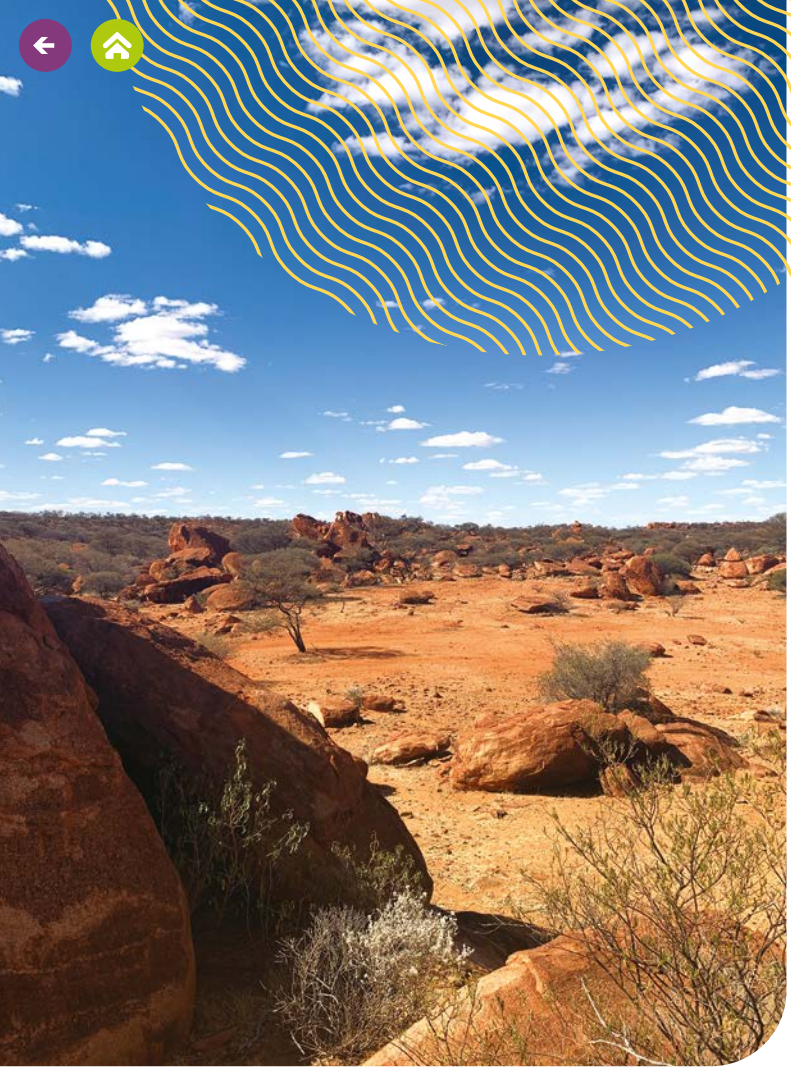
Partnerships

Key partnership engagement activities for the Commission this year had a significant focus on COVID-19 response and support, to ensure that mental health and alcohol and other drug services continued to be able to provide services to vulnerable cohorts in a safe manner. This is captured in our Significant Issues Impacting the Agency section.

Outside that work, in 2021-22 we:

- Co-chaired the Kimberley Aboriginal Youth Wellbeing Steering Committee (the Steering Committee) with the Kimberley Aboriginal Regional Governance Group (ARGG). The Steering Committee includes representatives from the ARGG and Directors General of State Government agencies. The purpose of the Steering Committee is to bring together all relevant WA Government agencies and Kimberley Aboriginal Community Controlled Organisations to support and enable Aboriginal community-led solutions to improve Aboriginal Youth Wellbeing outcomes in the Kimberley.
    - Current WA Government Agency membership on the Steering Committee includes:
        - Mental Health Commission
        - Department of the Premier and Cabinet
        - Western Australia Police Force
        - Department of Justice
        - Department of Education
        - Department of Communities
        - Department of Primary Industries and Regional Development
        - WA Country Health Service
        - Department of Health
        - Department of Treasury
        - Department of Local Government, Sport and Cultural Industries
        - Commissioner of Children and Young People.
    - The ARGG brings together seven key Kimberley ACCOs, Kimberley Land Council, Kimberley Language and Resource Centre, Kimberley Aboriginal Law and Culture Centre, Kimberley Aboriginal Medical Services, Kimberley Stolen Generation Aboriginal Corporation, West Kimberley Futures Empowered Communities, Empowered Communities East Kimberley (Binarri-binyja yarrawoo) and the Empowered Young Leaders into an interim regional governance arrangement to support this partnership.
    - Kimberley Aboriginal people have a long-standing aspiration for permanent regional governance which, when realised, will replace ARGG.
- Undertook significant work to contribute to the national mental health and suicide prevention strategic reform agenda, with the development of the first ever National Mental Health and Suicide Prevention Agreement. The Agreement, which came into effect on 8 March 2022, was developed in response to the Productivity Commission's Inquiry Report into Mental Health. The Agreement sets out the shared intention of the Commonwealth, state and territory governments to:
    - work in partnership to improve the mental health of all Australians
    - reduce the rate of suicide toward zero, and
    - ensure the sustainability and enhance the services of the Australian mental health and suicide prevention system.

  The associated Bilateral Schedule on Mental Health and Suicide Prevention: Western Australia was signed by the Western Australian Minister for Mental Health on 10 April 2022. The Bilateral Schedule will result in a $61.5 million investment in WA for mental health and suicide prevention over four years from 2022-23. Funding will be directed to:
    - a Child Health and Wellbeing Hub
    - State-wide Aftercare Services
    - Eating Disorder Services within the East Metropolitan Health Service.



- Updated and renewed our Memorandum of Understanding (MoU) with the Western Australian Primary Health Alliance (WAPHA) which facilitates joint planning, priority setting and commissioning of integrated care to enhance health outcomes. The MoU recognises the unique arrangement in WA whereby the working relationship between the Commission and WAPHA provides an opportunity for the two parties to work together in a coordinated and collaborative way to help influence system-wide improvements across mental health, AOD and suicide prevention services and programs.
  - It is acknowledged that the work of the partners most prominently intersects at the commissioning of community mental health, AOD and suicide prevention services. The updated MoU signifies the ongoing commitment to ensuring work related to this intersection is collaborative and well-coordinated.
  - The partnership also operates at the sector governance level. WAPHA is a member of the Commission-convened Community Mental Health, Alcohol and other Drug Council and the Co-Leadership Safety and Quality Mental Health Steering Group of the Mental Health Executive Committee.
  - The MoU also serves as a foundation for the development and implementation of joint regional mental health and suicide prevention plans – as outlined in the Fifth National Mental Health and Suicide Prevention Plan and the National Mental Health and Suicide Prevention Agreement.
  - The partnership provides a mechanism for addressing systemic problems which people with lived experience of mental illness or suicide and their carers and families currently face. Issues being addressed include fragmentation of services and pathways, service gaps, and duplication and inefficiencies in service provision.
- Strengthened collaborations with key agencies including the Department of Training and Workforce Development to progress training pathways for entry to, and upskilling in, mental health and AOD.
- Strong partnerships between non-government and government agencies will be key to creating positive and enduring change within the mental health and AOD system in WA. To support this, we have developed an Agency Commissioning Plan (ACP) as part of the State Commissioning Strategy focused on shaping a more cohesive and holistic approach to delivering sustainable human and community service outcomes in WA.
  - The ACP builds on the State Priorities plan and outlines the principles, Agency commissioning intentions and areas of focus over the next two to five-year period;
  - It is also supported by a Commissioning Schedule which will align current and new service agreements within program areas, detailing the stages of commissioning for each program over the next seven years.

Key Achievements

System supports and processes

In WA's mental health and AOD sector more than 100 organisations provide more than 600 services, supported by GPs and the wider health and community sector. Building a person-centred system where someone who needs help can access services that meet their individual needs is essential to achieving our vision of a Western Australian community that experiences minimal alcohol and other drug-related harms and optimum mental health.

Challenges:

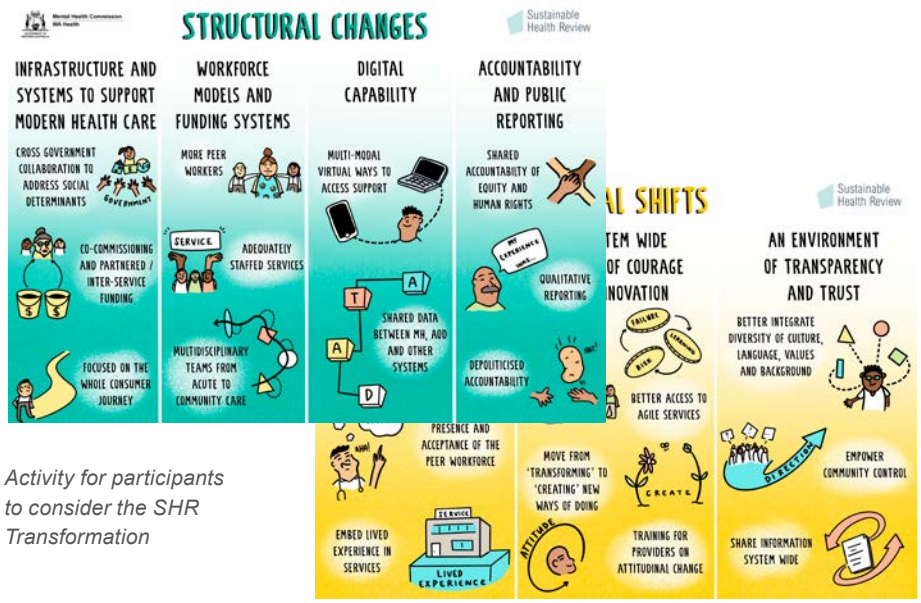
- The program of reform needed to build a truly integrated system that delivers better outcomes for people with mental health and AOD issues in WA is significant and will take several years to embed – there is no silver bullet for overnight success. But we are committed to continue working alongside families, NGOs and clinicians, and across government to address the most critical issues now while planning for longer-term needs.

Achieving effective mental health, alcohol and other drug systems and services that provide better outcomes for consumers is only possible through the collective action and coordinated effort between consumers, carers, support persons, clinicians, service providers, government agencies and non-government organisations.

Engagement

Sustainable Health Review Forum

The Sustainable Health Review (SHR) - Final Report continues to provide the blueprint for transforming the health system over the next 10 years to deliver equity in health outcomes, focus on prevention, and bring care closer to home. SHR Strategy 2 prioritises implementing models of care for people to access responsive and connected mental health services in the most appropriate setting, including early intervention, assessment and treatment outreach models to provide immediate assistance to people experiencing a mental health crisis in the community.



Activity for participants to consider the SHR Transformation

The second mental health, alcohol and other drug (AOD) sector-wide stakeholder forum was held on 20 October 2021 at the State Reception Centre, hosted by Sustainable Health Review (SHR) Strategy 2 Co-Leads Jennifer McGrath, Mental Health Commissioner and Liz MacLeod, Chief Executive East Metropolitan Health Service.

The forum was designed to build the engagement, leadership and partnership commitments required to deliver each of the Strategy 2 priorities. This forum had a particular focus on system transformation and the principles and practices required to deliver true system transformation.

There was a wide range of activities undertaken on the day including:

- a virtual overview of system transformation from Dr Norman Swan, Producer and Presenter of the Health Report on ABC Radio;
- a facilitated question and answer session on the practices and behaviours required for system transformation;
- an activity for participants to consider the SHR Transformation elements and their principles, and identify the practices and behaviours required for system transformation
- consultation on four new community-based models or initiatives (Transitional Care Unit, Community Care Unit, Community Treatment and Emergency Response, and the Western Australian Wellbeing Framework);
- an information session and activity on the development of an Outcomes Measurement Framework (OMF) for the WA State Priorities to support evidence-based decision-making; and consideration of what lived experience meant to Forum participants in one or two words.

The second mental health, alcohol and other drug (AOD) sector-wide stakeholder forum was held on 20 October 2021 at the State Reception Centre

Stakeholder Engagement Strategy

The Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018 – 2025 continues to provide a foundation for meaningful engagement across the Commission as well as external stakeholders. Applying the guiding principles of Safety, Authenticity, Humanity, Equity and Diversity naturally results in moving from a doing 'to' and 'for' approach, to a doing 'with' approach. Consequently, the Commission has seen an increase in lived experience participation particularly at leadership and decision-making levels across priority projects and initiatives.

We also initiated an internal Engagement Champions program as part of our overall Engagement Strategy launched in October 2021. This aims to increase capacity of each division to embed, coordinate and extend lived experience involvement for key planning and project work. A total of twelve people enrolled in the inaugural program which offers targeted including:

- Community & Stakeholder Engagement for Government Summit 2022
- IAP2 Engagement Essentials
- Approaches to support child mental health in culturally and linguistically diverse communities
- LGBTIQA+ Opening Closets Training

The Champions also meet online to discuss and share learnings to further their experience and progress their professional development. Additionally, we increased the number and type of designated lived experience roles (including employees and external advisors and consultants) within key projects to inform and guide our work and ensure the lived experience perspective is enshrined in everything we do.

The Stakeholder Connect e-newsletter commenced in December 2021 and is our primary communication tool for engagement. It provides an option for subscribers to tailor their feed to their specific areas of interest and/or experience, to ensure they receive updates and engagement opportunities relevant to them as individuals or organisations. The platform has been received enthusiastically, with subscriber numbers at:

- 269 organisations
- 1,563 community members
- 435 people with Lived Experience

Processes

Statutory review of the *Mental Health Act 2014*

A Statutory Review of the *Mental Health Act 2014* (the Act) is currently underway to identify those elements of the Act that work well and find opportunities for improvement. A Discussion Paper was published in August 2021 to support the public comment period from 13 August 2021 to 31 January 2022. Extensive consultation was undertaken with diverse groups, including people with a lived experience.

- 13 grants worth $188,148 (ex GST) were awarded to 12 organisations to facilitate face-to-face engagement sessions with a diverse array of lived experience stakeholders.
- More than 290 submissions were received from consumers, carers, and a range of government and non-government organisations. Analysis is underway with a Final Report and recommendations being developed.
- The Final Report will be tabled in Parliament, expected to be in 2022-23.

Graylands Reconfiguration and Forensic Taskforce (GRAFT)

The GRAFT's purpose is to oversee planning and development of contemporary services that meet the needs of Western Australians with a focus on the future of the Graylands Hospital site, the nearby Selby Older Adult Mental Health Service and Forensic Mental Health Services. We work closely with the Department of Health and other stakeholders to support this work, including forming and supporting the Lived Experience Advisory Group and Clinical Advisory Group to ensure that clinicians and people with lived experience are involved in decisions and planning about the services that impact them.

- In November 2021, following recommendations from Taskforce informed by both the Lived Experience and Clinical Advisory Groups the WA Government confirmed some high-quality services would be retained at Graylands as this was best for mental health consumers, carers and families, as well as the highly specialised workforce. (*reference A41 S1 20211118 p5708d-5708d.pdf (parliament.wa.gov.au)*)
- We continue to support progress on work to develop contemporary forensic mental health and rehabilitation services, including a model of care that will meet the diverse needs of consumers, carers and family members into the future.

Community Mental Health Treatment Services and Emergency Response Services Project (CTER)

We are leading the Community Mental Health Treatment Services and Emergency Response Services Project. The purpose of the project is to provide a clear vision for community mental health treatment and mental health emergency response services that will best meet the needs of people in Western Australia who require specialist community mental health care and/or emergency mental health care.

- A Steering Committee was appointed in May 2021 to oversee the Project and provide strategic oversight and guidance of the project.
- The Steering Committee is co-chaired by a Lived Experience Representative and the Chief Medical Officer Mental Health, Mental Health Commission. The Steering Committee includes clinical, lived experience, community peak body and Aboriginal representation.
- Phase one key achievements include a comprehensive literature review and commencement of stakeholder engagement to understand the challenges and opportunities.

Governance

The Commission continues to establish and cement itself as a leader in the mental health and AOD sector.

Mental Health Executive Committee

The Mental Health Executive Committee (MHEC) and the Community Mental Health, Alcohol and Other Drug Council (CMC) are the key mechanisms for implementing system and workforce transformation and delivering effective services to the community – both met quarterly this year.

The role of the MHEC is to strengthen integration and accountability within and across the public health system. The CMC strengthens collaboration between community services sectors.

In 2021-22, the MHEC and CMC discussions focussed on key strategic priorities:

- Community Mental Health Treatment Services, including Emergency Response Services Project
- Implementation of Infant Child and Adolescent Mental Health Taskforce recommendations (ICA)
- Mental Health, Alcohol and Other Drug Workforce planning
- Supporting the Graylands Reconfiguration and Forensics Taskforce (GRAFT)
- Long Stay Patient Project
- Oversight and information sharing of COVID-19 response across the sector
- Establishment of a Mental Health Transport Steering Group led by the Department of Health
- Finalising the Young Peoples Priority Action Plan across government
- Criminal Law (Mental Impairment) Bill Reform Bill progress
- Chief Psychiatrist's Review – Building rehabilitation and recovery services for people with severe enduring mental illness and complex needs, including those with challenging behaviour (2020).

In addition to the implementation of key government priorities, discussions at MHEC have centred around the emerging findings of other Mental Health and AOD key projects, and the intersection with reviews of existing services such as the recently completed Hospital in the Home (HiTH) Evaluation, the launch of MHC's Stakeholder Connect, progressing the actions of the Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025 including recruitment initiatives, progress towards the implementation of the Community Care Unit, the Mental Health Act Statutory Review, and the Mental Health National agenda.

In June 2022, the Minister for Mental Health reviewed the role of MHEC and determined it to be the appropriate forum to provide oversight and accountability for the implementation of key government strategies:

- Community Mental Health Treatment Services, including Emergency Response Services Project
- Implementation of Infant Child and Adolescent Mental Health Taskforce recommendations (ICA)
- Mental Health, Alcohol and Other Drug Workforce planning

As a result, the CMC quarterly meetings will now be held prior to MHEC to ensure timely consultation and inclusion of consumer, community and sector-wide perspectives to inform MHEC's decision-making process. Ad hoc out of session meetings are also being held as required. In addition, a sub-group of MHEC will provide a face-to-face update to the Minister for Mental Health after each quarterly meeting. This arrangement also serves to further strengthen the ties between MHEC and CMC.

The MHEC, CMC and MHLS are committed to engaging Lived Experience consumers and carer representation in decision-making and policy development. This has been essential throughout the planning, implementation and evaluation of MHEC projects.

Mental Health Leads Sub-Committee (MHLS)

The MHEC continued to be supported by the Mental Health Leads Sub-Committee (MHLS) which reports to and informs MHEC's decision-making. The purpose of MHLS is to assist the MHEC to lead the continuous development of a mental health and AOD system that is efficient, sustainable, evidence-based, recovery-focussed, co-designed, person-centred and integrated. MHLS is also responsible for facilitating and coordinating the operationalisation and implementation of the priorities, strategies and initiatives endorsed by the MHEC across the public health system, patient and sector flow, building leadership capacity in mental health services and ensuring clinical engagement in service planning and development.

The MHLS met monthly this year to:

- drive and operationalise system-wide improvements and reform
- help develop better treatment, care and support in the community
- consider the capacity and capabilities required by clinicians, service providers and consumers and carers in successfully transforming and implementing new services and building leadership capacity in mental health services.

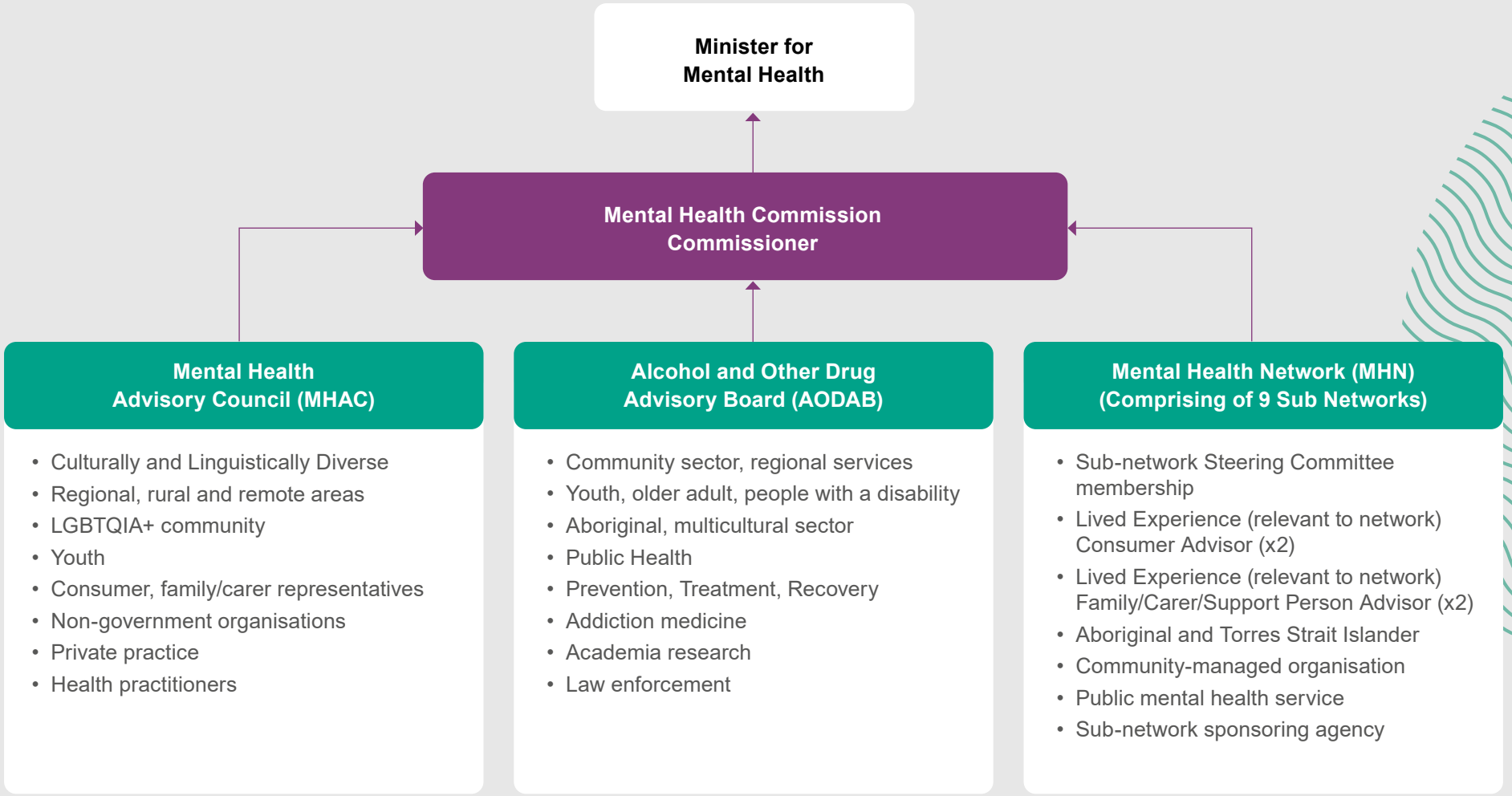
Chaired by Chief Medical Officer Mental Health with Deputy Chair as Director Treatment Services, membership includes Clinical and Executive mental health leads from each Health Service Provider, representatives from the Department of Health and the same carer and consumer representatives as MHEC and CMC, to provide consistency and oversight of consumer and carer perspectives across all issues and settings.

System Wide Data Working Group (SWDWG)

Established in 2021 to support the robust new governance mechanisms implemented to ensure system partners continue to provide shared leadership to deliver key system priorities, by undertaking time-limited data-related projects. These projects will provide advice in relation to the ongoing monitoring, reporting and evaluation of the Mental Health and AOD sector.

- The first project of the SWDWG is to develop an Outcomes Measurement Framework (OMF) to support evidence-based decision making and reporting on progress with achieving the outcomes anticipated in the State Priorities. The work is being undertaken in tranches. The first tranche of work included development of a draft Reporting Tool template and its Specification Guide, as well as a report titled 'Developing Lived Experience Outcome Indicators' which is available on the SWDWG webpage (https://www.mhc.wa.gov.au/about-us/sector-governance/system-wide-data-working-group/).
- Tranche two will include development of outcomes at the service stream and system levels and will also involve broader stakeholder consultation on the draft outcomes developed.

WA Mental Health, Alcohol and Other Drugs: Advisory Groups



Reporting Line →

Key Achievements

The **Alcohol and Other Drug Advisory Board (AODAB)** met bi-monthly to provide advice to the Commissioner on issues that require whole-of-government and cross-agency approach. The Board provides feedback on the effectiveness of the strategies adopted and actively contributes to problem solving and identifying potential improvements. This year saw the resignation of Chair Colleen Hayward AM, who has shown great dedication, passion and commitment to the AODAB since its inception on 2015. The AODAB is being ably led by Dr Mark Montebello until the Chair position is filled.

In 2021-22 the AODAB:

- Provided feedback on the Cross Government Western Australia Alcohol and Other Drug Strategy.
- Was consulted and provided feedback on the final report for the Immediate Drug Assistance Coordination Centre (IDACC).
- Provided advice to the Commissioner on the Commonwealth Kava Project and Volatile Substance Use.

The **Mental Health Advisory Council (MHAC)** met monthly (excluding January) to provide independent, strategic advice and guidance to the Commissioner on major issues affecting people with mental health problems, their families and service providers. MHAC works closely with the AODAB in joint consultations as appropriate. The Council values and respects diversity and works in an inclusive and accessible way with sensitivity to advocating for the most unheard voices.

In 2021-22 the MHAC:

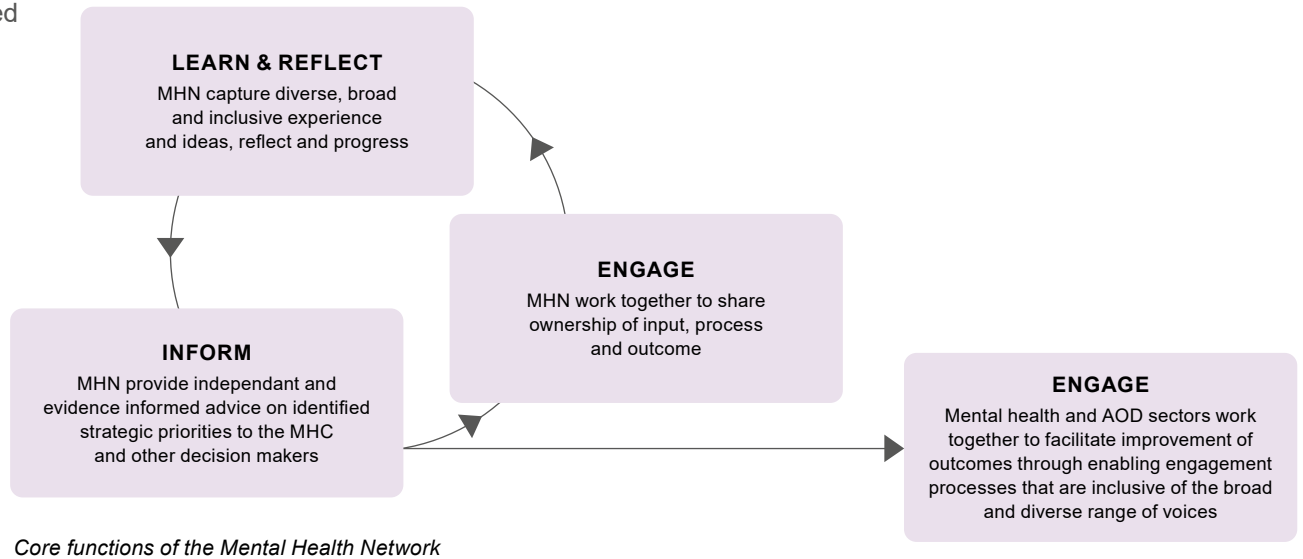
- Appointed two new members:
  - Jennifer Wilton, a registered nurse for the past 30 years who has been working as an endorsed Nurse Practitioner in the community for the past 12 years. Jen works with some of our most vulnerable community members to make positive changes in the health of homeless, Indigenous, CALD and people with lived experience of mental health issues.
  - Nafiso Mohamed, a young Somali Australian currently working for Services Australia. In 2020 Nafiso completed an internship at the United Nations Relief and Works Agency in Jordan focussing on combining gender mainstreaming with targeted interventions for women and girls as a tool to bridge historical gaps in gender equality, participation and access to services. She undertook research in Economic Development and Social Policy at the Centre for Strategic Studies, University of Jordan, and has engaged in various advocacy and mentor-based programs that support the inclusion of Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities in Australia through policy development and research evaluation.
- Appointed Patricia Councillor as Deputy Chair. Patricia is a Yamatji nyarlu (woman) from Meekatharra. Patricia has been working in mental health since 2009 and working as a mental health practitioner and counsellor since 2013. She has worked in government, non-government and Aboriginal controlled organisations. Patricia has been a carer for a family member with disability and mental health issues and she now shares her resources and pathways into mental health services with whoever asks.
- Provided verbal and written advice and feedback on a range of initiatives including the Graylands Reconfiguration and Forensics Taskforce, Immediate Drug Assistance Co-ordination Centre, Statutory Review of the Mental Health Act 2014 and the Workforce Strategic Framework.

- Provided advice to the Commissioner on a range of issues impacting Geraldton and the Midwest after an online meeting with regional representatives was held in place of the Council's annual visit which was postponed due to increased community spread of COVID-19.
- The MHAC continued to reflect its values of listening to the more unheard voices who may be most impacted by mental health, alcohol and other drug challenges by engaging with:
  - The Valuing Lived Experience Program at Curtin University
  - NDIS-related issues
  - Activities to better understanding and engage more effectively with LGBTIQ+ communities, primary healthcare and Lived Experience
  - (Peer) Workforce.

The **Mental Health Network** brings together nine specialised networks of independent entities that operate under the governance, and with the support, of the Commission, to identify and inform emerging needs in the mental health sector in Western Australia. This year we completed the Mental Health Network Governance and Strategic Alignment Project and committed to developing a new charter that reflects new system leadership and governance arrangements. The Commission is encouraging greater Mental Health Network contribution to important reform priorities, and the realignment project has provided best-practice structures and processes to ensure this.

The Mental Health Sub-Networks:

- Eating Disorders Mental Health Sub Network
- Forensic Mental Health Sub Network
- Multicultural Mental Health Sub Network
- Neuropsychiatry and Development Disability Mental Health Sub Network
- Older Adult Mental Health Sub Network
- Peel and Rockingham Kwinana Regional Mental Health Sub Network
- Perinatal and infant Mental health Sub Network
- Personality Disorders mental Health Sub Network
- Youth Mental Health Sub Network



Core functions of the Mental Health Network

Significant issues impacting the Agency

COVID-19 response

COVID-19 continues to impact people across Western Australia and has altered the way the Commission operates in response. This year we paused some areas of business as a significant number of staff switched focus to supporting COVID-19 initiatives developed internally to assist consumers across a range of groups.

COVID-19 Coordination and Communications Centre

There are 31 private psychiatric hostels (PPHs) in WA which accommodate approximately 700 of some of the most vulnerable people in our community. Clients can have severe co-occurring physical and mental health conditions associated with significant psychosocial disability. PPHs are high-risk environments in a pandemic and the workforce traditionally has limited clinical staffing.

This year's high-caseload settings and the potential for critical impact on some of our most vulnerable cohorts led us to establish the COVID-19 Coordination and Communications Centre (CC Centre). The objective of the CC Centre was to support the 31 PPHs to maintain the wellbeing of residents within their home-like environment wherever possible during periods of COVID-19 positive cases; a factor critical to minimising avoidable presentations to hospitals. This provided a framework for us to implement a range of strategies to support the hostels and their residents during these times. Support was also provided to other mental health and AOD residential services.

Key priorities were to ensure open collaboration and communication among services, regulatory bodies and government agencies. We worked collaboratively with relevant agencies to develop a coordinated approach to assist PPHs, taking direction from the State Health Incident Control Centre (SHICC) via Public Health Operations (PHOps) and the State Welfare Incident Control Centre (SWICC).

In 2021-22 the CC Centre:

- Provided additional mobile phones and tablets to enable residents to stay connected with their formal and informal supports online when face-to-face was not possible.
- Offered support to hostels to assist staff or residents with the use of technology and accessing online supports.
- Offered and delivered free Commission training to new staff engaged by private psychiatric hostels due to workforce shortages arising from the impacts of COVID-19.
- Delivered regular forums to provide PPHs with important updates and to promote information sharing.
- Ensured that relevant stakeholders including the Licensing and Accreditation Regulatory Unit, Office of the Chief Psychiatrist and the Mental Health Advocacy Service were kept informed of COVID-19 positive cases in PPHs.
- Provided initial contingency stocks of Personal Protective Equipment (PPE) and Rapid Antigen Tests (RATs) for use during confirmed COVID-19 cases/ COVID-19 outbreak.
- Sourced additional PPE and RATs when hostels' stocks ran low.
- Funded and coordinated fit testing of N95 masks for a range of metropolitan services. 482 staff from 33 supported accommodation and residential treatment services and other high-risk settings participated in fit testing.

- Contracted and facilitated provision of General Practitioner (GP) and/or nursing supports through Homeless Healthcare where hostels' own supports were unavailable.
- Distributed 200 pulse oximeters to hostels and other services such as metropolitan Community Alcohol Drug Services and some Sobering Up Centres.
- Ensured solutions to key issues were able to be scaled up or down through a staged approach to meet need, with minimal impact on residents and hostels.
- Established the Hostel COVID Contact Point; a dedicated telephone information and referral service manned by Commission staff which provided a single point of contact for PPHs experiencing COVID-19 related issues. Contact Point:
    - Was not an emergency line but provided PPHs with a single telephone number that connected them to Commission staff who were able to coordinate a response tailored to their specific needs.
    - Facilitated appropriate liaison with SHICC/PHOps which assisted PPHs to support residents in their current accommodation and out of the hospital environment.
    - Helped PPHs where possible to implement directions provided by PHOps.
    - Referred PPHs to supports provided by the CC Centre such as Personal Protective Equipment and to external services such as the Western Australian Council of Social Service Surge workforce and cleaning grants.
- While the majority of the CC Centre's functions related to PPHs, it also assisted in providing additional:
    - PPE to 84 mental health and AOD NGO services
    - RATs to 132 mental health and AOD NGO services

Other initiatives

- Additional funding for immediate assistance:
    - Up to $2.5 million funding committed to enable the 31 PPHs remain operational during COVID-19 positive outbreaks.
    - This one-off, non-recurrent grant funding helped to mitigate workforce shortages due to COVID-19 impacts and enabled hostel staff to support COVID-19 positive individuals in-situ.
    - Grants enabled PPHs to access supports such as assistance with additional cleaning, staffing shortages and purchasing of activity-based items for use by residents while isolating.

Grant recipients are required to undertake an acquittal process to ensure probity on spending within 30 days of the Grant Agreement expiring. Activity and financial reporting requirements outlined in the Grant Agreement are to be completed as part of the acquittal process and all underspends will need to be repaid to the Commission.

COVID-19 response

In 2021-22 the Coordination and Communications Centre provided additional mobile phones and tablets to enable residents to stay connected with their formal and informal supports online when face-to-face was not possible

PPE and RATS

More broadly we assisted Commission-funded mental health and AOD services through the provision of Rapid Antigen Tests (RATs) and/or Personal Protective Equipment (PPE). In total we distributed 281,382 items of PPE including masks, gowns and face shields, and 136,790 RATs to service providers.

PPE Distribution	
PPE Item	**Number Distrubuted**
N95 masks	136,467
Surgical masks	102,000
Gowns	34,270
Face shield	665
Gloves	5,355
Goggles	2,495
Hairnets	130
Total	**281,382**

Pulse Oximeters

We distributed 200 pulse oximeters to hostels and other services such as metropolitan CADS and some Sobering Up Centres. A pulse oximeter is a routine, non-invasive monitoring device which clips onto a person's finger. Pulse oximeters measure the amount of oxygen in a person's blood, which it shows as a percentage, as well as the person's heart rate.

In total we distributed 281,382 items of PPE including masks, gowns and face shields, and 136,790 RATs to service providers

Mental wellbeing campaign launched in 2022 to support the WA community through COVID-19 and other stressors

The ‘Learn to Look After You’ campaign

In February 2022, in partnership with specialist mental health provider THIS WAY UP and non-government organisation partner Cancer Council WA, we launched a new State-wide Think Mental Health campaign called ‘Learn to Look After You’. The campaign was developed in response to increasing community anxiety associated with COVID-19 in the WA community.

‘Learn to Look After You’ aimed to increase community wellbeing by promoting practical, evidence-based strategies people can integrate into their lives to help manage how they feel and to reduce stress and anxiety.

The ‘Learn to Look After You’ campaign was advertised across WA, led by State-wide TV and supported by cinema, catch-up TV, radio, press, social media, digital advertising and paid search. Advertising referred people to thinkmentalhealthwa.com.au for more information and advice about how to support their mental health and wellbeing.

Preliminary evaluation data found of the WA adults (aged 18 years and above) who recalled the campaign, four in five (82%) reported successfully implementing at least one of the evidence-based actions promoted in the ‘Learn to Look After You’ campaign.

Disclosures and Legal Compliance

Auditor General

INDEPENDENT AUDITOR'S REPORT
2022
Mental Health Commission

To the Parliament of Western Australia

Report on the audit of the financial statements

Opinion

I have audited the financial statements of the Mental Health Commission (Commission) which comprise:

- the Statement of Financial Position at 30 June 2022, and the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash Flows for the year then ended
- Administered schedules comprising the Administered assets and liabilities at 30 June 2022 and the Administered income and expenses by service for the year then ended
- Notes comprising a summary of significant accounting policies and other explanatory information.

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 2022 and the financial position at the end of that period
- in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

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

Responsibilities of the Commissioner for the financial statements

The Commissioner is responsible for:

- keeping proper accounts
- preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions
- such internal control as it 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 entity's ability to continue as a going concern
- disclosing, as applicable, matters related to going concern
- 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 responsibilities 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. 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.

A further description of my responsibilities for the audit of the financial statements is located on the Auditing and Assurance Standards Board website. This description forms part of my auditor's report and can be found at https://www.auasb.gov.au/auditors_responsibilities/ar4.pdf.

Report on the audit of 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 Commissioner are those policies and procedures established 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).

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 2022.

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 were implemented as designed.

An assurance engagement involves performing procedures to obtain evidence about the suitability of the controls design to achieve the overall control objectives and the implementation of those controls. The procedures selected depend on my judgement, including an 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 in operation, the overall control objectives may not be achieved so that fraud, error or non-compliance 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 audit of 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 2022. The key performance indicators are the Under Treasurer-approved key effectiveness indicators and 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 2022.

Matter of Significance

The Commission received an exemption from the Under Treasurer from reporting 7 key efficiency indicators for the year ended 30 June 2022 as outlined in the Treasury Exempted Key Efficiency Indicators section of the audited key performance indicators report. The exemption was approved due to difficulties in the Commission's ability to complete its validation audit for these key efficiency indicators within the required timeframe, because of COVID-19 restrictions.

Consequently, these key performance indicators have been reported as estimates and have not been audited. My opinion is not modified in respect of this matter.

The Commissioner's responsibilities 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 responsibilities

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 entity'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 report on financial statements, 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.

Other information

The Commissioner is responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2022, but not the financial statements, key performance indicators and my auditor's report.

My opinions on the financial statements, controls and key performance indicators do not cover the other information and, accordingly, I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, controls and key performance indicators, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements and key performance indicators or my knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I did not receive the other information prior to the date of this auditor's report. When I do receive it, I will read it and if I conclude that there is a material misstatement in this information, I am required to communicate the matter to those charged with governance and request them to correct the misstated information. If the misstated information is not corrected, I may need to retract this auditor's report and re-issue an amended report.

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 2022 included in the annual report 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, controls and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from the annual report. 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 contact the entity to confirm the information contained in the website version.

Sandra Labuschagne
Deputy Auditor General
Delegate of the Auditor General for Western Australia
Perth, Western Australia
16 September 2022

Certification of financial statements

For the reporting period ended 30 June 2022

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 2022 and the financial position as at 30 June 2022.

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.

Cameron Patterson
Chief Financial Officer
Mental Health Commission

16 September 2022

Kim Lazenby
A/Commissioner
Mental Health Commission
Accountable Authority

16 September 2022

Mental Health Commission
Statement of Comprehensive Income
For the year ended 30 June 2022

	Notes	2022 $	2021 $
COST OF SERVICES			
Expenses			
Employee benefits expenses	3.1 (a)	43,838,664	38,141,838
Service agreement - WA Health	3.2	853,720,231	772,960,840
Service agreement - non government and other organisations	3.2	172,717,886	161,783,732
Grants and subsidies	3.3	21,733,856	12,386,050
Supplies and services	3.4	20,207,758	14,262,445
Depreciation expense	5.1.1 & 5.2	523,795	520,540
Finance costs	5.2 & 7.3	6,148	5,252
Accommodation expenses	3.5	2,832,343	2,236,157
Other expenses	3.6	3,176,062	2,400,774
Total cost of services		**1,118,756,743**	**1,004,697,628**
Income			
Commonwealth grants and contributions	4.2	386,222	1,339,105
Other income	4.3	1,686,284	342,891
Total income		**2,072,506**	**1,681,996**
NET COST OF SERVICES		**1,116,684,237**	**1,003,015,632**
Income from State Government			
Service appropriation	4.1	822,170,000	722,496,000
Service agreement funding - Commonwealth	4.1	298,568,840	252,582,940
Income from other public sector entities	4.1	3,792,771	4,521,841
Resources received	4.1	2,253,956	1,888,825
Royalties for Regions Fund	4.1	17,258,000	15,321,000
Total income from State Government		**1,144,043,567**	**996,810,606**
SURPLUS/(DEFICIT) FOR THE PERIOD		**27,359,330**	**(6,205,026)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation surplus	9.10	791,190	103,534
Total other comprehensive income		**791,190**	**103,534**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**28,150,520**	**(6,101,492)**

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

Mental Health Commission
Statement of Financial Position
As at 30 June 2022

	Notes	2022 $	2021 $
ASSETS			
Current Assets			
Cash and cash equivalents	7.4.1	55,808,799	29,327,176
Restricted cash and cash equivalents	7.4.1	8,696,458	5,557,800
Receivables	6.1	702,759	251,641
Inventories	6.3	13,234	16,066
Other current assets	6.4	101,829	-
Total Current Assets		**65,323,079**	**35,152,683**
Non-Current Assets			
Restricted cash and cash equivalents	7.4.1	928,930	631,101
Amounts receivable for services	6.2	7,407,123	6,992,123
Property, plant and equipment	5.1	19,728,335	17,409,859
Right-of-use assets	5.2	112,234	126,039
Total Non-Current Assets		**28,176,622**	**25,159,122**
TOTAL ASSETS		**93,499,701**	**60,311,805**
LIABILITIES			
Current Liabilities			
Payables	6.5	3,040,055	2,234,762
Employee related provisions	3.1 (b)	7,493,873	7,042,957
Lease liabilities	7.1	37,933	40,930
Total Current Liabilities		**10,571,861**	**9,318,649**
Non-Current Liabilities			
Employee benefits provisions	3.1 (b)	2,131,564	2,040,777
Lease liabilities	7.1	78,361	87,984
Total Non-Current Liabilities		**2,209,925**	**2,128,761**
TOTAL LIABILITIES		**12,781,786**	**11,447,410**
NET ASSETS		**80,717,915**	**48,864,395**
EQUITY			
Contributed equity	9.10	37,385,891	33,682,891
Reserves	9.10	1,040,746	249,556
Accumulated surplus	9.10	42,291,278	14,931,948
TOTAL EQUITY		**80,717,915**	**48,864,395**

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

Mental Health Commission
Statement of Changes in Equity
For the year ended 30 June 2022

	Notes	2022 $	2021 $
CONTRIBUTED EQUITY	9.10		
Balance at start of period		33,682,891	34,451,091
Transactions with owners in their capacity as owners:			
Capital appropriation		666,000	4,103,000
Other contribution by owners - Royalties for Region Fund		3,037,000	7,061,000
Distribution to owner - Department of Planning, Land and Heritage		-	(4,000,000)
Other distribution to owner - Department of Communities		-	(7,932,200)
Balance at end of period		**37,385,891**	**33,682,891**
RESERVES			
Asset Revaluation Reserve			
Balance at start of period		249,556	146,022
Other comprehensive income for the period		791,190	103,534
Balance at end of period		**1,040,746**	**249,556**
ACCUMULATED SURPLUS	9.10		
Balance at start of period		14,931,948	21,136,974
Surplus/(deficit) for the period		27,359,330	(6,205,026)
Balance at end of period		**42,291,278**	**14,931,948**
TOTAL EQUITY	9.10		
Balance at start of period		48,864,395	55,734,087
Total comprehensive income/(loss) for the period		28,150,520	(6,101,492)
Transactions with owners in their capacity as owners		3,703,000	(768,200)
Balance at end of period		**80,717,915**	**48,864,395**

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

Mental Health Commission
Statement of Cash Flows
For the year ended 30 June 2022

	Notes	2022 $	2021 $
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		821,755,000	722,086,000
Capital appropriations	9.10	666,000	4,103,000
Service agreement funding - Commonwealth		298,568,840	252,582,940
Income from other public sector entities		3,661,876	4,394,947
Royalties for Regions Fund - Capital	9.10	3,037,000	7,061,000
Royalties for Regions Fund - Recurrent		17,258,000	15,321,000
Payment to Department of Communities - Royalties for Regions capital	9.10	-	(6,909,000)
Return of Royalties for Regions Fund	4.1	-	(44,000)
Net cash provided by State Government		**1,144,946,716**	**998,595,887**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits expenses		(42,930,699)	(37,261,852)
Service agreement - WA Health		(853,720,231)	(772,960,840)
Service agreement - non government and other organisations		(172,220,128)	(161,579,729)
Grants and subsidies		(21,733,856)	(12,386,050)
Supplies and services		(18,225,443)	(12,509,351)
Finance costs		(6,148)	(5,252)
Accommodation expenses		(2,800,139)	(2,223,210)
Other payments		(3,285,478)	(2,352,272)
Receipts			
Commonwealth grants and contributions		386,222	1,339,105
Other receipts		1,071,198	275,681
Net cash used in operating activities	7.4.2	**(1,113,464,702)**	**(999,663,770)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets	5.1	(1,510,738)	(1,792,605)
Net cash used in investing activities		**(1,510,738)**	**(1,792,605)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Lease payments		(53,166)	(56,009)
Net cash used in financing activities		**(53,166)**	(56,009)
Net increase / (decrease) in cash and cash equivalents		29,918,110	(2,916,497)
Cash and cash equivalents at the beginning of the period		35,516,077	38,432,574
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.4.1	**65,434,187**	**35,516,077**

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

Mental Health Commission
Summary of consolidated account appropriations
For the year ended 30 June 2022

	2022 Budget $	2022 Supplementary Funding $	2022 Revised Budget $	2022 Actual $	2022 Variance $
Delivery of Services					
Item 53 Net amount appropriated to deliver services	819,059,000	2,300,000	821,359,000	821,359,000	-
Amount Authorised by Other Statutes					
- *Salaries and Allowances Act 1975*	811,000	-	811,000	811,000	-
Total appropriations provided to deliver services	**819,870,000**	**2,300,000**	**822,170,000**	**822,170,000**	**-**
Capital					
Item 125 Capital appropriations	7,608,000	-	7,608,000	666,000	(6,942,000)
Administered Transactions					
Administered grants, subsidies and other transfer payments	11,254,000	-	11,254,000	11,254,000	-
Total administered transactions	**11,254,000**	**-**	**11,254,000**	**11,254,000**	**-**
GRAND TOTAL	**838,732,000**	**2,300,000**	**841,032,000**	**834,090,000**	**(6,942,000)**

Mental Health Commission
Administered Schedules
For the year ended 30 June 2022

Administered income and expense by service	Hospital Bed Based Services	Hospital Bed Based Services
INCOME FROM ADMINISTERED ITEMS	**2022**	**2021**
Income	**$**	**$**
Appropriations from Government for transfer to :		
Mental Health Tribunal	3,577,000	2,740,000
Mental Health Advocacy Service	3,703,000	2,858,000
Office of Chief Psychiatrist	3,974,000	3,272,000
Service received free of charge (a)	1,272,743	1,209,902
Other revenue	140,586	12,884
Total administered income	**12,667,329**	**10,092,786**
Expenses		
Employee benefits expense	9,171,073	7,978,012
Supplies and services	2,169,483	1,477,036
Depreciation expense	18,466	11,699
Finance costs	1,120	412
Accommodation expense	385,170	408,849
Other expenses	298,509	201,296
Total administered expenses	**12,043,821**	**10,077,304**

(a) Service received free of charge in 2021-22 includes $1,215,959 ($1,135,206 in 2020-21) from MHC (refer to note 9.11 'Services provided free of charge'), $20,436 ($22,318 in 2020-21) from the State Solicitor's Office and $36,347 from Department of Finance ($52,378 in 2020-21).

Mental Health Commission
Administered Schedules
For the year ended 30 June 2022

Administered assets and liabilities	2022 $	2021 $
Current Assets		
Cash and cash equivalents	2,665,620	1,870,620
Receivables	64,961	11,703
Total Administered Current Assets	**2,730,581**	**1,882,323**
Non-Current Assets		
Right-of-use assets	36,267	13,943
Total Administered Non-Current Assets	**36,267**	**13,943**
TOTAL ADMINISTERED ASSETS	**2,766,848**	**1,896,266**
Current Liabilities		
Payables	277,906	257,920
Provision	1,646,173	1,476,819
Lease Liabilities	12,131	8,489
Total Administered Current Liabilities	**1,936,210**	**1,743,228**
Non-Current Liabilities		
Provision	188,706	153,561
Lease Liabilities	24,705	5,759
Total Administered Non-Current Liabilities	**213,411**	**159,320**
TOTAL ADMINISTERED LIABILITIES	**2,149,621**	**1,902,548**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

1. Basis of preparation

The Mental Health Commission (MHC) is a WA Government entity, controlled by the State of Western Australia which is the ultimate parent. The MHC is a not-for-profit entity (as profit is not its principal objective).

Statement of compliance

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

The FMA and the TIs take precedence over AASs. Several AASs are modified by the TIs to vary application, disclosure format and wording. Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

Basis of preparation

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

Judgements and estimates

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

Accounting for Good and Services Tax (GST)

Income, expenses and assets are recognised net of the amount of goods and services tax (GST), except that the:
(a) amount of GST incurred by the MHC as a purchaser that is not recoverable from the Australian Taxation Office (ATO) is recognised as part of an asset's cost of acquisition or as part of an item of expense; and
(b) receivables and payables are stated with the amount of GST included.

Contributed equity

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 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.

Administered items

The MHC administers, but does not control, certain activities and functions for and on behalf of Government that do not contribute to the MHC's services or objectives. It does not have discretion over how it utilises the transactions in pursuing its own objectives. Transactions relating to the administered activities are not recognised as the MHC's income, expenses, assets and liabilities, but are disclosed in the accompanying schedules as 'Administered income and expenses', and 'Administered assets and liabilities'. The accrual basis of accounting and applicable AASs have been adopted.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

2. The MHC outputs

How the MHC operates

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

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

2.1 The MHC's objectives

Mission

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

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

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

Services

The MHC 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 MHC provides the following services.

Prevention

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

Hospital Bed Based Services

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

Community Bed Based Services

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

Community Treatment

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

Community Support

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

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

2.2 Schedule of Income and Expenses by Service

	Prevention		Hospital Bed Based Services		Community Bed Based Services		Community Treatment		Community Support		Total	
	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021
	$	$	$	$	$	$	$	$	$	$	$	$
COST OF SERVICES												
Expenses												
Employee benefits expenses	1,046,340	773,216	18,589,358	16,260,666	3,148,077	2,601,121	18,765,812	16,391,596	2,289,077	2,115,239	43,838,664	38,141,838
Service agreement - WA Health	20,376,565	15,669,565	362,011,744	329,529,421	61,306,091	52,712,838	365,448,033	332,182,786	44,577,798	42,866,230	853,720,231	772,960,840
Service agreement - non government and other organisations	4,122,425	3,279,700	73,239,336	68,971,799	12,402,961	11,033,004	73,934,539	69,527,159	9,018,625	8,972,070	172,717,886	161,783,732
Grants and subsidies	518,743	251,092	9,216,030	5,280,433	1,560,719	844,679	9,303,510	5,322,951	1,134,854	686,895	21,733,856	12,386,050
Supplies and services	482,318	289,130	8,568,903	6,080,379	1,451,130	972,642	8,650,241	6,129,340	1,055,167	790,955	20,207,758	14,262,445
Depreciation expense	12,502	10,552	222,110	221,917	37,614	35,499	224,218	223,704	27,350	28,868	523,795	520,540
Finance costs	147	106	2,607	2,239	441	358	2,633	2,258	321	291	6,148	5,252
Accommodation expenses	67,602	45,332	1,201,027	953,321	203,392	152,497	1,212,428	960,997	147,893	124,010	2,832,343	2,236,157
Other expenses	75,806	48,669	1,346,778	1,023,500	228,075	163,723	1,359,562	1,031,742	165,841	133,140	3,176,062	2,400,774
Total cost of services	26,702,448	20,367,361	474,397,893	428,323,675	80,338,500	68,516,361	478,900,976	431,772,533	58,416,927	55,717,698	1,118,756,743	1,004,697,628
Income												
Commonwealth grants and contributions	-	-	-	-	-	-	386,222	1,339,105	-	-	386,222	1,339,105
Other income	134,445	2,612	674,133	54,855	114,163	28,735	680,531	249,522	83,012	7,167	1,686,284	342,891
Total income	134,445	2,612	674,133	54,855	114,163	28,735	1,066,753	1,588,627	83,012	7,167	2,072,506	1,681,996
NET COST OF SERVICES	26,568,003	20,364,749	473,723,760	428,268,820	80,224,337	68,487,626	477,834,223	430,183,906	58,333,915	55,710,531	1,116,684,237	1,003,015,632
Income from State Government												
Service appropriation	24,290,104	17,305,128	312,920,621	278,001,817	72,192,167	60,111,714	353,721,521	312,534,082	59,045,587	54,543,258	822,170,000	722,496,000
Service agreement funding - Commonwealth	-	-	171,448,828	146,797,975	-	-	127,120,012	105,784,965	-	-	298,568,840	252,582,940
Income from other public sector entities	1,923,000	2,652,541	-	18,450	-	2,943	1,869,771	1,845,496	-	2,411	3,792,771	4,521,841
Resources received	53,797	38,291	955,768	805,246	161,858	128,810	964,840	811,730	117,692	104,749	2,253,956	1,888,825
Royalties for Regions Fund	954,113	243,000	-	-	9,835,000	7,821,000	5,869,659	6,541,000	599,228	716,000	17,258,000	15,321,000
Total income from State Government	27,221,014	20,238,960	485,325,217	425,623,488	82,189,025	68,064,468	489,545,803	427,517,273	59,762,508	55,366,418	1,144,043,567	996,810,606
SURPLUS/(DEFICIT) FOR THE PERIOD	653,012	(125,789)	11,601,457	(2,645,333)	1,964,688	(423,158)	11,711,581	(2,666,633)	1,428,593	(344,113)	27,359,330	(6,205,026)

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

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

2.3 Schedule of Assets and Liabilities by Service

	Prevention		Hospital Bed Based Services		Community Bed Based Services		Community Treatment		Community Support		Total	
	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021
	$	$	$	$	$	$	$	$	$	$	$	$
ASSETS												
Current assets	1,559,129	712,620	27,699,615	14,986,326	4,690,884	2,397,272	27,962,545	15,106,996	3,410,905	1,949,469	65,323,079	35,152,683
Non-current assets	672,519	510,029	11,948,022	10,725,861	2,023,378	1,715,752	12,061,435	10,812,226	1,471,269	1,395,254	28,176,622	25,159,122
Total Assets	2,231,648	1,222,648	39,647,637	25,712,189	6,714,262	4,113,024	40,023,980	25,919,222	4,882,174	3,344,723	93,499,701	60,311,805
LIABILITIES												
Current liabilities	252,329	188,909	4,482,895	3,972,736	759,171	635,495	4,525,447	4,004,723	552,020	516,786	10,571,861	9,318,649
Non-current liabilities	52,746	43,155	937,096	907,534	158,696	145,173	945,993	914,844	115,393	118,055	2,209,925	2,128,761
Total Liabilities	305,075	232,064	5,419,991	4,880,270	917,867	780,669	5,471,440	4,919,567	667,413	634,841	12,781,786	11,447,410
NET ASSETS	1,926,573	990,585	34,227,645	20,831,918	5,796,395	3,332,355	34,552,540	20,999,655	4,214,761	2,709,882	80,717,915	48,864,395

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

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

3. Use of our funding

Expenses incurred in the delivery of services

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

	Notes	2022 $	2021 $
Employee benefits expenses	3.1(a)	43,838,664	38,141,838
Employee benefits provisions	3.1(b)	9,625,437	9,083,734
Service agreements	3.2	1,026,438,117	934,744,572
Grants and subsidies	3.3	21,733,856	12,386,050
Supplies and services	3.4	20,207,758	14,262,445
Accommodation expenses	3.5	2,832,343	2,236,157
Other expenses	3.6	3,176,062	2,400,774

Mental Health Commission
Notes to the Financial Statements
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	2022	2021
3.1(a) Employee benefits expenses	**$**	**$**
Employee benefits	39,794,988	34,833,158
Termination benefits	127,331	-
Superannuation - defined contribution plans (a)	3,916,345	3,308,680
Total employee benefits expenses	**43,838,664**	**38,141,838**
Add: AASB 16 Non-monetary benefits (not included in employee benefits expense)	45,676	47,841
Less: Employee contributions (per the statement of comprehensive income)	(28,407)	(24,651)
Net employee benefits	**43,855,933**	**38,165,028**

(a) Defined contribution plans include West State, Gold State and GESB Super and other eligible funds. Super contribution paid to GESB for West State, Gold State and GESB Super is $3,068,814 (2020-21 $2,728,954).

Employee benefits include wages, salaries and social contributions, accrued and paid leave entitlements and paid sick leave and non-monetary benefits such as fringe benefits tax recognised under accounting standards other than AASB 16 (such as medical care, housing, cars and free or subsidised goods or services) for employees.

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

Superannuation is the amount recognised in profit or loss of the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, other GESB schemes or other superannuation funds.

AASB 16 non-monetary benefits are non-monetary employee benefits predominantly relating to the provision of vehicle benefits that are recognised under AASB 16 which are excluded from the employee benefits expense.

Employee contributions are contributions made to the MHC by employees towards employee benefits that have been provided by the MHC. This includes both AASB 16 and non-AASB 16 employee contributions.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

	2022	2021
3.1(b) Employee related provisions	**$**	**$**
Current		
Employee benefits provision		
Annual leave	4,197,326	3,727,796
Long service leave	3,255,791	3,187,798
Deferred salary scheme	40,756	127,363
Total current employee related provisions	**7,493,873**	**7,042,957**
Non-current		
Employee benefits provision		
Long service leave	2,131,564	2,040,777
Total employee related provisions	**9,625,437**	**9,083,734**

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

Annual leave liabilities are 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	2,925,108	2,602,650
More than 12 months after the end of the reporting period	1,272,218	1,125,146
	4,197,326	3,727,796

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

Long service leave liabilities are unconditional long service leave provisions and are classified as current liabilities as the MHC 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 MHC has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	925,546	872,751
More than 12 months after the end of the reporting period	4,461,809	4,355,824
	5,387,355	5,228,575

The provision of the long service leave liabilities are calculated at present value as the MHC does not expect to wholly settle the amounts within 12 months. The present value is measured taking into account the present value of expected future payments to be made in relation to services provided by employees up to the reporting date. These payments are estimated using the remuneration rate expected to apply at the time of settlement, discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

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

Within 12 months of the end of the reporting period	40,756	125,836
More than 12 months after the end of the reporting period	-	1,527
	40,756	127,363

Mental Health Commission
Notes to the Financial Statements
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3.1(b) Employee related provisions (cont.)

Key sources of estimation uncertainty – long service leave

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

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

* Expected future salary rates
* Discount rates
* Employee retention rates; and
* Expected future payments

Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision. Any gain or loss following revaluation of the present value of long service leave liabilities is recognised as employee benefits expense.

In estimating the non-current long service leave liabilities, employees are assumed to leave the MHC each year on account of resignation or retirement at 7.8%. This assumption was based on an analysis of the historical turnover rates exhibited by employees in the WA health services including the MHC. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

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

		2022	2021
3.2	**Service agreements**	**$**	**$**
	Service agreement - WA Health		
	East Metropolitan Health Service	210,997,000	193,230,498
	North Metropolitan Health Service	273,523,000	252,073,556
	South Metropolitan Health Service	159,773,688	133,304,363
	Child and Adolescent Health Service	73,192,342	68,096,956
	WA Country Health Service	136,234,201	126,255,467
	Total service agreement - WA Health	**853,720,231**	**772,960,840**

Metropolitan Health Service was abolished on 1 July 2016 and 5 Health Services Providers were established 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 MHC Service Agreements, public hospitals in WA Health provide specialised mental health services to the public patients and the

	Service agreement - non government and other organisations		
	Non-government and other organisations	**172,717,886**	**161,783,732**

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

	Total service agreements	**1,026,438,117**	**934,744,572**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

		2022	2021
3.3	**Grants and subsidies**	**$**	**$**
	Recurrent		
	Suicide Prevention Strategy	523,049	606,016
	Prevention and Anti-Stigma	5,000	105,000
	Transitional Community Based Beds for Long Stay Inpatients Pilot Program	594,000	2,463,901
	Perinatal Mental Health Pilot Programs	661,200	1,183,771
	Commitment to Aboriginal Youth Wellbeing - Aboriginal Engagement Girls Programs (a)	-	1,540,000
	Commitment to Aboriginal Youth Wellbeing	285,950	285,950
	GP Aftercare Pilot Program	-	400,000
	Active Recovery Team Pilot Project	2,506,565	505,409
	National Disability Insurance Scheme Programs	-	948,390
	Mental Health Residential Rehabilitation Beds Trial Program	490,000	490,000
	Covid-19 Pandemic Service Response	2,086,714	697,665
	Community Services Contracts 2021-2022 uplift	5,277,310	-
	Think Mental Health Campaign	600,000	-
	Mental Awareness, Respect and Safety Program	600,000	-
	Community Services Grants	1,648,886	-
	Youth Support & Wellbeing Programs	2,093,650	-
	Community Support Programs	1,043,407	-
	Other grants (a)	890,030	1,183,148
	Total recurrent grants and subsidies	**19,305,761**	**10,409,250**
	Capital		
	Refurbish building grants for A Safe Place Initiatives - Community Care Unit	1,710,909	1,556,800
	Refurbish building grants for A Safe Place Initiatives - Youth Mental Health and Alcohol and Other Drug Homelessness	368,686	420,000
	Refurbish building grants for The Recovery House Program - Woodville House Facility	348,500	-
	Total capital grants and subsidies	**2,428,095**	**1,976,800**
	Total grants and subsidies	**21,733,856**	**12,386,050**

(a) Grants and subsidies include payments to the Department of Communities $100,000 (2020-21 $nil), Department of Education $nil (2020-21 $1,540,000) and Department of Local Government Sport and Cultural Industries of $nil (2020-21 $2,682).

Transactions in which the MHC provides goods, services, assets (or extinguishes a liability) or labour to another party without receiving approximately equal value in return are categorised as 'Grant or subsidy expenses'. These payments or transfers are recognised at fair value at the time of the transaction and are recognised as an expense in the reporting period in which they are paid. They include transactions such as: grants, subsidies, personal benefit payments made in cash to individuals, other transfer payments made to public sector agencies, local government, non-government schools, and community groups.

The MHC is not responsible for administering a government subsidy scheme.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

		2022	2021
3.4	**Supplies and services**	**$**	**$**
	Purchase of outsourced services	10,662,852	8,884,613
	Corporate support services (c)	2,020,124	1,835,784
	Computer related services	664,529	250,600
	Consulting fees (a) (b) (d) (e)	5,404,770	2,143,288
	Consumables	708,092	548,892
	Communications	195,927	209,384
	Printing and Stationery	351,823	315,642
	Other	199,641	74,242
	Total supplies and services	**20,207,758**	**14,262,445**

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

(a) The Public Sector Commission $17,828 has been classified as consulting fees (2020-21 $16,215).
(b) Department of Finance $nil has been classified as consulting fees (2020-21 $14,399).
(c) Health Support Services has provided supply services, IT services, human resource services and finance services to the MHC free of charge.
(d) Landgate WA of $4,750 has been classified as consulting fees (2020-21 $2,783).
(e) Western Australia Treasury Corporation of $44,000 has been classified as consulting fees (2020-21 $nil).

3.5	**Accommodation expenses**		
	Office rental	2,685,341	2,087,865
	Utilities	147,002	148,292
	Total accommodation expenses	**2,832,343**	**2,236,157**

Office rental is expensed as incurred as Memorandum of Understanding Agreements between the MHC and the Department of Finance for the leasing of office accommodation contain significant substitution rights.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

3.6 Other expenses	2022 $	2021 $
Workers' compensation insurance (a)	214,217	152,096
Other employee related expenses (g)	441,715	348,146
Consumable equipment, repairs and maintenance (b) (f)	1,201,499	747,043
Expected credit losses expense	7,472	5,194
Travel related expenses (c)	122,194	245,002
Audit fees (d)	391,827	260,150
Legal fees (e)	158,301	135,161
Administration	273,443	226,106
Advertising	66,636	17,713
Other insurance (a)	139,947	135,636
Disposal of assets	7,408	-
Other	151,403	128,527
Total other expenditures	**3,176,062**	**2,400,774**

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

(a) Includes expense to RiskCover, $214,217 has been classified as workers' compensation insurance and $139,947 as other insurance (2020-21 $152,096 workers' compensation insurance and $135,636 other insurance).
(b) Includes expense to Department of Finance, $470,877 has been classified as consumable equipment, repairs and maintenance (2020-21 $129,380).
(c) Includes expense to Department of Finance - Statefleet $313 (2020-21 $323).
(d) Includes expense to Office of the Auditor General $218,080 (2020-21 $216,402).
(e) Includes expense to Department of Justice - State Solicitor's Office $136,887 (2020-21 $84,085) inclusive of resources received free of charge.
(f) Includes expense to Department of Fire and Emergency $5,130 (2020-21 $5,021).
(g) Includes expense to Public Sector Commission $10,290 (2020-21 $5,115).

Expected credit losses is recognised for movement in allowance for impairment of trade receivables. Please refer to note 6.1.1 Receivables for more details.

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

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

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

4. Our funding sources

How we obtain our funding

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

	Notes	2022 $	2021 $
Income from State Government	4.1	1,144,043,567	996,810,606
Commonwealth grants and contributions	4.2	386,222	1,339,105
Other income	4.3	1,686,284	342,891

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

		2022	2021
4.1	**Income from State Government**	$	$
	Service appropriation received during the period:		
	Amount appropriated to deliver services	821,359,000	721,687,000
	Amount authorised by other statutes:		
	Salaries and Allowances Act 1975	811,000	809,000
	Total service appropriation received	**822,170,000**	**722,496,000**
	Commonwealth service agreement funding from State Pool Account during the period:		
	National Health Reform Agreement	**298,568,840**	**252,582,940**

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. This 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 of WA and the MHC.

	Income from other public sector entities during the period:		
	Department of Health	175,626	443,670
	WA Country Health Service	-	1,141,268
	Department for Communities	-	2,280
	Department of Education	80,116	646,286
	WA Police	1,531,000	1,505,858
	Healthway	650,000	741,479
	Public Sector Commission	27,134	
	Department of Justice	267,895	41,000
	Department of Mines, Industry Regulation and Safety	1,061,000	-
	Total income from other public sector entities	**3,792,771**	**4,521,841**
	Resources received from other public sector entities during the period:		
	Services received free of charge:		
	State Solicitor's Office - legal advisory services	135,403	78,986
	Department of Finance - office accommodation leasing services	17,230	11,851
	Department of Finance - test kits	5,544	-
	Department of Health	75,655	6,204
	Health Support Services (a)	2,020,124	1,835,784
	Total services received free of charge	**2,253,956**	**1,932,825**

(a) Metropolitan Health Service was 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 MHC since 2010.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

		2022	2021
		$	$
4.1	**Income from State Government (cont.)**		
	Assets transferred out		
	Return of Royalties for Regions Fund	-	(44,000)
	Total resources received	**2,253,956**	**1,888,825**
	Royalties for Regions Fund		
	Regional Community Services Account	**17,258,000**	**15,321,000**
	Total income from State Government	**1,144,043,567**	**996,810,606**

Service Appropriations are recognised as income at fair value of consideration received in the period in which the MHC gains control of the appropriated funds. The MHC gains control of appropriated funds at the time those funds are deposited in the bank account or credited to the holding held at Treasury.

Income from other public sector entities are recognised as income when the MHC has satisfied its performance obligation under the funding agreement. If there is no performance obligation, income will be recognised when the MHC receives the funds.

Resources received from other public sector entities is recognised as income equivalent to the fair value of assets received or the fair value of services received that can be reliably determined and which would have been purchased if not donated.

Regional Community Services Account is a sub-fund within the over-arching 'Royalties for Regions Fund'. The recurrent funds are committed to projects and programs in WA regional areas and are recognised as income when the MHC receives the funds or when the performance obligations have been met.

4.2	**Commonwealth grants and contributions**		
	Specialist Dementia Care Program	264,000	260,000
	Continuity of Support Program	-	897,275
	Take Home Naloxone Pilot	122,222	181,830
	Total commonwealth grants and contributions	**386,222**	**1,339,105**

Commonwealth grants and contributions are recognised as income when the grants are receivable.

4.3	**Other income**		
	Refund of prior year's payment on contract for services (a)	782,097	111,304
	Interest revenue	25,202	16,072
	Services to external organisations	258,468	80,804
	Increment on revaluation of land (b)	493,400	4,600
	Other income	127,117	130,111
	Total other income	**1,686,284**	**342,891**

(a) Refunds were received from non-government organisations in 2021-22 and 2020-21, 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.

Revenue is recognised at a point-in-time for services provided. The performance obligation for these revenue are satisfied when the services have been provided.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

5. Key assets

Assets the MHC utilises for economic benefit or service potential

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

	Notes	2022 $	2021 $
Property, plant and equipment	5.1	19,728,335	17,409,859
Right-of-use assets	5.2	112,234	126,039

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

		2022	2021
5.1	**Property, plant and equipment**	**$**	**$**
	Land		
	Carrying amount at start of period (fair value)	**4,853,300**	**5,198,700**
	Revaluation increments / (decrements)	493,400	4,600
	Transfers (a)	-	(350,000)
	Carrying amount at end of period	**5,346,700**	**4,853,300**
	Buildings		
	Carrying amount at start of period (fair value)	**10,534,600**	**11,500,200**
	Transfer from Work in Progress	384,903	-
	Revaluation increments / (decrements)	791,190	103,534
	Depreciation	(400,881)	(395,934)
	Transfers (a)	-	(673,200)
	Carrying amount at end of period	**11,309,812**	**10,534,600**
	Computer equipment		
	Gross carrying amount	69,973	49,886
	Accumulated depreciation	(54,908)	(49,886)
	Carrying amount at start of period	**15,065**	**-**
	Additions	-	20,087
	Depreciation	(5,022)	(5,022)
	Carrying amount at end of period	**10,043**	**15,065**
	Medical equipment		
	Gross carrying amount	198,044	167,819
	Accumulated depreciation	(101,073)	(75,626)
	Carrying amount at start of period	**96,971**	**92,193**
	Additions	-	30,226
	Depreciation	(26,526)	(25,448)
	Carrying amount at end of period	**70,445**	**96,971**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

		2022	2021
5.1	**Property, plant and equipment (cont.)**	$	$
	Other plant and equipment		
	Gross carrying amount	384,346	330,268
	Accumulated depreciation	(180,637)	(144,148)
	Carrying amount at the start of year	**203,709**	**186,120**
	Additions	-	54,078
	Disposals	(7,408)	
	Depreciation	(37,015)	(36,489)
	Carrying amount at the end of year	**159,286**	**203,709**
	Artworks		
	Gross carrying amount	18,000	18,000
	Carrying amount at the start of year	**18,000**	**18,000**
	Carrying amount at the end of year	**18,000**	**18,000**
	Works in progress		
	Carrying amount at the start of year	1,688,214	-
	Additions	1,510,738	1,688,214
	Capitalised to asset classes	(384,903)	-
	Carrying amount at the end of year	**2,814,049**	**1,688,214**
	Total property, plant and equipment		
	Gross carrying amount	17,746,477	17,264,873
	Accumulated depreciation	(336,618)	(269,660)
	Carrying amount at the start of year	**17,409,859**	**16,995,213**
	Additions	1,510,738	1,792,605
	Transfers from Work in Progress	(384,903)	-
	Capitalised to asset classes	384,903	-
	Disposals	(7,408)	-
	Revaluation increments/(decrements)	1,284,590	108,134
	Depreciation	(469,444)	(462,893)
	Transfers (a)	-	(1,023,200)
	Carrying amount at the end of year	**19,728,335**	**17,409,859**

(a) Geraldton Sobering Up Centre transferred to Department of Communities - Housing Authority for 10 bed Community Mental Health Step up / Step down service for the Midwest Region based in Geraldton.

Initial recognition

Items of property, plant and equipment, costing $5,000 or more are measured initially at cost. Where an asset is acquired for no or nominal cost, the cost is valued at its fair value at the date of acquisition. Items of property, plant and equipment costing less than $5,000 are immediately expensed direct to the Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

5.1 Property, plant and equipment (cont.)

Subsequent measurement

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

Land is carried at fair value. Buildings are carried at fair value less accumulated depreciation and accumulated impairment losses.

Plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

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

Land and buildings were revalued as at 1 July 2021 by the Western Australian Land Information Authority (Valuations and Property Analytics).The valuations were performed during the year ended 30 June 2022 and recognised at 30 June 2022. In undertaking the revaluation, fair value was determined by reference to market values for land: $299,000 (2020-21 $275,000) and buildings $404,000 (2020-21 $378,000). 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).

5.1.1 Depreciation expense	**2022** **$**	**2021** **$**
Buildings	400,881	395,934
Computer equipment	5,022	5,022
Medical equipment	26,526	25,448
Other plant and equipment	37,015	36,489
Total depreciation for the period	**469,444**	**462,893**

As at 30 June 2022 there were no indications of impairment to property, plant and equipment.

All surplus assets at 30 June 2022 have either been classified as assets held for sale or have been written-off.

Mental Health Commission
Notes to the Financial Statements
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5.1 Property, plant and equipment (cont.)

5.1.1 Depreciation expense (cont.)

Useful lives

All property, plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits. The exceptions to this rule include assets held for sale, land and investment properties.

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

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

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

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

Impairment

There were no indications of impairment to property, plant and equipment at 30 June 2022. The MHC held no goodwill during the reporting period.

Non-financial assets, including items of plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised.

Where an asset measured at cost is written down to its recoverable amount, an impairment loss is recognised through profit or loss. Where a previously revalued asset is written down to its recoverable amount, the loss is recognised as a revaluation decrement through other comprehensive income.

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

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

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

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		2022	2021
5.2	**Right-of-use assets**	**$**	**$**
	Vehicles		
	Gross carrying amount	208,896	145,904
	Accumulated depreciation	(82,857)	(57,587)
	Accumulated impairment loss	-	-
	Carrying amount at start of period	**126,039**	**88,317**
	Additions	40,546	110,591
	Disposals	(16,876)	(47,599)
	Reversal of accumulated depreciation on disposal	16,876	32,377
	Depreciation expense	(54,351)	(57,647)
	Carrying amount at the end of year	**112,234**	**126,039**
	Gross carrying amount	232,566	208,896
	Accumulated depreciation	(120,332)	(82,857)
	Accumulated impairment loss	-	-

Initial recognition

At the commencement date of the lease, the MHC recognises right-of-use assets are measured at cost comprising of:

- the amount of the initial measurement of lease liability
- any lease payments made at or before the commencement date less any lease incentive received;
- any initial direct costs; and
- restoration costs, including dismantling and removing the underlying asset.

The MHC has elected not to recognise right-of-use assets and lease liabilities for short-term leases (with a lease term of 12 months or less) and low value leases (with an underlying value of $5,000 or less). Lease payments associated with these leases are expensed over a straight-line basis over the lease term.

Subsequent measurement

The cost model is applied for subsequent measurement of right-of-use assets, requiring the asset to be carried at cost less any accumulated depreciation and accumulated impairment losses and adjusted for any re-measurement of lease liability.

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5.2 Right-of-use assets (cont.)

Depreciation and impairment of right-of-use assets

Right-of-use assets are depreciated on a straight-line basis over the shorter of the lease term and the estimated useful lives of the underlying assets

If ownership of the leased asset transfers to the MHC at the end of the lease term or the cost reflects the exercise of a purchase option, depreciation is calculated using the estimated useful life of the asset.

Right-of-use assets are tested for impairment when an indication of impairment is identified. The policy in connection with testing for impairment is outlined in note 5.1.1

The following amounts relating to leases have been recognised in the statement of comprehensive income

	2022 $	2021 $
Depreciation expense of right-of-use assets	54,351	57,647
Lease interest expense	6,148	5,252
Expenses relating to variable lease payments not included in lease liabilities	907	324
Short-term leases	45,333	130,333
Gains or losses arising from sale and leaseback transactions	-	159
Total amount recognised in the statement of comprehensive income	**106,739**	**193,715**

The total cash outflow for leases in 2021-22 was $105,308 (2020-21: $191,918). As at 30 June 2022 there were no indications of impairment to right-of-use assets.

The MHC's leasing activities and how these are accounted for:

The MHC has leases for vehicles.

The MHC has also entered into a Memorandum of Understanding Agreements (MOU) with the Department of Finance for the leasing of office accommodation. These are not recognised under AASB 16 because of substitution rights held by the Department of Finance and are accounted for as an expense as incurred.

The MHC recognises leases as right-of-use assets and associated lease liabilities in the Statement of Financial Position.

The corresponding lease liabilities in relation to these right-of-use assets have been disclosed in note 7.1.

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6. Other assets and liabilities

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

	Notes	2022 $	2021 $
Receivables	6.1	702,759	251,641
Amounts receivable for services	6.2	7,407,123	6,992,123
Inventories	6.3	13,234	16,066
Other current assets	6.4	101,829	-
Payables	6.5	3,040,055	2,234,762

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		2022	2021
6.1	**Receivables**	**$**	**$**
	Current		
	Receivables (a)	611,090	145,021
	Allowance for impairment of receivables	(25,198)	(17,749)
	Accrued revenue	22,967	74,610
	GST receivables	93,900	49,759
	Total receivables	**702,759**	**251,641**

(a) Receivables include amounts owing from the Department of Communities $32,458 (2020-21 $nil) and the Department of Justice $130,895 (2020-21 $nil)

Receivables are initially recognised at their transaction price or, for those receivables that contain a significant financing component, at fair value. The MHC holds the receivables with the objective to collect the contractual cash flows and therefore subsequently measured at amortised cost using the effective interest method, less an allowance for impairment.
The MHC recognises a loss allowance for expected credit losses (ECLs) on a receivable not held at fair value through profit or loss. The ECLs based on the difference between the contractual cash flows and the cash flows that the MHC expects to receive, discounted at the original effective interest rate. Individual receivables are written off when the MHC has no reasonable expectations of recovering the contractual cash flows.
For trade receivables, the MHC recognises an allowance for ECLs measured at the lifetime expected credit losses at each reporting date. The MHC has established a provision matrix that is based on its historical credit loss experience, adjusted for forward-looking factors specific to the debtors and the economic environment. Please refer to note 3.6 for the amount of ECLs expensed in this financial year.

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 MHC, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service, Health Support Services, WA Country Health Service, QE II Medical Centre Trust, PathWest Laboratory Medicine WA, Quadriplegic Centre and Health and Disability Services Complaints Office.

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

6.1.1 Movement in the allowance for impairment of receivables

	2022	2021
Reconciliation of changes in the allowance for impairment of receivables:		
Opening balance	17,749	15,380
Expected credit losses expense	7,472	5,194
Amount recovered during the period	(23)	(893)
Amount written off during the period	-	(1,932)
Allowance for impairment at the end of the period	**25,198**	**17,749**

The maximum exposure to credit risk at the end of the reporting period for receivables is the carrying amount of the asset inclusive of any allowance for impairment as shown in the table at Note 8.1(c) 'Financial instruments disclosures'. The MHC does not hold any collateral as security or other credit enhancements for receivables.

6.2 Amounts receivable for services

Non-current amounts receivable for services	**7,407,123**	**6,992,123**

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

The amounts receivable for services are financial assets at amortised cost, and are not considered impaired (i.e. there is no expected credit loss of the holding accounts).

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		2022	2021
6.3	**Inventories**	**$**	**$**
	Current		
	Pharmaceutical stores - at cost	**13,234**	**16,066**

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

6.4 Other current assets

Prepayments	**101,829**	**-**

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

6.5 Payables

Current		
Trade payables (a)	220,917	593,418
Accrued salaries	1,315,524	923,006
Accrued expenses (a)	1,503,614	718,338
Total payables at the end of period	**3,040,055**	**2,234,762**

(a) Includes amounts not yet paid to the Public Sector Commission $9,338 (2020-21 $nil), Department of Premier and Cabinet $nil (2020-21 $75,788), Department of Education $444,122 (2020-21 $nil) and the Department of Finance $20,370 (2020-21 $nil).

Payables are recognised at the amounts payable when the MHC becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value as settlement for the MHC is generally within 15-20 days.

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

6.6 Grant liabilities

Reconciliation of changes in grants liabilities

Opening balance	-	126,894
Revenue recognised in the reporting period	-	(126,894)
Total grant liabilities at the end of period	**-**	**-**
Current	-	-
Non-current	-	-

The MHC grant liabilities relate to the service yet to be performed at the end of the reporting period. Typically, a grant agreement payment is received upfront for 12 months of services.

The MHC expects to satisfy the performance obligation unsatisfied as the end of the reporting period within the next 12 months.

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7. Financing

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

	Notes
Lease liabilities	7.1
Assets pledged as security	7.2
Finance costs	7.3
Cash and cash equivalents	7.4
Reconciliation of cash	7.4.1
Reconciliation of operating activities	7.4.2
Capital commitments	7.5

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		2022	2021
7.1	**Lease liabilities**	**$**	**$**
	Current	37,933	40,930
	Non-current	78,361	87,984
	Total lease liabilities	**116,294**	**128,914**

Initial measurement

At the commencement date of the lease, the MHC recognises lease liabilities measured at the present value of lease payments to be made over the lease term. The lease payments are discounted using the interest rate implicit in the lease. If that rate cannot be readily determined, the MHC uses the incremental borrowing rate provided by Western Australia Treasury Corporation.

Lease payments included by the MHC as part of the present value calculation of lease liability include:

* Fixed payments (including in-substance fixed payments), less any lease incentives receivable;
* Variable lease payments that depend on an index or a rate initially measured using the index or rate as at the commencement date;
* Amounts expected to be payable by the lessee under residual value guarantees;
* The exercise price of purchase options (where these are reasonably certain to be exercised);
* Payments for penalties for terminating a lease, where the lease term reflects the MHC exercising an option to terminate the lease.

The interest on the lease liability is recognised in profit or loss over the lease term so as to produce a constant periodic rate of interest on the remaining balance of the liability for each period. Lease liabilities do not include any future changes in variable lease payments (that depend on an index or rate) until they take effect, in which case the lease liability is reassessed and adjusted against the right-of-use asset.

Periods covered by extension or termination options are only included in the lease term by the MHC if the lease is reasonably certain to be extended (or not terminated).

Variable lease payments, not included in the measurement of lease liability, that are dependant on sales are recognised by the MHC in profit or loss in the period in which the condition that triggers those payment occurs.

This section should be read in conjunction with note 5.2.

Subsequent measurement

Lease liabilities are measured by increasing the carrying amount to reflect interest on the lease liabilities; reducing the carrying amount to reflect the lease payments made; and remeasuring the carrying amount at amortised cost, subject to adjustments to reflect any reassessment or lease modifications.

7.2	**Assets pledged as security**		
	The carrying amounts of non-current assets pledged as security are:		
	Right-of-use assets: vehicles	112,234	126,039
	Total assets pledged as security	**112,234**	**126,039**

The MHC has secured the right-of-use assets against the related lease liabilities. In the event of default, the rights to the leased assets will revert to the lessor.

7.3	**Finance costs**		
	Lease interest expense	**6,148**	**5,252**

Finance costs relate to the interest component of lease liability repayments.

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		2022	2021
7.4	**Cash and cash equivalents**	**$**	**$**
7.4.1	**Reconciliation of cash**		
	Cash and cash equivalents	55,808,799	29,327,176
	Restricted cash and cash equivalents:		
	- Commonwealth special purpose account (b)	5,017,755	5,000,123
	- Royalties for Regions Fund (c)	3,678,703	557,677
	- Accrued salaries suspense account (a)	928,930	631,101
	Total restricted cash and cash equivalents at end of period	**65,434,187**	**35,516,077**

(a) Funds held in the suspense account used only for the purpose of meeting the 27th pay in a financial year that occurs every 11 years. This account is classified as non-current for 10 out of 11 years.

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

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

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

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

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

Net cost of services		(1,116,684,237)	(1,003,015,632)
Non-cash items:	**Notes**		
Resources received	4.1	2,253,956	1,932,825
Depreciation expense	5.1.1 & 5.2	523,795	520,540
Loss from disposal of non-current assets		7,408	-
Increment on revaluation of land	4.3	(493,400)	(4,600)
Expected credit losses expense	3.6	7,472	5,194
Adjustment for other non-cash items		(23)	(2,985)
(Increase)/decrease in assets:			
Current receivables (a)		(327,672)	(171,618)
Inventories		2,832	(3,626)
Other current assets		(101,829)	6,114
Increase/(decrease) in liabilities:			
Current payables		805,293	178,732
Current provisions		450,916	1,056,253
Non-current provisions		90,787	(164,967)
Net cash used in operating activities		**(1,113,464,702)**	**(999,663,770)**

(a) This excludes allowance for impairment of receivables and income from state government as it does not form part of the reconciling item.

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		2022	2021
		$	$
7.5	**Capital commitments**		
	Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements, are payable as follows:		
	Within 1 year	6,730,440	4,584,005
	Later than 1 year and not later than 5 years	2,858,924	2,896,414
		9,589,364	**7,480,419**

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8. Risks and Contingencies

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

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

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8.1 Financial risk management

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

(a) Summary of risks and risk management

Credit risk

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

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

Liquidity risk

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

The MHC 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 MHC's income or the value of its holdings of financial instruments. The MHC 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:

	2022 $	2021 $
Financial Assets		
Cash and cash equivalents	55,808,799	29,327,176
Restricted cash and cash equivalents	9,625,388	6,188,901
Receivables (a)	585,892	127,272
Accrued revenue	22,967	74,610
Amounts receivable for services	7,407,123	6,992,123
Total financial assets	**73,450,169**	**42,710,082**
Financial Liabilities		
Financial liabilities measured at amortised cost	3,156,349	2,363,676
Total financial liabilities	**3,156,349**	**2,363,676**

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

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8.1 Financial risk management (cont.)

(c) Credit risk exposure

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

		Days past due					
	Total	Current	<30 days	31-60 days	61-90 days	90-180 days	>180 days
	$	$	$	$	$	$	$
30 June 2022							
Expected credit loss rate		0.00%	0.00%	0.00%	0.00%	0.00%	19.99%
Estimated total gross carrying amount at default	611,090	419,005	12,243	40,637	-	13,134	126,071
Expected credit losses	(25,198)	-	-	-	-	-	25,198
30 June 2021							
Expected credit loss rate		0.00%	2.00%	0.00%	0.00%	33.07%	15.24%
Estimated total gross carrying amount at default	145,021	29,707	1,177	541	-	2,323	111,273
Expected credit losses	(17,749)	-	24	-	-	768	16,957

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8.1 Financial risk management (cont.)

(d) Liquidity risk and interest rate exposure

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

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

		Interest rate exposure					Maturity Dates				
	Weighted averag effectiv 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
	%	$	$	$	$	$	$	$	$	$	$
2022											
Financial Assets											
Cash and cash equivalents	-	55,808,799	-	-	55,808,799	55,808,799	55,808,799	-	-	-	-
Restricted cash and cash equivalents	0.6%	9,625,388	-	5,017,755	4,607,633	9,625,388	9,625,388	-	-	-	-
Receivables (a)	-	585,892	-	-	585,892	585,892	585,892	-	-	-	-
Accrued revenue	-	22,967	-	-	22,967	22,967	22,967	-	-	-	-
Amounts receivable for services	-	7,407,123	-	-	7,407,123	7,407,123	-	-	-	-	7,407,123
		73,450,169	-	5,017,755	68,432,414	73,450,169	66,043,046	-	-	-	7,407,123
Financial Liabilities											
Payables	-	3,040,055	-	-	3,040,055	3,040,055	3,040,055	-	-	-	-
Lease liabilities (b)	4.7%	116,294	116,294	-	-	126,041	4,356	8,713	29,426	83,546	-
		3,156,349	116,294	-	3,040,055	3,166,096	3,044,411	8,713	29,426	83,546	-
2021											
Financial Assets											
Cash and cash equivalents	-	29,327,176	-	-	29,327,176	29,327,176	29,327,176	-	-	-	-
Restricted cash and cash equivalents	0.3%	6,188,901	-	5,000,123	1,188,778	6,188,901	6,188,901	-	-	-	-
Receivables (a)	-	127,272	-	-	127,272	127,272	127,272	-	-	-	-
Accrued revenue	-	74,610	-	-	74,610	74,610	74,610	-	-	-	-
Amounts receivable for services	-	6,992,123	-	-	6,992,123	6,992,123	-	-	-	-	6,992,123
		42,710,082	-	5,000,123	37,709,959	42,710,082	35,717,959	-	-	-	6,992,123
Financial Liabilities											
Payables	-	2,234,762	-	-	2,234,762	2,234,762	2,234,762	-	-	-	-
Lease liabilities (b)	4.4%	128,914	128,914	-	-	140,554	3,879	7,758	33,903	91,744	3,270
		2,363,676	128,914	-	2,234,762	2,375,316	2,238,641	7,758	33,903	91,744	3,270

(a) The amount of receivables excludes GST recoverable from the ATO (statutory receivable).
(b) The amount of lease liabilities $116,294 (2020-21: $128,914) is from leased vehicles.

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8.1 Financial risk management (cont.)

(e) Interest rate sensitivity analysis

The following table represents a summary of the interest rate sensitivity of the MHC'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
	$	$	$	$	$
2022					
Financial Assets					
Restricted cash and cash equivalents	5,017,755	(50,178)	(50,178)	50,178	50,178
Total Increase/(Decrease)		(50,178)	(50,178)	50,178	50,178

		-100 basis points		+100 basis points	
	Carrying amount	Surplus	Equity	Surplus	Equity
	$	$	$	$	$
2021					
Financial Assets					
Restricted cash and cash equivalents	5,000,123	(50,001)	(50,001)	50,001	50,001
Total Increase/(Decrease)		(50,001)	(50,001)	50,001	50,001

Fair values

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

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8.2 Contingent assets and liabilities

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

At the reporting date, the MHC is not aware of any contingent assets.

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

Contaminated sites

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

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

8.3 Fair value measurements

Assets measured at fair value:	**Level 1**	**Level 2**	**Level 3**	**Fair Value At end of period**
2022	**$**	**$**	**$**	**$**
Land (Note 5.1)	-	299,000	5,047,700	5,346,700
Buildings (Note 5.1)	-	404,000	10,905,813	11,309,813
	-	**703,000**	**15,953,513**	**16,656,513**
2021				
Land (Note 5.1)	-	275,000	4,578,300	4,853,300
Buildings (Note 5.1)	-	378,000	10,156,600	10,534,600
	-	**653,000**	**14,734,900**	**15,387,900**

Valuation techniques to derive Level 2 fair values

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

Fair value has been determined by reference to market evidence of sales prices of comparable assets.

Mental Health Commission
Notes to the Financial Statements
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8.3 Fair value measurements (cont.)

Fair value measurements using significant unobservable inputs (Level 3)	Land	Buildings
2022	**$**	**$**
Fair value at start of period	4,578,300	10,156,600
Transfer from work in progress	-	303,599
Revaluation increments/(decrements) recognised in Profit or Loss	469,400	-
Revaluation increments/(decrements) recognised in Other Comprehensive Income	-	838,114
Depreciation expense	-	(392,500)
Fair value at end of period	**5,047,700**	**10,905,813**
2021		
Fair value at start of period	4,578,700	10,444,200
Revaluation increments/(decrements) recognised in Profit or Loss	(400)	-
Revaluation increments/(decrements) recognised in Other Comprehensive Income	-	94,014
Depreciation expense	-	(381,614)
Fair value at end of period	**4,578,300**	**10,156,600**

Valuation processes

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 current replacement cost. 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, adjusted for obsolescence. Obsolescence encompasses physical deterioration, functional (technological) obsolescence and economic (external) obsolescence.

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

Basis of Valuation

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

Mental Health Commission
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9. Other disclosures

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

Mental Health Commission
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9.1 Events occurring after the end of the reporting period

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

9.2 Future impact of Australian Accounting Standards not yet operative

The MHC 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. Where applicable, the MHC plans to apply the following Australian Accounting Standards from their application date.

Title		Operative for reporting periods beginning on/after
AASB 17	*Insurance Contracts* This Standard establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts The MHC has not assessed the impact of the Standard.	1 Jan 2023
AASB 2020-1	*Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current* This Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current. There is no financial impact.	1 Jan 2023
AASB 2020-3	*Amendments to Australian Accounting Standards – Annual Improvements 2018–2020 and Other Amendments* This Standard amends: (a) AASB 1 to simplify the application of AASB 1; (b) AASB 3 to update a reference to the Conceptual Framework for Financial Reporting; (c) AASB 9 to clarify the fees an entity includes when assessing whether the terms of a new or modified financial liability are substantially different from the terms of the original financial liability; (d) AASB 116 to require an entity to recognise the sales proceeds from selling items produced while preparing property, plant and equipment for its intended use and the related cost in profit or loss, instead of deducting the amounts received from the cost of the asset; (e) AASB 137 to specify the costs that an entity includes when assessing whether a contract will be loss-making; and (f) AASB 141 to remove the requirement to exclude cash flows from taxation when measuring fair value. There is no financial impact.	1 Jan 2022

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

Title		Operative for reporting periods beginning on/after
AASB 2020-6	*Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current – Deferral of Effective Date* This Standard amends AASB 101 to defer requirements for the presentation of liabilities in the statement of financial position as current or non-current that were added to AASB 101 in AASB 2020-1. There is no financial impact.	1 Jan 2022
AASB 2021-2	*Amendments to Australian Accounting Standards – Disclosure of Accounting Policies and Definition of Accounting Estimates* This Standard amends: (a) AASB 7, to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements; (b) AASB 101, to require entities to disclose their material accounting policy information rather than their significant accounting policies; (c) AASB 108, to clarify how entities should distinguish changes in accounting policies and changes in accounting estimates; (d) AASB 134, to identify material accounting policy information as a component of a complete set of financial statements; and (e) AASB Practice Statement 2, to provide guidance on how to apply the concept of materiality to accounting policy disclosures. There is no financial impact.	1 Jan 2023
AASB 2021-6	*Amendments to Australian Accounting Standards – Disclosure of Accounting Policies: Tier 2 and Other Australian Accounting Standards* This standard amends: (a) AASB 1049, to require entities to disclose their material accounting policy information rather than their significant accounting policies; (b) AASB 1054 to reflect the updated accounting policy terminology used in AASB 101 Presentation of Financial Statements; and (c) AASB 1060 to required entities to disclose their material accounting policy information rather than their significant accounting policy and to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements. There is no financial impact.	1 Jan 2023

Mental Health Commission
Notes to the Financial Statements
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9.3 Key Management Personnel

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

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

Compensation of Senior Officers Band ($)	**2022**	**2021**
470,001 - 480,000	-	1
440,001 - 450,000	1	-
400,001 - 410,000	-	1
370,001 - 380,000	1	-
350,001 - 360,000	-	1
320,001 - 330,000	1	-
240,001 - 250,000	-	1
230,001 - 240,000	1	-
220,001 - 230,000	-	1
210,001 - 220,000	-	1
200,001 - 210,000	1	1
190,001 - 200,000	1	2
180,001 - 190,000	-	1
170,001 - 180,000	1	1
160,001 - 170,000	1	-
150,001 - 160,000	1	-
130,001 - 140,000	-	1
120,001 - 130,000	1	-
60,001 - 70,000	1	-
50,001 - 60,000	2	-
30,001 - 40,000	1	1
	$	**$**
Short-term employee benefits	2,035,527	2,461,283
Post-employment benefits	225,702	287,999
Other long-term benefits	217,357	291,116
Termination benefits	127,331	-
Total compensation of senior officers	**2,605,917**	**3,040,398**

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

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

9.4 Related Party Transactions

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

Related parties of the MHC include:

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

Significant transactions with Government-related entities

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

- service appropriation (Note 4.1);
- contribution by owners (Note 9.10);
- services received free of charge from the other state government agencies (Note 4.1);
- royalties for regions fund (Note 4.1);
- income received from other public sector entities (Note 4.1);
- services agreement WA Health (Note 3.2);
- grants and subsidies payment to other government agencies (Note 3.3);
- legal fees (Note 3.6) - Department of Justice including State Solicitor's Office;
- corporate support services - Health Support Services (Note 3.4);
- valuation services payment to Landgate WA (Note 3.4);
- purchase of outsourced services and consulting fees (Note 3.4), leases and accommodation (Note 3.5) and repairs and maintenance (Note 3.6) from the Department of Finance;
- consulting expense (Note 3.4) and employment related payments (Note 3.6) to the Public Sector Commission;
- consulting expense (Note 3.4) to the Western Australian Treasury Corporation;
- workers' compensation and other insurance payment to Riskcover (Note 3.6);
- audit fee payments to the Office of the Auditor General (Note 3.6 and Note 9.9);
- annual monitoring related payments to the Department of Fire and Emergency Services (Note 3.6);
- administration related payment to North Metropolitan TAFE (Note 3.6);
- services provided free of charge to other state government agencies (Note 9.11).

Mental Health Commission
Notes to the Financial Statements
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9.4 Related Party Transactions (cont)

Material transactions with related parties

Outside of normal citizen type transactions with the MHC, there were no other related party transactions that involved key management personnel and/or their close family members and/or their controlled (or jointly controlled) entities.

Material transactions with other related parties

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

9.5 Related bodies

A related body is a body that receives more than half of its funding and resources from the MHC and is subject to operational control by the MHC. The MHC had no related bodies during the financial year.

9.6 Affiliated bodies

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

During the financial year the following affiliated bodies received funding from the MHC:	2022	2021
	$	$
Albany Halfway House Association Incorporated	1,323,215	1,654,449
Garl Garl Walbu Aboriginal Corporation	683,403	613,055
Goldfields Rehabilitation Services Inc	3,167,529	-
Home Health Pty Ltd (trading as Tender Care)	1,419,744	1,273,599
Local Drug Action Groups Inc.	715,265	646,779
Palmerston Association Inc.	11,945,058	10,492,383
Pathways Southwest Inc.	963,477	905,361
Richmond Wellbeing Incorporated	21,631,334	17,649,310
WA Council on Addictions (trading as Cyrenian House)	15,231,485	13,238,524
Total affiliated bodies	**57,080,510**	**46,473,460**

In addition, Mental Health MHC 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 MHC. It is funded by parliamentary appropriation of $3,577,000 for 2021-22 ($2,740,000 for 2020-21).

Mental Health Advocacy Service is a government administered body that received administrative support from, but is not subject to operational control by the MHC. It is funded by parliamentary appropriation of $3,703,000 for 2021-22 ($2,858,000 for 2020-21).

Office of Chief Psychiatrist is a government administered body that received administrative support from, but is not subject to operational control by the MHC. It is funded by parliamentary appropriation of $3,974,000 for 2021-22 ($3,272,000 for 2020-21).

Mental Health Commission
Notes to the Financial Statements
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		2022	2021
9.7	**Non-current Assets classified as assets held for distribution to owner**	**$**	**$**
	Opening balance	-	4,000,000
	Adjustment to asset valuation	-	-
	Less asset distributed to owner	-	(4,000,000)
	Closing balance	-	-

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

Subsequent to the merger of Mental Health MHC and Drug and Alcohol Office in 1 July 2015, the amalgamated Mental Health Commission moved to new premises in April 2016 and services ceased at old site in late 2018. As a result the site has become surplus to requirement and assessed not to be practical from use for mental health and alcohol & other drug services. Management was committed to a plan to sell and developed the decommissioning project of the site. The Department of Planning, Lands and Heritage (DPLH) is the only agency with the power to sell Crown land. The site was transferred in 2020-21 to DPLH for sale and the MHC accounted for the transfer as a distribution to owner (Note 9.10).

9.8 Special purpose accounts

State Managed Fund (Mental Health) Account (a)

The purpose of the special purpose account is to hold money received by the Mental Health MHC, 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 start of period	-	-
Receipts:		
Service appropriations (State Government)	302,674,019	284,035,998
Royalties for Region Fund (State Government) (b)	4,062,880	-
Commonwealth grants and contributions	136,868,803	114,368,971
	443,605,702	**398,404,969**
Payments:		
Block grant funding to local hospital networks in WA Health	(413,301,251)	(375,722,918)
Block grant funding to non-government organisation	(12,985,392)	(6,526,886)
Block grant funding to next step drug and alcohol services	(17,319,060)	(16,155,165)
Balance at end of period	-	-

(a) Established under section 16(1)(b) of FMA.
(b) The Commonwealth provides block funding for subacute services which is partially funded by the Royalties for Regions fund. The funding is provided to non-government organisations to deliver the services.

9.9 Remuneration of auditors

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	**190,900**	**185,800**

Mental Health Commission
Notes to the Financial Statements
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		2022	2021
9.10	**Equity**	**$**	**$**
	Contributed equity		
	Balance at start of period	33,682,891	34,451,091
	Transactions with owners in their capacity as owners:		
	Capital appropriation	666,000	4,103,000
	Other contribution by owners - Royalties for Region Fund	3,037,000	7,061,000
	Distribution to owners:		
	Land and buildings transferred to the Department of Planning, Land and Heritage	-	(4,000,000)
	Other distribution to owner - Department of Communities:		
	Land and buildings transferred to the Department of Communities	-	(1,023,200)
	Other distribution to owner - Department of Communities	-	(6,909,000)
	Total contributed equity at end of period	**37,385,891**	**33,682,891**
	Asset revaluation surplus		
	Balance at start of period	249,556	146,022
	Net revaluation increments / (decrements) :		
	Buildings	791,190	103,534
	Balance at end of period	**1,040,746**	**249,556**
	Accumulated surplus / (deficit)		
	Balance at start of period	14,931,948	21,136,974
	Result for the period	27,359,330	(6,205,026)
	Total asset revaluation surplus at end of period	**42,291,278**	**14,931,948**
	Total equity at end of period	**80,717,915**	**48,864,395**
9.11	**Services provided free of charge**		
	Services provided free of charge to other agencies during the period:		
	Mental Health Tribunal - corporate services	320,489	319,562
	Mental Health Advocacy Service - corporate services	389,595	355,209
	Office of the Chief Psychiatrist - corporate services and accommodation	505,875	460,435
	Total services provided free of charge	**1,215,959**	**1,135,206**
9.12	**Supplementary financial information**		
	Write-offs		
	During the financial year 2021-22 $nil ($1,932 in 2020-21) was written off the MHC's asset register under the authority of:		
	The Mental Health Commissioner	**-**	**1,932**

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10. Explanatory statements

This section explains variations in the financial performance of the MHC.

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

10.1 Explanatory statement for controlled operations

This explanatory section explains variations in the financial performance of the MHC undertaking transactions under its own control, as represented by the primary financial statements.
All variances between annual estimates (original budget) and actual results for 2022, and between the actual results for 2022 and 2021 are shown below. Narratives are provided for key major variances which vary more than 10% from their comparative and that the variation is more than 1% of the dollar aggregate of:

* Total Cost of Services for the previous year for the Statements of Comprehensive Income and Statement of Cash Flows (i.e. 1% of $1,004,697,628), and
* Total Assets for the previous year for the Statement of Financial Position (i.e. 1% of $60,311,805)

10.1.1 Statement of comprehensive income variances

	Variance Note	Estimate 2022 $	Actual 2022 $	Actual 2021 $	Variance between estimate and actual $	Variance between actual results for 2022 and 2021 $
COST OF SERVICES						
Expenses						
Employee benefits expenses		41,452,000	43,838,664	38,141,838	2,386,664	5,696,826
Service agreement - WA Health	A	855,195,000	853,720,231	772,960,840	(1,474,769)	80,759,391
Service agreement - non government and other organisations	1	190,788,000	172,717,886	161,783,732	(18,070,114)	10,934,154
Supplies and services		13,118,000	20,207,758	14,262,445	7,089,758	5,945,313
Grants and subsidies	2	5,958,000	21,733,856	12,386,050	15,775,856	9,347,806
Depreciation expense		415,000	523,795	520,540	108,795	3,255
Finance costs		10,000	6,148	5,252	(3,852)	896
Accommodation expenses		3,141,000	2,832,343	2,236,157	(308,657)	596,186
Other expenses		4,169,000	3,176,062	2,400,774	(992,938)	775,288
Total cost of services		**1,114,246,000**	**1,118,756,743**	**1,004,697,628**	**4,510,743**	**114,059,115**
Income						
Revenue						
Commonwealth grants and contributions		264,000	386,222	1,339,105	122,222	(952,883)
Other income		364,000	1,686,284	342,891	1,322,284	1,343,393
Total income other than income from State Government		**628,000**	**2,072,506**	**1,681,996**	**1,444,506**	**390,510**
NET COST OF SERVICES		**1,113,618,000**	**1,116,684,237**	**1,003,015,632**	**3,066,237**	**113,668,605**
Income from State Government						
Service appropriation	B	819,870,000	822,170,000	722,496,000	2,300,000	99,674,000
Service agreement funding - Commonwealth	3, C	262,200,000	298,568,840	252,582,940	36,368,840	45,985,900
Income from other public sector entities		1,902,000	3,792,771	4,521,841	1,890,771	(729,070)
Resources received		4,221,000	2,253,956	1,888,825	(1,967,044)	365,131
Royalties for Regions Fund		22,393,000	17,258,000	15,321,000	(5,135,000)	1,937,000
Total income from State Government		**1,110,586,000**	**1,144,043,567**	**996,810,606**	**33,457,567**	**147,232,961**
SURPLUS / (DEFICIT) FOR THE PERIOD		**(3,032,000)**	**27,359,330**	**(6,205,026)**	**30,391,330**	**33,564,356**
OTHER COMPREHENSIVE INCOME						
Changes in asset revaluation surplus		-	791,190	103,534	791,190	687,656
Total other comprehensive income		**-**	**791,190**	**103,534**	**791,190**	**687,656**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(3,032,000)**	**28,150,520**	**(6,101,492)**	**31,182,520**	**34,252,012**

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10.1.2 Statement of financial position variances

	Variance Note	Estimate 2022 $	Actual 2022 $	Actual 2021 $	Variance between estimate and actual $	Variance between actual results for 2022 and 2021 $
ASSETS						
Current Assets						
Cash and cash equivalents		24,912,000	55,808,799	29,327,176	30,896,799	26,481,623
Restricted cash and cash equivalents		5,171,000	8,696,458	5,557,800	3,525,458	3,138,658
Receivables		89,000	702,759	251,641	613,759	451,118
Inventories		12,000	13,234	16,066	1,234	(2,832)
Other current assets		-	101,829	-	101,829	101,829
Total Current Assets		**30,184,000**	**65,323,079**	**35,152,683**	**35,139,079**	**30,170,396**
Non-Current Assets						
Restricted cash and cash equivalents		494,000	928,930	631,101	434,930	297,829
Amounts receivable for services		7,407,000	7,407,123	6,992,123	123	415,000
Property, plant and equipment	4, D	29,793,000	19,728,335	17,409,859	(10,064,665)	2,318,476
Right-of-use assets		119,000	112,234	126,039	(6,766)	(13,805)
Total Non-Current Assets		**37,813,000**	**28,176,622**	**25,159,122**	**(9,636,378)**	**3,017,500**
TOTAL ASSETS		**67,997,000**	**93,499,701**	**60,311,805**	**25,502,701**	**33,187,896**
LIABILITIES						
Current Liabilities						
Payables		2,346,000	3,040,055	2,234,762	694,055	805,293
Employee related provisions	5	5,987,000	7,493,873	7,042,957	1,506,873	450,916
Lease liabilities		41,000	37,933	40,930	(3,067)	(2,997)
Grant liabilities		127,000	-	-	(127,000)	-
Total Current Liabilities		**8,501,000**	**10,571,861**	**9,318,649**	**2,070,861**	**1,253,212**
Non-Current Liabilities						
Employee benefits provisions	5	2,206,000	2,131,564	2,040,777	(74,436)	90,787
Lease liabilities		85,000	78,361	87,984	(6,639)	(9,623)
Total Non-Current Liabilities		**2,291,000**	**2,209,925**	**2,128,761**	**(81,075)**	**81,164**
TOTAL LIABILITIES		**10,792,000**	**12,781,786**	**11,447,410**	**1,989,786**	**1,334,376**
NET ASSETS		**57,205,000**	**80,717,915**	**48,864,395**	**23,512,915**	**31,853,520**
EQUITY						
Contributed equity		36,996,000	37,385,891	33,682,891	389,891	3,703,000
Reserves		608,000	1,040,746	249,556	432,746	791,190
Accumulated surplus		19,601,000	42,291,278	14,931,948	22,690,278	27,359,330
TOTAL EQUITY		**57,205,000**	**80,717,915**	**48,864,395**	**23,512,915**	**31,853,520**

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10.1.3 Statement of cash flows variances

	Variance Note	Estimate 2022 $	Actual 2022 $	Actual 2021 $	Variance between estimate and actual $	Variance between actual results for 2022 and 2021 $
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation	E	819,455,000	821,755,000	722,086,000	2,300,000	99,669,000
Capital appropriations		7,608,000	666,000	4,103,000	(6,942,000)	(3,437,000)
Service agreement funding - Commonwealth	6, F	262,200,000	298,568,840	252,582,940	36,368,840	45,985,900
Income from other public sector entities		1,902,000	3,661,876	4,394,947	1,759,876	(733,071)
Royalties for Regions Fund - Capital		1,500,000	3,037,000	7,061,000	1,537,000	(4,024,000)
Return of Royalties for Regions Fund		-	-	(44,000)	-	44,000
Payment to Department of Communities - Royalties for Regions capital		(3,189,000)	-	(6,909,000)	3,189,000	6,909,000
Royalties for Regions Fund - Recurrent		25,430,000	17,258,000	15,321,000	(8,172,000)	1,937,000
Net cash provided by State Government		**1,114,906,000**	**1,144,946,716**	**998,595,887**	**30,040,716**	**146,350,829**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits expenses		(41,294,000)	(42,930,699)	(37,261,852)	(1,636,699)	(5,668,847)
Service agreement - WA Health	G	(855,195,000)	(853,720,231)	(772,960,840)	1,474,769	(80,759,391)
Service agreement - non government and other organisations		(190,788,000)	(172,220,128)	(161,579,729)	18,567,872	(10,640,399)
Supplies and services		(9,041,000)	(18,225,443)	(12,509,351)	(9,184,443)	(5,716,092)
Grants and subsidies	7	(5,958,000)	(21,733,856)	(12,386,050)	(15,775,856)	(9,347,806)
Finance costs		(10,000)	(6,148)	(5,252)	3,852	(896)
Accommodation expenses		(3,110,000)	(2,800,139)	(2,223,210)	309,861	(576,928)
Other payments		(4,069,000)	(3,285,478)	(2,352,272)	783,522	(933,206)
Receipts						
Commonwealth grants and contributions		264,000	386,222	1,339,105	122,222	(952,883)
Other receipts		364,000	1,071,198	275,681	707,198	795,517
Net cash used in operating activities		**(1,108,837,000)**	**(1,113,464,702)**	**(999,663,770)**	**(4,627,702)**	**(113,800,932)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets	8	(12,199,000)	(1,510,738)	(1,792,605)	10,688,262	281,867
Net cash used in investing activities		**(12,199,000)**	**(1,510,738)**	**(1,792,605)**	**10,688,262**	**281,867**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Lease payments		(66,000)	(53,166)	(56,009)	12,834	2,843
Net cash used in financing activities		**(66,000)**	**(53,166)**	**(56,009)**	**12,834**	**2,843**
Net increase / (decrease) in cash and cash equivalents		(6,196,000)	29,918,110	(2,916,497)	36,114,110	32,834,607
Cash and cash equivalents at the beginning of the period		36,773,000	35,516,077	38,432,574	(1,256,923)	(2,916,497)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**30,577,000**	**65,434,187**	**35,516,077**	**34,857,187**	**29,918,110**

Mental Health Commission
Notes to the Financial Statements
For the year ended 30 June 2022

10.1 Explanatory statements (cont.)

Statement of Comprehensive Income Major Estimate and Actual (2022) Variance Narratives for Controlled Operations

1 Service agreement payments to non government organisations are under budget by $18,070m (9.5%) due to a classification change in expenditure from supplies and services to grants and subsidies expenditure. This was mainly for one-off grant expenditures associated with COVID readiness and response and various small grant expenditures for services including complex mental health community beds and alcohol and drug (AOD) rehabilitation services. This changes occurred after the budgets were finalised.

2 Grants and subsidies payments are over budget by $15,776m (264.8%) due to one-off grant payments associated with COVID readiness and response and various small grants payments for other mental health services.

3 The variance of $36,369m (13.9%) in service agreement funding compared to budget is due to increased funding received from the Commonwealth under the National Health Reform Agreement arising from an increase in non-admitted mental health funding and a change in the mix of services eligible as in-scope activity.

Statement of Comprehensive Income Major Actual (2022) and Comparative (2021) Variance Narratives for Controlled Operations

A The increase of $80,759m (10.5%) in service agreement - WA health expenditure is primarily attributable to cost and demand escalation for public mental health hospital services and additional mental health inpatient beds.

B The increase of $99,674m (13.8%) in service appropriations is largely due to improving mental health, alcohol and other drug services in Western Australia together with new funding received from the 2021 election commitments.

C The increase of $45,986m (18.2%) in service agreement funding is due to increased funding received from the Commonwealth under the National Health Reform Agreement arising from an increase in non-admitted mental health funding and a change in the mix of services eligible as in-scope activity.

Statement of Financial Position Major Estimate and Actual (2022) Variance Narratives for Controlled Operations

4 Property, plant and equipment is under budget by $10,065m (33.8%) due to delays in commencing the establishment of the new works relating to various programs such as The Immediate Drug Assistance Coordination Centre, a 20-Bed AOD Rehabilitation Facility in the Metropolitan Region and the Youth Long Term Housing and Support Program. The expected commencement of this expenditure will be incurred in the next financial year.

5 Employee provisions (current and non-current) are over budget by $1,432m (25.2%) which is due to the transfer of leave provisions of new employees to the Commission.

Statement of Financial Position Major Actual (2022) and Comparative (2021) Variance Narratives for Controlled Operations

D The increase of $2,318m (13.3%) in property, plant and equipment is largely attributable to upgrading works for the Broome step up/step down programs and Porth Hedland sobering up centres as well as an increase in the valuations of the Commission's land and buildings by Landgate.

Statement of Cash Flows Major Estimate and Actual (2022) Variance Narratives for Controlled Operations

6 The variance of $36,369m (13.9%) in service agreement funding compared to budget is due to increased funding received from the Commonwealth under the National Health Reform Agreement.

7 Grants and subsidies payments are over budget by $15,776m (264.8%) due to one-off grant payments associated with COVID readiness and response and various small grants payments for other mental health services.

8 The purchase of non-current assets is under budget by $10,688m (87.6%) due to delays in commencing the establishment of the new works relating to various programs such as The Immediate Drug Assistance Coordination Centre, a 20-Bed AOD Rehabilitation Facility in the Metropolitan Region and the Youth Long Term Housing and Support Program.

Statement of Cash Flows Major Actual (2022) and Comparative (2021) Variance Narratives for Controlled Operations

E The increase of $99,669m (13.8%) in service appropriations is largely due to improving mental health, alcohol and other drug services in Western Australia together with new funding received from the 2021 election commitments.

F The increase of $45,986m (18.2) % in Commonwealth service agreement funding is due to increased funding received from the Commonwealth under the National Health Reform Agreement.

G The increase of $80,759m (10.4%) in service agreement - WA health expenditure is primarily attributable to cost and demand escalation for public mental health hospital services and additional mental health inpatient beds.

Mental Health Commission Administered Schedules
Notes to the Financial Statements
For the year ended 30 June 2022

10.2 Explanatory statement for administered items

This explanatory section explains variations in the financial performance of the Department undertaking transactions as an agent of the government, as detailed in the administered schedules.

All variances between annual estimates and actual results for 2022, and between the actual results for 2022 and 2021 are shown below. Narratives are provided for key major variances which vary by more than 10% from their comparative and that the variation is more that 1% of the Total Administered Income for the previous year (i.e. 1% of $10,092,786).

Administered income and expense by service		Estimate 2022 $	Actual 2022 $	Actual 2021 $	Variance between estimate and actual $	Variance between actual results for 2022 and 2021 $
Income						
For transfer:						
Administered appropriation						
Mental Health Tribunal	A	3,577,000	3,577,000	2,740,000	-	837,000
Mental Health Advocacy Service	A	3,703,000	3,703,000	2,858,000	-	845,000
Office of Chief Psychiatrist	A	3,974,000	3,974,000	3,272,000	-	702,000
Service received free of charge		1,280,000	1,272,743	1,209,902	(7,257)	62,841
Other revenue	1, B	-	140,586	12,884	140,586	127,702
Total administered income		**12,534,000**	**12,667,329**	**10,092,786**	**133,329**	**2,574,543**
Expenses						
Employee benefits expense	C	9,840,000	9,171,073	7,978,012	(668,927)	1,193,061
Supplies and services	C	1,984,000	2,169,483	1,477,036	185,483	692,447
Depreciation expense		12,000	18,466	11,699	6,466	6,767
Finance costs		2,000	1,120	412	(880)	708
Accommodation expense		314,000	385,170	408,849	71,170	(23,679)
Other expenses		382,000	298,509	201,296	(83,491)	97,213
Total administered expenses		**12,534,000**	**12,043,821**	**10,077,304**	**(490,179)**	**1,966,517**

Major Estimate and Actual (2022) Variance Narratives

1 The variance of $140,586 is largely related to the additional funding from Department of Justice to The Office of the Chief Psychiatrist for the Criminal Law (Mental Impairment) Bill 2021 and the contribution towards NDIS Access Support service from the Mental Health Commission to Mental Health Advocacy Services.

Major Actual (2022) and Comparative (2021) Variance Narratives

A The combined increase of $2,384m (26.9%) is largely attributable to additional appropriations for meeting statutory obligations of the Mental Health Act.

B The increase in other revenue of $127,702 (991.2%) is largely related to the additional funding from Department of Justice to The Office of the Chief Psychiatrist for the Criminal Law (Mental Impairment) Bill 2021 and the contribution towards NDIS Access Support service from the Mental Health Commission to Mental Health Advocacy Services.

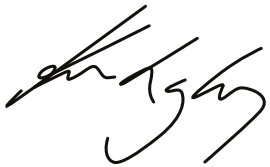
C The increase of $1,193m (14.9%) in employee benefits expense and an increase of $692,447 (46.9%) in supplies and services is largely attributable to additional employee and service expenses for meeting statutory obligations of the Mental Health Act.

Certification of KPIs

Mental Health Commission

Certificate of Key Performance Indicators for the year ended 30 June 2022.

I hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the Mental Health Commission and fairly represent the performance of the Mental Health Commission for the financial year ended 30 June 2022.



Kim Lazenby
A/Commissioner
Mental Health Commission
Accountable Authority

16 September 2022

Certified KPIs

Detailed Key Effectiveness Indicators Information

Outcome 1

Improved mental health and wellbeing

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

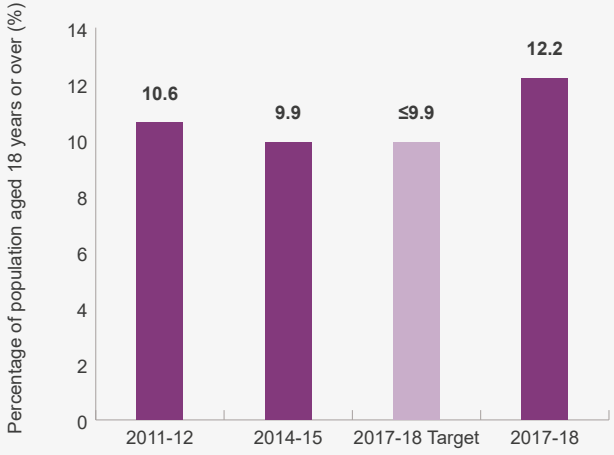
Measures the psychological distress of the Western Australia population aged 18 years and over. A higher proportion of people with high or very high levels of psychological distress is indicative of potential population requiring mental health services.

Data for the indicator is derived from the 10-item Kessler Psychological Distress Scale (K10) administered as part of the Australian Bureau of Statistics (ABS) National Health Survey, which is conducted every three years.

The most recent National Health Survey (2017-18) indicated that 12.2% of the Western Australian population aged 18 years and over experienced high or very high levels of psychological distress. This result was 2.3 percentage points higher than the 2017-18 target and the 2014-15 result.

In 2021-22, the target for the percentage of the population with high or very high levels of psychological distress was ≤12.2% which was based on the 2017-18 result. Achieving a lower percentage, indicates better performance. The 2020-21 National Health Survey state-based results will be published late 2022.

Percentage of population aged 18 years and over with high or very high levels of psychological distress (%)



Outcome 2

Reduced incidence of use and harm associated with alcohol and other drug use

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

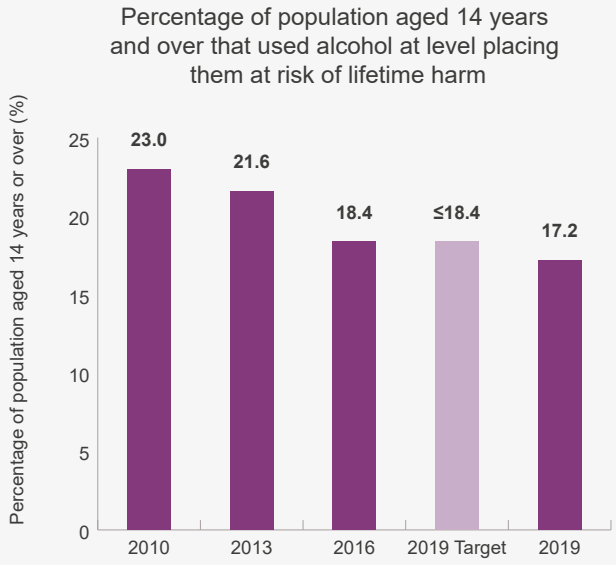
Measures the percentage of the Western Australian population aged 14 years and over reporting alcohol consumption at levels placing them at risk of lifetime harm. Data for the indicator is derived from the National Drug Strategy Household Survey; a national survey conducted every three years that provides a view of reported illicit drug and alcohol use over time. This indicator reflects the impact of preventative initiatives across a range of government departments, including the Commission, on reducing the incidence of use and harm associated with alcohol consumption.

The data presented were collected prior to 2020 and so alcohol-related risk of harm was determined using the 2009 National Health and Medical Research Council (NHMRC) guidelines. The 2009 guidelines recommended 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. Preventing or delaying the onset of risky alcohol consumption contributes to the prevention of long-term health related harm.

In 2020, NHMRC released an updated Australian guideline to reduce health risks from drinking alcohol. The 2020 guidelines recommend healthy people should drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day to reduce the risk of harm from alcohol-related disease or injury.

The most recent survey conducted in 2019 indicated that 17.2% of the Western Australian population aged 14 years and over reported use of alcohol at lifetime risky levels. This result was comparable to the 2019 target and 2016 result (1.2 percentage points lower than 18.4%).

The 2021-22 target for the percentage of the population aged 14 years and over reporting recent use of alcohol at level placing them at risk of lifetime was ≤17.2% which was based on the 2019 result. Achieving a lower percentage, indicates better performance. The 2022 National Drug Strategy Household Survey result will be published during 2023.



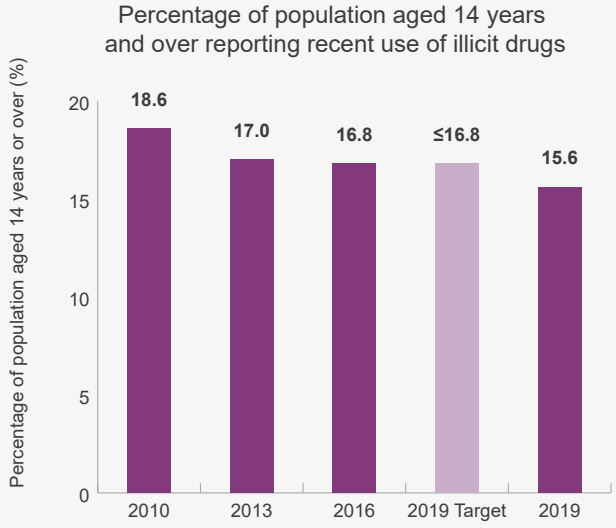
Key Effectiveness Indicator 2.2: Percentage of the population aged 14 years and over reporting recent use of illicit drugs

Measures the proportion of the Western Australian population aged 14 years and over reporting recent use of illicit drugs. The term 'Illicit drugs', as reported in the National Drug Strategy Household Survey (NDSHS), includes illegal drugs (such as cannabis, ecstasy, heroin and cocaine), prescription pharmaceuticals (such as tranquillisers, sleeping pills, and opioids) used for non-medical purposes, and volatile substances used inappropriately such as inhalants. The term 'recent use' refers to the use of drugs or alcohol within 12 months prior to being surveyed for the NDSHS. The NDSHS is conducted every three years and is coordinated by the Australian Institute of Health and Welfare.

Reducing illicit drug use lowers the impact of short-term risk and contributes to the prevention of long-term health related harm. 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 illicit drug use.

The most recent survey conducted in 2019 stated that 15.6% of the Western Australian population aged 14 years and over reported recent use of illicit drugs. This result was comparable to the 2019 target and 2016 result (1.2 percentage points lower than 16.8%).

In 2021-22, the target for the percentage of the population aged 14 years and over reporting recent use of illicit drugs was ≤15.6%, which was based on the 2019 result. Achieving a lower percentage, indicates better performance. The 2022 National Drug Strategy Household Survey result will be published during 2023.



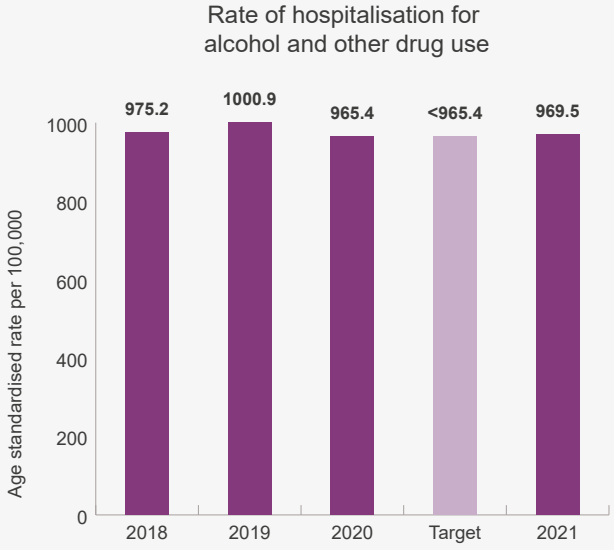
Key Effectiveness Indicator 2.3: Rate of hospitalisation for alcohol and other drug use

Measures the age-standardised rate of hospitalisations attributable to alcohol and other drug use per 100,000 population. To determine what proportion of hospitalisations are likely due to the effects of alcohol and other drugs, estimates are used. These estimates are called Aetiological Fractions (AFs) and are based on published literature. Hospitalisation data is a robust measure of harmful health effects attributable to the use of alcohol and other drugs in the community. Data is provided by Department of Health's Epidemiology Branch for the calendar year using the Hospital Morbidity Data Collection.

This indicator reflects the effectiveness of preventative initiatives of a range of government departments, including the Commission, and alcohol and other drugs services that aim to provide high quality and appropriate treatments and supports to reduce the harm associated with alcohol and other drug use. It can be broadly interpreted as a measure of the impact of alcohol and other drug use on the health of the general population of Western Australia.

In 2021-22, the target for the rate of hospitalisations for alcohol and other drug use was <965.4 per 100,000 population which was based on the 2020 result. Achieving a lower rate, indicates better performance.

The latest available data is for the 2021 calendar year and the age-standardised rate of hospitalisations attributable to alcohol and other drug use is 969.5 per 100,000 population. The 2021 result is comparable to the 2020 result and 2021-22 target, being only 0.4% higher than the target.



The latest available data has been used to report performance and in this instance the result is for the 2021 calendar year

Outcome 3

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

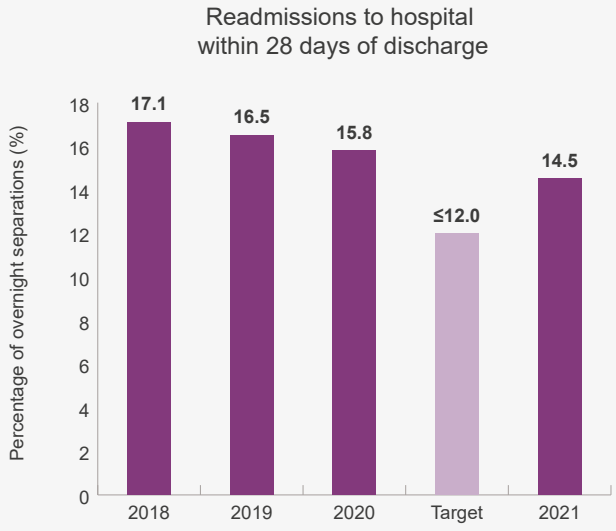
Key Effectiveness Indicator 3.1: Readmissions to hospital within 28 days of discharge from acute specialised mental health units

Measures the proportion of overnight separations from acute specialised mental health inpatient units that are followed by a readmission to the same or another specialised mental health inpatient unit within 28 days of discharge from hospital. This indicator measures the appropriateness and quality of care provided by mental health services. The readmission rate is an indicator of the objective to provide effective care and continuity of care in the delivery of mental health services.

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. It should be noted that the readmission rate does not differentiate between planned and unplanned readmissions, which can affect the overall readmission rates. Planned readmissions may be part of a staged discharge plan or the model of care for the diagnosis. Data is provided by the Department of Health's Hospital Morbidity Data Collection for the calendar year.

In 2021-22, the set target for the percentage of readmissions to hospital within 28 days of discharge from acute specialised mental health inpatient units was ≤12.0%, which is the national target. Achieving a lower percentage, indicates better performance.

The latest available data is for the 2021 calendar year, and the result for the readmission rate to acute mental health inpatient facilities within 28 days of discharge was 14.5%. This result is 2.5 percentage points higher than the target of ≤12.0% and 1.3 percentage points lower than the 2020 result of 15.8%. Since 2017, there has been a continued improvement in readmission rates and the Commission continues to work with the mental health services to monitor and improve performance.



The latest available data has been used to report performance and in this instance the result is for the 2021 calendar year

Key Effectiveness Indicator 3.2: Percentage of contacts with community-based public mental health non-admitted services within 7 days post-discharge from public mental health inpatient units

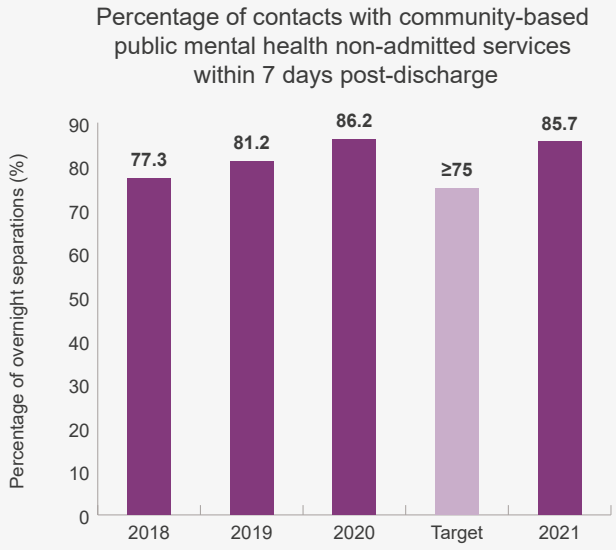
Measures the proportion of overnight separations from public mental health inpatient units where a community-based mental health service contact occurred within seven days following discharge (post-discharge follow-up). Seven days was recommended nationally as an indicative time period for contact within the community following discharge from hospital. 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. Data is sourced from the Department of Health's Mental Health Information Data Collection and Hospital Morbidity Data Collection for the calendar year.

A higher percentage of contact with mental health services within seven days post-discharge should lead to a lower proportion of readmissions. These community treatment services provide ongoing clinical treatment and access to a range of programs that maximise an individual's independent functioning and quality of life.

Discharge from mental health inpatient units is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have heightened levels of vulnerability and, without adequate follow up, may relapse and/or need to be readmitted into hospital.

In 2021-22, the target for the percentage of contacts with community-based public mental health non-admitted services within 7 days post-discharge from public mental health inpatient units was ≥75.0%, which is the national target. Achieving a higher percentage, indicates better performance.

The latest available data is for the 2021 calendar year, and the percentage of post-discharge follow up was 85.7%. This result is 10.7 percentage points higher than the lower limit of the target and 0.5 percentage points lower than the 2020 result of 86.2%. The Commission continues to monitor this indicator and regularly reviews results with WA health to further improve performance and enhance data capture.



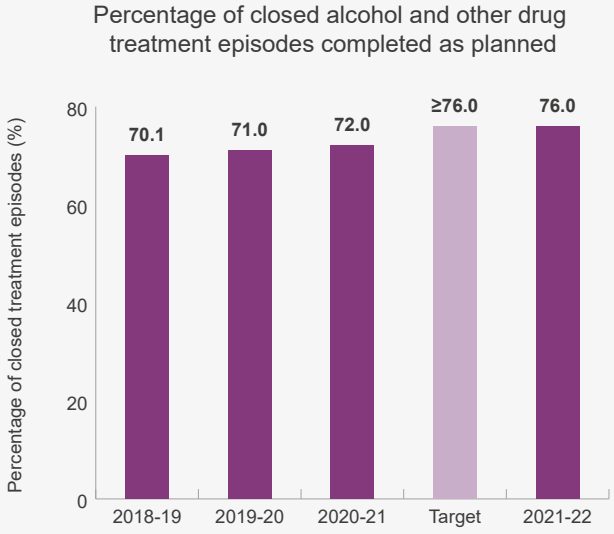
The latest available data has been used to report performance and in this instance the result is for the 2021 calendar year

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

Measures the percentage of closed treatment episodes in alcohol and other drug treatment services that were completed as planned. An episode is the period of care between the start and end of treatment. A high percentage of closed alcohol and other drug treatment episodes completed as planned is indicative of high quality and appropriate care in alcohol and other drug treatment and support. Data is sourced from the Commission's De-identified Treatment Agency Database and is for the 12-month period from April to March to allow for a three-month lag for coding and auditing purposes.

In 2021-22, the target for the percentage of closed alcohol and other drug treatment episodes completed as planned was ≥76.0%, which is the national target. Achieving a higher percentage, indicates better performance.

In 2021-22, the percentage of closed treatment episodes that were completed as planned was 76.0%. This result falls within the lower limit of the 2021-22 target and is 4 percentage points higher than the 2020-21 result of 72.0%. The Commission is continuing to work towards the target to ensure high quality and appropriate care.

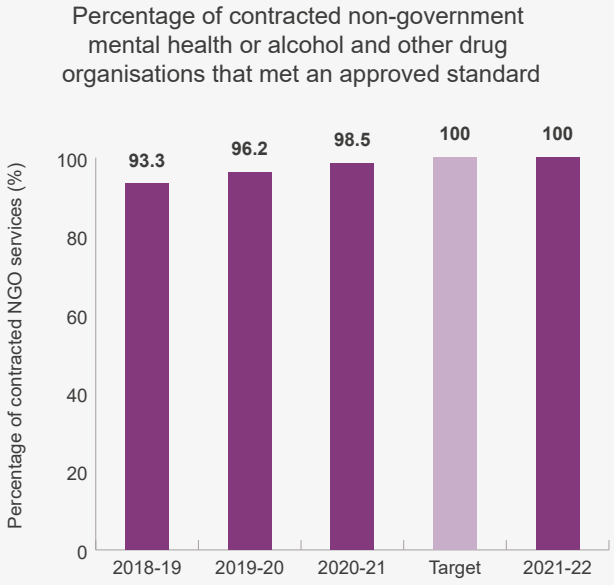


Key Effectiveness Indicator 3.4: Percentage of contracted non-government mental health or alcohol and other drug services that met an approved standard

Measures the appropriateness and quality of mental health and alcohol and other drug treatment services provided by organisations against an approved accreditation standard. All Commission funded services delivering mental health and alcohol and other drug treatment are required to be accredited and maintain accreditation against an approved standard. For providers of mental health services, the agreed standard is the National Standards for Mental Health Services 2010. For providers of alcohol and other drug services the approved accreditation standards have been established by the National Quality Framework for Drug and Alcohol Treatment Services (2018). The Commission contract officers review the accreditation reports as they are submitted and note any areas of concern as part of the Commission's contract management processes. Data is sourced from the Commission's Sector Development and Quality area. Access to high quality services provides clients confidence in the services and support available to them.

In 2021-22, the target for the percentage of contracted non-government mental health or alcohol and other drug services that met an approved standard was equal to 100%. The aim was for all non-government services to meet an approved standard.

In 2021-22, the percentage of non-government mental health and alcohol and other drug organisations that met an approved standard by 30 June 2022 was 100%. This result is equal to the 2021-22 target of 100% and 1.5 percentage points higher than the 2020-21 result of 98.5%.



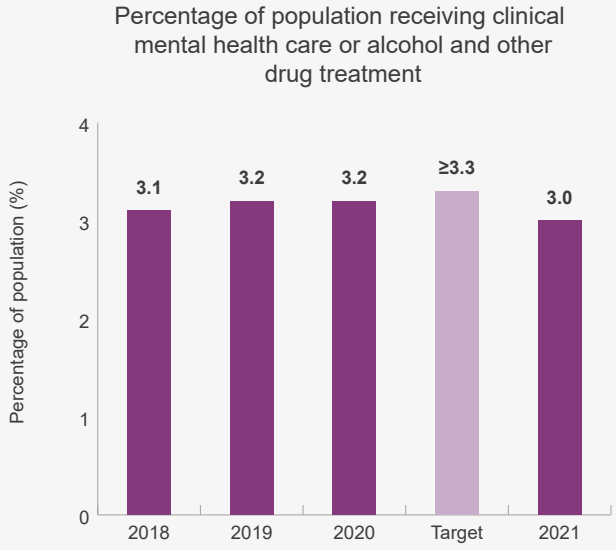
Key Effectiveness Indicator 3.5: Percentage of the population receiving public clinical mental health care or alcohol and other drug treatment

Measures the proportion of the Western Australian population using a specialised public mental health service or receiving public alcohol and other drug treatment. Data on the public clinical mental health care is for a 2021 calendar year and is sourced from the Department of Health's Mental Health Information Data Collection and the Hospital Morbidity Data Collection. The population figures are sourced from the Australian Bureau of Statistics (ABS). Data is based on the ABS June 2021 population estimate released in December 2021 and last updated on 28 June 2022.

The Alcohol and other Drug Treatment Services National Minimum Data Set (AODTS NMDS) collection covers the majority of publicly funded alcohol and other drug treatment services, including government and non-government organisations. It is noted that it is difficult to fully quantify the scope of alcohol and other drug services in Australia as people receive treatment for alcohol and other drug-related issues in a variety of settings not in scope for the AODTS NMDS. The out-of-scope services include but are not exclusive to private treatment agencies, prisons, accommodation services and general practitioners. Alcohol and other drug treatment data is for the 2020-2021 financial year.

In 2021-22, the target for the percentage of the population receiving public clinical mental health care or alcohol and other drug treatment was ≥3.3%. A higher percentage is indicative of greater accessibility to services by those in need.

In 2021, the percentage of the Western Australian population receiving public mental health care or alcohol and other drug treatment was 3.0%. The 2021 result is 0.2 percentage points lower than the 2020 result and 0.3 percentage points lower than the 2021-22 target.



Certified KPIs

Detailed Key Efficiency Indicators Information

Service 1

Prevention

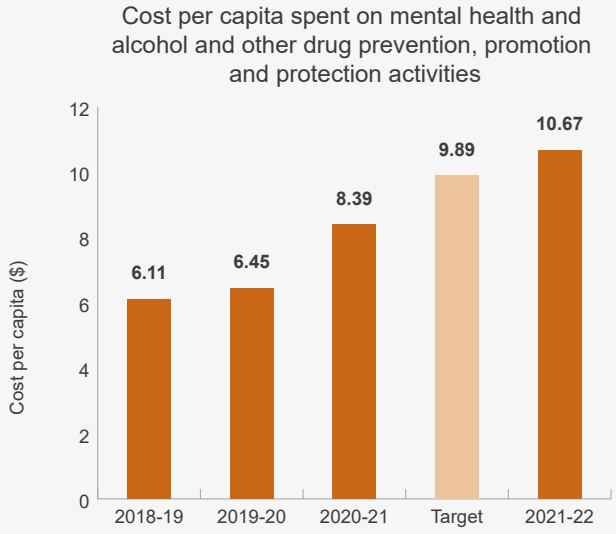
Key Efficiency Indicator 1.1: Cost per capita spent on mental health and alcohol and other drug prevention, promotion and protection activities

Measures the per capita expenditure by the Commission on mental health and alcohol and other drug prevention, promotion and protection activities for the Western Australian population. Mental health prevention, promotion and protection activities target all ages while alcohol and other drug initiatives target individuals 14 years of age and over. This indicator monitors investment by the Commission in activities that aim to eliminate or reduce modifiable risk factors associated with individual, social and environmental health determinants to enhance mental health and wellbeing and prevent mental illnesses and alcohol and other drug related harm before they occur. The aim is to increase the proportional investment in the prevention service and gain a return in health, economic and social benefits for the Western Australian community.

Data is sourced from the Commission's Financial Systems, while population figures for Western Australia are from the Australian Bureau of Statistics (ABS). The population data for the 2021-22 result is based on the ABS June 2021 population estimate for Western Australia, released in December 2021 and last updated on 28 June 2022. Cost data is for the financial year.

In 2021-22, the target for the cost per capita spent on mental health and alcohol and other drug prevention, promotion and protection activities was $9.89. A higher cost per capita indicates greater funding towards prevention, promotion and protection activities in Western Australia. The 2021-22 target is higher than the 2020-21 result primarily due to increased spending for the Strong Spirit Strong Minds; Suicide Prevention; Parents, Young People and Alcohol Campaign; and Aboriginal Social and Emotional Wellbeing initiatives.

In 2021-22, the cost per capita spent on mental health and alcohol and other drug prevention, promotion and protection activities was $10.67. The result is 7.9% higher than the 2021-22 target of $9.89 and 27.2% higher than the 2020-21 result of $8.39. The increased cost in 2021-22 is primarily due to new funding for the 'Mental Awareness, Respect and Safety' program and additional expenditure for campaigns such as the 'Alcohol. Think Again' public education campaign.



Service 2

Hospital Bed-Based Services

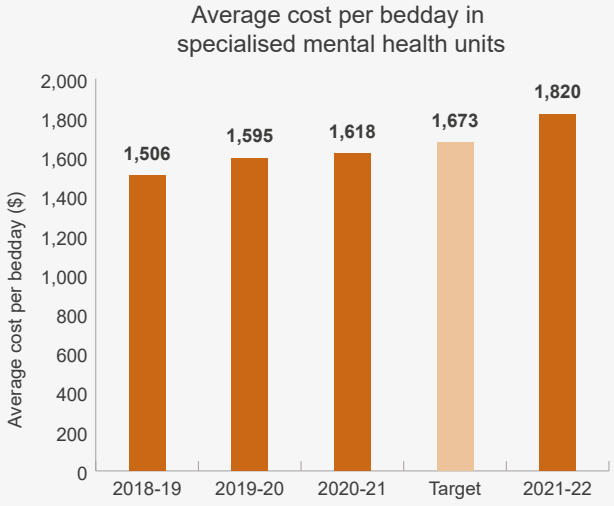
Key Efficiency Indicator 2.1: Average cost per purchased bedday in specialised mental health units

Measures the average cost per purchased bedday in specialised acute and sub-acute mental health units. Cost per inpatient bedday is defined as expenditure on inpatient services divided by the number of inpatient beddays for acute and subacute units. Data is for the financial year and is drawn from the Commission's Financial Systems, BedState from the Department of Health, and Next Step data extracted from the Commission's De-identified Treatment Agency Database.

Acute hospital beds provide hospital-based inpatient assessment and treatment services for people experiencing severe episodes of mental illness. Acute inpatient services also include the Next Step inpatient withdrawal units. Sub-acute hospital services provide hospital-based treatment and rehabilitation for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour. Sub-acute services provide mental health treatment, rehabilitation and support for adults, older adults and young people (18 years old and over).

In 2021-22, the target for the average cost per purchased bedday in specialised mental health units was $1,673. A result below target indicates there were more beddays or less funding provided than expected. A result above target indicates there were fewer beddays or more funding provided than expected.

In 2021-22, the average cost per bedday in specialised mental health units was $1,820. This result is 8.8% higher than the 2021-22 target of $1,673 and 12.5% higher than the 2020-21 result of $1,618. The higher 2021-22 result is due to the quarantining of mental health beds to allocate resources to support the COVID-19 effort.



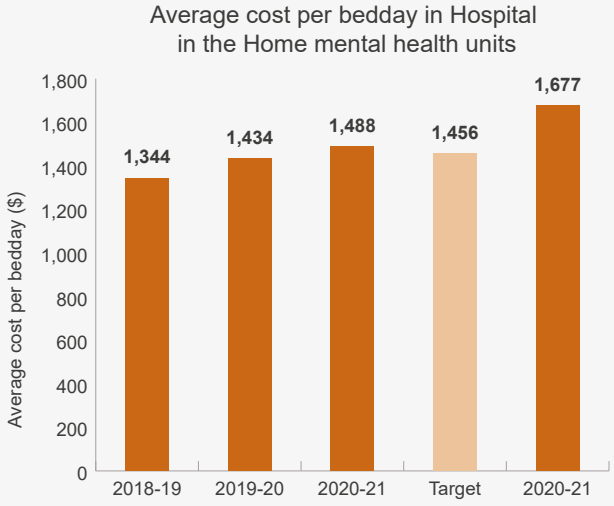
Key Efficiency Indicator 2.2: Average cost per purchased bedday in hospital in the home mental health units

Measures the average cost per bedday for patients in the Hospital in the Home Mental Health (HITH-MH) program. Data is for the financial year and is sourced from the Commission's Financial Systems, and Bedstate from the Department of Health.

The HITH-MH program offers individuals the opportunity to receive hospital level treatment delivered in their home, where clinically appropriate. HITH-MH is consistent with the approach of providing mental health care in the community, closer to where individuals live. HITH-MH is delivered by multidisciplinary mental health teams with a service focus of mental health interventions and support towards recovery. People admitted into this program remain under the care of a treating hospital doctor. HITH-MH is delivered in the community, but measured and funded as inpatient hospital activity, 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.

In 2021-22, the target for the average cost per purchased bedday for HITH-MH was $1,456. A result below target indicates there were more beddays or less funding provided than expected. A result above target indicates there were fewer beddays or more funding provided than expected.

In 2021-22, the average cost per bedday for HITH-MH services was $1,677. This result is 15.1% higher than the 2021-22 target of $1,456 and 12.7% higher than the 2020-21 result of $1,488. The higher result in 2021-22 compared to the 2021-22 target and 2020-21 result is due to the closure of some HITH-MH beds due to staffing shortages and the delay in opening new HITH-MH services.



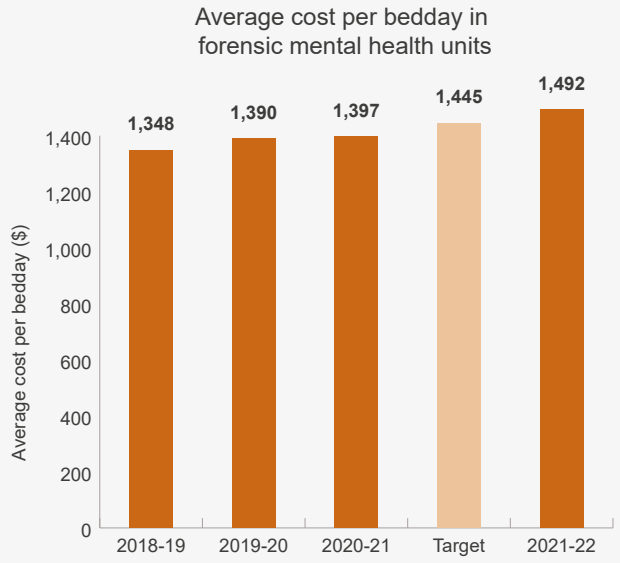
Key Efficiency Indicator 2.3: Average cost per purchased bedday in forensic mental health units

Measures the average cost per inpatient bedday in forensic mental health units. The unit cost of admitted patient care in forensic specialised mental health units is closely monitored in order to ensure cost effectiveness. Data is for the financial year and is sourced from the Commission's financial systems and Bedstate from the Department of Health.

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 court order. Cost per inpatient bedday is defined as expenditure on forensic inpatient services divided by the number of forensic inpatient beddays.

In 2021-22, the target for the average cost per purchased bedday in forensic mental health units was $1,445. A result below target indicates there were more beddays or less funding provided than expected. A result above target indicates there were fewer beddays or more funding provided than expected.

In 2021-22, the average cost per bedday in forensic units was $1,492. This result is comparable to the 2021-22 target (3.2% higher than $1,445) and 6.7% higher than the 2020-21 result of $1,397. The higher result in 2021-22 compared to the 2020-21 is due to cost escalations.



Additional KPIs

Unaudited Key Performance Indicators

As disclosed in the Performance Management Framework section of this report, the Commission was granted an exemption on the reporting of results for several key efficiency indicators due to COVID-19 related issues which prevented the independent verification of data from service providers within the required timeframe.

While these results have not been audited, the Commission has published the results for information only. The Commission does not make any representation or warrants that the information presented below forms part of the certified and audited KPIs.

A similar exemption on the reporting of results for several key efficiency indicators due to COVID-19 related issues which prevented the independent verification of data from service providers within the required timeframe was granted for the 2019-20 reporting period and is also referenced in the following results.

Service 3

Community Bed Based Services

Key Efficiency Indicator 3.1: Average cost per purchased bedday in mental health 24 hour and non-24 hour staffed community bed based services

Measures the average cost per bedday in mental health 24 hour and non-24 hour staffed community bed based services. Data is for the financial year, and is sourced from the Commission's financial systems, the Commission's Contract Acquittal Data Collection (CADC). Activity data is for 6 months (July 2021 to December 2021) extrapolated to 12 months.

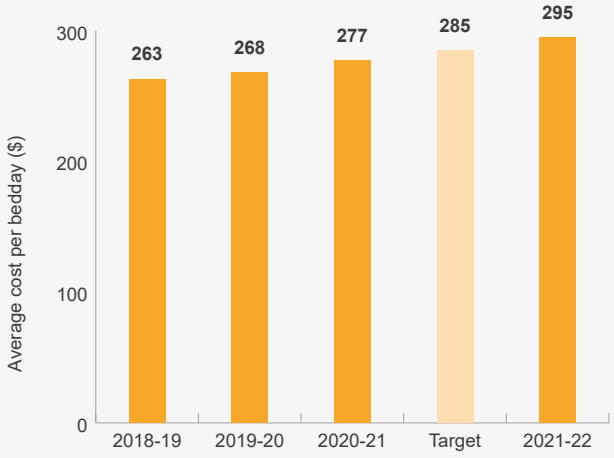
Non-government organisations provide accommodation in residential units for people affected by mental illness who require support to live in the community. Services include support with self-management of personal care and daily living activities as well as initiating appropriate treatment and rehabilitation to improve the quality of life. These services provide support for adults who have severe and persistent symptoms of mental illness, who have significant behavioural problems, and who have support and care needs above those that would enable them to live independently in the community.

Services can be staffed either 24 hours a day for those who require more intensive support or less than 24 hours a day for people with less severe mental health and behavioural problems. Where services are staffed less than 24 hours a day, appropriate staff are still available (e.g. on call) when required.

In 2021-22, the target for the average cost per purchased bedday in mental health 24 hour and non-24 hour staffed community bed based services was $285. A result below target indicates there were more beddays or less funding provided than expected. A result above target indicates there were fewer beddays or more funding provided than expected.

In 2021-22, the average cost per purchased bedday for 24 hour and non-24 hour staffed community bed-based services was $295. This result is comparable to the 2021-22 target (3.5% higher) and higher than the 2020-21 result (6.5% higher). The higher result for 2021-22, compared to the 2020-21 result, is due to cost escalations.

Average cost per purchased bedday in mental health 24 hour and non-24 hour staffed community bed based services



An exemption was obtained from reporting these KPIs due to COVID-19. The data presented for 2019-20 and 2021-22 are unaudited

Key Efficiency Indicator 3.2: Average cost per bedday in mental health step up/step down community bed based units

Measures the average cost per bedday in mental health step up/step down community bed-based units. Cost data is for the financial year and is sourced from the Commission's financial systems. Activity data is for 6 months (July 2021 to December 2021) extrapolated to 12 months and is sourced from the Commission's Contract Acquittal Data Collection (CADC).

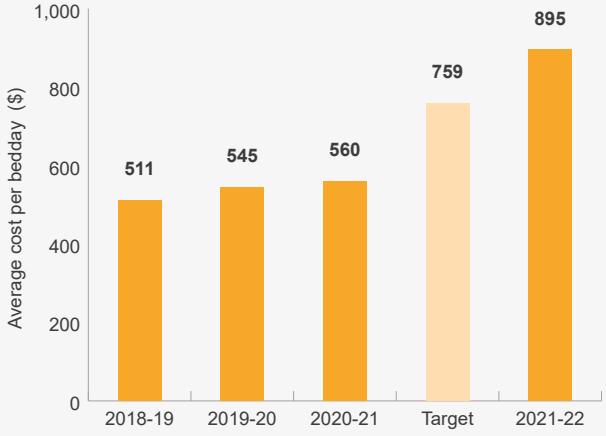
The Mental Health step up/step down service in Western Australia provides short-term mental health care in a residential setting, that promotes recovery and reduces the disability associated with mental illness. These are comprehensive services designed to deliver support to individuals that is aimed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

In 2021-22, the target for the average cost per purchased bedday in mental health step up/step down community bed-based units was $759. A result below target indicates there were more beddays or less funding provided than expected. A result above target indicates there were fewer beddays or more funding provided than expected.

The 2021-22 target was set higher than the 2020-21 result. This was to include the new Geraldton and Kalgoorlie services, which were expected to have a lower occupancy rate until they became fully operational.

In 2021-22, the average cost per purchased bedday in step-up/step-down community bed-based units was $895. This is 17.9% higher than the 2021-22 target of $759 and higher than the 2020-21 result (59.9% higher). The higher result for 2021-22, compared to the 2021-22 target and 2020-21 result, is due to lower than anticipated bed-days for the new services in Geraldton and Kalgoorlie, reluctance of consumers who can become anxious to access a new service during COVID-19 pandemic, and difficulties in recruiting staff.

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



An exemption was obtained from reporting these KPIs due to COVID-19. The data presented for 2021-22 is unaudited

Key Efficiency Indicator 3.3: Average cost per closed treatment episode in alcohol and other drug residential rehabilitation and low medical withdrawal services

Measures the average cost per closed treatment episode in alcohol and other drug residential rehabilitation and low medical withdrawal services. Treatment episode data is sourced from the De-identified Treatment Agency Database for the 12-month period April to March and allows for a three- month lag for coding and auditing purposes. Cost data is for the financial year and is sourced from the Commission's financial systems.

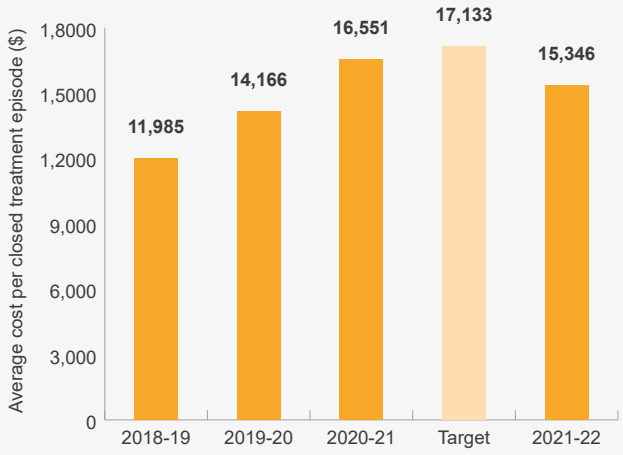
Alcohol and other drug community bed-based services include residential rehabilitation and low medical withdrawal services which provide 24 hour, seven days per week, recovery orientated treatment in a residential setting. Bed based low medical withdrawal provides a supportive care model, based on non-medical or low medical interventions with support provided by a visiting doctor or nurse specialist.

These programs are most appropriate when the withdrawal symptoms are likely to be low to moderate and there is a lack of social support or an unstable home environment. Residential rehabilitation provides clients (following withdrawal) with a structured program of medium to longer-term duration that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills and group work.

In 2021-22 the target for the average cost per closed treatment episode in alcohol and other drug residential rehabilitation and low medical withdrawal services was $17,133. A result below target indicates there were more closed treatment episodes or less funding provided than expected. A result above target indicates there were fewer closed treatment episodes or more funding provided than expected.

In 2021-22, the average cost per completed treatment episode in alcohol and other drug residential rehabilitation services was $15,346. This is 10.4% lower than the 2021-22 target of $17,133 and 7.3% lower than the 2020-21 result of $16,551. This was due to a higher than anticipated number of closed treatments episodes, primarily for the new services in Midland and Goldfields.

Average cost per closed treatment episode in alcohol and other drug residential rehabilitation and low medical withdrawal services



An exemption was obtained from reporting these KPIs due to COVID-19. The data presented for 2019-20 and 2021-22 are unaudited.

Service 4

Community Treatment

Key Efficiency Indicator 4.1: Average cost per purchased treatment day of ambulatory care provided by public clinical mental health services

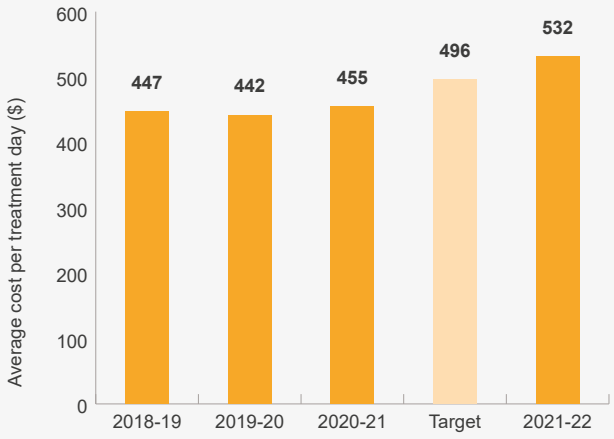
Measures the average cost per purchased treatment day of ambulatory care provided by public clinical mental health services. Treatment days is sourced from the Department of Health's Mental Health Information Data Collection (MIND), the Commission's Contract Acquittal Data Collection (CADC) and non-government organisations. Treatment days from the Department of Health is for financial year, while for non-government organisations it is for 6 months (July 2021 to December 2021) extrapolated to 12 months. Cost data is for the financial year and is sourced from the Commission's financial systems.

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

In 2021-22, the target for the average cost per purchased treatment day of ambulatory care provided by public clinical mental health services was $496. A result below target indicates that there were more treatment days or less funding provided than expected. A result above target indicates that there were fewer treatment days or more funding provided than expected.

In 2021-2022, the average cost per purchased treatment day of ambulatory care provided by public clinical mental health services was $532. This is higher than the 2021-22 target (7.2% higher) and the 2020-21 result (16.9% higher). The higher cost was primarily due to lower treatment days as a result of staff shortages due to COVID-19 public health measures (including mandatory days off work and isolation requirements) and delays in the expansion of services due to the inability to fill vacancies.

Average cost per purchased treatment day of ambulatory care



An exemption was obtained from reporting these KPIs due to COVID-19. The data presented for 2019-20 and 2021-22 are unaudited.

Key Efficiency Indicator 4.2: Average cost per closed treatment episode in community treatment-based alcohol and other drug services

Measures the average cost per closed treatment episode in community treatment-based alcohol and other drug services. Treatment episode data is for the 12-month period April to March and allows for a three-month lag for coding and auditing purposes and it is sourced from the De-identified Treatment Agency Database and the Alcohol Dug and Information Services database. Cost data is for the financial year and is sourced from the Commission's financial systems.

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

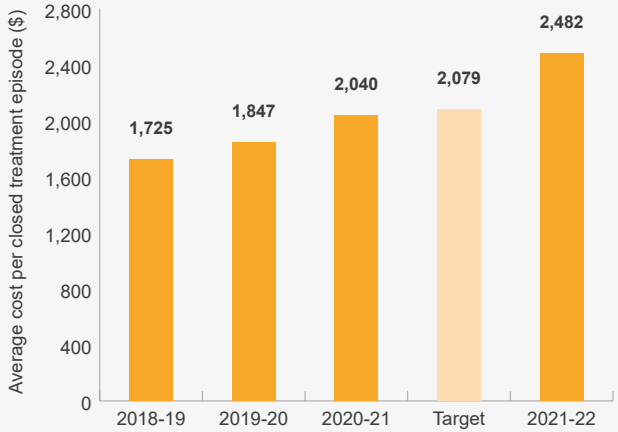
The Western Australian Diversion Program aims to reduce crime by diverting offenders with drug use problems away from the criminal justice system and into treatment to break the cycle of offending and address their drug use. The Alcohol and Drug Support Service (ADSS) is a 24-hour, State-wide, confidential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

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

In 2021-22, the target for the average cost per closed treatment episode in community treatment-based alcohol and other drug services was $2,079. A result below target indicates there were more closed treatment episodes or less funding provided than expected. A result above target indicates there were fewer closed treatment episodes or more funding provided than expected.

In 2021-22, the average cost of a completed treatment episode in community-based alcohol and other drug services was $2,482. This is 19.4% higher than the 2021-22 target of $2,079 and 21.7% higher than the 2020-21 result of $2,040 due to lower-than-expected closed treatment episodes in 2021-22 as a result of COVID-19 related restrictions.

Average cost per closed treatment episode in community treatment based alcohol and other drug services



An exemption was obtained from reporting these KPIs due to COVID-19. The data presented for 2019-20 and 2021-22 are unaudited.

Service 5

Community Support

Key Efficiency Indicator 5.1: Average cost per hour for community support provided to people with mental health issues

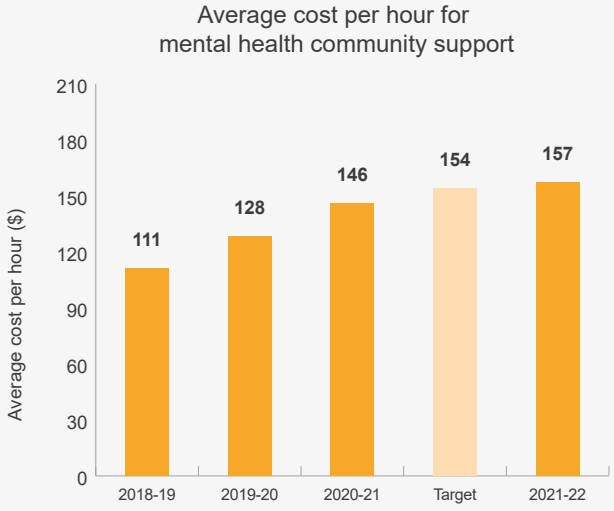
Measures the average cost per hour for community support provided to people with mental health services. Cost data is for the financial year and is sourced from the Commission's financial systems. Activity data is for 6 months (July 2021 to December 2021) extrapolated to 12 months and is sourced from the Commission's Contract Acquittal Data Collection (CADC) and the Individualised Community Living Strategy (ICLS) service providers.

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.

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

In 2021-22, the target for the average cost per hour for community support provided to people with mental health issues was $154. A result below target indicates there were more hours for community support or less funding provided than expected. A result above target indicates there were fewer hours for community support or more funding provided than expected.

In 2021-22, the average cost per hour of community support provided to people with mental health issues was $157. This result is 1.9% higher than the 2021-22 target ($154) and 7.5% higher than the 2020-21 result ($146). The higher result for 2021-22 as compared to 2020-21 result is due to recruitment challenges across the sector and COVID-19 impact on service delivery.



An exemption was obtained from reporting these KPIs due to COVID-19. The data presented for 2019-20 and 2021-22 are unaudited.

Key Efficiency Indicator 5.2: Average cost per episode of care in safe places for intoxicated people

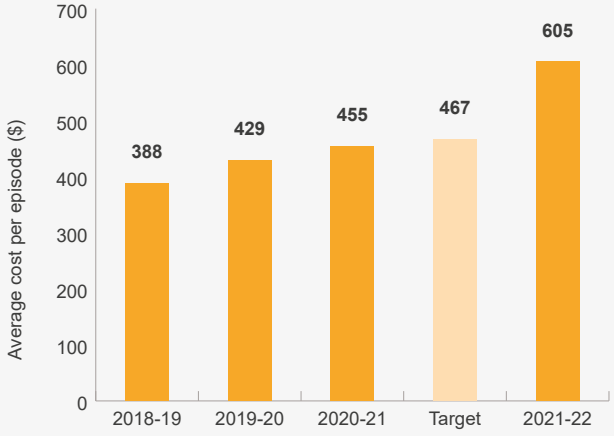
Measures the average cost per episode of care in safe places for intoxicated people. Treatment data for the periods 2017-18 to 2018-19 is for the 12-month period from April to March to allow for a three-month lag for coding and auditing purposes. Due to changes to the data collection process, data for 2019-20, 2020-21, and 2021-22 is for the financial year. Cost data is presented for the financial year. Data is sourced from the Commission's financial systems and the Sobering Up Centre database.

Safe places for intoxicated individuals or sobering up centres provide residential care overnight for intoxicated individuals. As at 30 June 2021, there were nine sobering up centres in Western Australia providing a safe, care-oriented environment in which people found intoxicated in public may sober up. Sobering up centres help to reduce the harm associated with intoxication for the individual, their families and the broader community, and play a key role in the response to family and domestic violence. People may refer themselves to a centre or be brought in by the police, a local patrol, health/welfare agencies, or other means. Attendance at a centre is voluntary.

In 2021-22, the target for the average cost per episode of care in safe places for intoxicated people was $467. A result below target indicates there were more episodes of care or less funding provided than expected. A result above target indicates there were fewer episodes of care or more funding provided than expected.

In 2021-22, the average cost per treatment episode of care in safe places for intoxicated people was $605. This result is 29.5% higher than the 2021-22 target of $467 and 33.0% higher than the 2020-21 result of $455. The higher result for 2021-22 as compared to the 2021-22 target and 2020-21 result is due to the reduction of beds in some sobering up centres due to COVID-19 restrictions and the closure of some sobering up centres for some time due to staff shortages relating to COVID-19.

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

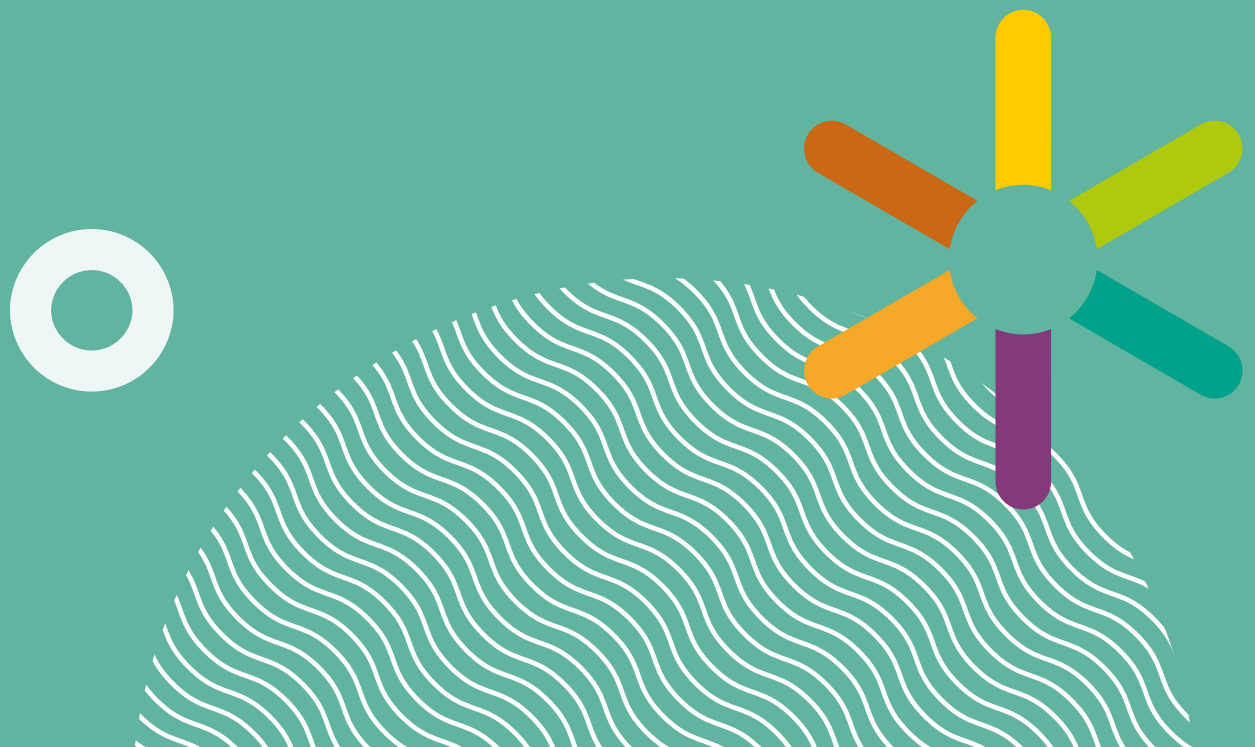


An exemption was obtained from reporting these KPIs due to COVID-19. The data presented for 2019-20 and 2021-22 are unaudited.

Ministerial directives

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 2021-22.



Other legal requirements

Personal expenditure

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

Number of instances the Purchasing Card has been used for Personal Use:	3
Aggregate amount:	$47.44
Aggregate amount settled by due date:	$47.44
Aggregate amount settled after due date:	NIL
Aggregate amount outstanding:	NIL
Number of referrals for disciplinary action:	NIL

Expenditure on advertising, market research, polling and direct mail

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

Name	Category	Spend
303MullenLowe	Advertising agencies	$144,384.00
Likeable Creative	Advertising agencies	$7,450.00
Initiative	Media advertising	$38,141.10
Public education campaigns via Cancer Council WA	Media advertising	$5,581,681.19
Kantar Public	Market research	$608,900.00
The Behaviour Change Collaborative	Market research	$246,101.27
Total		**$6,626,657.56**

Disability Access and Inclusion Plan

The Disability Access and Inclusion Plan (DAIP) demonstrates our commitment to ensuring we are proactive about removing any barriers that may exclude people from accessing information, services, facilities, events and employment opportunities within the Commission. The DAIP is available to members of the public through the Commission's website and to all employees through the Commission's intranet.

- The Commission's current Disability Access and Inclusion Plan (DAIP) expires this year and a new five-year plan has been developed which is in final approvals stage. The Commission invited comments and feedback from employees, people with disability, their family and carers, and organisations representing people with disability to identify access and inclusion barriers and improvement opportunities.
- We engage regularly with consumers who experience disability regarding the development of workforce training and resources. Key resources are revised regularly based on consumer feedback.
- Existing programs are regularly reviewed to ensure the quality and capacity of non-government mental health and AOD services meet community needs now and into the future. The review process includes independent facilitation of workshops and people with disability are offered a range of supports to participate. These can include the use of Auslan interpreters and assistive technology.

This year we:

- Ensured all training venues were accessible, confirming with providers upon booking
- Continued to provide appropriate flexible working arrangements for staff
- Provided disability recruitment training through National Disability Services
- Hosted a guest speaker for International Day of People with Disability to increase staff awareness
- Made personal emergency evacuation plans available for staff with disability
- Considered access and inclusion principles as part of the office accommodation refurbishment design.

Multicultural Plan

The Commission's Multicultural Plan 2021 was developed through consultation with all Divisions to identify priority actions for implementation. We are currently consulting with key stakeholders to inform development of the next stage of the Multicultural Plan.

Priorities completed this year included:

- Consideration of cultural requirements when planning events and training sessions.
- Translation of Alcohol and Drug Support Service information where required, including some printed materials translated into 12 languages and available on the Commission's website.
- Culturally and Linguistically Diverse (CaLD) clients are stated as a priority group in all Commission mental health and AOD service agreements.
- The Commission has actively sought to engage people from CaLD backgrounds to participate in the co-design process for three youth community support and accommodation services (election commitments).
- We supported the WA National Disability Insurance Agency to establish a WA Mental Health Reference group which has CaLD representation.
- People with CaLD backgrounds are represented on key internal decision-making committees including the People and Culture Group, OSH Committee and Conciliation Action Plan Committee.

Compliance with public sector standards and ethical codes

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

During 2021-22, the Commission received one breach of Standard claim relating to the Employment Standard. The claim was declined by the Public Sector Commission, satisfied that the matter was appropriately resolved and the candidate was treated equitably.

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 Records Act and the standards and policies of the State Records Commission (SRC). The Commission's current Recordkeeping Plan was approved by the SRC in August 2019.

In line with the Commission's Recordkeeping Plan, all new staff are provided with a comprehensive induction on recordkeeping and its Electronic Document Records Management System (EDRMS). The staff Induction includes a presentation on individual officers' responsibilities and the services of our Information Management team. Recordkeeping is embedded in the Commission's Code of Conduct and in addition to inductions, all new starters are enrolled in mandatory online awareness training, face-to face or virtual EDRMS training.

A total of 10 Recordkeeping and EDRMS Training sessions were delivered to staff and support agencies by the Information Management Team in 2021-22.

In response to the ongoing COVID-19 pandemic and changing staff work arrangements in the agency during 2021-22, the Information Management Team continued to maintain a Working From Home portal to allow staff to access information regarding recordkeeping responsibilities at home and continued to deliver virtual EDRMS and Recordkeeping training. The Information Management Team continued to maintain a Remote Working portal to enable staff to remain productive in a remote setting and provide access to services more flexibly.

In 2021-22, 78% 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. More than 70 publications are available for staff, including fact and advice sheets and training videos, regarding recordkeeping matters via the corporate intranet.

The Commission will continue its shift to a greater electronic records management operation and digital recordkeeping practices which significantly improves compliance with the Act.

Government Policy Requirements

Staffing, Occupational Safety, Health and Injury Management

Staffing Approved full-time equivalent staff	2021-22 Budget FTE	2021-22 Actual FTE	Variation
Mental Health Commission	297	313	(16)
Office of the Chief Psychiatrist	17	17	–
Mental Health Advocacy Service	10	7	3
Mental Health Tribunal	11	12	(1)
Total	**335**	**349**	**(14)**

Our commitment

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

Our senior leaders recognise that Occupational Safety and Health practices are a major contributor to reducing hazards and risks and are committed to embedding strong OSH practices in all training, planning, purchasing and business activities. The Commission has an Occupational Safety and Health Policy and an Injury/ Rehabilitation Management Policy in place which outline our commitment to safety and health to its employees.

Consultation mechanisms

The Occupational Safety and Health Committee is the primary consultation mechanism for raising and managing workplace health and safety issues. The Committee comprises employer representatives across the Commission and all safety and health representatives. The Committee meets bi-monthly to discuss and resolve health and safety issues, which includes reviewing accidents, incidents and hazards. Minutes from Committee Meetings are made available to employees on the intranet. The contact details of all Safety and Health Representatives are also communicated on the Commission's intranet and noticeboards.

Workers' compensation and injury management

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

Employee health and wellbeing

The Commission is committed to ensuring employees are supported and provided with an environment that actively assists them to maximise their overall health. During 2021-22, the following wellness events and activities were held to enhance employee wellbeing:

- influenza vaccinations
- health checks
- step challenge
- salary packaging and superannuation seminars (financial wellness)
- RU OK? Day and Mental Health Week activities and guest speakers
- Christmas decoration competition (social/ emotional wellness).

During the year, the Commission continued to focus on the mental health and wellbeing of employees through the availability of:

- a comprehensive Employee Assistance Program
- in-house Mental Health First Aid Officers
- webinars and materials to support mental wellbeing during the COVID-19 pandemic
- provision of the EAP MyMentalFitness App
- provision of corporate health insurance rates through HBF and Medibank.

National Strategic Plan for Asbestos Awareness and Management 2019-2023

The Commission is committed to working towards Western Australia's targets to eliminate asbestos-related diseases in Australia. The Commission reports progress in relation to asbestos management, to the Department of Mines, Industry Regulation and Safety biannually. Building Management and Works are engaged every two years to complete inspections of our buildings to assess asbestos-related risks.

Occupational Safety and Health Reporting

Measure	Results 2019-20	Results 2020-21	Results 2021-22	Target
Number of Workers Compensation Claims Received	3	0	1	Zero (0)
Number of fatalities	0	0	0	Zero (0)
Lost time injury/disease incidence rate	0.27	0	0.9%	<0.41
Lost time injury/disease severity rate	0	0	0	Zero (0) or a 10% improvement on the previous 3 years
Percentage of injured workers returned to work within 13 weeks	100%	100%	100%	Greater than or equal to 80%
Percentage of injured workers returned to work within 26 weeks	100%	100%	100%	Greater than or equal to 80%
Percentage of managers trained in occupational safety, health and injury management responsibilities	84%	83%	73%	Greater than or equal to 80%
Number of contacts made to access the in-house Mental Health First Aid Program	86	161	248	NA

Board and Committee Remuneration

Position	Member's name	Type of remuneration	Period of membership	Gross remuneration
Chair	Emeritus Professor Colleen Hayward	Annual	1 July 2020 – 22 March 2022	$15,944.79
Deputy Chair	Dr Mark Montebello	Annual	1 July 2020 – present	$17,507.60
Member	Ms Jill Rundle	N/A	1 July 2020 – present	$0
Member	Ms Miriam Rudd	Sessional	1 July 2020 – present	$2,572.90
Member	Ms Julia Stafford	Sessional	1 July 2020 – present	$3,485.90
Member	Ms Keisha Calyun	Sessional	25 January 2021 – present	$553.30
Member	Ms Nafiso Mohamed	Sessional	7 June 2020 – present	$2,572.90
Member	Commander Lawrence Panaia	N/A	25 January 2021 – present	$0

Alcohol and Other Drugs Advisory Board

The Alcohol and Other Drugs Advisory Board, which provides advice to the Commission on matters relevant to section 11 functions of the *Alcohol and Other Drug Act 1974*, reconvened in 2021 with new members appointed.

Mental Health Advisory Council

The Mental Health Advisory Council provides strategic advice and guidance to the Mental Health Commissioner regarding key matters affecting people with mental issues, their families and service providers. The Council reconvened in 2021 with new members appointed.

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 2021-22 financial year is as follows:

President:	$289,676.01
Member (high):	$201,159.59
Member (average):	$52,425.07
Member (low):	$448.80

Position	Member's name	Type of remuneration	Period of membership	Gross remuneration
Chair	Ms Margaret Doherty	Annual	1 July 2020 – present	$21,259.72
Member	Ms Virginia Catterall	Sessional	1 January 2021 – present	$5,505.50
Member	Dr Pauline Cole	Sessional	1 January 2021 – present	$5,505.50
Member	Ms Patricia Councillor	Sessional	1 July 2020 – present	$10,386.20
Member	Ms Nafiso Mohamed	Sessional	1 February 2022 – present	$2,379.30
Member	Dr Richard Oades	Sessional	1 July 2020 – present	$5,505.50
Member	Mr Paul Parfitt	Sessional	1 July 2020 – present	$5,311.90
Member	Ms Lee Steel	Sessional	1 July 2020 – present	$4,398.90
Member	Ms Emily Wilding	Sessional	1 July 2020 – present	$4,954.40
Member	Mr Andrew Williams	Sessional	1 July 2020 – 1 October 2021	$553.30
Member	Ms Jennifer Wilton	Sessional	1 February 2022 – present	$2,379.30
Member	Ms Tracey Young	Sessional	1 July 2020 – present	$5,311.90
Member	Ms Jessica Nguyen	N/A	1 July 2020 – present	$0
Member	Ms Gemma Powell	N/A	1 Jul 2020 – 1 October 2021	$0

Acronyms

ADSS	Alcohol and Drug Support Service
AOD	Alcohol and Other Drugs
ART	Active Recovery Team
CADS	Community Alcohol and Drug Services
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Service
CMC	Community Mental Health, Alcohol and Other Drug Council
CMOMH	Chief Medical Officer, Mental Health
CoMHWA	Consumers of Mental Health Western Australia
DACAS	Drug and Alcohol Clinical Advisory Service
EMHS	East Metropolitan Health Service
ETS	Emergency Telehealth Service
FASD	Fetal Alcohol Spectrum Disorder
HSPs	Health Service Providers
KPI	Key Performance Indicator
MHAC	Mental Health Advisory Council
MHAS	Mental Health Advocacy Service
MHEC	Mental Health Executive Committee
NDSHS	National Drug Strategy Household Survey
NGOs	Non-Government Organisations
NMHS	North Metropolitan Health Service
SHICC	State Health Incident Control Centre
SHR	Sustainable Health Review
SMHS	South Metropolitan Health Service
SSSM	Strong Spirit Strong Mind
SUSD	Step up/ step down
SWDWG	System Wide Data Working Group
SWICC	State Welfare Incident Control Centre
WACHS	WA Country Health Service
YCATT	Youth Community Assessment and Treatment Team

Abbreviations

The Act	*Mental Health Act 2014*
A Safe Place	A Safe Place: A Western Australian strategy to provide safe and stable accommodation, and support to people experiencing mental health, alcohol and other drug issues 2020-2025
Commission	Mental Health Commission
ICA Taskforce	Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0 to 18 in Western Australia
Next Step	Next Step Drug and Alcohol Services
The Plan	Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025
Records Act	State Records Act 2000
YPPA	Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025

Glossary

Aboriginal people

Within Western Australia, the term Aboriginal people is used in preference to Aboriginal and Torres Strait Islander people, in recognition that Aboriginal people are the original inhabitants of WA. Reference to Aboriginal people throughout this report is respectfully inclusive of Torres Strait Islanders.

Forensic mental health services

Refers to mental health services that principally provide assessment, treatment and care of people with a mental health issue and/or mental illness who are in the criminal justice system, or who have been found not guilty of an offence because of mental impairment. Forensic mental health services are provided in a range of settings, including prisons, hospitals and the community.

LGBTIQA+

Throughout this report we have used the acronym LGBTIQA+ to refer to lesbian, gay, bisexual, transgender, queer, questioning, intersex and any other person or group that is diverse in sex, gender or sexuality. We also recognise that many people and populations have additional ways of describing their distinct histories, experiences and needs outside this acronym.

Secure (mental health/beds)

A bed staffed 24 hours a day that is designated by the Department of Health or authorised by the Chief Psychiatrist to accommodate patients requiring a higher level of care and involuntary containment where clinically appropriate.

Separations

Discharge from hospital.

Social and Emotional Wellbeing

The traditional Aboriginal understanding of health is holistic and does not refer to the individual but encompasses the social, emotional and cultural wellbeing of the whole community. The social and emotional wellbeing (SEWB) of Aboriginal people is strongly influenced by their connection to family, Elders, community, culture, Country, and spirituality. These connections work together to provide a culturally safe environment for Aboriginal people and helps individuals to maintain and enhance their SEWB.

Service Stream descriptions

Prevention

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

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

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

Community support services

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

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

Community treatment

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

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

Community bed-based services

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

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

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

Hospital bed-based services

Hospital bed-based services include acute, subacute and non-acute inpatient units, consultation and liaison services and inpatient AOD withdrawal services. Hospital bed-based services provide treatment and support in line with mental health recovery oriented service provision, including promoting good general health and wellbeing.

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