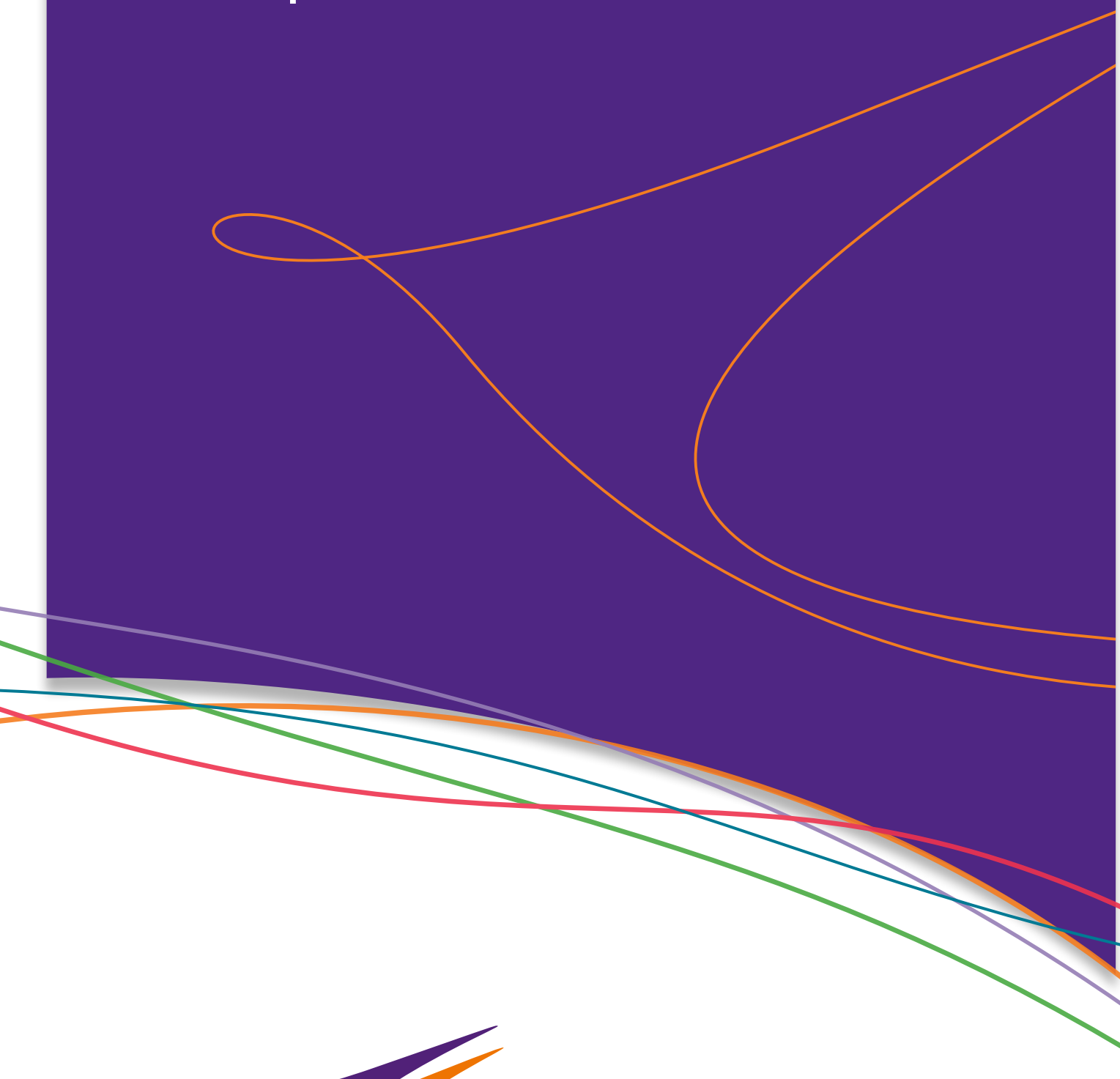
Annual Report



mhcc
mental health coordinating council

2011-2012

Mental Health Coordinating Council
is funded by NSW Health

mhcc
mental health coordinating council

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Organisational Profile

The Mental Health Coordinating Council (MHCC) is the peak body for community-managed organisations (CMOs) working for mental health throughout New South Wales (NSW). MHCC's membership includes CMOs, both specialist and mainstream, and others interested in mental health.

MHCC works with its members to strengthen the community mental health sector and improve mental health service delivery in NSW.

VISION

To be part of a society that fosters and supports positive mental health for all of its members.

MISSION

To provide leadership for and build capacity of non-government services working to improve the mental health of our community.

UNDERLYING PRINCIPLES

- Good mental health is about the whole person – their psychological, physical, emotional and spiritual needs.
- Service user input is central to the promotion of mental health and the delivery and management of services.
- Communities need to provide a range of mental health services designed to meet local needs.
- An across-governmental approach to mental health promotion and service delivery is required.

KEY PRIORITIES

1. Developing the capacity of community-based services within the mental health sector
2. Thought leadership and policy formulation
3. Exemplary management and governance

About Our Sector

MHCC members provide a range of services including: self-help and peer support, information, advocacy and promotion, leisure and recreation, employment and education, accommodation support and outreach, family and carer support, helplines and counselling.

The NSW mental health CMO sector is a crucial part of the mental health system. Our members contribute to improved outcomes for people experiencing mental illness, and their families and carers. Our sector is flexible and responsive and one of its key strengths is the inclusion of people with lived experience of mental health conditions and of their families and carers in the planning and development of services.


mhcc
Membership Application

Our principles

The Mental Health Coordinating Council (MHCC) is the peak body for the community managed mental health sector in NSW.

MHCC committed to the principles of recovery and is guided by the lived experience of consumers and carers in all its endeavours.

Our major funder is NSW Health

Member Benefits

- Have greater impact through collaboration
- Inform and stay informed - MHCC members receive regular updates through media releases, events, our weekly e-newsletter FYI and View From the Peak
- Direct and drive the sector - have a say in what MHCC does - Ordinary Members* also have voting rights at MHCC general meetings and the right to nominate a Delegate to the Board

MHCC members may access resources including:

- Research and project papers
- Submissions
- Policy Resource documents
- Access to funding and research opportunities
- Discounts on specialised Learning and Development courses
- Scholarships and training subsidies

For access to resources and other information visit www.mhcc.org.au

Membership categories

Organisations

- Ordinary Members include not-for-profit Community Managed Organisations (CMOs) whose business or activity is wholly or in part to promote the welfare and rehabilitation of people with mental health problems.
- Associate Members include organisations with an interest in mental health (eg. Local Hospital Districts and Medicare Locals)
- Branch Members are branches or departments of Ordinary or Associate Members

Individuals

Subscription Members are individuals with an interest in the mental health but not restricted to the CMO sector in NSW

Let us know what you're interested in

Sector development
Policy resources
Events and networking opportunities
Grant opportunities
Consultations
Publications and submissions
Trauma Informed Care and Practice (TICP)
Medicare Locals Network
Drug and Alcohol Research Network
Learning and Development courses
Scholarships and training subsidies

To apply for membership, please complete the form overleaf and return to MHCC.

DO NOT forward payment with your application. You will receive an invoice on approval by the MHCC Board.

mhcc

MEMBERSHIP

MHCC is committed to being an industry relevant organisation and involves its membership in all its activities and projects.

MHCC Members:

Direct and drive the sector

- Members have a say in what MHCC does.
- Members belong to an organisation that works with them and for them.
- Members contribute to making the sector dynamic and responsive.

Have impact through collaboration

- Participate in policy campaigning, forums, working groups, committees and projects.

Access practical support

- Discounts to seminars and conferences.
- Access to recovery-orientated training and resources.
- Links with other similar organisations.

Inform and stay informed

- MHCC keeps members up to date with information affecting the sector.
- Opportunities to share the experience of other organisations.
- Contribute to the sector's quarterly publication, *View From The Peak.*
- Access to educational events, conferences, seminars and forums.

MHCC Board

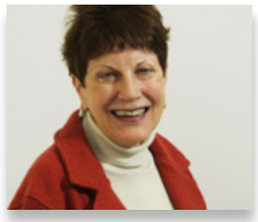
Karen Burns
Chair
Uniting Care
Mental Health

Leone Crayden
Vice Chair
On Track Community
Programs

Phil Nadin
Treasurer
PRA

John Malone
Secretary
Aftercare

Judi Higgin
New Horizone
Enterprises



Pam Rutledge
Richmond
Fellowship of NSW

Peri O'Shea
NSW CAG

Sue Sacker
Schizophrenia
Fellowship

Sylvia Grant
Neami

Dr Cathy Kezelman
ASCA

MHCC Staff

CEO

Jenna Bateman

Policy & Sector Development

Corinne Henderson - Senior Policy Officer
Tina Smith - Senior Policy Officer - Workforce Development
Stephanie Maraz - Policy & Partnerships Officer
Tully Rosen - Policy & Information Systems Officer
Lucy Corrigan - Volunteer

Administration

Erika Hewitt - Operations & HR Manager
Ian Bond - IT Support Officer
Jill Dimond - Finance Officer
Elaine McLeod - Reception and Office Administration (18/07/11–23/09/11)
Colleen Mosch - Reception and Office Administration (commenced 28/09/11)

Quality & Communications

Nick Roberts - Quality Coordinator
Lenny Pelling - Promotions Officer (commenced 09/11/11)
Carrie Stone -Community Engagement Officer
Rochelle Whatman - Promotions Officer (18/10/10 – 14/10/11)

Project Staff

Deb Payne - MHDAO Research Network (24/03/11 – 15/12/11)
Deb Tipper - MHDAO Research Network (commenced 14/02/12)
Christina Thomas - Policy (commenced 13/12/11)

Consultants

Kay Hughes
Ilse Blignault
Jacqueline Ford

Learning & Development (LD)

Simone Montgomery - Manager LD
Jacqueline Moreno Ovidi - Training Services Team Leader

Administration

Simona Adochiei - Administration Officer
Nicole Cother - Administration Assistant (commenced 30/04/12)
Rebecca Forrester - Scholarships & Grants Administration Officer
Christine Kam - Student Support & Administration Officer (commenced 01/02/12)
Kat Fardian - Online Learning Officer
Joanne Timbs - Senior Administration Officer
Lisa Van Praag -Training Logistics Coordinator

Course Coordination

Zoe Bloom - Course Coordinator
Lorna Downes - Mental Health Connect Course Coordinator
Tracy Noelle - Partnership & Development Coordinator

Trainers & Assessors

Jenyfer Locke (12/04/10 – 31/05/12)
Amanda Marsters (21/02/11 – 13/01/12)
Stephanie Webster (27/01/10 – 18/11/11)

Chair's Report

Another year has passed, and it is time to reflect on what has occurred within the mental health sector, and the planning that is required for the upcoming year in what is heralded as a time of dynamism and change. This year has seen some community-managed organisations merge together as they prepare for the future, and others have developed more mature partnerships that provide additional choices for mental health consumers that utilise the services of these organisations.

The establishment of the NSW Mental Health Commission to monitor, review and improve the NSW mental health system was announced during the year. A Taskforce, comprised of members with a broad range of expertise, and including the Mental Health Coordinating Council, was created to examine existing models of Mental Health Commissions, consult broadly and analyse the feedback from community consultations that were held in the early portion of the year. One of the future tasks for the NSW Mental Health Commission is to prepare a Strategic Plan for the NSW mental health system in consultation with providers of mental health and related services, and to then monitor and report on the implementation of the Strategic Plan. MHCC views this as an integral partnership and will continue to engage strongly with the Commission moving forward.

This year saw the transition and formation of Medicare Locals across the nation, which are tasked with ensuring that a broad range of primary care services are available for local communities and to plan and collaborate with existing programs and services for a coordinated response to care. MHCC has been at the forefront in developing and supporting relationships between community-managed organisations and Medicare Locals, recognising that these strategic partnerships are required to achieve health reform and the social inclusion agenda. It is envisaged that many community-managed organisations will foster and develop robust referral pathways with Medicare Locals for the proposed 'Partners in Recovery' programs.

Another focus this year has been the well-documented link between physical health and mental health. The MHCC Physical Health Reference Group highlighted the cultural change required for the sector with an engaging and well-attended conference, raising awareness for community-managed organisations of the physical health issues that can be associated with enduring mental illness, and opportunities to support mental health consumers to address their physical health needs. MHCC has continued to provide access to topical information and dialogue on this important issue.

The Learning and Development Unit continues to provide the sector with quality, responsive training and professional development, and provides a range of training pathways for students to complete training and attain qualifications. Supporting this process is the Professional Development Scholarship Program, funded by the NSW Health Department and administered by MHCC, which aims to encourage workers to undertake training in a variety of areas to build capacity within the sector and improve long-term outcomes for consumers.

This Annual Report again demonstrates that the work of MHCC is more important than ever, in engaging and consul.

I would like to acknowledge the leadership and commitment of our CEO and the professionalism and dedication of the team at MHCC in bringing the strategic directions to life. Thank you to the MHCC board members for their participation, lively discussion and commitment over the last year. I look forward to a dynamic twelve months ahead.

Karen Burns - Chair, MHCC

CEO Report

Each year the philosophies and practice approaches of the community managed mental health sector are more defined and better articulated. The inclusion of the sector in key state and national strategies and agendas is rarely overlooked as it once was.

There is now wide acknowledgment that the community managed sector has played a leadership role in relation to defining and implementing recovery orientated practice and in promoting recognition of trauma as fundamental to the experience of many people with mental health conditions.

This leadership has been possible as a direct result of the sector's ability to hear the voices of people with lived experience and to support and encourage their participation in the development of governance, policy and practice approaches.

This year has seen further development of MHCCs commitment to the experience of people with mental health conditions across our submissions, projects, training, events and collaboration activities, selections of which are highlighted in this report.

Confidence in the abilities and capacities of the CMO mental health sector has grown over 2011/12 at the state and national levels. The Commonwealth has all but completed a national minimum data set (NMDS) for the CMO sector and responded to requests from Community Mental Health Australia (CMHA) to develop a national suite of outcome measures to ensure the sector is outcomes driven. This comes in addition to the NMDS providing improved understanding of who the sector is supporting and with what resources. MHCC is leading this work on behalf of CMHA as well as working at the state level with MHDAO on a sector benchmarking initiative designed to better determine where the gaps in services are across NSW. This work dovetails with the national data work and is scheduled for completion by mid-2013.

For NSW 2011/12 has been particularly eventful for the mental health CMO sector and this is in large part due to Minister Humphries determination to understand and fix the mental health system in NSW. The year was spent developing the legislation for establishment of a Mental Health Commission (MHC) in NSW to which John Feneley was appointed on August 1st 2012. The coming year is likely to see a high degree of reorganisation as the MHC and MHDAO identify the most effective allocation of responsibilities and resources to undertake the reforms it is hoped the MHC will spearhead.

Minister Humphries has expressed strong support for the sector and has approved funding for a number of programs including support for mothers and babies in contact with the criminal justice system, support for those people living in boarding houses, and support for people moving from institutional care situations to community living.

The Minister's commitment aligns with broader Ministry of Health directions to reform how it plans, monitors and funds CMOs across the Ministry. This has been a consultative process done through the Grants Management Improvement Taskforce (GMIT) headed up by Chris Puplick. In addition to reviewing the more administrative functions of the grant program this taskforce has a mandate to explore the potential for more collaborative approaches between public and CMO providers along with the transfer of identified services to the CMO sector. MHCC has been fully engaged in assisting this review process throughout the year.

Continued from page 7

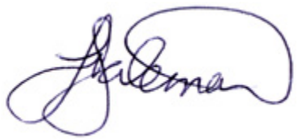
MHCC has been undergoing its own review process over the year with development of the 2012/15 MHCC Strategic Plan. This process has been consultative and lengthy but the end result is well worth the effort. It is currently in design phase for wide release to all stakeholders. I would like to thank all the MHCC members who took the time to comment on MHCC future directions as part of the consultation process. Thanks also to the MHCC Board and staff who not only contributed to setting the priorities within the plan but also spent many hours word smithing the final product. I think the 2012/15 MHCC Strategic Plan is a strong document that usefully details the work needed to continue the growth and development of community services to people with mental health conditions.

MHCC has wonderful, talented staff to enable it to achieve to the level it does. MHCC staff have an immense capacity and commitment to people with mental health conditions and to the community sector. Simone Montgomery has continued to establish MHCC Learning and Development (LD) as a respected, innovative and quality sector resource. Securing traineeships for aboriginal people to work in the sector has been just one of many highlights this year outlined within this report. Jacqui Moreno Ovidi as the LD Team Leader has done an excellent job of keeping the LD running smoothly and she is well supported by a committed and skilled staff. Unfortunately there are too many individuals in the LD to mention however I would like to acknowledge the contributions of Lorna Downes this year in respect of MH Connect. Lorna has made this course one of exceptional innovation and quality.

In the policy arm of MHCC Senior Policy staff Corinne Henderson and Tina Smith are both exceptional contributors to our sector. Tina's work in workforce development through projects such as *ROSSAT* and her work at the national level to ensure our inclusion in national workforce strategies is extremely important to the sector's future. Corinne has worked tirelessly on rights based policy issues and progressed the national agenda on trauma informed care and practice. She has also undertaken member requested project work. *Implementing Supervision Practice in CMOs in NSW* is just one example of this work. Policy staff Stephanie Maraz and Tully Rosen have been exceptional this year in their respective portfolio areas; Steph, making real inroads into supporting a range of better partnerships across sectors and Tully, progressing data strategies and projects at the state and national levels.

MHCC would not run half so well without Erika Hewitt as our operations and human resource manager. Erika is invaluable to MHCC and is continually improving our internal systems. 2011/12 has seen the MHCC communications team members Lenny Pelling and Carrie Stone performing wonderful improvements in our communication and information processes and systems this year and the results are clear to see. I want to acknowledge all MHCC staff for their dedication and hard work over the year.

Last but not least I would like to thank the MHCC Board for their guidance and support over 2011/12 particularly Karen Burns who now in her second term as Chair is a great asset to MHCC. I look forward to working with the MHCC Board, our members and partners over the coming year.



Jenna Bateman
Chief Executive Officer, MHCC

Our work over the past year

What follows is a snapshot of MHCC activity during 2011-2012 aligned to our Strategic Plan Key Priority areas:

KEY PRIORITY 1:

Developing the capacity of community-based services working within the mental health sector

Strategic option 1: Information sharing
Strategic option 2: Building relationships
Strategic option 3: Enhancing quality
Strategic option 4: Information technology
Strategic option 5: Workforce development
Strategic option 6: Building sustainability of Learning and Development Unit

KEY PRIORITY 2:

Thought leadership and policy formulation

Strategic option 7: Positioning the sector
Strategic option 8: Vision for mental health services
Strategic option 9: Engaging with the State and Commonwealth
Strategic option 10: Building knowledge

KEY PRIORITY 3:

Exemplary management and governance

Strategic option 11: Developing organisational infrastructure
Strategic option 12: A skilled and focused board
Strategic option 13: Responding to growth

More detailed information on our work can be found on our website at www.mhcc.org.au and we encourage you to visit the site.

KEY PRIORITY 1:
Developing the capacity of community-based services working within the mental health sector

The 2011-2012 year has again seen sector development as a key focus of MHCC. The sector remains dynamic and ready for a challenging future. MHCC continued supporting the capacity of the sector through information sharing and dissemination; intersectoral relationship building; ongoing quality improvement of services; and workforce development.

INFORMATION SHARING

With the mental health and community sectors producing so many valuable sources of information, one of MHCC's roles is the dissemination of this information. 2011-2012 saw MHCC able to have a more specialised team taking on this role to ensure that our members are kept informed about matters impacting their organisations and those utilising their services.

SELECTED HIGHLIGHTS

View from the Peak

Our quarterly newsletter, *View from the Peak* (VFP), continues to be an important communication channel for MHCC through which we highlight a range of activities, opinion pieces and emerging issues of interest to our members.

VFP has continued to cement MHCC's brand presence after the 2010 redesign, with increasing positive feedback received from members. MHCC is committed to VFP and is continuously looking for additional value for our members. As such we are building on the Member Spotlight section and introducing a new regular feature, *Spotlight on the Sector*, in which members are invited to share and celebrate programs and activities that have recently been introduced, achieved positive evaluation or are particularly innovative.

Articles in the editions published during the 2011-2012 year are listed below.

Spring 2011

- MHCC Regional Forums
- Self Directed Funding and the Community-Managed Mental Health Sector
- Physical Health Forum: Unravelling physical health issues associated with mental illness
- Aboriginal Mental Health Traineeships
- Community Mental Health Drug & Alcohol Research Network (CMHDARN)
- Trauma Informed Care & Practice Conference
- Understanding Consumers with a History of Trauma
- Trauma Informed Practice Training for Corrective Services Staff NSW
- A Diagnosis of Borderline Personality Disorder: Cutting to the core of a 'sense of self'
- Domestic Violence: Coming out of another closet
- Meet Frank Quinlan, CEO MHCA
- Supporting Good Mental Health in Aged Care Facilities
- TheMHS Conference 'Resilience in Change'
- RU OK? Day – National day of action for suicide prevention

Summer 2012

- AGM 2010-2011
- Social Enterprise feature including Trieste origins, SE Conference 2011, Parramatta Council profile and SE resources, International SE Models, La Trobe University study
- Australian Centre for Disability Law
- Summary–Roadmap for Mental Health Reform
- Centre for Health Research in Criminal Justice
- MHCC/BRC Recruitment Partnership
- Medicare Locals Project
- MHCC Must See–web resources
- Professional Development Series
- New Mental Health Connect
- Member Profile – PRA
- Breathe Easy – Smoking Cessation
- MHCSA Audit/ Mindshare
- Top 10 Tips for Health
- What's On – PLAC Awards 2012

Autumn 2012

- Injury Management Project
- Aboriginal Careers in Mental Health Initiative
- CMHDARN Seeding Grants Launch
- CMHA Update
- Mental Health Act Review
- MHCC Must See: ROSSAT
- Sector Benchmarking Project Update
- MHCC Green Practices
- Meet Your Neighbour Update
- Hoarding and Squalor Conference
- Mental Health Professionals Network
- Member Profile: Wayside Chapel
- ACON/MHCC Partnership: MH Connect and Peace of Mind Program

FYI e-newsletter

MHCC distributes news and information on a weekly basis to its membership through our FYI e-newsletter. FYI continues to be well received, with overall feedback being consistently positive.

The NSW Mental Health Rights Manual: Consumer Guide to the Legal and Human Rights of People with Mental Illness in NSW (3rd Edition) 2011

In 2009, the NSW Law and Justice Foundation funded the NSW Mental Health Rights Manual project which MHCC undertook in partnership with the Public Interest Advocacy Centre (PIAC). During 2010-11 the completed guide to the legal and human rights of people with mental illness in NSW was developed as an online resource, ensuring its currency as a 'living' document. Written in plain language, the manual incorporates the latest legislative reform and government directives. It also brings together vital information crucial to anyone needing to navigate the complexities of the mental health and legal service systems and wishing to find out where they can access support, information and guidance for themselves or those that they wish to assist.

A monthly data gathering report enables MHCC to analyse statistics which has shown unusually high traffic within the first 12 months. Evidence clearly shows that this resource is relevant to consumers, carers and the mental health and human service sectors. For example, regarding specific data in relation to the complaints issues, we found that there were a total of 2092 hits on these locations, with particular interest in: 'rights in public hospitals', 'supporting your family or friend' and 'complaints bodies'. We intend to further expand cross-organisational linkages in the future to maximise utilisation of the resource across service sectors. Over a 12 month period there have been 2659 downloads of the entire manual, and over 17500 visits to the manuals link on the MHCC website.

BUILDING RELATIONSHIPS

MHCC has continued to focus on developing partnerships and building relationships within and across sectors to promote quality service delivery. MHCC has progressed this focus through hosting forums to encourage sector partnerships, project and activity advisory group participation, continuing the *Meet Your Neighbour* initiative, raising awareness of the roles of Medicare Locals and undertaking the Regional Forums initiative.

Building relationships with Medicare Locals

Developing working relationships with the newly established Medicare Locals has been an ongoing activity for MHCC this year. A MHCC webpage dedicated to raising awareness and supporting engagement between Medicare Locals and CMOs went live early in the year. A promotional brochure aimed at Medicare Locals to inform on various aspects of the mental health CMO sector including the range of services and programs and the qualifications of the CMO workforce was developed. Information for CMOs is also provided on the webpage to explain the role of Medicare Locals and encourage proactive networking and engagement. Additionally, Medicare Locals attend and participate in MHCC events including *Meet Your Neighbour* and Regional Forums. Representatives also sit on the *Physical Health Reference Group* and participate in related activities.

Supporting partnership development

MHCC is promoting partnerships by building structures and processes that enhance effective partnership behaviour, and by building capacity in the sector to work in effective partnership arrangements. A MHCC webpage has been created and dedicated to promoting inter-sector and cross-sector engagement with information specific to developing partnerships.

MHCC and the Network of Alcohol and other Drug Agencies (NADA) collaborated and held the second annual Partnerships Forum on 9th May 2012 with participants attending from across sectors including representatives from Local Health Districts and Medicare Locals. The primary aim was to develop and explore the partnerships and linkages required to ensure effective and sustainable pathways between services to meet the needs of individuals, families and communities affected by co-existing mental health and drug and alcohol issues.

Meet Your Neighbour

Meet Your Neighbour (MYN) is MHCC's approach to encouraging organisations to meet, learn more about each other and find ways to work better together at the local level.

This year, sixteen MYN events have been held across regional and metropolitan NSW with good cross sector attendance. The Aged Care sector has been included in all invitations through our collaborating partner, Aged & Community Services Association of NSW & ACT (ACS) resulting in a large increase in attendees from community and residential aged care services who are keen to learn more about the mental health sector and improve referral pathways. Medicare Locals and existing Divisions of General Practice have also been attending and hosting *Meet Your Neighbour* events and have found it to develop their awareness of local community-based organisations. Host Medicare Locals often take the opportunity to include a consultation session with attendees.

Organisation	Location	Date
New Horizon	Tweed Heads	05/07/11
Break Thru	Dubbo	12/07/11
Central Sydney GP Network	Ashfield	09/08/11
Attorney General Dept	Parramatta	26/9/2011
Nepean Division of GP	Penrith	29/09/11
Neami	Newcastle	21/11/11
Uniting Care Mental Health	Central Coast	7/12/11
On Track Community Programs	Tweed Heads	07/02/12
Northern Rivers Social Development Council	Lismore	08/02/12
Uniting Care Mental Health	Central Coast	28/02/12
Breakthru Employment	Coffs Harbour	05/03/12
Neami	Illawarra	14/03/12
Wayside Chapel	Sydney	20/03/12
Breakthru	Taree	19/04/12
Mission Australia	Newcastle	20/04/12
Municipal Council	Lane Cove	21/05/12

Regional Forums

In addition to MHCC reaching regional and rural areas through the *Meet Your Neighbour* initiative, MHCC also coordinated a series of regional forums to the following locations:

- Newcastle 2/8/11
- Wagga 5/8/11
- Dubbo 8/8/11
- Ballina 12/8/11
- Nowra 15/8/11
- Sydney 17/8/11

Each location saw sessions on:

- Trauma Informed Care in Practice
- Community Mental Health and Drug & Alcohol Research Network (CMHDARN)
- Service Coordination
- National Mental Health Standards and Implementation
- Recovery Oriented Services Self-Assessment Tool (ROSSAT)
- A presentation was also given by a local Medicare Local representative.
- The Regional Forums also provided a platform for members to be consulted regarding the MHCC Strategic Plan.

CEO Forum

The Minister for Mental Health, the Hon. Kevin Humphries (pictured), opened the forum held on 28th May 2012 and referenced a number of key issues that the government will focus on in making "mental health everyone's business." He talked about the importance of wrap-around services and partnerships between government and CMOs. He stressed the importance of the new Mental Health Commission in securing long-term strategies. He stressed housing as the key platform for recovery with a focus on a model of service hubs. A number of other presentations were given, including: Frank Quinlan, CEO, MHCA - The National Disability Insurance Scheme (NDIS): Impact on our sector; Georgie Harman, Deputy CEO, National Mental Health Commission: Update on the National Report Card; MHCC - Psychological Injury: Management and Prevention; MHCC - Developing Practice Supervision in CMOs; and, Sebastian Rosenberg, Senior Lecturer in Mental Health Policy, Brain and Mind Institute, University of Sydney provided an open forum discussing concerns about Activity Based Funding (ABF), and how to foster a model with no evidence base that entrenches consumer rights. The forum was followed by MHCC Learning and Development Graduation Ceremony at which Dr Cathy Kezelman, ASCA made the opening address on Complex Trauma and trauma informed care and practice initiatives.

Aged Care and Mental Health Project: Promoting integrated approaches

MHCC and Aged & Community Services Association of NSW & ACT (ACS) have developed a collaborative relationship to promote inter-sectoral partnerships to improve access and quality of care for people who are ageing with or at risk of mental health problems. This year MHCC was involved with the annual Positive Living in Aged Care (PLAC) Awards initiative, which helps to promote the importance of addressing mental health in aged care facilities. The awards identify and showcase Commonwealth-funded residential aged care facilities in NSW which have developed and implemented strategies to maintain and/or improve the mental health and wellbeing of residents, their friends, family, carers and staff. Meet Your Neighbour (MHCC's networking events) are also being promoted to the aged care sector to foster working relationships and improve service coordination across the two sectors.

In June 2012, MHCC and ACS presented at the Creating Synergy 2012 Drug and Alcohol Conference in Wollongong where they talked about linking aged care services with mental health and drug and alcohol services as key to improving health and wellbeing and promoting recovery. By breaking down the silos of specialist services and improving service coordination, the diverse needs of clients can be better met. Whilst mental health and drug and alcohol CMOs have been working together for some time to bridge the gap between services, aged care has emerged as an issue which needs particular focus. This presentation provided an overview of some current initiatives in this area as well as highlighting the opportunities, challenges and barriers to coordination.

MHCC and ACS are planning a joint forum late in 2012 in which organisations from both the mental health and aged care sectors including NSW Health Specialist Mental Health Services for Older People (SMHSOP), Aged Care Assessment Team (ACAT), Medicare Locals, GPs, member organisations and consumers and carers will come together to raise awareness and understanding of the issues and discuss potential strategies to better support people with mental health conditions who are ageing.

Physical Health

MHCC's *Physical Health Reference Group* (PHRG) continues to meet bimonthly to help better address the overall health outcomes for individuals with mental health issues by ensuring that physical health needs are also seen as important and given attention and support. Meetings have seen regular attendance from a broad range of organisations including: PRA, Mental Health Association, Inner West Sydney Medicare Local, Neami, Black Dog Institute, Schizophrenia Fellowship, Fitness Australia.

The first major initiative of the PHRG was the *Unravelling Physical Health Issues Associated with Mental Illness* Forum on 7th October 2011 at the Wesley Conference Centre. The forum aimed to build knowledge and capacity across service sectors and enable CMOs to better address the serious rates of illness and premature death of people with persistent mental health issues. Keynotes where given from Dr Rod McKay, MHDAO and Janet Meagher, PRA. The evaluations gave excellent feedback. Interactive panel discussions facilitated by Julie McCrossin ensured lively audience participation. Consultative processes and feedback have indicated that we must work towards more holistic and connected services. A MHCC webpage dedicated to 'physical health' includes the Summary Report and a webcast of the forum.

MHCC will also hold a Forum on 7th September 2012, *Exploring Better Mental and Physical Health Outcomes Through Collaboration* at Australian Technology Park, Sydney. Guest speaker and visiting USA specialist Dr Joe Parks, MD will present leading-edge research on why integrating mental health with physical health care is vital to reducing early death rates of people with mental illness.

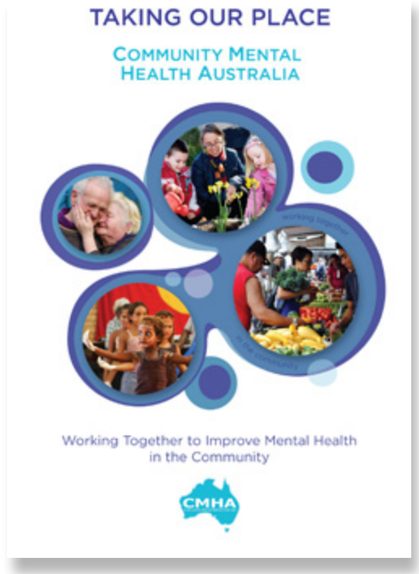
Community Mental Health Australia (CMHA)

CMHA became an Incorporated Association in December 2011. The decision to formalise the alliance of State and Territory mental health peak bodies was taken to enable CMHA to take a further step in establishing the mental health community sector as an integral part of the mental health service system. The secretariat is to be located in ACT from December 2012 to allow greater access to national meetings, politicians and government policy makers.

CMHA launched its flagship document, *Taking our Place – working together to improve mental health in the community* on World Mental Health Day 2012 at the Ministerial Breakfast event in Canberra. This publication was designed to alert politicians, policy makers and the general public to the activities and directions of the community mental health sector. MHCC took the lead in this publication's development on behalf of CMHA.

CMHA enables the community mental health sector to be represented on National committee structures in a way that is not open to the state peaks individually. MHCC currently holds seats on the National Safety and Quality Partnership Subcommittee (SQPS) and the Mental Health Workforce Advisory (MHWAC) Committee on behalf of CMHA. The Mental Health Coalition of SA holds the CMHA seat on the Mental Health Information Subcommittee. Participation on these committees has allowed development of a greater understanding of the role and function of the sector to the range of stakeholders on these committees. It has allowed articulation of sector capacity and development needs and provided opportunity to ensure the sector is included in national strategic and policy directions.

CMHA has been funded to undertake various projects with different states taking the lead depending on capacity and interest. Over 2011-2012, projects and activities have included the *Day to Day Living (D2DL) Capacity Building* project which is funded by DoHA to facilitate identification and dissemination of good practice among D2DL program providers. This project is managed by Qld Alliance and concludes in June 2013. Another project underway this year is the *National Minimum Data Set* (NMDS) project funded by DoHA to develop a NMDS for community mental health organisations which will allow a picture of the size and scope of the sector to be developed, and is being designed to integrate with state-based data collections. This project is being managed by MHCC along with the *National NGO Outcome Measurement* project which is being completed in partnership with the Australian Mental Health Outcomes and Classification Network and is also funded by DoHA. It aims to identify a suite of outcome tools that, aligned to the NGO NMDS, will allow consistency of reporting on consumer outcomes nationally.



Taking Our Place – Working Together to Improve Mental Health in the Community

ENHANCING QUALITY

One of MHCC's key objectives is that of continual delivery of quality services across the sector. Throughout 2011-2012 MHCC has worked on enhancing quality at the national and state level as well as internally.

Infrastructure Grants Program

The Infrastructure Grant Program (IGP) has been administered by MHCC in partnership with NSW Health since 2006-2007. This year saw the final projects across all three streams completed, culminating in the overall implementation of 117 different projects across 64 different organisations.

Over the various streams and life of this extraordinary project which MHCC have been fortunate enough to oversight, the IGP has seen nearly $4.4 million of funding enter the sector to assist in building its infrastructure. The concept behind the IGP has been one-off funding for projects to enable CMOs to improve existing services and progress towards quality accreditation.

2011-2012 saw the completion of 18 Round 3 – General IGP projects ranging from purchasing of new IT equipment and vehicles to staff training and development. 11 *No NGO left behind* Stage 2 projects were completed in various areas from writing or reviewing policy manuals and governance structures to site refurbishments. All recipients of *No NGO left behind* grants had not previously received funding through the IGP and were small to medium organisations.

The year also saw the completion of 13 *Smoking Reduction* projects across 12 organisations. *Smoking Reduction* projects were aimed at providing knowledge, training and the tools to assist staff and consumers to reduce their smoking or quit completely. All projects reported positive outcomes, with most participants significantly reducing the number of cigarettes smoked or quitting altogether. Participants who did not reduce or quit were mostly open to future attempts.

MHCC member survey

The 2012 MHCC member survey was conducted between 4th May and 8th June. It was promoted through *FYI*, *View From The Peak*, emails to board members and CEOs and other miscellaneous email alerts. Forty six responses were received. This is a response rate of 25.1%.

Members expressed a 'good to excellent' level of satisfaction with MHCC services. The category 'keeping members informed' prompted the highest number 'good' and 'excellent' responses (91%). General comments about the level of satisfaction with our services were very positive, including quotes such as "a very proactive peak body", "grateful to be a member", "the team at MHCC are accessible and knowledgeable" and "the Learning and Development Unit has significantly expanded and is very impressive". Some suggestions for improvement in this section were holding events without politicians present to enable frank discussion, holding more regional events, and "paying more attention to the needs of people from other cultures".

The majority of respondents felt all MHCC projects were useful ('very' or 'somewhat'). The three projects identified as most useful to members were the *Mental Health Rights Manual* (49% responded 'very useful'), trauma informed care and practice information (40%) and the *Working Safe Toolkit* (35%).

When rating the quality of MHCC learning and development (LD) services, the areas prompting the greatest level of satisfaction were the *Professional Development Scholarship Program* (71% rated as good or excellent), and 'providing relevant training' (71%), followed by 'quality of training' (62%).

Comments related to having more training for management, segmenting our marketing emails

to avoid 'bombarding' members with training promotions, more rural/regional training, and better tracking of marking and student progress.

In comparison to survey data from 2010, we were very encouraged to see increases in various aspects of MHCC's performance which were rated as 'good' or 'excellent'. This included a doubling in responses which rated our 'proactive reform agenda' as excellent.

We thank all the members who participated in this year's member survey, and encourage everyone to have their say again next year!

INFORMATION TECHNOLOGY

Due to MHCC leadership on information system issues through the Data Management Strategy, MHCC was asked to represent CMHA to work with the Australian Institute of Health and Welfare on the Mental Health Non-Government Organisation National Minimum Data Set Project. The final report of this project, based on extensive consultation, contained a formal definition for mental health CMOs, a national mental health CMO service taxonomy, a data set specification and proposed models of data collection.

MHCC continues to represent CMHA by sitting on the NGO Establishments (NGOE) National Minimum Data Set Working Group where all major national and state funders of mental health services negotiated the attributes of the upcoming NGOE National Minimum Data Set, including data item specification, collection methodology, service typology and linkages with the National Mental Health Service Performance Framework. When implemented, the National Minimum Data Set will begin the process of standardised reporting requirements from NSW funders and the Commonwealth Departments of Health and Ageing (DoHA) and Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).

CMHA's engagement with the Mental Health Information Strategy Subcommittee (MHIS) has resulted in the funding of a National CMO Outcome Measurement Project in which MHCC will work with the Australian Mental Health Outcomes and Classification Network (AMHOCN) on an exploratory national consultation on the current state of outcome measurement in the community-managed sector.

At the state level MHCC partnered with Deloitte which volunteered its staff and resources to hold a workshop with MHCC's members on data management and E-Health in the community-managed sector. Specialist consultants from Deloitte provided a broad overview of the Government's plans for Personally Controlled E-Health Records (PCEHR). Members were given the opportunity to troubleshoot their own data management issues, and topics raised continue to inform MHCC work on data management issues.

WORKFORCE DEVELOPMENT

The development of the sector's workforce continues to be a priority area for MHCC, not only through the work of MHCC Learning and Development but also through our engagement with national mental health workforce planning structures.

National directions in mental health workforce development

MHCC continues to provide national leadership in the area of community sector mental health workforce development. During 2011-12 we represented Community Mental Health Australia (CMHA) on the national Mental Health Workforce Advisory Committee (MHWAC). A highlight of this activity was completion of the first ever National Mental Health Workforce Strategy and Plan which was endorsed in late 2011 and includes consideration of community sector, peer work and vocational education and training (VET) workforce development directions. The Strategy/Plan has five broad outcomes areas: to develop, support and secure the current workforce; build capacity for workforce innovation and reform; build the supply of the mental health workforce; build the capacity of the general health and wellbeing workforce; and strengthen workforce data, monitoring and evaluation. MHCC has since represented CMHA on the working group developing an implementation plan for the strategy. The MHWAC group will cease at the end of 2012 and discussions to ensure the plan is implemented are underway. Future opportunities to progress community sector mental health workforce development directions will include CMHA's relationships with the new National Mental Health Commission, Health Workforce Australia (HWA) and the Australian Workforce and Productivity Agency (AWPA, formerly Skills Australia).

A key activity for 2012-13 will be the development of mental health workforce competencies including a greater understanding of clinical, community and peer work roles, this should make for some interesting discussions about role delineation. This work will be undertaken by HWA along with other projects related to mental health workforce development, which is a priority area for them. In 2011-12, MHCC worked with HWA to develop a series of four factsheets to promote the findings of the Mental Health NGO Workforce Scoping Study.

MHCC continues to chair CMHA's Workforce Development Reference Group which teleconferences quarterly and as the need arises. A key focus of this group is strategizing to obtain funding to increase the capacity of both CMHA and the state and territory peaks to respond to increasing national workforce development directions that we anticipate will continue to increase as the community-managed mental health sector grows in both size and importance.

L to R: Tony Aumuller (NSW Department of Education and Communities), Hon. Kevin Humphries, Jenna Bateman, and Simone Montgomery

Aboriginal workforce

The Hon. Kevin Humphries, Minister for Mental Health, launched the *Aboriginal Careers in Mental Health Initiative* at the National Centre of Indigenous Excellence in Redfern on Thursday 22nd March. This exciting initiative between MHCC, the NSW Department of Education and Communities and the Commonwealth Department of Education, Employment and Workplace Relations provides 50 Aboriginal trainee and cadet positions in the community mental health sector in NSW. Organisations selected to participate in the initiative will support trainees and cadets while also building the cultural capacity of their organisations. This initiative not only enables trainees and cadets to gain skills and knowledge to work in community mental health settings but also provides a career pathway in mental health and related fields.

The well-attended forum showcased the current work of numerous community organisations in developing and retaining Aboriginal staff while sharing key learning's in relation to supporting trainees and cadets in the workplace. The forum also provided comprehensive information to prospective organisations interested in placing an Aboriginal cadet or trainee in a mental health role. Interested organisations were required to submit an expression of interest no later than April 2012 and selection was completed in June 2012.

BUILDING THE SUSTAINABILITY OF MHCC LD

MHCC Learning and Development (LD) continued to deliver high quality and affordable workforce professional development opportunities to the sector throughout 2011–2012. The total number of training days delivered to the sector increased by 3% from the previous year to 368 days, with 113 of these days held in regional locations. 30.7% of all training conducted was offered in regional and interstate locations in NSW such as Wagga Wagga, Bourke, Orange, Kempsey, Wollongong, Melbourne, Adelaide and the Northern Territory. As indicated in the following chart 57% of training days were based on organisational request and the remaining 43% were accessed through our public training calendar.

Based on the significant demand from organisation for in-house solutions, the LD will continue to provide innovative and flexible delivery opportunities, particularly for regional and remote locations, as more courses and qualifications are delivered to meet both workforce and sector development needs. This year MHCC LD delivered a total of 75 training courses to the sector across numerous areas of interest as outlined in the following table.

Course title	Number of courses commenced 2011-2012
Certificate IV in Mental Health	7
Certificate IV in Training and Assessment	3
Diploma of Community Services (Alcohol, other drugs and mental health)	17
Advanced Diploma of Community Sector Management	6
Mental Health Connect	28
Professional Development Series	14
Total	**75**

In addition the Australian Council for Educational Research (ACER) independent benchmarking process for 2011 illustrated how MHCC LD achieved an 86% overall learner satisfaction rating, in comparison to a national average of 81%. Employer satisfaction with MHCC LD was 87%, compared to a national average of 83%. We are particularly pleased at the high rating of 88% satisfaction with MHCC trainer quality expressed by our learners.

Key achievements for 2011- 2012

MHCC launched the *Professional Development Series* and conducted 14 workshops which included topic areas such as *Working with Voices, Tools for Supporting Recovery, A Recovery Approach to Risk, Working Together for a Trauma Informed Response to Aboriginal Healing Needs* and *Motivational Interviewing*. MHCC underwent re-registration as a Registered Training Organisation with the Australian Skills Quality Authority (ASQA). This was an important process to ensure MHCC LD was compliant with the national framework and standards and could continue to provide services to the sector into the future.

The highly successful *Professional Development Scholarship Program* funded by NSW Health provided a total of 253 scholarships across all streams which comprised of 68 for the Diploma of Community Services, 59 for the Certificate IV in Training and Assessment, 48 for the Clinical Pathway, 48 for the Advanced Diploma and 30 for the Certificate IV in Mental Health. Due to the success of the program, at the beginning of 2012, NSW Health approved an extension to the program timelines and funding in order to utilise all funds that were apportioned to this program and it will now conclude in 2013 rather than 2012.

MHCC LD received funding from the Cancer Council of NSW to assist community-managed organisations to address smoking through organisational change. MHCC will work closely with organisations over a six-month period using a staged approach to assist organisations to make the necessary changes to ensure smoking cessation is part of their core business.

The LD continues to participate in numerous committees and present at relevant conferences including the THeMHS Conference and the Aboriginal Mental Health Workers Forum. LD participates in numerous industry committees including: NSW Community Trainers and Assessors Network, Western Sydney Mental Health Forum, MHDAO Mental Health Workforce Development Committee and it's Mental Health Education and Training Working Group, MHDAO Aboriginal Mental Health Workforce Committee, MHDAO Prevention and Promotion groups, various national Community Services and Health Industry Skills Council (CSHISC) working groups, and the NSW Community Services and Health Industry Training Advisory Body (ITAB). MHCC LD sit as an executive member of the ITAB Board.

Future

The coming year will see the LD begin implementation of the 2012-2015 MHCC Strategic Plan as we move forward in the following areas:

- Pilot and rollout of *Trauma Informed Care* and Practice training to the sector
- Expansion of the *Professional Development Series*
- Represent the mental health CMO sector as part of the CSHISC review of the Community Services Training Package (Training Package Advisory Committee), including participation on the Subject Matter Expert Group reviewing mental health related qualifications in the training package
- Involvement in the development of the learning and assessment resources for the recently endorsed Certificate IV in Mental Health Peer Worker qualification
- Develop and enhance existing partnership opportunities with a diverse range of organisations throughout the community sector
- Strengthen and grow our casual and contract trainer workforce with targeted recruitment and incentives

All LD staff, including casual and contract trainers, are acknowledged for working tirelessly throughout the year to provide high quality learning outcomes for participants.

MHCC acknowledges the ongoing support of the sector and their active engagement in shaping and informing future practice through MHCC's Mental Health Workforce Training and Development Reference Group and involvement in numerous industry reference groups throughout the year.

KEY PRIORITY 2:
Thought leadership and policy formulation

MHCC built on our knowledge base through research and consultation with members and proactively engaged with all levels of government during 2011-2012. MHCC made numerous submissions and attended and presented at conferences, forums and meetings to this end.

Submissions and Position Papers

2011-2012 saw MHCC author numerous submissions and position papers in response to both Commonwealth and State inquiries, as well as providing feedback on policy reform and implementation. Below is a selection that highlights the breadth of this work.

- National Health & Medical Research Council: Development of Clinical Practice Guidelines for the treatment and management of Borderline Personality Disorder (BPD)
- National Mental Health Statement of Rights & Responsibilities
- Law Reform Commission Review of the Crimes (Sentencing Procedures) Act 1999
- Inquiry into the consolidation of Tribunals in NSW
- Development of a charter for the Mental Health Commission (MHC)
- NSW Mental Health Commission Taskforce Accountability Framework
- Ten Year Roadmap for National Mental Health Reform
- NSW Whole of Government Ageing Strategy
- Policy amendment Housing NSW and/or community housing waiting lists
- NSW Health, Transfer of Care (ToC) from Mental Health Inpatient Services

Royal Australian & New Zealand College of Psychiatrists: Psychotherapy training in psychiatry

- Preliminary Comments to the Review of the NSW Mental Health Act 2007
- Living Life My Way: Putting people with a disability at the centre of decision making about their supports in NSW
- Mental Health Professionals On line Development (MH-POD) NGO Sector Trial
- Coordinated Care and Flexible Care Package (FCP) Funding
- Concept paper for a Museum of the Mind
- Workforce Competencies: providing continuity of care and supporting self-direction.
- An education and training skills needs analysis.
- Taking Our Place: working together to improve mental health in the community (on behalf of Community Mental Health Australia)
- Implementing Supervision Practices in Mental Health Community-Managed Organisations in NSW.
- Social enterprise and the employment of people with a labour market disadvantage: the strategic environment

POSITIONING THE SECTOR

Policy resource

During 2011-12 MHCC developed a recovery oriented service *Policy Resource* for member organisations. The final framework for the resource is below and it consists of more than 200 separate policy, procedure and template documents. Of particular interest are innovative policy resource items related to: Leadership; Palliative Care; Research and Development; Substance Use; Supervision Practice; and Service Coordination. The resource also includes updated information around the requirements of the new work health and safety (WH&S) legislation and has been informed by MHCC's *Psychological Injury Management* project. The policies have also been mapped to the National Mental Health Standards, Disability Standards and *ROSSAT*, which will assist organisations with quality improvement processes and accreditation requirements.

A pilot of the resource was conducted resulting in further refinements. The resource is now being professionally designed and IT advice and support sought prior to placing it as an e-resource on MHCC's website. MHCC greatly values the many contributions of member agencies and partner organisations that participated in the Reference Group to develop the *Policy Resource*, MHCC also acknowledge the contributions of NADA regarding the original product concept. The resource will be available in the second half of 2012 and will be a valuable asset in the establishment of 'Partners in Recovery' organisations.

A. Service Management

1) Leadership
2) Governance & Management
3) Legal & Regulatory
4) Communications
5) Environmental Sustainability
6) Facilities & Equipment
7) Financial Management
8) Human Resources
   a) Professional & Personal Development
      i) Supervision Practice
   b) Volunteers
   c) Student Placement
9) Information Management
10) Policy Development & Review
11) Quality Improvement
12) Strategic & Operational Planning
   a) Project Planning
   b) Event Management
   c) Program Evaluation
13) Work Health and Safety
   a) Risk Management
   b) Emergency & Critical Incidents
      i) Notification of Death
   c) First Aid
   d) Infection Control

B. Decision Making, Rights & Feedback

1) Abuse & Neglect
2) Advocacy
3) Duty of Care
4) Feedback & Complaints
5) Informed Decision Making
6) Privacy & Confidentiality

C. Family, Community and Diversity

1) Community and Service Directory
2) Diversity
3) Family and Carers

D. Promotion & Prevention

1) Health and Medical
   a) Medication
   b) Palliative Care
2) Individual Support
   a) Substance Use
3) Integration
4) Participation
5) Promotion & Prevention
6) Valued Status

E. Research and Development

Research and Development

F. Service Access

1) Service Entry
2) Service Coordination
3) Service Exit & Re-Entry

VISION FOR MENTAL HEALTH SERVICES

NSW Mental Health Commission (NSWMHC)

Planning for establishment of the NSW Mental Health Commission was progressed over 2011-2012. MHCC's CEO was a Ministerial appointment to the Taskforce created to advise on the functions and powers of a MHC and to provide advice regarding the enabling legalisation required to create the Commission. The MHC was formally operationalized on July 1st 2012. John Feneley took up the position of Mental Health Commissioner on August 1st 2012. In addition to investigating possible legislative frameworks for the MHC the Taskforce members reviewed international experience of MHC establishment particularly those in New Zealand, Canada and California. Consideration of the pros and cons of advocacy, accountability and monitoring models as against a fund holder model was a key activity area for Taskforce members. Whilst the fund holder model was seen to have potentially high levels of short-term reform gains, it was felt that in the long term, the system was at risk of reverting to rigid and bureaucratic operation whereas the advocacy model was seen to be more autonomous and better placed to represent the perspectives of consumers, carers and other stakeholders. Following the achievements of the WA MHC (which has adopted the fund holder model) will be informative. MHCC is very supportive of the aims of the NSW MHC and has developed strong linkages to the Commissioner.

Care coordination (Service Coordination Strategy)

MHCC's Service Coordination Strategy is being pursued to progress recommendations 3 and 5 of the 2010 Sector Mapping Project, which are related to enhancing continuity of care and strengthening pathways and linkages between services. The findings of our 2011 *Care Coordination Literature Review and Discussion Paper* were discussed with member organisations, and consumers and their families and carers, during MHCC's Regional Forums toward identifying directions for the *Service Coordination Strategy*. It was agreed that an important next step was to close the literature gaps identified regarding the views of people affected by mental illness as to what constitutes good care and service coordination, especially as this relates to the skills required by workers to achieve effective service coordination.

Commencing in June 2012, MHCC undertook consumer, carer and service provider consultations to close these knowledge gaps. These consultations were informed by a background paper titled *Work Competencies: Providing continuity of care and supporting self-directed care – An Education and Training Skills Needs Analysis*. Findings from these consultations are now being analysed against the current funding, policy and practice environment, including an identification of the gap that may exist around which existing mental health and service coordination related vocational qualifications might be strengthened.

The final report on this activity will include recommendations to both vocational and university education and training stakeholders to better embed service coordination skills in workforce development directions. The final report will also make recommendations for implementation, evaluation and capacity building for the new 'Partners in Recovery' care coordination initiative. Consideration is also being given to how the *Service Coordination Strategy* will next be progressed, given implementation of 'Partners in Recovery' from early 2013 and the NSW launch of the National Disability Insurance Scheme (NDIS) from mid-2013. This may involve the development of a LD *Professional Development Series* course to assist workers across a range of settings to acquire service coordination skills.

Modeling the Sector - Sector Benchmarking Project

The NSW Ministry of Health has funded MHCC to progress the NSW CMO Mental Health *Sector Benchmarking Project*. This is following Recommendation 2 of the *Sector Mapping Project Report* which proposed that CMO services should be accessible in local areas, with the amount of support available being population-based, using needs-based variation parameters (i.e. taking into account socio-demographic characteristics, existing mental health infrastructure and other general community resources). MHCC has held the first two Reference Group meetings, with broad consultations to follow.

This project will develop NSW population benchmarks against the forthcoming national taxonomy being developed by the Australian Institute of Health and Welfare (AIHW) in collaboration with Community Mental Health Australia (CMHA). For each core service area, population-based core support and needs-based variation parameters will be defined. The major outcome of this project will be enhanced CMO mental health sector planning capacity and clearer directions for both the public, clinical and community-based mental health sectors working together in partnership.

ENGAGING WITH THE STATE AND COMMONWEALTH

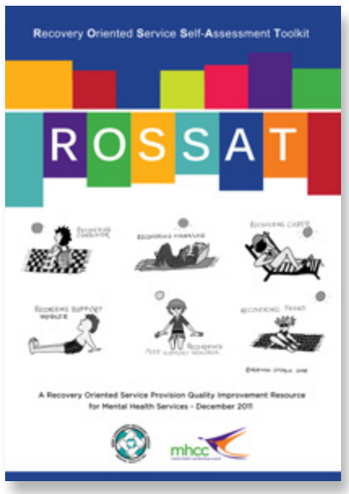
MHCC has continued to develop strategic relationships with key state and national government agencies. At the national level, relationship building is increasingly done on behalf of CMHA to provide government with one representative voice wherever possible. MHCC has been involved in meetings with DoHA personnel around CMO data collection, NGO workforce development, quality and accreditation and the National Recovery Framework.

MHCC receives requests to attend a wide range of one-off roundtables, forums and advisory groups. In addition MHCC endeavours to participate in ongoing government and community sector committees to provide advice, raise the profile of the community mental health sector, inform on the key role the sector plays in supporting consumers to live well in the community and to advocate for resources to develop the broad community mental health sector.

2011-12 has seen MHCC increase participation in national meetings, particularly as a member of Community Mental Health Australia (CMHA). MHCC represent CMHA on the National Safety and Quality Partnership Subcommittee and the National Workforce Advisory Committee. In addition MHCC LD has strong links to the National Community Services and Health Industry Skills Council (CSHISC) and has a developing relationship with Health Workforce Australia. Other national engagement has involved the National Mental Health Commission, the National Mental Health Information Subcommittee, the Mental Health Council of Australia and government agencies: DoHA, FAHCSIA and DEEWR on community sector programs and issues.

At the NSW level we endeavour to meet the range of requests for our participation on committees and roundtables. As a snapshot

of our engagement, we can report that our relationship with the Mental Health Drug and Alcohol Office (MHDAO) remains very positive and we attend a range of policy, program and workforce committees at MHDAO on behalf of our membership. At the NSW Ministry of Health we are represented on the NGO Advisory Group which is currently reviewing the NGO Grants Management Improvement Program. We have increasing engagement with Justice Health and Corrections NSW as attention on people with mental illness in the criminal justice system becomes a key advocacy platform. Our relationship with PIAC continues to be strong and we also engage with a range of legal and human rights groups. We sit on the Community Services Ageing, Disability and Home Care Integrated Services Program (ISP) reference group and engage broadly with disability groups, particularly in relation to the National Disability Insurance Scheme, including the NSW Ombudsman's Office, the Disability Council and NCOSS. Housing and homelessness have been high on the agenda over 2011-12 and MHCC has participated in committees advocating better access to affordable housing and supported accommodation options for people with mental health conditions.



ROSSAT resource

BUILDING KNOWLEDGE

MHCC has actively been pursuing mechanisms to enable promotion of sector knowledge through research and project activities.

The Recovery Oriented Service Self-Assessment Toolkit

The *Recovery Oriented Service Self-Assessment Toolkit* (ROSSAT) was developed by MHCC and the NSW Consumer Advisory Group (CAG) through an Infrastructure Grant as a CMO sector quality improvement instrument that organisations can use to assess the consistency of their services with regards to recovery oriented service provision. ROSSAT is also mapped to the National Standards for Mental Health Services and can be used as evidence towards accreditation. ROSSAT was developed following a comprehensive literature review on the concept of recovery, and following extensive consultation with consumers, carers and service providers regarding what constitutes good practice.

During 2011-12, the *ROSSAT Tool for Organisations* (T4O) and *Tool for Workers* (T4W) were further modified on the basis of pilot feedback, with the final product being publicly made available through the MHCC and CAG websites in March 2012. Numerous conference presentations have been made to promote the availability of ROSSAT. Interest in ROSSAT, especially the T4W, has been very high and we have been contacted by public mental health services, the NSW Official Visitors, and international consumer organisations regarding its use. ROSSAT has also been used to shape development of the National Mental Health Recovery Practice Framework. The uptake of ROSSAT is being monitored and an evaluation of sector implementation will occur in early 2013.

Trauma Informed Care and Practice (TICP): Towards a cultural shift in policy reform in mental health and human services in Australia

In October 2011, and following on from our June 2011 *Trauma Informed Care and Practice: Meeting the Challenge* Conference, MHCC launched a portal devoted to TICP matters hosted from its website. We encouraged everyone across the human services sector – including public, private and community sector providers – to join a network, and MHCC continues to regularly remind members and other stakeholders to visit the portal to find out about the latest news and events, access resources, research papers and video presentations including those of key speakers from the conference. The network is steadily growing and now comprises some 230 interested persons.

At the same time, MHCC and partners Adults Surviving Child Abuse (ASCA), the NSW Health Education Centre Against Violence (ECAV) and the Private Mental Health Consumer Carer Network Australia (PMHCCN) established the Trauma Informed Care and Practice Advisory Working Group (TICP AWG). The TICP AWG is a small national group with experience and expertise in the trauma field, established with the aim of improving the mental health and wellbeing of people with trauma histories by advocating for systemic reform and the development of a strategy that embodies a shift in service delivery culture across mental health and human service sectors, and including workforce training and professional development to support the approach. The TICP AWG provides a centralised reference point for coordination of initiatives of MHCC and its collaborating partners.

The TICP AWG aims to provide advice to government, members and key stakeholders in relation to evidence-based policy and programs on TICP across the mental health community, public and privately managed sectors, as well as the human service sectors. The group will also advocate TICP education, training and research, and the development and implementation of national standards, guidelines and implementation of strategies and frameworks and advise on sector/workforce development requirements.

Implementing Supervision in Mental Health Community-Managed Organisations in NSW

MHCC have developed a resource which provides recommendations for the implementation of supervision practices in the community-managed mental health sector. The issue of supervision is one that has clearly emerged as a critical issue in sector workforce development and the creation of best practice in community-managed workplace culture. The project arose as a response to an evidence gap in the knowledge base surrounding supervision practices in CMOs across the community mental health and human services sectors in NSW.

The resource explores different understandings and definitions of supervision, examines histories and theories of supervision, outlines practice models and reports on the findings from the study conducted into supervision practices within the mental health community managed sector in NSW. During 2011 MHCC conducted interviews with fifteen managers in six community organisations and investigated the challenges and opportunities that organisations, their managers and supervisors are experiencing. Apart from a report analysing the themes arising from the interviews, we also examined the potential benefits and costs and identified some of the barriers to the effective use of supervision, with the aim of offering suggestions for organisations to consider when developing a supervision model appropriate to a particular program type, or when reviewing an existing model.

MHCC proposes that this resource will go some of the way in filling the gap in knowledge around supervisory practices and provide a useful springboard to further studies and research in the field.

Psychological Injury Management Guide

At the request of members to assist organisations combat soaring workers' compensation premiums, MHCC developed the online *Psychological Injury Management Guide* (PIM Guide). This resource assists organisations to more easily access information about a contemporary approach to the management of workplace injuries. It focuses primarily on the prevention and management of psychological injury in the workplace, though the processes outlined are also relevant to, and may refer to, physical injury.

The *PIM Guide* contains information and resources for members to consider and adapt as they develop and review their own injury management systems. It is envisaged that members who use the PIM Guide will develop a proactive, integrated approach to injury management, provide clear pathways for employee return-to-work, improve climate, leadership and employee wellbeing, and – over time – reduce their workers' compensation premiums.

Community Mental Health Drug and Alcohol Research Network

The Community Mental Health Drug and Alcohol Research Network (CMHDARN) is a NSW Health funded partnership initiative of MHCC and NADA being conducted from 2010 to 2013. CMHDARN builds on previous work undertaken by MHCC and NADA since 2005 to increase the capacity of the community sector to better respond to the needs of people affected by co-existing mental health and substance use issues. The project is administered by MHCC. In 2011-2012, all CMHDARN activities and key performance indicators (KPIs) have been substantially progressed through ongoing meetings and involvement of the Steering Committee and the Project Reference Group. A CMHDARN logo has been developed to brand and promote this important initiative to build community sector research capacity, and the CMHDARN website is now 'live'. Our e-newsletter has been named *CMHDARN YARN*.

Research events have included a forum held on 24th August 2011 to consider *Research and Evaluation in Community Managed Mental Health and Drug and Alcohol Organisations* and another held on 24th April 2012 to reflect upon *From Ideas to Action-Developing your research proposal*. The latter was held in anticipation of the CMHDARN Seeding Grants Program. Another forum, *Nothing About Us, Without Us - We Are the Evidence: Consumer representation and participation in research - the what, why, where, when and how!* Will be held in August 2012.

The research *Seeding Grants Program* EOI process commenced in May and 15 organisations were successful in obtaining grants. A second funding round is targeting MHCC member organisations in non-metropolitan locations. The *Reflective Practice Forum* is a journal club and aims to increase CMHDARN participation for people in rural and regional areas by including an IT/webinar based approach. The initial webinar explores stigma and discrimination against people affected by mental health and/or drug and alcohol issues and subsequent events will consider peer reviewed journal publications arising from the earlier *Research Grants* initiative completed in 2010. The CMHDARN membership has been surveyed on two occasions to explore directions for the *Mentoring Program* including the development of a register of people interested in participating and the promotion of access to mentors for *Seeding Grants Program* recipients.

PUBLICATIONS

- **New Paradigm, 23/09/11. VICSERV Journal** *The Mental Health Coordinating Council: What's happening in the community managed mental health sector in NSW*, September 2011.
- **International Journal of Mental Health-** SUMMER 2011/VOL. 40, NO. 2 Special edition on mental health services in Australia with a MHCC contribution on behalf of the CMO sector. *Taking Our Place: Community Managed Mental Health Services in Australia.*

KEY PRIORITY 3:
Exemplary management and governance

Over 2011-12 MHCC has improved its management and governance structures through strengthening its internal communication and policy review mechanisms. A Customer Relationship Management (CRM) tool was introduced to improve communication with our membership and stakeholders, and the MHCC Board have reviewed their strategic and governance obligations through review of board meeting structure and agenda.

DEVELOPING ORGANISATIONAL INFRASTRUCTURE AND RESPONDING TO GROWTH

ACHS Accreditation Status

MHCC became accredited with the Australian Council on Healthcare Standards (ACHS) in 2010, when MHCC's processes were reviewed to see how we comply with the standards that are assessed against (the EQuIP standards). The ACHS accreditation cycle lasts four years, and our mid-cycle periodic review occurred on 19th June.

At this review, ACHS auditors reviewed MHCC functions, processes and evidence against certain key criteria within four functions: Leadership and Management, HR Management, Information Management and Work Health & Safety (WHS). The evidence we provided included our board and governance records, strategic and operational plans, HR and WHS records and records of how we manage the wealth of information that we generate and receive. Evidence of our work to develop the information management capacity of the sector was also presented.

The auditors gave praise for the manner in which MHCC had contextualised criteria relating to areas such as WHS and continuous improvement, for an office-based as opposed to direct service provision environment. They also complimented MHCC on our evidence of strategic processes and evaluation.

RTO Status

As a registered training organisation (RTO), MHCC is required to be audited by the Australian Skills Quality Authority (ASQA) when we wish to change our scope, and to renew our registration. ASQA conducted their audit of all learning and development products and processes on 18th and 19th June.

The ASQA auditors conducted a very thorough review of all of the LD training and assessment materials to check compliance with the vocational education and training quality framework. They also reviewed our record keeping, administrative processes, risk management, continuous improvement framework, and policies to check that they are all geared towards providing high quality training and assessment.

Whilst being time consuming, this was a very valuable in helping us to critically review our processes and materials, and make improvements.

A SKILLED AND FOCUSED BOARD

The MHCC Board over 2011-12 has been comprised of representatives from large and small organisations including single-issue and consumer organisations, providing MHCC with a range of perspectives through its deliberations. Board member attendance was high throughout the year.

Development of the 2012-15 Strategic Plan has been a key activity this year resulting in a strong brief for MHCC over the next three years. The plan has been through internal and external consultations and is supported by a detailed operations plan.

2011-12 was the second term for Karen Burns (Uniting Care Mental Health) as MHCC Chair. A particular focus for the Chair and CEO over 2011-12 has been review of sign-off processes and reporting around Board responsibilities.

RESPONDING TO GROWTH

As MHCC's growth and development continues across both the policy and training arms of the organisation there is an increased need to create avenues for clear communication, joint decision making and cross-fertilisation. This year MHCC has worked hard to establish team based meeting structures that engage a cross-sector of staff, promoting consistent, shared and dynamic directions for the organisation.

MHCC has increasing demands from state, national and community sector sources. Whilst it is positive that mental health really is 'becoming everyone's business', this means MHCC as the peak body has a wider range of government agencies and organisations to support and respond to as they seek advice on improving services. The Commonwealth is now fully engaged in providing mental health services and strengthening infrastructure in relation to data collection, reporting and workforce development and MHCC dedicates significant secretariat resource to these undertakings because of their potential to establish the community mental health sector as an integral part of the service landscape.

MHCC LD continues to respond to a wide range of requests from organisations for customised training and workforce development support as well as maintaining a high profile and engagement with state and national industry training bodies. A recent restructure will allow more flexibility in MHCC LD to respond to growth opportunities.

MHCC undertook a review of our membership benefits and administrative processes this year which will result in more streamlined membership applications, more targeted communication and clearer member benefits. Current membership sits at 114 voting members, 94 branch and subscription members and 12 Associate members.

MHCC - working for mental health

Financial Statements 2011-2012

O'Neill & O'Brien Pty Limited
Accountants and Auditors

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Director
Bruce Lawrence BBus, CPA

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ABN 12 003 157 177

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
ABN 52 279 168 647

FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2012

CONTENTS

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD
Mental Health Co-ordinating Council Incorporated

Report on the financial report

We have audited the accompanying financial report, being a special purpose financial report of Mental Health Co-ordinating Council Incorporated, which comprises the balance sheet as at 30 June 2012, and the income statement, a summary of significant accounting policies, other explanatory notes and the statement by the members of the board.

Board's responsibility for the financial report

The board members of the association are responsible for the preparation and the presentation of the financial report and have determined that the accounting policies described in Note 1 to the financial statements,which form part of the financial report are consistent with the financial reporting requirements of the Associations Incorporation Act and are appropriate to meet the needs of the Board. The Board's responsibilities also include establishing and maintaining internal control relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error, selecting and applying appropriate accounting policies, and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. No opinion is expressed as to whether the accounting policies used, as described in Note 1, are appropriate to meet the needs of the Board. We conducted our audit in accordance with Australian Auditing Standards. These Auditing Standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error, in making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates by the board, as well as evaluating the overall presentation of the financial report

The financial report has been prepared for distribution to the board for the purpose of fulfilling the board's financial reporting under the Associations Incorporation Act. We disclaim any assumption of responsibility for any reliance on this report or on the financial report to which it relates to any person other than the board, or for any purpose other than that for which it was prepared

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Independence

In conducting our audit, we have complied with the independence requirements of Australian professional ethical pronouncements.

Auditor's Opinion

In our opinion, the financial report of Mental Health Co-ordinating Council Incorporated presents fairly, in all material respects the financial position of Mental Health Co-ordinating Council Incorporated as at 30 June 2012 and of its financial performance for the year then ended in accordance with the accounting policies described in Note 1 to the financial statements.

Name of Auditor: **Bruce Lawrence**
Member - CPA **Auditor's Number: 1837**

Address: **Unit 6**
13 Larkin Street
RIVERWOOD NSW 2210

Signature: Bruce Lawrence
Bruce Lawrence

Dated this 9TH day of NOVEMBER 2012.

AUDITORS INDEPENDENCE DECLARATION
UNDER SECTION 307C OF THE CORPORATIONS ACT 2001

To the Directors of MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED

I declare that, to the best of my knowledge and belief, in relation to the audit of MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED for the year ended 30 June 2012 there have been;

a) no contraventions of the auditor independence requirements as set out in the Corporations Act 2001 in relation to the audit: and

b) no contraventions of any applicable code of professional conduct in relation to the audit.

Bruce Lawrence
Bruce Lawrence

Dated this 9TH day of NOVEMBER 2012

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
ABN: 59 279 168 647
Statement by Members of The Board
For the Year Ended 30 June 2012

The Board has determined that the association is not a reporting entity and that this special purpose financial report should be prepared in accordance with the accounting policies outlined in Note 1 to the financial statements.

In the opinion of the Board the financial report as set out on pages 1 to 25.

1 Presents a true and fair view of the financial position of Mental Health Co-ordinating Council Incorporated as at 30 June 2012 and its performance for the year ended on that date.

2 At the date of the Statement, there are reasonable grounds to believe that Mental Health Co-ordinating Council Incorporated will be able to pay its debts as and when they fall due.

This statement is made in accordance with a resolution of the board and signed for and on behalf of the Board by:

President.....

Treasurer.....

Dated this 9th day of Nov. 2012

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
Statement of Comprehensive Income
For the Year ended 30 June 2012

	Note	2012 $	2011 $
Revenue	2	4,654,512	5,789,775
Finance Costs	4	935	1,995
Employee Benefits Expense	3	1,987,658	1,828,541
Depreciation and Amortisation	3	40,248	41,744
Other Expenses	3	1,654,812	3,048,477
Profit	5	970,859	869,018
Total Comprehensive Income		970,859	869,018

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
Statement of Financial Position
As at 30 June 2012

	Note	2012 $	2011 $
Current Assets			
Cash and Cash Equivalents	6	4,394,845	3,715,407
Trade and Other Receivables	8	198,587	185,581
Total Current Assets		4,593,432	3,900,988
Non-Current Assets			
Property, Plant and Equipment	9	133,287	163,410
Total Non-Current Assets		133,287	163,410
Total Assets		4,726,719	4,064,398
Current Liabilities			
Trade and Other Payables	10	207,866	138,060
Short-Term Financial Liabilities	11	44,501	13,551
Provisions	12	549,113	141,341
Other	13	1,400,661	2,217,727
Total Current Liabilities		2,202,141	2,510,679
Total Liabilities		2,202,141	2,510,679
Net Assets		2,524,578	1,553,719
Equity			
Retained Profits	14	2,524,578	1,553,719
Total Equity		2,524,578	1,553,719

The accompanying notes form part of these financial statements.

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
Statement of Changes in Equity
For the Year ended 30 June 2012

	2012 $	2011 $
Opening Balance	1,553,719	684,701
Retained Earnings		
Profit for the year	970,859	869,018
	970,859	869,018
Closing Balance	2,524,578	1,553,719
Reconciliation of Retained Earnings		
Opening Balance	1,553,719	684,701
Profit for the year	970,859	869,018
Closing Balance	2,524,578	1,553,719
Total Equity	2,524,578	1,553,719

The accompanying notes form part of these financial statements.
These financial statements should be read in conjunction with the attached.

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
ABN: 59 279 168 647

Statement of Cash Flows
For The Year Ended 30 June 2012

	Note	2012 $	2011 $
CASH FLOWS FROM OPERATING ACTIVITIES			
LDU - Course Payment (inclusive of GST)		3,384,701	2,916,911
Seminar Revenue (inclusive of GST)		7,926	120,557
Receipts from Members (inclusive of GST)		42,441	13,505
Government & Other Grants Received (inclusive of GST)		1,167,639	3,075,207
Payments to Suppliers & Employees (inclusive of GST)		-4,117,973	-6,720,157
Interest Received		198,178	195,751
Other Receipts		6,651	23,768
Net Cash Provided by Operating Activities		**689,563**	**-373,458**
CASH FLOW FROM INVESTING ACTIVITIES			
Payments for Property, Plant & Equipment		10,125	59,699
Proceeds from Sale of Property, Plant & Equipment			
Net Cash Used in Investing Activities		**10,125**	**59,699**
CASH FLOW FROM FINANCING ACTIVITIES			
Net Cash Used In Financing Activities			
Net Increase (Decrease) in Cash Held		679,438	-433,157
Cash at the Beginning of the Financial Year		3,715,407	4,148,564
Cash at the End of the Financial Year		**4,394,845**	**3,715,407**

1. STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

The financial statements cover MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED as an individual entity. MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED is an association incorporated New South Wales under the Associations Incorporation Act 1981.

Basis of Preparation

The financial statements are general purpose financial statements that have been prepared in accordance with Australian Accounting Standards (including Australian Accounting Interpretations) of the Australian Accounting Standards Board and the Corporations Act 2001.

Australian Accounting Standards set out accounting policies that the AASB has concluded would result in financial statements containing relevant and reliable information about transactions, events and conditions. Compliance with Australian Accounting Standards ensures that the financial statements and notes also comply with International Financial Reporting Standards. Material accounting policies adopted in the preparation of the financial statements are presented below and have been consistently applied unless otherwise stated.

The financial statements have been prepared on an accruals basis and are based on historical costs, modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities.

Accounting Policies

(a) **Cash and Cash Equivalents**
Cash and cash equivalents include cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are shown within borrowings in current liabilities on the statement of financial position.

(b) **Provisions**
Provisions are recognised when the company has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured.

Provisions are measured using the best estimate of the amounts required to settle the obligation at the end of the reporting period.

(c) **Employee Benefits**
Provision is made for the company's liability for employee benefits arising from services rendered by employees to the end of the reporting period. Employee benefits that are expected to be settled within one year have been measured at the amounts expected to be paid when the liability is settled.

Employee benefits payable later than one year have been measured at the present value of the estimated future cash outflows to be made for those benefits. In determining the liability, consideration is given to employee wage increases and the probability that the employees may not satisfy vesting requirements. These cash flows are discounted using market yields on national government bonds with terms to maturity that match the expected timing of cash flows.

(d) **Property, Plant and Equipment**
Each class of property, plant and equipment is carried at cost or fair value as indicated less, where applicable, any accumulated depreciation and impairment losses.

Plant and Equipment
Plant and equipment are measured on the cost basis and are therefore carried at cost less accumulated depreciation and any accumulated impairment. In the event the carrying value of plant and equipment is greater than the estimated recoverable amount, the carrying value is written down immediately to the estimated recoverable amount. A formal assessment of recoverable amount is made when impairment indicators are present (refer to Accounting Policy note - Impairment).

The cost of fixed assets constructed within the consolidated group includes the cost of materials, direct labour, borrowing costs and an appropriate proportion of fixed and variable overheads.

Subsequent costs are included in the asset's carrying value or recognised as a separate asset, as appropriate, only when it is probable that future economic benefits associated with the item will flow to the entity and the cost of the item can be measured reliably. All other repairs and maintenance are charged to the statement of comprehensive income during the financial period in which they are incurred.

Depreciation
The depreciation method and useful life used for items of property, plant and equipment (excluding freehold land) reflects the pattern in which their future economic benefits are expected to be consumed by the company. Depreciation commences from the time the asset is held ready for use. Leasehold improvements are depreciated over the shorter of either the unexpired period of the lease or the estimated useful lives of the improvements. The depreciation method and useful life of assets is reviewed annually to ensure they are still appropriate.

The depreciation rates used for each class of depreciable asset are:

Buildings	2 %
Plant and Equipment	5 - 10 %
Leased Plant and Equipment	10 %

The assets' residual values and useful lives are reviewed, and adjusted if appropriate, at the end of each reporting period.

An asset's carrying value is written down immediately to its recoverable amount if the asset's carrying value is greater than its estimated recoverable amount.

Gains and losses on disposals are determined by comparing proceeds with the carrying value. These gains or losses are recognised immediately in profit or loss. When revalued assets are sold, amounts included in the revaluation reserve relating to that asset are transferred to retained earnings.

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
Notes to the Financial Statements
For the Year ended 30 June 2012

(e) **Borrowing Costs**
Borrowing costs directly attributable to the acquisition, construction or production of assets that necessarily take a substantial period of time to prepare for their intended use or sale, are added to the cost of those assets, until such time as the assets are substantially ready for their intended use or sale.

All other borrowing costs are recognised in profit or loss in the period in which they are incurred.

(f) **Leases**
Leases of fixed assets, where substantially all the risks and benefits incidental to the ownership of the asset (but not the legal ownership) are transferred to entities in the consolidated group, are classified as finance leases.

Finance leases are capitalised by recognising an asset and a liability at the lower of the amounts equal to the fair value of the leased property or the present value of the minimum lease payments, including any guaranteed residual values. Lease payments are allocated between the reduction of the lease liability and the lease interest expense for the period.

Leased assets are depreciated on a straight-line basis over their estimated useful lives where it is likely that the consolidated group will obtain ownership of the asset or over the term of the lease.

Lease payments for operating leases, where substantially all the risks and benefits remain with the lessor, are recognised as expenses in the periods in which they are incurred.

Lease incentives under operating leases are recognised as a liability and amortised on a straight-line basis over the life of the lease term.

(g) **Financial Instruments**
Initial Recognition and Measurement
Financial assets and financial liabilities are recognised when the entity becomes a party to the contractual provisions to the instrument. For financial assets, this is equivalent to the date that the company commits itself to either purchase or sell the asset (i.e. trade date accounting is adopted).

Financial instruments are initially measured at fair value plus transactions costs except where the instrument is classified 'at fair value through profit or loss', in which case transaction costs are expensed to profit or loss immediately.

Classification and Subsequent Measurement
Finance instruments are subsequently measured at fair value, amortised cost using the effective interest rate method or cost. Where available, quoted prices in an active market are used to determine fair value. In other circumstances, valuation techniques are adopted.

Amortised cost is calculated as:

- the amount at which the financial asset or financial liability is measured at initial recognition;
- less principal repayments;
- plus or minus the cumulative amortisation of the difference, if any, between the amount initially recognised and the maturity amount calculated using the effective interest method; and
- less any reduction for impairment.

The effective interest method is used to allocate interest income or interest expense over the relevant period and is equivalent to the rate that exactly discounts estimated future cash payments or receipts (including fees, transaction costs and other premiums or discounts) through the expected life (or when this cannot be reliably predicted, the contractual term) of the financial instrument to the net carrying value of the financial asset or financial liability.

Revisions to expected future net cash flows will necessitate an adjustment to the carrying value with a consequential recognition of an income or expense item in profit or loss.

Fair value is determined based on current bid prices for all quoted investments. Valuation techniques are applied to determine the fair value for all unlisted securities, including recent arm's length transactions, reference to similar instruments and option pricing models.

The group does not designate any interests in subsidiaries, associates or joint venture entities as being subject to the requirements of Accounting Standards specifically applicable to financial instruments.

Financial Assets at Fair Value through Profit and Loss

Financial assets are classified at 'fair value through profit or loss' when they are held for trading for the purpose of short term profit taking, derivatives not held for hedging purposes, or when they are designated as such to avoid an accounting mismatch or to enable performance evaluation where a group of financial assets is managed by key management personnel on a fair value basis in accordance with a documented risk management or investment strategy. Such assets are subsequently measured at fair value with changes in carrying value being included in profit or loss.

Impairment

At the end of each reporting period, the company assesses whether there is objective evidence that a financial instrument has been impaired. In the case of available-for-sale financial instruments, a prolonged decline in the value of the instrument is considered to determine whether an impairment has arisen. Impairment losses are immediately recognised in profit or loss. Also, any cumulative decline in fair value previously recognised in other comprehensive income is reclassified to profit or loss at this point.

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
Notes to the Financial Statements
For the Year ended 30 June 2012

Derecognition

Financial assets are derecognised where the contractual rights to receipt of cash flows expires or the asset is transferred to another party whereby the entity no longer has any significant continuing involvement in the risks and benefits associated with the asset.

Financial liabilities are derecognised where the related obligations are either discharged, cancelled or expire. The difference between the carrying value of the financial liability extinguished or transferred to another party and the fair value of consideration paid, including the transfer of non-cash assets or liabilities assumed is recognised in profit of loss.

(h) **Financial Guarantees**

Where material, financial guarantees issued, which requires the issuer to make specified payments to reimburse the holder for a loss it incurs because a specified debtor fails to make payment when due, are recognised as a financial liability at fair value on initial recognition.

The guarantee is subsequently measured at the higher of the best estimate of the obligation and the amount initially recognised less, when appropriate, cumulative amortisation in accordance with AASB 118: Revenue. Where the entity gives guarantees in exchange for a fee, revenue is recognised under AASB 118.

The fair value of financial guarantee contracts has been assessed using a probability weighted discounted cash flow approach. The probability has been based on:

- the likelihood of the guaranteed party defaulting in a year period;
- the proportion of the exposure that is not expected to be recovered due to the guaranteed party defaulting; and
- the maximum loss exposed if the guaranteed party were to default.

(i) **Revenue and Other Income**

Revenue is measured at the fair value of the consideration received or receivable after taking into account any trade discounts and volume rebates allowed. Any consideration deferred is treated as the provision of finance and is discounted at a rate of interest that is generally accepted in the market for similar arrangements. The difference between the amount initially recognised and the amount ultimately received is interest revenue.

Interest revenue is recognised using the effective interest rate method, which for floating rate financial assets is the rate inherent in the instrument. Dividend revenue is recognised when the right to receive a dividend has been established.

Revenue recognition relating to the provision of services is determined with reference to the stage of completion of the transaction at the end of the reporting period and where outcome of the contract can be estimated reliably. Stage of completion is determined with reference to the services performed to date as a percentage of total anticipated services to be performed.

Where the outcome cannot be estimated reliably, revenue is recognised only to the extent that related expenditure is recoverable.

All revenue is stated net of the amount of goods and services tax (GST).

(j) **Trade and Other Payables**
Trade and other payables represent the liabilities at the end of the reporting period for goods and services received by the company that remain unpaid.

(k) **Comparative Figures**
When required by Accounting Standards, comparative figures have been adjusted to conform to changes in presentation for the current financial year.

Where the company has retrospectively applied an accounting policy, made a retrospective restatement of items in the financial statements or reclassified items in its financial statements, an additional statement of financial position as at the beginning of the earliest comparative period will be disclosed.

(l) **Critical Accounting Estimates and Judgments**
The directors evaluate estimates and judgments incorporated into the financial statements based on historical knowledge and best available current information. Estimates assume a reasonable expectation of future events and are based on current trends and economic data, obtained both externally and within the company.

Key Estimates - Impairment
The company assesses impairment at the end of each reporting period by evaluation of conditions and events specific to the company that may be indicative of impairment triggers. Recoverable amounts of relevant assets are reassessed using value-in-use calculations which incorporate various key assumptions.

(m) **New Accounting Standards for Application in Future Periods**
The Australian Accounting Standards Board has issued new and amended Accounting Standards and Interpretations that have mandatory application dates for future reporting periods and which the company has decided not to early adopt. The company does not anticipate early adoption of any of the reporting requirements would have any material effect on the company's financial statements.

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
Notes to the Financial Statements
For the Year ended 30 June 2012

	2012 $	2011 $
2. Revenue		
Government & Other Grants	1,070,395	2,795,643
		2,795,643
Other Income		
Interest Received	198,178	196,751
LDU Course Payments	3,333,500	2,651,738
Membership Subscriptions	38,583	12,277
Salary Packaging Admin Fee	-	4,510
Seminars and Sundry Income	13,856	128,856
	3,584,117	2,994,132
	4,654,512	5,789,775
3. Expenses		
Employee Benefits Expense	1,987,658	1,828,541
Depreciation and Amortisation Expenses	40,248	41,744
Advertising	11,634	7,243
Bank Charges	873	1,139
Insurance	27,031	20,969
Library	1,609	482
Postage	7,824	20,788
Printing & Stationery	58,821	136,465
Repairs & Maintenance	4,053	15,352
Telephone	17,905	29,058
Other Expenses	1,525,062	2,816,981
	3,682,718	4,918,762
4. Finance Costs		
Bank Card Charges	935	1,995
	935	1,995
5. Profit for the Year	**970,859**	**869,018**
Profit from continuing operations includes the following specific expenses:		
Charging as Expense		
Finance Costs	935	1,995

	2012 $	2011 $
Movements in Provisions		
Depreciation		
- Depreciation of Property, Plant and Equipment	40,248	41,744
Net Expenses Resulting from Movement in Provisions	40,248	41,744
Bad & Doubtful Debts:-		
- Bad debts written off	2,000	16,152
	2,000	16,152
Remuneration of the Auditor:-		
- Audit & review of financial reports	7,000	5,000
	7,000	5,000
Crediting as Income:		
Interest from :		
- Other Corporations	198,178	196,751
Total Interest Revenue	198,178	196,751

6. Cash and Cash Equivalents

Deposits	1,675	1,945
Cash Management Account	249,846	509,079
Cash on Hand	300	300
Security Deposit	200	200
Business Day Term Deposit	4,142,824	3,203,883
	4,394,845	3,715,407
Cash Reconciliation		
Cash and Cash Equivalents	4,394,845	3,715,407
	4,394,845	3,715,407

	2012 $	2011 $
7. Cash Flow Information		
Reconciliation of Cash Flow from Operations with Profit after Income Tax		
Profit	970,859	869,018
Adjustments for Non-Cash Components in Profit:		
Depreciation	40,248	41,744
Changes in Assets and Liabilities		
Increase in Trade and Other Receivables	(13,006)	144,183
Decrease in Trade and Other Payables	(716,310)	(1,451,933)
Increase in Provisions	407,772	23,530
Net Cash Provided by Operating Activities	689,563	(373,458)

8. Trade and Other Receivables

Current		
Trade Debtors	197,184	185,581
Accrued Income	1,406	-
Total Trade and Other Receivables	198,587	185,581

9. Property, Plant and Equipment

Plant and Equipment		
Plant & Equipment	179,043	171,501
Less Accumulated Depreciation	113,304	98,239
	65,739	73,262
Motor Vehicles	72,173	72,173
Less Accumulated Depreciation	30,065	20,362
	42,108	51,811
Computer Equipment	77,005	75,928
Less Accumulated Depreciation	51,565	37,591
	25,440	38,337
Total Plant and Equipment	133,287	163,410

	2012 $	2011 $
10. Trade and Other Payables		
Current		
PAYGWH Tax Payable	20,557	28,407
Trade Creditors	187,309	109,653
Total Trade and Other Payables	207,866	138,060
11. Financial Liabilities		
Current		
GST Creditor	44,501	13,551
	44,501	13,551
Total Financial Liabilities	44,501	13,551
12. Provisions		
Current		
Provision for Holiday Pay	128,816	109,145
Provision for Long Service Leave	47,615	32,196
Provision for Training Venue	372,682	-
	549,113	141,341
Total Provisions	549,113	141,341

An amount of $372,682 has been set aside for the renting and fitting out premises for training in the future.

13. Other		
Current		
Accrued Charges	10,250	70,689
Deferred Income	1,235,941	2,147,038
Income in Advance	154,470	-
	1,400,661	2,217,727
14. Retained Earnings		
Retained Earnings at the Beginning of the Financial Year	1,553,719	684,701
Add		
Net profit attributable to members of the company	970,859	869,018
Retained Earnings at the End of the Financial Year	2,524,578	1,553,719

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
Notes to the Financial Statements
For the Year ended 30 June 2012

	2012 $	2011 $
15. Auditors Remuneration		
BRUCE LAWRENCE was the auditor of MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED		
- Audit & review of financial reports	7,000	5,000
	7,000	5,000

These notes should be read in conjunction with the attached Audit Report.

NOTE 16: PROPERTY, PLANT & EQUIPMENT

Reconciliations

Reconciliations of the carrying amounts of each class of property, plant and equipment at the beginning and end of the current financial year are set out below:

	Motor Vehicles	Plant & Equipment	Computer Equipment	Total
Carrying Amount at 1/7/11	51,811	73,262	38,337	163,410
Additions		8,446	1,679	10,125
Disposals				0
Depreciation Expense (Note 3)	9,703	15,969	14,576	40,248
Carrying Amount at 30/6/12	**42,108**	**65,739**	**25,440**	**133,287**

NOTE 17: SEGMENT REPORTING

Mental Health Co-ordinating Council Inc. is the peak body for Non-Government Organisations working in Mental Health in New South Wales.

NOTE 18: CONTRIBUTED EQUITY

Mental Health Co-ordinating Council Inc is an association which does not issue equity.

NOTE 19: FINANCIAL INSTRUMENTS

(a) Terms, Conditions and Accounting Policies

The Association's accounting policies, including the terms and conditions of each class of financial asset and financial liability and equity instrument, both recognised and unrecognised at the balance date, are as follows:

Recognised Financial Instruments	Balance Sheet Notes	Accounting Policies	Terms and Conditions
i) Financial Assets			
Receivables - Trade	7	Trade receivables are carried at nominal amounts due less any provision for doubtful debts. A provision for doubtful debts is recognised when collection of the full nominal amount is no longer probable.	The majority of credit sales are on 30 day terms.
Bank Accounts	6	The bank accounts are carried at the nominal amount. Interest earned is included as income as it is accrued.	Details of bank balances are set out at note 6.
ii) Financial Liabilities			
Creditors	9	Liabilities are recognised for amounts to be paid in the future for goods and services received, whether or not billed to the Association.	Trade Creditors are normally settled on 30 day terms.
Deferred Income	9	Deferred income represents grants received by the Association prior to year end which are to be acquitted in subsequent financial periods.	Deferred income does not attract interest expense, and is generally acquitted within twelve months of balance date.

(b) Net Fair Values

All carrying values approximate fair value for all recognised financial instruments.

(c) **Credit Risk Exposures**

The Association's maximum exposure to credit risk at balance date in relation to each class of recognised financial assets is the carrying amount of those assets as indicated in the balance sheet.

Credit risk in trade receivables is managed in the following way:

(i) the provision of credit is covered by a risk assessment process for all customers, including restricting each transaction to manageable amounts.

Interest Rate Risk Exposures

The Association's exposure to interest rate risk for each class of financial assets and financial liabilities is set out below.

	Floating Interest Rate 2012 $	Non Interest Bearing 2012 $	Total 2012 $
Financial Assets			
Cash	4,394,845		4,394,845
Receivables		198,587	198,587
	4,394,845	**198,587**	**4,593,432**
Financial Liabilities			
Trade and Other Payables		262,617	262,617
Deferred Income		1,390,411	1,390,411
	0	**1,653,028**	**1,653,028**
Net Financial Assets/ Liabilities	**4,394,845**	**-1,454,441**	**2,940,404**

NOTE 19: FINANCIAL INSTRUMENTS (cont'd)

	Floating Interest Rate 2011 $	Non Interest Bearing 2011 $	Total 2011 $
Financial Assets			
Cash	3,715,407		3,715,407
Receivables		185,581	185,581
	3,715,407	**185,581**	**3,900,988**
Financial Liaiblities			
Trade and Other Creditors		222,300	222,300
Deferred Income		2,147,038	2,147,038
	0	**2,369,338**	**2,369,338**
Net Financial Assets/ (Liabilities)	**3,715,407**	**-2,183,757**	**1,531,650**

Reconciliation of Net Financial Assets to Net Assets

	2012 $	2011 $
Net Financial Assets as above	2,940,404	1,531,650
Property, Plant & Equipment	133,287	163,410
Provisions	-549,113	-141,341
Net Assets as per Statement of Financial Position	**2,524,578**	**1,553,719**

NOTE 20: EVENTS SUBSEQUENT TO BALANCE DATE

No matters or circumstances have arisen since the end of the financial year which significantly affected or may significantly affect the operations of the association, the results of those operations or the state of affairs of the association in financial years subsequent to the financial year ended 30 June, 2012.

NOTE 21: REMUNERATION OF BOARD MEMBERS

	2012 $	2011 $
Income paid or payable, or otherwise made available, to board members by the associaiton in connection with the management of affairs of the association.	Nil	Nil

The number of board members whose total income from the association or related parties was within the specified bands are as follows:

$	$	2012	2011
0 -	9,999	10	10

NOTE 22: RELATED PARTIES

Names of Board Members
The names of persons who were board members of the association at any time during the financial year are as follows.

Phil Nadin	Cathy Kezelman	Judi Higgin
Leone Crayden	John Malone	Sylvia Grant
Karen Burns	Sue Sacker	Pam Rutledge
Peri O'Shea		Karen Oakley

New Members
The following board members were elected at the Association's Annual General Meeting:
Cathy Kezelman
John Malone
Peri O'Shea

Resigning Members
The following board members stood for re-election at the Association's Annual General Meeting.
Cathy Kezelman
John Malone
Peri O'Shea

Remuneration
Information on remuneration of board members is disclosed in Note 18.

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
ABN: 59 279 168 647
Notes to the Financial Statements
For the Year Ended 30 June 2012

NOTE 23: EMPLOYEE ENTITLEMENTS

	2012 $	2011 $
Employee Entitlement Liabilities:		
Provision for Employee Entitlements-Current (Note 12)	176,431	141,341
Aggregate Employee Entitlement Liability	**176,431**	**141,341**

NOTE 24: FUNDING APPROVAL

As part of funding approval Mental Health Co-ordinating Council Incorporated charges most funded projects a grant administration fee which is recorded as a project expense and as grant administration fee income for the organisation.

NOTE 25: ENTITY DETAILS

Principal Place of Business is:

Mental Health Co-ordinating Council Incorporated
Broughton Hall
Cnr Church & Glover Streets
LILYFIELD NSW 2040

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
Income and Expenditure Statement
For the Year ended 30 June 2012

	2012 $	2011 $
Revenue		
Government & Other Grants	1,070,395	2,795,643
Membership Subscriptions	38,583	12,277
Seminar	7,205	109,598
Sundry Income	6,651	19,258
Interest Received		
- Other Corporations	198,178	196,751
LDU Course Payments	3,333,500	2,651,738
Salary Packaging Admin Fee	-	4,510
	4,654,512	5,789,775
Expenditure		
Accommodation	34,734	36,367
Administration Costs	97,949	315,101
Advertising	11,634	7,243
Accreditation Expenses	8,799	-
Auditor's Remuneration		
- Audit & review of financial reports	7,000	5,000
Bad Debts Written Off	2,000	16,152
Bank Charges	873	1,139
Bank Card Charges	935	1,995
Catering	41,544	26,369
Cleaning	5,800	5,851
Consultancy Fees	316,424	388,996
Courier Expenses	10,209	7,302
Construction Expenses	-	(133,198)
Computer Software	43,438	27,968
Depreciation	40,248	41,744
Electricity	-	7,164
Equipment Purchases	7,201	16,423
Filing Fees	91	48
Fines	212	239
Fringe Benefits Tax	14,677	10,378
Grants Paid	10,000	1,108,554
Insurance	27,031	20,969
Internet Expense	19,522	1,228
Library	1,609	482
Motor Vehicle Expenses	16,921	16,370
Office Expenses	-	2,238
Postage	7,824	20,788
Printing & Stationery	58,821	136,465
Provision for Annual Leave	19,672	25,406
Provision for Long Service Leave	15,419	(1,876)
Repairs & Maintenance	4,053	15,352
Recruitment Expenses	30,247	48,130
Scholarships	258,677	222,298
Security Costs	1,173	525

The accompanying notes form part of these financial statements.
These financial statements should be read in conjunction with the attached .

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
Income and Expenditure Statement
For the Year ended 30 June 2012

	2012 $	2011 $
Speaker & Seminar Expenses	13,267	45,735
Staff Amenities	6,087	8,290
Subsidies Paid	-	20,810
Subscriptions	15,124	21,668
Sundry Expenses	3,062	5,868
Superannuation Contributions	159,846	148,647
Telephone	17,905	29,058
Trainers	359,452	361,536
Training	7,941	3,393
Travelling Expenses	88,373	86,529
Utilities	235	-
Venue Hire	69,438	122,789
Wages	1,820,611	1,663,471
Waste Disposal	1,890	1,878
Web Design	5,685	1,875
	3,683,653	4,920,757
Profit before Income Tax	970,859	869,018

The accompanying notes form part of these financial statements.
These financial statements should be read in conjunction with the attached .

mhcc
mental health coordinating council

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