# 2012-13 Annual Report

mhcc
mental health coordinating council


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# ORGANISATIONAL PROFILE

The Mental Health Coordinating Council (MHCC) is the peak body for mental health community-managed organisations (CMOs) throughout New South Wales (NSW). MHCC members provide a range of psychosocial and clinical services with a focus on recovery orientated practice. MHCC works with its members to strengthen the community mental health sector and improve mental health service delivery in NSW.

MHCC works in partnership with state and commonwealth governments, participates extensively in policy and sector development and facilitates linkages across systems, services and sectors. The organisation also manages and conducts projects on behalf of the sector and builds capacity through partnerships, collaboration, and workforce development; provides accredited training and professional development and supports and mentors member organisations through grant programs, scholarships and research opportunities.

## VISION

People with lived experience are the drivers of positive change in all mental health services and mental health reform.

## OUR PURPOSE

To build the capacity and ability of community organisations to support people on their recovery journey.

## 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 diversity of mental health services designed to meet local needs.
- An across-government and sector approach to mental health promotion and service delivery is required.

## 30 YEARS OF MHCC

In 2013 the Mental Health Coordinating Council is celebrating 30 years of working for mental health. MHCC was founded in 1983 by a small group of specialist mental health service providers with membership growing to over 200 organisations and individuals across a range of the not-for-profit community.

To commemorate this milestone, MHCC policy and promotions staff are currently assembling a history of MHCC and the broader community mental health sector, highlighting developments, challenges and achievements from the past 30 years. This historical document, the first record of its kind for MHCC, will be produced in a limited edition and is scheduled for release in late 2013.


MHCC's website is also being given a birthday 'facelift' to improve accessibility. The redesigned site is scheduled to go live in August with an official launch at the 2013 regional forums. The current format of the website is incredibly complex, presenting ongoing challenges around maintenance. The new site structure has been designed around key areas outlined in MHCC's strategic plan to ensure easy and logical access to information and resources.

And finally, MHCC will hold a gala anniversary dinner at the end of 2013. This invite-only dinner presents a great opportunity for special guests, former staff and Board members and other key stakeholders from the past 30 years to share stories of MHCC's contributions to improving outcomes for people with lived experience of mental health conditions.

The NSW mental health CMO sector is a crucial part of the mental health and human service systems. Our members contribute to improved outcomes for people experiencing mental health conditions. Our sector is flexible and responsive. One of its key strengths is the inclusion of mental health consumers and their families and carers, in the planning and development of services and strategic directions.

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

Above: Just some of the diverse services and programs delivered by our members.
(Images courtesy of Aftercare - PHaMs Program)

## MEMBERSHIP

MHCC is committed to its role as 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 consultation, advocacy, forums, working groups, committees and projects.

#### Access practical support

- Discounts to seminars and conferences.
- Access to trauma-informed recovery-orientated training and resources.
- Network to other similar organisations and across sectors.

#### Inform and stay informed

- MHCC keeps members up to date with information affecting the sector.
- MHCC keeps members informed about evidence based best practice from the latest research.
- 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.

# THE PEOPLE BEHIND MHCC

## MHCC Board

**KAREN BURNS**
(Chair)
UnitingCare Mental Health

**SUE SACKER**
(Treasurer)
Schizophrenia Fellowship

**LEONE CRAYDEN**
(Vice Chair)
On Track Community Programs

**JOHN MALONE**
(Secretary)
Aftercare

**JUDI HIGGIN**
New Horizone Enterprises

**PAM RUTLEDGE**
Richmond Fellowship of NSW

**PERI O'SHEA**
NSW CAG

**SYLVIA GRANT**
Neami

**DR CATHY KEZELMAN**
ASCA

**DEBORARH BANKS**
Lous Place

## 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 Officer Research, Information Systems & Housing
Lucy Corrigan - Policy Assistant

### ADMINISTRATION
Erika Hewitt - Operations & HR Manager
Colleen Mosch - Reception & Office Administration
Ian Bond - IT Support Officer
Jill Dimond - Finance Officer

### QUALITY & COMMUNICATIONS
Carrie Stone - Community Engagement Officer
Craig Healy, Volunteer
Lenny Pelling - Promotions Officer
Nick Roberts - Quality Coordinator (05/01/09 – 22/03/13)
Sheena Lee - Compliance & Quality Officer (commenced 08/05/13)

### PROJECT STAFF
Christina Thomas - Policy (13/12/11 – 20/09/12)
Deb Tipper - MHDAO Research Network

### LEARNING & DEVELOPMENT (LD)
Simone Montgomery - Manager LD
Chris Keyes - Project Liaison & Development Team Leader (commenced 14/01/13)
Jacqueline Moreno Ovidi - Training Services Team Leader

### ADMINISTRATION
Christine Kam - Student Support & Administration Officer
Joanne Timbs - Senior Administration Officer
Kat Fardian - Online Learning Officer
Liesl Homes - Administration Officer
Lisa Van Praag - Training Logistics Coordinator
Nicole Cother - Student Support & Administration Officer
Rebecca Forrester - Scholarships & Grants Administration Officer (24/03/11 – 26/09/12)
Simona Adochiei - Scholarships & Grants Administration Officer
Rainbow Yuen - Administration Assistant (commenced 07/01/13)

### COURSE COORDINATION
Lorna Downes - Short Course Coordinator
Tracy Noelle - Partnership & Development Coordinator (21/03/11 – 19/09/12)
Zoe Bloom - Course Coordinator (09/03/11 – 21/12/12)

# CHAIR'S REPORT

As another year draws to a close, it is again time to reflect on the significant opportunities and changes that the last 12 months have heralded. It is clear that many of the proposed changes for the community managed mental health sector in NSW will focus on increased collaborative efforts, which require new models of partnerships and shared decision making processes. These conversations have required appraisals of the work that organisations currently undertake and what future roles they may play in a newly constructed mental health sector landscape. For some community managed organisations, there have been concerns of some potentially challenging scenarios, particularly in response to the Grants Management Improvement Program.

This year saw the commencement of the NSW Mental Health Commission (MHC), with the appointment of the Commissioner and Deputy Commissioners. MHCC and the MHC have undertaken a number of partnership activities together, such as a recent CEO forum, and together have supported a position in the Hunter region to monitor the implementation of the NDIS pilot. MHCC will continue to work closely with the MHC in a range of areas, including the development of the Strategic Plan for Mental Health in NSW. There have been many achievements by MHCC in sector development over the last 12 months, including the NSW Community Managed Mental Health Sector Benchmarking Project. This project established population planning targets across a range of service types for specific locations. This will be extremely helpful for a broad range of organisations, both community managed and government, to assist in future planning and equitable program funding processes.

Other areas where MHCC has aimed to increase the capacity of the sector has been through the *Recovery Oriented Language Guide*, and the *MHCC Organisation Builder (MOB) - Policy Resource*, to name only two resources. These tools have been developed in partnership with MHCC members and have cross sectorial utility. They aim to strengthen organisations in recovery oriented practices for people living with a mental illness and those who support them.

I would like to thank my fellow Board members for their honest and forthright conversations over the past year, in a time of busyness and change. This year also saw long standing MHCC Board member and Treasurer Phil Nadin depart, and we welcomed Deb Banks to the Board. Sue Sacker also took on the role as treasurer. I thank Phil for the significant impact he has made to MHCC and the community managed mental health sector through this contribution.

Finally, I would like to acknowledge the tireless work of the staff of MHCC, and our Chief Executive Officer, Jenna Bateman. Jenna has been at the forefront of seeking government engagement and systemic advocacy on behalf of member organisations, in a time of significant change.

**Karen Burns**

MHCC is celebrating MHCC's 30th birthday this year. It has been 30 years since a handful of mental health support providers got together over lunch and made a decision: it was time to form an alliance so their work in supporting people with a mental illness to live in the community could be better recognised and understood. 1983 saw regular meetings between these organisations commence. Since that time the challenges before MHCC member organisations have been many and varied. The activities of state and commonwealth governments impact on service providers profoundly, and this year that activity has been particularly evident. Acronyms such as NDIS/DCA, PIR, GMIP, ABF and MHC are now part and parcel of sector conversations.

If there are consistent and emerging themes in the activities of government this year they are around issues of 'joined-up' services and collaboration; around fewer and stronger organisations or consortia able to expand and diversify their operations; and around smarter, less siloed spending. At the policy level in NSW, these directions have been most apparent in the Ministry of Health's Grants Management Improvement Plan. This plan aims to consolidate and streamline the community sector programs delivered through LHDs and through the NGO Grants Program. MHCC has been working with the Ministry of Health (MoH), MHDAO and other health peak bodies to ensure this process achieves better outcomes for consumers and carers and that organisations are provided adequate time to put effective collaborative arrangements in place.

The LHD/CMO partnership sub-acute services, established this year in two rural sites in NSW, are a welcome example of collaboration and rational spending. For the first time in NSW, MoH program funding for clinical positions has been specifically directed to the community sector. They are also the first NSW MoH funded services that have a 'step-up' component – a long overdue model here and hopefully the first of many. Further innovation in service modelling was announced this year with allocation of state funds to pilot an innovative co-location community hub model. This aims to provide accessible 'joined-up' recovery-orientated treatment and support. MHCC has strongly advocated this model over the last few years.

Through all the actual and potential change before the sector, MHCC members have demonstrated amazing resilience and maturity. Of particular note has been the competitive entry of Medicare Locals (MLs) into the traditional space of mental health community organisations. Throughout this challenge the sector has demonstrated both strength and flexibility in developing and managing relationships with these new entities. It is important to acknowledge that the MHCC Board agreed to allow MLs entry to MHCC membership this year in line with the existing MHCC constitution.

This year has seen the launch of the National Disability Insurance Scheme (NDIS). Psychosocial disability was a late inclusion in the scheme and this has implications in terms of organisational readiness to engage with the NDIS processes. MHCC has raised the neglect of mental health providers in this regard and will continue to do so. MHCC has partnered with the NSW MHC to place an MHCC staff member directly into the Hunter launch site. This capacity is providing valuable opportunity for MHCC members to understand and engage with the NDIS. Likewise MHCC participation on the Mental Health Council of Australia's (MHCA) Capacity Building project, and on the National Advisory to the NDIS Board (on behalf of Community Mental Health Australia), will give members additional representation and support. There is still much to determine about how the NDIS can best support consumer recovery and families and carers; and for people deemed ineligible for the scheme, access to support services will need to be assured.

# CEO REPORT

Running alongside the various initiatives in the sector this year has been the reform agenda of the MHC, well led by Commissioner John Feneley. MHCC has been closely involved with the processes around development of a strategic plan for the NSW mental health system by March 2014. The '*across the life stages*' framework for the plan has encouraged the involvement of a range of health and human service agencies and sectors that provide valuable perspectives on key issues for reform.

Outside of government initiatives, MHCC has further progressed the trauma informed care and practice agenda, which we commenced in 2011 with facilitation of a national conference. We are currently developing an organisational toolkit to assist member organisations to become trauma informed across their operations. Our work on the physical health of people with mental health issues is currently focused on researching sector innovation in this space and identifying good practices. We are researching the psychometric properties and evidence items for ROSSAT; progressing practice placements for university trained health disciplines in community organisations; and continuing our partnership with NADA to assist members to increase their research capacity. These represent only a few of the activities MHCC policy and project staff have been engaged with over the year. Full details are provided in this report.

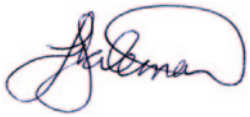
I would like to take this opportunity to recognise the outstanding contributions of the MHCC policy team: Tina Smith, Corinne Henderson, Tully Rosen and Stephanie Maraz. Each brings a wealth of expertise, knowledge and commitment to their roles. I would also like to recognise the excellent oversight of Deb Tipper to the ongoing development of the MHCC/NADA Research Network (CMHDARN).

MHCC Learning and Development (MHCC LD), managed by Simone Montgomery, continues to provide Certificate IV to Advanced Diploma VET qualifications to the sector. This year MHCC LD took on development of the training materials for the MH Peer Worker Certificate IV (on behalf of CMHA) funded by the National Mental Health Commission. MHCC LD also facilitated the Aboriginal Careers in Mental Health Traineeship program funded by DET which has seen 44 Aboriginal people commence careers in mental health community organisations. Simone is dedicated and highly skilled and many thanks go to her and her team for all they have achieved this year.

Thanks also go to all administration and communications staff particularly Operations and Human Resources Manager Erika Hewitt for her invaluable support and trouble-shooting; and to our Finance Officer, Jill Dimond, for managing MHCC's sometimes complex financial picture.

The MHCC Board has been a pleasure to work with. There has been a good mix of members this year allowing me access to a good range of perspectives. My thanks to chair Karen Burns for her keen understanding of the sector and emerging issues, her courage and her willingness to share her knowledge and experience. Thanks also to MHCC members who have participated in MHCC advisory and project working groups, completed surveys, attended forums and to those who have provided feedback on our activities. I hope members have found useful insights, guidance and resources through MHCC activities this year.

**Jenna Bateman**



# OUR WORK OVER THE PAST YEAR

What follows is a snapshot of MHCC activity during 2012-2013 aligned to our 2012-2015 Strategic Directions Key Priority areas:


## 1. SECTOR DEVELOPMENT

- Developing our workforce
- Creating a framework for practice recognition
- Improving service effectiveness and quality
- Enhancing practice approaches
- Creating new service models
- Integrating service delivery
- Building sector infrastructure

## 2. POLICY LEADERSHIP, INFLUENCE & REFORM

- Responding flexibly to policy reform
- Empowering strategic relationships
- Ensuring equitable access to services

Contributing to the development and implementation of planning and resourcing frameworks

## 3. RESEARCH & DEVELOPMENT

- Facilitating an evidence based practice research and evaluation direction for the sector
- Promoting the evidence base for community managed approaches
- Improving service effectiveness and quality

## 4. MHCC ORGANISATIONAL DEVELOPMENT

- Reviewing systems for MHCC governance, management and operations
- Improving MHCC quality improvement processes
- Consolidating the business viability of the LD

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.

# 1. SECTOR DEVELOPMENT

*The development of sector capacity to deliver effective services continues to be a priority area for MHCC. Projects and initiatives providing guidance and support on practice approaches and organisational systems have been well received. Workforce development has been a focus not only through the work of MHCC Learning and Development (MHCC LD) but also through our engagement with national mental health workforce planning structures.*

## Developing our workforce

### NATIONAL DIRECTIONS IN MENTAL HEALTH WORKFORCE DEVELOPMENT (WFD)

MHCC continues to provide national leadership in the area of community sector mental health workforce development. During 2012-13, we represented Community Mental Health Australia (CMHA) on the national Mental Health Workforce Advisory Committee (MHWAC). However, this group's work finished in December 2012 following a review by the new national Mental Health Drug and Alcohol Principal Committee (MHDAPC) of all its working groups. During 2012-13, MHCC contributed to MHWACs review of the National Mental Health Practice Standards and to development of the implementation plan for the National Mental Health Workforce Strategy and Plan. This is inclusive of consideration of some mental health workforce development directions for community sector, peer work and vocational education and training (VET) qualified work roles. Implementation accountability for mental health workforce development now sits with the MHDAPC.

In addition to our partnership with the National Mental Health Commission to develop the Certificate IV Mental Health Peer Work learning and assessment materials, MHCC on behalf of CMHA have also been working closely with Health Workforce Australia (HWA) during the first six months of 2013 on their new Mental Health Workforce Reform Project Advisory Group. This has involved three specific projects: Mental Health Peer Workforce Project; Mental Health Capabilities Project (including representation on a Technical Working Group), and the Mental Health Workforce Project (data and workforce development). HWA report that mental health will continue to be a workforce innovation priority area for them moving into 2013-14.

MHCC continues to chair CMHA's Workforce Development Working Group. A key focus of this group is strategising to obtain funding to increase the capacity of both CMHA and the state/territory peaks to respond to increasing national workforce development directions. We anticipate these directions will continue to increase as the community managed mental health sector grows in both size and importance. The working group has begun to explore what is required to support our sector to get workforce ready for implementation of the DisabilityCare Australia initiative (i.e., our National Disability Insurance Scheme).

### MHCC LD OVERVIEW

MHCC LD is a leader in community mental health sector workforce development. As such, MHCC LD prioritised workforce initiatives that enhanced sector capability and capacity in the short and long term. MHCC LD also continues to deliver high quality and affordable workforce professional development opportunities to the sector. 42% of all MHCC LD training was delivered as part of the general calendar, and 58% was delivered as per organisational specifications and requests. Specific areas of workforce development included: recruitment and support of 45 Aboriginal Mental Health trainees; understanding and responding to trauma; funding received for the development of the Certificate IV in Mental Health Peer Work; online learning in the form of virtual classrooms; and supporting community workers to gain skills in mental health through customised Mental Health Connect training in Aged Care and GLBT communities.

## UNDERSTANDING AND RESPONDING TO TRAUMA

Over the last few years a significant area of work for MHCC has been building knowledge and practice in the sector regarding Trauma Informed Care and Practice. In 2012 MHCC LD piloted and launched the course Understanding and Responding to Trauma for mental health and community sector workers. This course has significantly impacted the way the sector understands contemporary thought on trauma informed care and how these principles can be practically applied in the workplace. Workers who have completed the course have expressed more confidence in responding to, and supporting, people who have experienced trauma. To date 87 people have completed the course. To further support the sector MHCC LD will launch a course in 2014 specifically designed to support implementation of trauma informed practices in an organisational context.

## MENTAL HEALTH PEER WORKER QUALIFICATION

In April this year, MHCC commenced the Mental Health Peer Work Qualification Development Project on behalf of Community Mental Health Australia (CMHA) to develop national learning and assessment resources for the Certificate IV in Mental Health Peer Work (CHC42912).

The project is funded by the National Mental Health Commission (NMHC). This project will allow Registered Training Organisations (RTOs) across Australia to deliver a recognised Peer Work qualification for the consumer and carer peer workforce, without duplication of development effort. All resources will be available at no cost through the NMHC.

Peer work is arguably the fastest growing workforce in mental health in Australia. Many community organisations are increasingly looking to the peer workforce as an effective adjunct to their existing workforce. The project aims to support and grow the peer workforce, acknowledging and validating the importance of this work through completion of a national qualification. Based on identified sector need, the Community Services and Health Industry Skills Council (CS&HISC) developed the Certificate IV in Mental Health Peer Work in 2012 to meet the needs of this emerging workforce. The nationally endorsed qualification also includes a skill set for peer workers who are in leadership, mentoring or senior roles.

## THE PROFESSIONAL DEVELOPMENT SERIES

The Professional Development Series (PDS) launched in early 2012 has gone from strength to strength. It has significantly expanded to include topic areas such as: Emotional Intelligence in the Workplace; Mindfulness; Working Together for a Trauma Informed Response to Aboriginal Healing Needs; and Motivational Interviewing. There has been a 33% increase in the demand for PDS courses this year. The most popular courses have been Understanding and Responding to Trauma, and Motivational Interviewing. Emerging areas of workforce development include: supporting implementation of trauma informed practice in the workplace; consumer self advocacy; care coordination; effective training and facilitation skills; foundational and advanced coaching skills; and using coaching effectively to support consumers.

## VIRTUAL CLASSROOMS

MHCC LD's Virtual Classroom project was developed in conjunction with the National VET e-learning Strategy and Winangay Resources Inc., an Aboriginal not-for-profit community managed organisation. MHCC received funding for the purpose of making the Advanced Diploma of Community Sector Management CHC60312, more accessible for rural and remote workers through the implementation of "Virtual Classrooms". These Virtual Classrooms supplemented existing face-to-face training. The two modules developed related to Human Resources Management and Financial Management.

Different to the mass presentation style format of a webinar, the Virtual Classrooms were designed to replicate a traditional classroom. They have smaller numbers of participants using audio, video, breakout groups and other interactive methods to communicate, creating an interactive environment. During the project both students and trainers were interviewed and evaluation indicated an average rating of 4/5 in all areas and a satisfaction rate of 80%. This project has opened up a range of opportunities for MHCC LD to further develop our e-learning platform.

### COMMUNITY SERVICES TRAINING PACKAGE REVIEW

MHCC LD also played a key role in representing the sector as part of the CS&HISC review of the Community Services training Package CHC08. MHCC LD has been able to work with stakeholders to influence the shape of mental health and associated qualifications to ensure they are commensurate with current and emerging industry practice and standards.

### MENTAL HEALTH CONNECT FOR GLBT PEOPLE

This one-day workshop for gay, lesbian, bisexual or transgender people (GLBT) was developed to increase the confidence and understanding of community members. This includes supporting understanding of the experience of mental distress, and increasing confidence in supporting people who experience mental health problems. The course was adapted from Mental Health Connect, in partnership with the Aids Council of NSW (ACON) through the *Peace of Mind* program, with funding from the NSW Ministry of Health. Two pilots and 11 community workshops were held in NSW in 2012/2013. ACON's post course evaluation found that: 91% of participants felt more confident in providing support for the recovery process; and 98% of participants indicated they would recommend the workshop to others.

### MH CONNECT AGED CARE

One of the recommendations that arose from MHCC's Mental Health of Older People Connecting Sectors Forum (2012) was to increase uptake of Mental Health Connect and Trauma Informed Care professional development. The aim is to increase the aged care sector's awareness of, and capacity to respond to, older consumers in recovery oriented ways. MHCC LD held consultations with key stakeholders and produced a customised version of Mental Health Connect for aged care workers. Feedback from the pilot showed that: 94% of the participants felt the content was relevant; 89% felt they learned new skills; and 89% said they will use what they learned in their workplace.

### ABORIGINAL CAREERS IN MENTAL HEALTH

The Aboriginal Careers in Mental Health (ACIMH) initiative has been a highly innovative workforce development program coordinated by MHCC. It is endorsed by the MHCC Aboriginal Reference Group which has been in operation since 2010. The initiative works in partnership with the Aboriginal Employment Unit (AEU) within State Training Services (STS) toward a number of important aims in providing Aboriginal Mental Health Trainee positions across NSW.

The project has supported 11 community mental health organisations to recruit 48 Aboriginal Mental Health Trainees since August 2012. The positions provide a pathway for trainees to enter the sector, working across programs such as Personal Helpers and Mentors (PHaMs) and the Housing Accommodation and Support Initiative (HASI).

MHCC and the AEU within STS provide a tailored package of support to organisations with effective and culturally appropriate approaches to recruitment and retention of trainees, workplace mentoring, ongoing education and advice. The "*Yarn Up*" bi-monthly Newsletter was also established as a means of facilitating connections and learning across the project, providing

updates, profiles, experiences and impacts of the traineeships. Trainees and host organisations are heavily involved in informing and developing this publication.

ACIMH has seen significant recruitment in NSW, including in rural and remote areas, such as Broken Hill, Dubbo, Orange, Tamworth, Lismore, Newcastle, Ulladulla and Sydney metropolitan. An Employer Network Meeting was established to facilitate networking, cross-collaboration, sharing of resources and learning across host organisations. This supports changes and impacts to continue well beyond the life of the project.

Workshops on cultural awareness and supervision have further enhanced skills to enable effective engagement with Aboriginal people.

All 48 trainees have commenced nationally accredited training in the Certificate IV in Mental Health with MHCC. The training is provided in block release delivery to allow trainees to benefit from peer support, and enables sharing of work experiences and learning.

## Creating a framework for practice recognition

The MHCC Board have recently indicated that they are supportive of directions for strengthening the recognition of psychosocial disability and recovery support practice. Directions are emerging related to the likely certification/accreditation/registration of workers funded through the NDIS who may not be regulated health professionals (i.e., vocationally qualified). There are also potential opportunities and challenges associated with industry discussion about a future need for generic disability, aged and mental health vocationally qualified workers. These need to be better understood through the journey of exploring a framework for psychosocial rehabilitation and recovery support practice recognition. This issue has been placed on the Community Mental Health Australia (CMHA) agenda for 2013-14 as a national approach is required.

## Improving service effectiveness and quality

### POLICY RESOURCE

Policy development and review is an important task that all organisations must undertake to improve the quality and effectiveness of the services that they deliver, and to move toward meeting the requirements of accreditation. In an increasingly complex mental health environment, the need for policies to be developed or reviewed can be triggered by numerous events. This is important for ensuring contemporary evidence-based and recovery-oriented practice.

MHCC extends our appreciation to the members of the Reference Group that completed development of our sector's new *MHCC Organisation Builder (MOB) Policy Resource* in 2012. The *MOB Policy Resource* was made available to the sector in January 2013 and was officially launched by the NSW Mental Health Commissioner, John Feneley, at the MHCC CEO and Senior Leaders Forum in May along with an underpinning *Recovery Oriented Language Guide* that was made available to the sector in April.


The resource is available on MHCC's website. It is a web-based resource that also includes a User Guide. It consists of more than 200 separate policy and other supporting documents and reference materials to assist organisational development. These have been organised into the following six key categories with cross-referencing between policies:

- Service Management;
- Decision Making, Rights & Feedback;
- Family, Community & Diversity;
- Promotion & Prevention;
- Research & Development; and
- Service Access.

The policies have also been mapped to the following frameworks to support accreditation processes:

- EQuIP4 and EQuIP5 (Australian Council on Healthcare Standards);
- Health and Community Service Standards (6th edition) (Quality Improvement Council);
- The National Standards for Mental Health Services;
- The NSW Disability Services Standards; and
- MHCC's *Recovery Oriented Service Self-Assessment Toolkit* (ROSSAT).

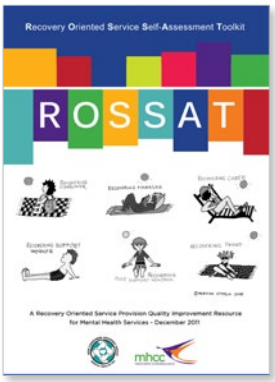
The *Recovery Oriented Language Guide* that underpins the Policy Resource has received many compliments from across the sector. MHCC has been making large quantities of the resource available upon request.

## ROSSAT

The *Recovery Oriented Service Self-Assessment Toolkit* (ROSSAT) was developed by MHCC and the NSW Consumer Advisory Group (CAG). It is a continuous quality improvement resource designed to assist organisations and staff to assess their level of recovery oriented service provision and practice, and to identify areas that require improvement. ROSSAT is also mapped to the 2010 National Standards for Mental Health Services and can be used as evidence towards accreditation. ROSSAT was developed following a comprehensive literature review, and consultations with consumers, carers and service providers on recovery and recovery oriented practice. ROSSAT has also undergone a trial with four community managed organisations and been promoted widely, including at conferences. The Tool for Workers (T4W) and Tool for Organisations (T4O) have recorded 885 and 987 downloads respectively.

During the 2012-13 Regional Forums, MHCC delivered a workshop entitled '*ROSSAT: Recovery Oriented Service Self-Assessment Toolkit - Strengthening Recovery Oriented Service Provision and Practise in Your Organisation*'. The workshop was run to help promote uptake of ROSSAT and to better understand implementation barriers. The workshop was also useful to identify individuals and organisations using ROSSAT, and to better understand the mental health sectors needs in relation to uptake of the ROSSAT tools.

At the end of 2012-13, a Stage 2 ROSSAT development project commenced. This aims to address existing feedback and identify any gaps in content since the original literature review in 2009. This project also aims to begin assessment of the psychometric properties of ROSSAT by establishing the face validity, content validity and response process validity of the T4W and T4O. A Reference Group for this work has been established and academic research partner (University of Sydney) identified. The ethics application has been approved and focus groups are planned as part of the agreed research methodology. Consultations will also address the usability and feasibility of the tools. The findings from the review and consultations will be used to strengthen the ROSSAT T4W, T4O and User Guide where necessary. This is in preparation for further psychometric testing, specifically construct validity and reliability.




ROSSAT:
Recovery Oriented Service Self-Assessment Toolkit - Strengthening Recovery Oriented Service Provision and Practise in Your Organisation

The full document is available for download at www.mhcc.org.au

## Enhancing practice approaches

### TRAUMA-INFORMED CARE AND PRACTICE

People impacted by trauma characteristically present at a wide range of services. They often have severe and persistent mental health conditions and coexisting substance abuse problems. Frequently they are the highest users of the inpatient, crisis, and residential services. Their challenges are often exacerbated by inadequate responses from the community including the mental health sector. The National Trauma-Informed Care and Practice Advisory Working Group (NTICP AWG), established by MHCC and Adults Surviving Child Abuse (ASCA) in 2011, has been working towards finalising their position paper '*Trauma-Informed Care and Practice: towards a cultural shift and policy reform across mental health and human services in Australia: Trauma-Informed Care and Practice – a national strategic direction'.* The paper provides recommendations promoting a strategic direction and provides evidence as to how the principles of trauma-informed care and practice can be incorporated into systems and service delivery across sectors. The paper describes the rationale for recommendations informed by extensive international and national evidence. It also provides a platform from which the AWG will advocate for broad-based policy reform across jurisdictions, systems and sectors. During this year, there have been a number of workforce and organisational capacity building developments. MHCC has committed to producing an organisational toolkit to support organisations to implement trauma informed care and practice.


Trauma-Informed Care and Practice: towards a cultural shift and policy reform across mental health and human services in Australia: Trauma-Informed Care and Practice – a national strategic direction

The full document is available for download at www.mhcc.org.au

Dr Cathy Kezelman, Jenna Bateman and Corinne Henderson receive the Silver Award in the Special Achievement category for Trauma-Informed Care and Practice from Professor Allan Fels at the Mental Health Services Conference.

## Creating new service models

### COMMUNITY HUB/ INTEGRATED SERVICES MODEL

MHCC played a key role in advocating for this model, to which the government committed $1.8 million in this year's budget. Three pilots are to be established in the greater Sydney area. Under the Integrated Services Model the reality of 'no wrong door' is more fully achieved. People seeking support enter a service where there is coordinated assessment and a plan which encompasses the breadth of issues that brought them to seek help. Co-location of public mental health services, community sector providers (including employment) and primary health care providers means less system navigation for consumers and carers. These also provide a more holistic response and more choice. For practitioners it means clearer role delineations; and better access to, and more understanding and respect for, other skill sets. Better coordinated and applied use of state and commonwealth funding streams is a further benefit of the Integrated Service Model. The proposed model has the potential to revolutionise the experience of consumers and carers seeking support for mental health conditions.

### 'STEP UP' SUB-ACUTE PARTNERSHIP MODEL

This year saw the launch of two innovative 10 bed 'sub-acute' units in the western NSW towns of Broken Hill and Dubbo. These units focus on preventing hospital admissions and improving community connection. They do this by joining public and community sector expertise to fill a service gap that has been longstanding in NSW. MHCC advocated this model for NSW and was closely involved in the design stages with the Western and Far Western NSW Local Health District (LHD). NSW has traditionally had a range of options for people transitioning out of acute care. However there has been a lack of focus on giving people a place to go when they and their family realise they are becoming unwell. These units are focused on providing a place for people to go before they become so unwell hospital admission is the only option. Whilst they do support people transitioning out of acute care, the model's proactive focus makes the new Dubbo and Broken Hill units unique in NSW.

## Integrating service delivery

### SERVICE COORDINATION

MHCC's Service Coordination Strategy is being pursued to progress Recommendations 3 and 5 of the 2010 Sector Mapping Project. These relate to enhancing continuity of care and strengthening pathways and linkages between services. In 2011, MHCC undertook a *'Care Coordination Literature Review and Discussion Paper'.* The findings were discussed in consultations with member organisations, consumers and their families and carers. The Paper identified as essential that the views of people with lived experience of mental distress are used in the process of shaping our understanding about the education and training that is provided to mental health service workers. It also discussed what is needed to develop the skills that result in effective, client self-directed service coordination, practice and continuity of care.

In 2012, MHCC undertook consultations to close knowledge gaps identified in the earlier literature review. 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 were analysed against the current funding, policy and practice environment, including an identification of a potential gap around which existing mental health and service coordination related vocational qualifications might be strengthened. This resulted in the publication '*Service Coordination Workforce Competencies: An investigation into service user and provider perspective'.*

The final report on this activity includes nine recommendations to both vocational and university education and training stakeholders. These recommendations should embed service coordination skills in workforce development directions more effectively; and provide next steps for progressing the Service Coordination Strategy. The final report makes 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. The implementation of *'Partners in Recovery'* and also the NSW launch of the National Disability Insurance Scheme (NDIS) from July 2013 need to be considered in this progression. The development of an LD Professional Development Series course to assist workers to acquire service coordination skills across a range of settings may also be involved.


Service Coordination Workforce Competencies: An investigation into service user and provider perspective.

The full document is available for download at www.mhcc.org.au

## 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. Cross-sector attendance including representatives from member organisations, LHDs, Medicare Locals and human service agencies and organisations was experienced. MHCC hosted its own MYN event this year on the grounds of Callan Park which was well received by over 40 participants and provided a great opportunity for MHCC staff to meet representatives from local organisations.


Right: MHCC's Policy & Partnerships Officer, Stephanie Maraz visits JewishCare in Sydney (with MHCC LD Manager, Simone Montgomery) and On Track in Coffs Harbour.

| 2012-13 Host Organisation | Location | Date |
|---|---|---|
| Billabong House | Tamworth | 10 July |
| Community Mental Health | Orange | 31 July |
| GWAHS | Dubbo | 1 August |
| WentWest Medicare Local | Blacktown | 21 August |
| ACON | Darlinghurst | 28 September |
| HeadSpace | Parramatta | 30 October |
| North Sydney Medicare Local | Pennant Hills | 11 February |
| JewishCare | Eastern Suburbs | 26 February |
| On Track | Coffs Harbour | 4 March |
| SFNSW & RichmondPRA | Wagga Wagga | 20 March |
| Interrelate | Lismore | 11 April |
| Red Cross | Gosford | 13 May |
| MHCC | Inner West | 23 May |
| SIDS & Kids | Newcastle | 27 May |
| Bankstown Community Drug Action Team (CDAT) | Bankstown | 17 June |

## Building sector infrastructure

### NATIONAL DATA PROJECTS

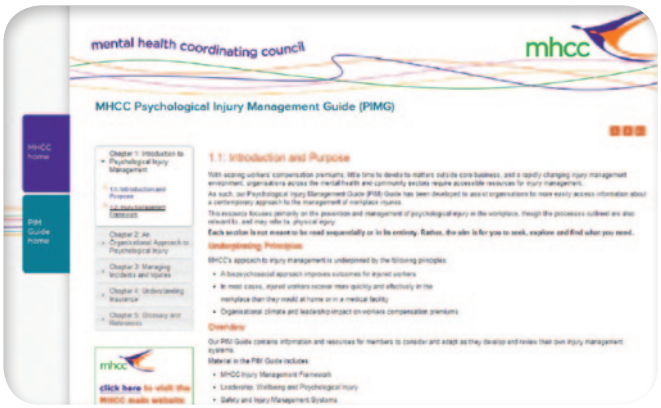
The Department of Health and Ageing (DoHA) funded MHCC, through Community Mental Health Australia (CMHA), to work on two projects for the Mental Health Information Strategy Standing Committee (MHISSC). (i) National CMO Outcome Measurement Project – working with the Australian Mental Health Outcomes and Classification Network (AMHOCN): This project contributed to a literature review, carried out a national survey and consultation workshops, and co-authored the final scoping paper for presentation to MHISSC. (ii) Continued work on the Mental Health NGO Establishments National Minimum Data Set: This project involved attending consultations and working with the Australian Institute of Health and Welfare (AIHW) on the implementation of the NGO Establishments National Minimum Data Set.

### NATIONAL CMO OUTCOME MEASUREMENT PROJECT

MHCC, in partnership with AMHOCN, embarked on a national survey of organisations and broad consultation of state and national funding bodies of mental health programs. It produced an extensive literature review on 136 different outcome measurement tools either in use or suitable for use in the sector. The results of these activities were presented to a workshop of key sector and funding body stakeholders in May 2013.The National Leadership Workshop was successful in developing consensus between MHISSC member agencies, CMHA and other stakeholders on a future direction for outcome measurement activities in the CMO sector. The final report was delivered to DoHA in June 2013 and is scheduled to be tabled at MHISSC in October 2013. Project recommendations were: (i) routine outcome measurement should include the collection of a universal measure of consumer or carer experience of service provision. It should then be supplemented by specific measures depending on CMO service type and program characteristics; (ii) there should be production of a "guidebook" that builds upon the results of the current project. The guidebook would also outline measures, data collection protocols and the preconditions necessary for the implementation of routine outcome measurement in the sector; and (iii) the guidebook would be used to structure discussion between CMO peak bodies, service providers, consumers, carers and funding bodies. This would enable the implementation of routine outcome measurement to be presented to the sector.

### PSYCHOLOGICAL INJURY MANAGEMENT GUIDE

The *Psychological Injury Management (PIM) Guide* was developed at the request of members to assist organisations to combat soaring workers' compensation premiums. This online 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 Guide was presented to members during our 2012 Regional Forums and was received with great interest. We have since developed the PIM Guide into a training workshop.




Visit the Psychological Injury Management (PIM) Guide at pimg.mhcc.org.au

Both the interactive workshop and online Guide are designed to provide participants with background knowledge and practical strategies in regard to the prevention and management of workplace psychological injury. These include: practical strategies to prevent and respond to psychological injury; integrated approaches to injury management; leadership culture and employee wellbeing; pathways for employee return-to-work; workers compensation premium reductions; and opportunities for participants to consider how to embed the above concepts into organisational policies and procedures.

## PRACTICE PLACEMENT PROJECT

In the first half of 2013, MHCC was funded by Health Workforce Australia (HWA) via the NSW Health Education and Training Institute (HETI) and Sydney Interdisciplinary Clinical Training Network (ICTN) to undertake the 'Practice Placements Project in the Community Managed Mental Health Sector'. The primary objective of the project was to meet the priority student placement need in mental health. This was achieved by establishing relationships between universities and CMOs to increase professional entry practice placement opportunities in the following disciplines: Nursing, Medicine, Psychology, Occupational Therapy, Social Work, Nutrition/Dietetics, and Exercise Physiology.

The aim of this project was to explore, increase and provide quality practice placements in the community managed mental health sector for potential new entrant health workers. The long term goal of this project is to contribute to the development of the future mental health workforce. To achieve this goal, it is essential in the short term that students are exposed to current trends and practices and a diverse range of work roles within a mental health setting. For students to consider mental health as a future career pathway the number and quality of placements must be increased. Essentially, we 'piloted' interprofessional 'clinical'/ practice placements at four host MHCC member organisations between 2nd April and mid-May: UnitingCare Mental Health; RichmondPRA; Neami; and Newtown Neighbourhood Centre. The students were from a broad range of disciplines within three universities: Sydney University, the University of Western Sydney and the University of Notre Dame.

Future priorities arising from the projects recommendations include: enhancing the sector's interprofessional and work integrated learning practice supervision capacity; and increasing understanding of the role of key regional drivers in increasing capacity for training places. A cost/ benefit and productivity analysis is also recommended to further refine the proposed practice placement model.


Top: The Practice PLacement Resources.
Above: Senior MHCC Policy Officer, Tina Smith, leads a Q&A session during the Practice Placement Project Webinar. Also pictured are Dr Cathy Kezelman, Karen Burns and Professor Lindy Mc Allister.
Practice Placement resources are available to download from www.mhcc.org.au

# 2. POLICY LEADERSHIP, INFLUENCE & REFORM

*MHCC has been actively engaged with government and key service delivery and representational agencies, both state and federal, to develop sound mental health policy and to represent sector interests. Strategic relationships have been developed by MHCC and member organisations to improve service coordination and increase cross sector engagement.*

## Responding flexibly to policy reform

MHCC has built on our knowledge base through research and consultation with members, consumers, carers and other stakeholders. MHCC has authored 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. MHCC Submissions are published on the MHCC website.

### KEY SUBMISSIONS AND POSITION PAPERS

- Minister for Ageing and Minister for Disability Services. Discussion Paper, *'Living Life My Way: Putting people with a disability at the centre of decision making about their supports in NSW'*
- NCOSS - Pre Budget Submission 2013-14
- Minister for Mental Health NSW. - Improving 'Open Disclosure' processes following a suicide whilst in care/post discharge and moving to a more effective, accountable, collaborative model of care for people at risk of suicide
- NDIS - Disability Reform; eligibility & reasonable and necessary support
- Deputy Director-General, Strategy and Resources, NSW Ministry for Health - '*National Primary Health Care Strategic Framework - Consultation Draft*'
- Independent Commission Against Corruption (ICAC) – Response to *'Funding NGO Delivery of Human services in NSW: A period of transition'*
- NSW Health Grants Management Improvement Taskforce (GMIT) – Response to GMIT Discussion paper for consultation
- Mental Health Council of Australia - Partners in Recovery Capacity Building
- Community Services and Health Industry Skills Council– Environmental Scan 2013
- Minister for Mental Health NSW – Response to discussion Paper: *'Issues arising under the NSW Mental Health Act 2007'*
- Premier's Council on Homelessness - Pathways into homelessness: child protection, prison post release; mental health
- Mental Health Council of Australia - NDIS Bill
- Department of Family and Community Services - '*Reforming NSW Disability Support: Legislative Structure and Content Discussion Paper'*
- Office of Fair Trading - Model Rules under the NSW Associations Incorporation Act 2009: Division 2 s35
- Minister Families, Community Services and Indigenous Affairs, Disability Reform: Early intervention and the NDIS

## Empowering strategic relationships

MHCC is building strategic relationships within and across sectors to increase awareness of the CMO sector and promote quality service delivery. The Meet Your Neighbour initiative continues to support networking and promote service coordination and referral pathways. Ongoing relationship building with Medicare Locals, the Aged Care sector and the Regional Forums initiative are also working to promote the CMO sector and support strategic partnership development.

## MENTAL HEALTH COMMISSION OF NSW

The Mental Health Commission of NSW (MHC) commenced operations in August 2012. The establishment of the Commission was welcomed by MHCC to guide development of a Mental Health Strategic Plan currently lacking in NSW. John Feneley, the appointed Commissioner took a very consultative and collaborative approach from early on in his term and MHCC was quick to enage him with our members and stakeholders. In September 2012 John agreed to participate in the MHCC Regional Forums allowing him to get an understanding of issues for our members in rural as well as metro areas. MHCC has continued to work closely with the MHC as it has grown in capacity and we have been closely involved in opportunities to provide input into the developing Strategic Plan due to be presented to government in March 2014. MHCC is partnering with the MHC in four important endeavours (i) to better understand and influence implications for people with psychosocial disability in the NDIS Hunter launch (ii) to support the ongoing development of the Community Mental Health and Drug and Alcohol Research Network (iii) to ensure the currency and dissemination of the Mental Health Rights Manual and (iv) to support dissemination of the *'Recovery Language Guide*'.

## MEDICARE LOCALS

Communications with Medicare Locals over the past 2 years has improved understanding and supported working relationships at the local level. Medicare Locals attend and participate in MHCC events including the Regional Forums and regularly host Meet Your Neighbour events as a strategy for connecting with local CMOs. The MHCC webpage dedicated to raising awareness and supporting engagement between Medicare Locals and CMOs is currently being updated along with the new website. Most recently, the establishment of the Partners in Recovery (PIR) initiative has promoted collaborative partnerships to good outcome between CMOs and Medicare Locals through the consortia arrangements. MHCC is currently working in conjunction with PIR lead organisations including Medicare Locals to develop PIR Support Facilitator induction training.

MHCC has also been working collaboratively with NCOSS to support and further inform their activities in promoting engagement across the human services sector with Medicare Locals.

## AGED CARE

This year the cooperative relationship between Aged & Community Services Association of NSW & ACT (ACS) resulted in the *Mental Health and Older People: Connecting Sectors Forum* on 2 November 2012 which helped to raise awareness and build relationships between the sectors. The event explored areas of commonality and difference, and ways to start addressing service and care coordination issues. The challenges and achievements of ageing and living with a mental health problem were highlighted through consumer and carers' stories. The event also showcased best practice coordinated approaches to care and support in both residential and community aged care settings. The *Summary Report* details outcomes and recommendations for the way forward which are currently being addressed and discussed with ACS and other stakeholders. MHCC now sits on the NSW Ministry of Health Mental Health of Older People Working Group to keep informed of the broader issues related to the major reforms in this area and ensure a CMO perspective.

The Mental Health Connect course has now been tailored for the aged care sector, with involvement from key stakeholders. This outcome meets a key recommendation of the Connecting Sectors report.

## CMHA Representation

### SAFETY AND QUALITY PARTNERSHIP STANDING COMMITTEE (SQPSC)

The SQPSC is oversighted by DoHA and has quality improvement of the mental health service system broadly as its brief. Membership comprises the chief psychiatrists from each state, consumer and carer representation, the Private Mental Health Alliance, Mental Health Council of Australia, Community Mental Health Australia and the National Safety and Quality Commission. Key work this year has focused on a range of endeavours including exploring mechanisms to increase implementation of the National Standards for Mental Health Services. For the community sector this involved funding of an online portal capable of allowing quality data to be assessed against a range of human service standards thus streamlining the accreditation process for providers required to meet more than one set of service standards. This will be accessible on the CMHA website. SQPSC was also responsible for the review of the Statement of Rights and Responsibilities; oversight of the national project to reduce the use of seclusion and restraint in MH services; the ongoing roll out of MH-POD including consideration of access by non-government organisations; oversight of the Mental Health Practice Standards and initiatives around better use of medications and development of the National Recovery Framework.

### HEALTH WORKFORCE AUSTRALIA (HWA)

With the cessation of the National Mental Health Workforce Advisory Committee (MHWAC) at the end of 2012 MHCC has had the opportunity to strengthen their working relationship with Health Workforce Australia (HWA). HWA have a growing innovation and reform priority agenda that relates to mental health workforce development. MHCC represent CMHA on HWA's Mental Health Workforce Reform Project Advisory Group (PAG). The PAG had oversight of three mental health projects in this fiscal year: 1) Peer Work Project; 2) Mental Health Capabilities Project (including participation on an Expert Reference Group); and 3) Mental HealthWorkforce Project (data/development).

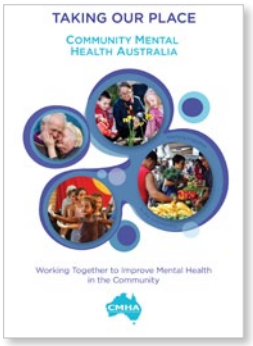
The Peer Work Project paper, including recommendations for peer workforce development, will be presented to HWA for endorsement in late 2013. The Capabilities Project is aligned to the Common Health Competencies Framework and will soon commence a field testing phase. The capabilities build on the recently revised National Mental Health Practice Standards. The Mental Health Workforce Project was recently endorsed by the HWA Board and will soon be posted on their website. Mental health data collections will likely be aligned with the National Mental Health Service Planning Framework 'direct care' component and not be inclusive of prevention, promotion, early intervention or community development activity, etc.

In addition to HWA, various aspects of the National Mental Health Workforce Strategy and Plan developed by MHWAC have gone to subcommittees of the new Mental Health Drug and Alcohol Principle Committee with the later having oversight for implementation (replacing the Mental Health Standing Committee that previously auspiced MHWAC).

CMHA/MHCC is proud of their contributions to MHWAC over seven years to raise the profile of community sector mental health workers – both peer and non-peer – and vocationally qualified mental health workers. We look forward to continuing to work with HWA to achieve mental health workforce development innovation and reform.

## Ensuring equitable access to services

### CMHA – Taking our place




CMHA launched its flagship document, '*Taking our Place – working together to improve mental health in the community'* on World Mental Health Day in October 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.

### NSW Community Managed Mental Health Sector Benchmarking Project

In 2012 the NSW Ministry of Health funded MHCC to develop the NSW Community Managed Mental Health Sector Benchmarking Project. The project was completed over a period of 18 months and has successfully established population planning targets across a range of nationally established community managed mental health service types. Based on the epidemiology and modelling methods of the Ministry's Mental Health Clinical Care and Prevention (MH-CCP) Model, it is designed to provide evidence and justification to enable more equitable program funding decisions by funders in a language that they can understand.

There were four inter-related activities that provided the basis of the final resource provided to the Ministry and the Mental Health Commission:

1. Comprehensive analysis and updating of sector mapping data against NSW population & socioeconomic data. (counted approx. 400 programs across the state)
2. Literature search and broad sector consultations to establish benchmarks for CMO community mental health service delivery
3. Identification of the gaps for CMO community mental health services, to address population needs
4. Proposing recommendations for development of the CMO community mental health sector to address the gaps (e.g. directions for future program and infrastructure development).

The project findings highlighted varied and complicated gaps in community mental health service provision. Detailed profiles will be delivered to each LHD to encourage them to focus on service areas where they may be able to provide the most effective boost to mental health service access.

The planning targets quantify the major lack of resourcing currently known to exist in the community managed mental health sector. These findings are generally consistent with the estimates being developed by the Ministry of Health for the National Mental Health Service Planning Framework, which also takes into account planning targets for hospital and acute services.

MHCC continues to work with the Ministry of Health to tailor the final document to the needs of future planners and managers.

### The NSW Mental Health Rights Manual

The NSW Mental Health Rights Manual was launched in 2011. This online resource is a guide to the legal and human rights of people with a mental illness in NSW. Written in plain language, it is an invaluable readily accessible resource, bringing together vital information crucial to anyone who has to navigate the complexities of the mental health and legal service system in NSW. There is no other resource that covers such a broad spectrum of topics as well as explaining the interface between the legal and service systems as they interact in

NSW. It speaks to a diverse mental health community, and has been developed specifically for people with a mental illness, their carers and families; and non-legal community service providers in NSW. The Manual enables people to become acquainted with their rights, the legal and service systems and find out where they can access support, information and guidance for themselves or those that they wish to assist. As an online resource it is possible to gather extensive data on usage across a number of specific fields. MHCC have clearly established the broad-based use of this resource. Surveys conducted have also confirmed that the sector finds the Manual easily accessible and presents useful information.

The Manual is undergoing a review to include the many changes in an extremely dynamic environment including the establishment of the national and the NSW Mental Health Commissions and the launch of the National Disability Care initiative. The Manual will be relaunched in 2014 under a collaborative partnership and co-branding agreement with the NSW Mental Health Commission and NSW Health.

## Contributing to the development and implementation of planning and resourcing frameworks

### National Disability Insurance Scheme (NDIS) / Disability Care Australia (DCA)

Following two years of uncertainty and MHCC policy/legislative submissions psychosocial disability was included in the Disability Care Australia initiative – our National Disability Insurance Scheme (NDIS). MHCC is now working in partnership with the NSW Mental Health Commission to explore and analyse the situation from a mental health perspective at the Hunter NDIS transition launch site. MHCC will work in the Hunter launch site exploring the opportunities and barriers for people with high levels of psychosocial disability in addition to living with a mental illness.

The activity outcomes are to make recommendations to address how psychosocial disability is understood and included under the DCA in terms of access and eligibility, existing community sector and public mental health programs, safeguards and workforce appropriateness. The project will also consider the wider DCA and health services interface, especially as thisrelates to the unmet physical health needs and high prevalence of substance misuse by people living with mental illness. The project learning will also contribute to the national discourse regarding the situating of mental health within the NDIS. The activity will conclude with a final report summarising activity undertaken and project findings with related recommendations for strengthening the situation of mental health within the NDIS.

The work that occurs at the Hunter launch site over the next three years will help to inform both NSW and national directions for people with high levels of psychosocial disability and the community organisations that provide services to them. It is estimated that at full rollout, 57 thousand Australians living with psychosocial disability will benefit from DCA services and 19 thousand of these may be from NSW.

MHCC needs to have a good sense of impacts upon, and sector development needs in response to, NDIS and this knowledge continues to be acquired and consolidated; especially as this relates to reconciling essential philosophic differences between the mental health and disability sectors with regard to recovery oriented practice.

MHCC continues to hold a watching brief on the policy and legislation in relation to roll-out of DCA particularly with regards to the development of processes for people with psychosocial disability accessing flexible packages. A particular focus is on how operating guidelines will address complexity. MHCC is also closely watching the development of monitoring and safeguard mechanisms and the continuity of service provision to people ineligible under the criteria.

## NATIONAL RECOVERY FRAMEWORK

MHCC as the CMHA representative on SQPSC ensured concepts of trauma-informed care and practice approaches were included in the National Recovery Framework as they are crucial to the recovery-orientation of services. In addition MHCC provided extensive comment on drafts of the Framework and met with the project consultant Leanne Craze to contribute resource and reference lists to support the evidence base of the project. Referenced MHCC resources include ROSSAT and '*Philosophy into Action – a workforce development guide*', the *Recovery Oriented Language Guide* and the 2010 *MHCC Sector Mapping Report*. MHCC's carriage of the National CMO Outcome Measurement Project also enabled policy alignment with the Framework.

## NATIONAL NGO ESTABLISHMENTS MINIMUM DATA SET

MHCC has also been representing CMHA on the working groups developing the Mental Health NGO Establishments National Minimum Data Set (NGOE NMDS) which is planned to be implemented in FY 2014–15. This work is being carried out by the Australian Institute of Health and Welfare (AIHW).

The main purpose for creating the NGOE NMDS is to enable the collection of nationally consistent information on the activity of mental health CMOs, and to provide reliable data to better inform policy, practice and planning of national mental health NGO activities. There is currently no national collection of mental health CMO activity beyond very basic and incomplete counts of state funding allocations.

The scope of the Mental Health NGOE NMDS is any mental health-related CMO funded to provide services under one or more of the service types included in the service type taxonomy. This taxonomy is also becoming the basis of other national and state service mapping and planning projects.

The collection methodology for the Mental Health NGOE NMDS requires a CMO to provide aggregated data to its respective funders, at either state and territory or national levels. The funder is then responsible for submission to the AIHW. Depending on the funder this information may be required to be collected through the AIHW's own collection tool.

The following mandatory minimum information about a Mental Health CMO will be required:

- Funding jurisdiction (for example, New South Wales)
- Funding source (for example, Ministry of Health)
- Australian Business Number (ABN)
- Organisation name
- Statistical area level 2 (SA2) (that is, where the service is located, as per the ABS SA2 code)
- Information on assessment against quality standards
- Not-for-profit indicator
- Consumer-managed organisation indicator
- Full-time equivalent paid overhead staff (average)

Depending on the arrangements made with the funder, some of this information may be pre-populated in a data collection tool.

MHCC and CMHA continue to advocate for information infrastructure support to be made available to the CMO sector to increase data collection, evaluation and reporting capacity.

# 3. RESEARCH & DEVELOPMENT

*MHCC has been building the evidence base for the work of the community-managed mental health sector this year by facilitating sector engagement with academics, universities and health disciplines. This has included research partnerships through the ROSSAT validation process, sector benchmarking and population planning, the Practice Placements Project, Trauma-Informed Care & Practice (TICP) development, and activities involving physical health programs and the mental health of older people.*

*The Community Mental Health Drug and Alcohol Research Network (CMHDARN) has broadened involvement of the community mental health and drug and alcohol (MHDA) sector in practice based research.*

*Across these initiatives and through improved relationships, MHCC seeks to build research capacity in the CMO sector and foster closer relationships between sector research and practice.*

## Facilitating an evidence based practice research and evaluation direction for the sector

### PHYSICAL HEALTH

MHCC's Physical Health Industry Reference Group (PHRIG) 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: RichmondPRA, Schizophrenia Fellowship, Neami National, Mental Health Association and New Horizons. A MHCC webpage dedicated to 'physical health' continues to be updated and includes information on all past events and provides helpful information and web links.

The second major initiative of the PHRG was the *Exploring Better Mental and Physical Health Outcomes through Collaboration Forum* on 7 September 2012 at Australian Technology Park. Leading-edge research was presented by visiting expert Dr Joe Parks, Chief Clinical Officer Missouri Department of Mental Health, on why integrating mental health with physical health care is vital to reducing early death rates of people with mental illness. The event was also timely with the announcement of the Partners in Recovery (PIR) program providing an ideal opportunity to look at the importance of cross sector engagement and enabled discussion around PIR implications and possibilities.


Above: Dr Joe Parks, Jenna Bateman and Geoff Harris at the Exploring Better Mental and Physical Health Outcomes through Collaboration Forum

### PHYSICAL HEALTH RESEARCH PROJECT

MHCC is currently working in partnership with the University of Sydney to undertake a research project funded by the Ministry of Health. The project titled, Delivering Physical Health Programs in the Community Managed Mental Health Sector aims to better understand the current status of physical health programs within CMOs, the challenges and barriers to improving physical health outcomes for people with mental health conditions and the necessary steps required to work more effectively with consumers and carers to support them to self-manage their physical health. Members of the existing PHRG are participants on the projects Reference Group, including a consumer and carer representative, and will be key informants to this research which aims to be completed by January 2014. A summary report with recommendations will be produced as well as an academic article summarising the research and outcomes.

## Improving service effectiveness and quality

### IMPLEMENTING PRACTICE SUPERVISION IN MENTAL HEALTH COMMUNITY MANAGED ORGANISATIONS IN NSW

MHCC's *Implementing Practice Supervision in Mental Health Community Managed Organisations in NSW* was launched in August 2012. This resource sets out to provide recommendations for the development of effective practice supervision programs and policy across the community managed mental health sector. Through the literature review it explores different understandings and definitions of supervision, examines histories and theories of supervision and outlines practice models. It also reports on the findings from the study conducted by MHCC into current supervision practices within the mental health community managed sector in NSW. Suggested readings and case studies direct those with a deeper interest to access information which can further assist them in developing policy and practice. MHCC sought to provide the reader with a guide to the main issues in supervision, and to provoke discussion on the appropriate application of supervision in NSW CMOs. The resource provides a range of templates and checklists for planning an effective practice supervision program to guide managers, supervisors and supervisees.


Implementing Practice Supervision in Mental Health Community Managed Organisations in NSW

The full document is available for download at www.mhcc.org.au

## Promoting the evidence base for community managed approaches

### COMMUNITY MENTAL HEALTH DRUG AND ALCOHOL RESEARCH NETWORK

The Community Mental Health Drug and Alcohol Research Network (CMHDARN) was established to broaden involvement of the community mental health and drug and alcohol (MHDA) sector in practice based research, to promote the value of research and the use of research evidence in practice, to facilitate capacity building across the sectors and to improve service delivery to consumers of services. To this end, during 2012-13, CMHDARN offered a range of activities for workers. Activities in the last six months have specifically focused on implementation science and the pathway to integrating research findings into practice. These activities included:

#### Research forums

These interactive research forums bring people from CMOs together with academic staff. Topics included:

- Consumer Representation and Participation in Research, 'Nothing about us, without us'
- Ethics in Research- 'They're more important than you think'
- Research Seeding grants- 'Sharing our learning'
- 'Realising research in rural areas', with workshop - 'Understanding Implementation Science: what does it mean and how do you do it?'

#### Reflective Practice Webinars

These hour long practice forums bring researchers directly in contact with CMHDARN members to hear about and discuss recent published research. Topics included:

- Stigma and Discrimination towards people with MHDA issues
- Co-existing issues of substance abuse amongst consumers of a mental health service.

# RESEARCH & DEVELOPMENT




Top: CMHDARN Yarn newsletter
Middle: cmhdaresearchnetwork.com.au
Bottom: CMHDARN Project Officer, Deb Tipper, addresses the attendees of the Consumer Research Forum in 2012

### CMHDARN Yarn

There were two issues of this new quarterly e-newsletter which focuses specifically on research related information, events and resources, as well as providing information about CMHDARN activities.

### CMHDARN Website

The website (left) was developed and launched, and is regularly updated. (www.cmhdaresearchnetwork.com.au)

### CMHDARN Mentoring Program

CMHDARN continues to develop options for offering mentoring to workers in CMOs, and has now reached an in- principle agreement with the NDARC Centre for Research Excellence in Mental Health and Substance Use (CREMS) to partner in linking postdoctoral students with workers in CMOS.

People engaging with CMHDARN activities have increased during the past year, with members of the network growing from around 130 to over 220. An additional 83 people have participated in activities, and 950 people have accessed the website since it went live in September 2012.

Collaboration between CMHDARN and academic researchers has included a variety of roles such as presentations to, and workshop facilitation of CMHDARN research forums and workshops, attendance at CMHDARN organised events, membership of CMHDARN Project Reference Group, and support through CMHDARN Research Seeding Grants.

### CMHDARN Seeding Grants Program

16 successful applicants have implementedtheir projects over the last year. Organisations are utilising the grants to explore preliminary research approaches into internal practice issues, capacity building for staff promoting improved inclusion of consumers in their work and exploring new approaches to service delivery.

# 4. ORGANISATIONAL DEVELOPMENT

*Central to the MHCC's capacity to deliver on its objectives is ensuring it is a sustainable organisation and, beyond this, becomes an employer of choice. This commitment has resulted in internal changes to further streamline systems and processes and enhance the experience of staff in undertaking their responsibilities.*

## Reviewing systems for MHCC governance, management and operations

MHCC continues its ongoing review of systems at all levels from governance through to internal operations. The review of our governance practice has led to incorporating further reporting mechanisms to the Board and the expansion of the duties of the Finance Sub-committee to include governance audit matters. The Finance and Audit Sub-committee now review the items of the Board Matters Schedule relevant to each meeting and along with the monthly financials of MHCC make recommendations to the full Board.

At an internal management level a change in the meeting structure has occurred providing for greater input from the team leaders within MHCC. We moved from a single meeting of management to a 2 tiered system which provides for both Operational and Strategic Directions discussions to occur. This new structure has increased cross organisational planning and transfer of knowledge been policy and LD staff.


## Improving MHCC quality improvement processes

### ACCREDITATION

MHCC became accredited with the Australian Council on Healthcare Standards (ACHS) in 2010, when MHCC's processes were reviewed to evaluate how we rate against the EQuIP standards. The ACHS accreditation cycle runs in annual phases for four years and the fourth phase periodic review was conducted on 19 June 2012.

MHCC received favourable ratings where all criterion ratings reviewed were increased or upheld in comparison to the 2010 audit rating findings. The summary of auditor findings was received in October 2012 and MHCC has been able to successfully maintain accreditation. MHCC is currently undergoing re-accreditation after the initial four year cycle and will be preparing for the next organisation-wide survey from external auditors in February 2014.

### MHCC MEMBER SURVEY

The 2013 Member Survey was conducted from 17 May 2013 to 7 June 2013. The survey was promoted through the CEO Forum, emails to members, CEOs and other miscellaneous email alerts.

MHCC's overall performance received *Good to Excellent* ratings from members (93%). Among the services provided, 'Member Services' received the highest number of *Good to Excellent* ratings (72%); and the Member Services identified to have received the highest number of *Good to Excellent* ratings were 'Keeping members informed' (81%) and 'FYI weekly newsletter' (79%). In the comments section, members identified areas where MHCC has been doing well. This included 'Meet Your Neighbour', 'forums, submissions, government liaison, sector development' and 'training.' Areas where suggestions for improvement were made include increasing advertising and promotion and making information and resources easier to find on the website.

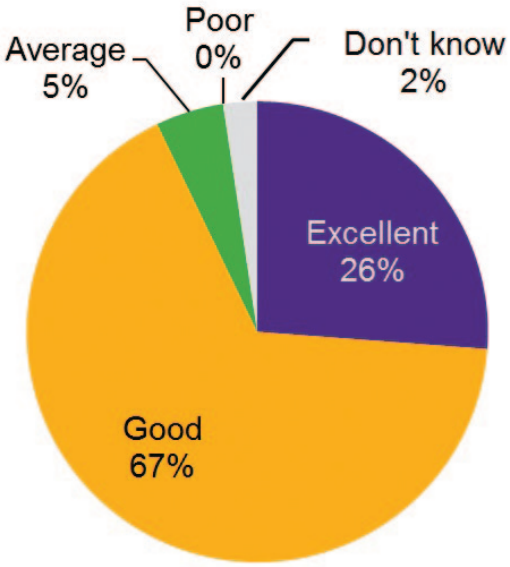



**Figure 1 - Overall performance of MHCC**

The majority of respondents rated MHCC projects as *Somewhat Useful* and *Very Useful.* 'Mental Illness & Physical Health Issues' (81%) and 'NSW Mental Health Rights Manual' (70%), both received the highest number of *Somewhat Useful* to *Very Useful* ratings, followed by 'Regional Forums' and the 'Recovery Oriented Language Guide' (with 65 and 63% respectively).

Among the MHCC Learning & Development (MHCC LD) services provided, 'Relevant MH training' received the most number of *Good to Excellent* ratings (79%), followed by 'Training quality; and 'Customer service' (both with 67%).

We would like to thank our members who gave their time to complete the 2013 MHCC Member Survey and encourage everyone to participate in sharing your opinions for the next survey. The full report is available on the MHCC website.

2012/13 MHCC Learning & Development student receive a standing ovation at the graduation held at Aerial Function Centre on April 15th 2013.

## Consolidating the business viability of the LD

2012-13 has seen the establishment of a subcommittee of the MHCC Board to provide oversight and regular review of the sustainability of the MHCC LD. The subcommittee has been charged with the task of ensuring the continual business viability of the MHCC LD. Through this sustained viability MHCC will be able to continue providing the high quality yet affordable training to the sector through both qualifications and the professional development series we are currently delivering.

# MEMBERSHIP LIST

Following is a list of Ordinary and Associate members of MHCC as of June 2013.
For more details please visit www.mhcc.org.au

| | | |
|---|---|---|
| ACON - Darlinghurst | Family Drug Support | ONE80TC |
| Action Foundation for Mental Health Inc | Good Grief Ltd | Open Minds |
| Adults Surviving Child Abuse (ASCA) | GROW NSW | Peer Support Foundation Limited |
| Aftercare | Heal for Life Foundation | Pegasus Care |
| Ageing, Disability & Homecare | Home in Queanbeyan | RichmondPRA |
| Alcohol & Drug Foundation NSW | Hope Street Urban Compassion | Roam Communities |
| Anglicare | Hornsby Ku-ring-gai Association | Rosemount Good Shepherd Youth & Family Services |
| Anxiety Disorders Association of NSW | Independent Community Living Australia | Samaritans Foundation |
| ARAFMI NSW (Mental Health Carers ARAFMI NSW Inc) | Intensive Support Pty Ltd | Schizophrenia Fellowship of NSW |
| Australian Kookaburra Kids Foundation Inc | Interrelate Family Centres | SOMA Health Association of Australia Ltd |
| Australian Red Cross - NSW | Jewish House Limited | South West Women's Housing |
| B Miles Womens Foundation | JewishCare - Fischl House | Southern Community Welfare Inc |
| Baptist Community Services (NSW & ACT) | Justice Action | St Luke's Anglicare |
| Benelong's Haven Ltd | Kamira Alcohol & Other Drug Treatment Services | St Vincent de Paul Society - NSW & ACT |
| Billabong Clubhouse | Katakudu Women's Housing | St Vincent's Mental Health Service |
| Black Dog Institute | Kedesh Rehabilitation Service | Stepping Out Housing Program |
| Blue Mountains Food Services | Keepwell (Aust) | Suicide Prevention Australia Inc |
| Bobby Goldsmith Foundation | Life Without Barriers | Survivors & Mates Support Network Ltd |
| Bonnie Support Services Ltd | Lou's Place | Sydney Womens Counselling Centre |
| Break Thru People Solutions | Mai-Wel Limited | Ted Noffs Foundation |
| Brown Nurses | Make a Difference | The ARC Group NSW Inc |
| Care Connect Ltd | Mandala Community Counselling Service | The Benevolent Society |
| Carers Alliance | Manly Drug Education & Counselling Centre | The Disability Trust |

# MEMBERSHIP LIST

| | | |
|---|---|---|
| Carers NSW Inc | Manning Mental Health Service | The Lorna Hodgkinson Sunshine Home |
| Castle Personnel Services Ltd | Mental Health Association NSW | The Oolong Aboriginal Corporation |
| CatalystBreakthru | Mind Australia | The Personnel Group Ltd |
| Catholic Healthcare | Mission Australia - NSW | The Salvation Army |
| Catholic Social Services NSW/ACT | Mountains Community Resource Network | The Station Ltd |
| CatholicCare - Ageing, Dementia & Disability Care | Murrumbidgee Medicare Local | The Wayside Chapel |
| Centacare - Community Lifestyle Support | NALAG Centre for Loss & Grief Dubbo | Transcultural Mental Health Centre |
| Central Coast Disability Network | Neami National | Uniting Care - Disability |
| Cessnock Community Healthcare | New Horizons | Uniting Care - Institute of Family Practice |
| CHESS Head Office (Coffs Harbour Employment Support Service) | Newtown Neighbourhood Centre | Uniting Care Mental Health |
| Club Speranza | NSW Consumer Advisory Group (CAG) | Wagga Women's Health Centre |
| CO AS IT | NSW Rape Crisis Centre | WAYS Youth Services |
| Community Links Wollondilly | NSW Users & AIDS Association | Weave Youth Family Community Inc |
| Community Options Illawarra Inc | Oakdene House Foundation | Wesley Mission |
| Community Programs Inc | OCTEC LIMITED | Wesley Mission - Mental Health Support Services |
| Counsellors & Psychotherapists Accociation of NSW Inc (CAPA) | Official Visitors Program NSW Dept of Health | WHOS (We Help Ourselves) |
| Education Centre Against Violence (ECAV) | On Track Community Programs | Wollongong West Street Centre |
| Exodus Foundation | One Step at a Time Counselling | |

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

Unit 6 – 13 Larkin St
Riverwood NSW 2210

P.O. Box 930
Riverwood NSW 2210

Telephone (02) 8515 1666
Facsimile (02) 8515 1655
Email:
admin@oneillobrien.com.au

Director
Bruce Lawrence BBus, CPA

ACN 003 157 177
ABN 12 003 157 177

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

## *FINANCIAL STATEMENTS*

## *FOR THE YEAR ENDED 30 JUNE 2013*

## 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 2013, 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 responsbility 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 2013 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**

**Dated this** 21st **day of** October. **2013.**

**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 2013 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

**Dated this** 21st **day of** October. **2013.**

# MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
## ABN: 59 279 168 647
## Statement by Members of The Board
## For the Year Ended 30 June 2013

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 2013 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 14 day of October 2013

## MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
### Statement of Comprehensive Income
### For the Year ended 30 June 2013

| | Note | 2013 $ | 2012 $ |
|---|---|---|---|
| Revenue | 2 | 3,812,727 | 4,654,512 |
| Finance Costs | 4 | 927 | 935 |
| Employee Benefits Expense | 3 | 2,009,442 | 1,987,658 |
| Depreciation and Amortisation | 3 | 29,864 | 40,248 |
| Other Expenses | 3 | 1,876,267 | 1,654,812 |
| **Profit (Loss)** | 5 | (103,776) | 970,859 |
| **Total Comprehensive Income** | | (103,776) | 970,859 |

*The accompanying notes form part of these financial statements.*

# MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
## Statement of Financial Position
## As at 30 June 2013

| | Note | 2013 $ | 2012 $ |
|---|---|---|---|
| **Current Assets** | | | |
| Cash and Cash Equivalents | 6 | 3,592,532 | 4,394,845 |
| Trade and Other Receivables | 8 | 535,262 | 198,587 |
| **Total Current Assets** | | 4,127,794 | 4,593,432 |
| **Non-Current Assets** | | | |
| Property, Plant and Equipment | 9 | 115,673 | 133,287 |
| **Total Non-Current Assets** | | 115,673 | 133,287 |
| **Total Assets** | | 4,243,467 | 4,726,719 |
| **Current Liabilities** | | | |
| Trade and Other Payables | 10 | 236,967 | 207,866 |
| Short-Term Financial Liabilities | 11 | 58,125 | 44,501 |
| Provisions | 12 | 561,391 | 549,113 |
| Other | 13 | 966,182 | 1,400,661 |
| **Total Current Liabilities** | | 1,822,665 | 2,202,141 |
| **Total Liabilities** | | 1,822,665 | 2,202,141 |
| **Net Assets** | | 2,420,802 | 2,524,578 |
| **Equity** | | | |
| Retained Profits | 14 | 2,420,802 | 2,524,578 |
| **Total Equity** | | 2,420,802 | 2,524,578 |

*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 2013

| | 2013<br>$ | 2012<br>$ |
|---|---|---|
| **Opening Balance** | 2,524,578 | 1,553,719 |
| **Retained Earnings** | | |
| (Loss)Profit for the year | (103,776) | 970,859 |
| | (103,776) | 970,859 |
| **Closing Balance** | 2,420,802 | 2,524,578 |
| **Reconciliation of Retained Earnings** | | |
| Opening Balance | 2,524,578 | 1,553,719 |
| Profit for the year | (103,776) | 970,859 |
| Closing Balance | 2,420,802 | 2,524,578 |
| **Total Equity** | 2,420,802 | 2,524,578 |

*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 2013

| | Note | 2013 $ | 2012 $ |
|---|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | | |
| LDU - Course Payment (inclusive of GST) | | 2,176,000 | 3,384,701 |
| Seminar Revenue (inclusive of GST) | | 20,947 | 7,926 |
| Receipts from Members (inclusive of GST) | | 54,272 | 42,441 |
| Government & Other Grants Received(inclusive of GST) | | 1,679,780 | 1,167,639 |
| Consultancy & co-ord fee (inclusive of GST) | | 95,953 | 0 |
| Payments to Suppliers & Employees (inclusive of GST) | | -4,968,876 | -4,117,973 |
| Interest Received | | 148,838 | 198,178 |
| Other Receipts | | 3,023 | 6,651 |
| **Net Cash Provided by Operating Activities** | | **-790,063** | **689,563** |
| **CASH FLOW FROM INVESTING ACTIVITIES** | | | |
| Payments for Property, Plant & Equipment | | 12,250 | 10,125 |
| Proceeds from Sale of Property, Plant & Equipment | | | |
| **Net Cash Used in Investing Activities** | | **12,250** | **10,125** |
| **CASH FLOW FROM FINANCING ACTIVITIES** | | | |
| **Net Cash Used in Financing Activities** | | | |
| **Net Increase (Decrease) in Cash Held** | | -802,313 | 679,438 |
| Cash at the Beginning of the Financial Year | | 4,394,845 | 3,715,407 |
| **Cash at the End of the Financial Year** | | **3,592,532** | **4,394,845** |

# MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
## Notes to the Financial Statements
## For the Year ended 30 June 2013

### 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 in New South Wales under the Associations Incorporation Act 2009.

**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. The association is a not-for-profit entity for financial reporting purposes under Australian Accounting Standards.

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.to which they apply. Material accounting policies adopted in the preparation of these financial statements are presented below and have been consistently applied unless stated otherwise.

The financial statements, except for the cash flow information, have been prepared on an accrual 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. The amounts presented in the financial statements have been rounded to the nearest dollar.

**Accounting Policies**

(a) **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 amount of plant and equipment is greater than the estimated recoverable amount, the carrying amount is written down immediately to the estimated recoverable amount and impairment losses are recognised either in profit or loss or as a revaluation decrease if the impairment losses relate to a revalued asset. 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 by the association 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 amount 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 association and the cost of the item can be measured reliably. All other repairs and maintenance are recognised as expenses in profit or los during the financial period in which they are incurred.

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

Depreciation
The depreciation amount of al fixed assets, including buildings and capitalised lease assets, is depreciated on a straight-line basis over the asset's useful life co9mmencing from the time the asset is available 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 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.

Gains and losses on disposals are determined by comparing proceeds with the carrying amount. These gains or losses are recognised in profit or loss when the item is derecognised. When revalued assets are sold, amounts included in the revaluation surplus relating to that asset are transferred to retained surplus.

(b) **Employee Provisions**
Provision is made for the association's liability for employee benefits arising from services rendered by employees to the end of the reporting period. Employee provisions 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 provisions 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 employee may not satisfy any vesting requirements. Those cash outflows are discounted using market yields on national government bonds with terms to maturity that match the expected timing of cash flows.

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

(d) **Accounts receivable and Other Debtors**
Accounts receivable and other debtors include amounts due from members as well as amounts receivable from customers for gods sold in the ordinary course of business. Receivables expected to be collected within 12 months of the end of the reporting period are classified as current assets. All other receivables are classified as non-current assets.

Accounts receivable are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. Refer to notes for further discussion on the determination of impairment losses.

## MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
### Notes to the Financial Statements
### For the Year ended 30 June 2013

(e) **Revenue and Other Income**

Non-reciprocal grant revenue is recognised in profit or loss when the association obtains control of the grant it is probable that the economic benefits gained from the grant will flow to the association and the amount of the grant can be measured reliably.

If conditions are attached to the grant which must be satisfied before it is eligible to receive the contribution, the recognition of the grant as revenue will be deferred until those conditions are satisfied.

When grant revenue is received whereby the association incurs an obligation to deliver economic value directly back to the contributor, this is considered a reciprocal transaction and the grant revenue is recognised in the statement of financial position as a liability until the service has been delivered to the contributor, otherwise the grant is recognised as income on receipt.

The association receives non-reciprocal contributions of assets from the government and other parties for zero or a nominal value. These assets are recognised at fair value on the date of acquisition in the statement of financial position, with a corresponding amount of income recognised in the statement of profit or loss and other comprehensive income.

Donations and bequests are recognised as revenue when received.

Interest revenue is recognised using the effective interest 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 from the rendering of a service is recognised upon the delivery of the service to the customer.

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

(f) **Goods and Services Tax (GST)**

Revenues, expenses and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office (ATO).

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the ATO is included with other receivables or payables in the statement of financial position.

Cash flows are presented on a gross basis. The GST components of cash flows arising from investing or financing activities which are recoverable from, or payable to, the ATO are presented as operating cash flows included in receipts from customers or payments to suppliers.

(g) **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 association has retrospectively applied an accounting policy, made a retrospective restatement of items in the financial statements, an additional statement of financial position as at the beginning of the earliest comparative period will be disclosed.

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

(h) **Accounts Payable and Other Payables**

Accounts payable and other payables represent the liability outstanding at the end of the reporting period for goods and services received by the association during the reporting period that remain unpaid. The balance is recognised as a current liability with the amounts normally paid within 30 days of recognition of the liability.

(i) **Provisions**

Provisions are recognised when the association 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 recognised represent the best estimate of the amounts required to settle the obligation at the end of the reporting period.

(j) **Critical Accounting Estimates and Judgments**

The committee evaluates 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.

(k) **Key Judgments**

*Provision for impairment of receivables*

Included in accounts receivable and other debtors at the end of the reporting period are amounts receivable from Mental Health Coalition of SA in relation to unpaid course fees from 2013 amount to $123,000. The committee has received undertakings from the coalition that such amounts will be paid and therefore no provision for impairment has been made.

(l) **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.

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

## MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
### Notes to the Financial Statements
### For the Year ended 30 June 2013

| | 2013 $ | 2012 $ |
|---|---|---|
| **2. Revenue** | | |
| Government & Other Grants | 1,527,074 | 1,070,395 |
| | 1,527,074 | 1,070,395 |
| **Other Income** | | |
| Interest Received | 148,838 | 198,178 |
| LDU Course Payments | 1,978,182 | 3,333,500 |
| Membership Subscriptions | 49,338 | 38,583 |
| Co-ord Fee | 24,545 | - |
| Seminars and Sundry Income | 22,066 | 13,856 |
| Consultancy Income | 62,684 | |
| | 2,285,653 | 3,584,117 |
| | 3,812,727 | 4,654,512 |
| **3. Expenses** | | |
| Employee Benefits Expense | 2,023,067 | 1,987,658 |
| Depreciation and Amortisation Expenses | 29,864 | 40,248 |
| Advertising | 14,415 | 11,634 |
| Bank Charges | 737 | 873 |
| Insurance | 28,143 | 27,031 |
| Library | 728 | 1,609 |
| Postage | 14,403 | 7,824 |
| Printing & Stationery | 93,407 | 58,821 |
| Repairs & Maintenance | 7,339 | 4,053 |
| Telephone | 19,223 | 17,905 |
| Other Expenses | 1,685,177 | 1,525,062 |
| | 3,916,503 | 3,682,718 |
| **4. Finance Costs** | | |
| Bank Card Charges | 927 | 935 |
| | 927 | 935 |
| **5. (Loss)Profit for the Year** | **(103,776)** | **970,859** |
| Profit from continuing operations includes the following specific expenses: | | |
| **Charging as Expense** | | |
| Finance Costs | 927 | 935 |

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

| | 2013 $ | 2012 $ |
|---|---|---|
| Movements in Provisions | | |
| Depreciation | | |
| - Depreciation of Property, Plant and Equipment | 29,864 | 40,248 |
| Net Expenses Resulting from Movement in Provisions | 29,864 | 40,248 |
| Bad & Doubtful Debts:- | | |
| - Bad debts written off | 327 | 2,000 |
| | 327 | 2,000 |
| Remuneration of the Auditor:- | | |
| - Audit & review of financial reports | 6,500 | 7,000 |
| | 6,500 | 7,000 |
| **Crediting as Income:** | | |
| Interest from : | | |
| - Other Corporations | 148,838 | 198,178 |
| Total Interest Revenue | 148,838 | 198,178 |

## 6. Cash and Cash Equivalents

| | | |
|---|---|---|
| Deposits | 4,050 | 1,675 |
| Cash Management Account | 48,536 | 249,846 |
| Cash on Hand | 300 | 300 |
| Security Deposit | 200 | 200 |
| Business Day Term Deposit | 3,539,446 | 4,142,824 |
| | 3,592,532 | 4,394,845 |
| **Cash Reconciliation** | | |
| Cash and Cash Equivalents | 3,592,532 | 4,394,845 |
| | 3,592,532 | 4,394,845 |

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

# MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
## Notes to the Financial Statements
## For the Year ended 30 June 2013

| | 2013<br>$ | 2012<br>$ |
|---|---|---|
| **7. Cash Flow Information** | | |
| **Reconciliation of Cash Flow from Operations with Profit after Income Tax** | | |
| Profit (Loss) | (103,776) | 970,859 |
| **Adjustments for Non-Cash Components in Profit:** | | |
| Depreciation | 29,864 | 40,248 |
| **Changes in Assets and Liabilities** | | |
| Increase in Trade and Other Receivables | (336,675) | (13,006) |
| Decrease in Trade and Other Payables | (391,754) | (716,310) |
| Increase in Provisions | 12,278 | 407,772 |
| **Net Cash Provided by Operating Activities** | (790,063) | 689,563 |
| **8. Trade and Other Receivables** | | |
| **Current** | | |
| Trade Debtors | 535,262 | 197,184 |
| Accrued Income | 0 | 1,406 |
| **Total Trade and Other Receivables** | 535,262 | 198,587 |
| **9. Property, Plant and Equipment** | | |
| **Plant and Equipment** | | |
| Plant & Equipment | 188,173 | 179,043 |
| Less Accumulated Depreciation | 125,269 | 113,304 |
| | 62,904 | 65,739 |
| Motor Vehicles | 72,173 | 72,173 |
| Less Accumulated Depreciation | 37,960 | 30,065 |
| | 34,213 | 42,108 |
| Computer Equipment | 80,125 | 77,005 |
| Less Accumulated Depreciation | 61,569 | 51,565 |
| | 18,556 | 25,440 |
| Total Plant and Equipment | 115,673 | 133,287 |

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

| | 2013 $ | 2012 $ |
|---|---|---|
| **10. Trade and Other Payables** | | |
| **Current** | | |
| PAYG Witholding Tax Payable | 24,130 | 20,557 |
| Trade Creditors | 212,837 | 187,309 |
| **Total Trade and Other Payables** | 236,967 | 207,866 |
| **11. Financial Liabilities** | | |
| **Current** | | |
| GST Creditor | 58,125 | 44,501 |
| | 58,125 | 44,501 |
| **Total Financial Liabilities** | 58,125 | 44,501 |
| **12. Provisions** | | |
| **Current** | | |
| Provision for Holiday Pay | 134,460 | 128,816 |
| Provision for Long Service Leave | 54,249 | 47,615 |
| Provision for Training Venue | 372,682 | 372,682 |
| | 561,391 | 549,113 |
| **Total Provisions** | 561,391 | 549,113 |

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 | 0 | 10,250 |
| Deferred Income | 870,984 | 1,235,941 |
| Income in Advance | 95,198 | 154,470 |
| | 966,182 | 1,400,661 |
| **14. Retained Earnings** | | |
| Retained Earnings at the Beginning of the Financial Year | 2,524,578 | 1,553,719 |
| **Less** | | |
| Net Loss attributable to members of the company | 103,776 | 970,859 |
| Retained Earnings at the End of the Financial Year | 2,420,802 | 2,524,578 |

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

## MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
### Notes to the Financial Statements
### For the Year ended 30 June 2013

| | 2013<br>$ | 2012<br>$ |
|---|---|---|
| 15. **Auditors Remuneration** | | |
| BRUCE LAWRENCE was the auditor of MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED | | |
| - Audit & review of financial reports | 6,500 | 7,000 |
| | 6,500 | 7,000 |

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

# MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
## ABN: 59 279 168 647
## Notes to the Financial Statements
## For the Year Ended 30 June 2013

### 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 1/7/12 | 42,108 | 65,739 | 25,440 | 133,287 |
| Additions | | 9,130 | 3,120 | 12,250 |
| Disposals | | | | 0 |
| Depreciation Expense (Note 3) | 7,895 | 11,965 | 10,004 | 29,864 |
| **Carrying Amount at 30/6/13** | **34,213** | **62,904** | **18,556** | **115,673** |

### 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.

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

# MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
## ABN: 59 279 168 247
## Notes to the Financial Statements
## For the Year Ended 30 June 2013

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.

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

(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 2013 $ | Non Interest Bearing 2013 $ | Total 2013 $ |
|---|---|---|---|
| **Financial Assets** | | | |
| Cash | 3,592,532 | | 3,592,532 |
| Receivables | | 535,262 | 535,262 |
| | **3,592,532** | **535,262** | **4,127,794** |
| **Financial Liabilities** | | | |
| Trade and Other Payables | | 295,092 | 295,092 |
| Deferred Income | | 966,182 | 966,182 |
| | 0 | **1,261,274** | **1,261,274** |
| **Net Financial Assets/ Liabilities** | **3,592,532** | **-726,012** | **2,866,520** |

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

## MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
## ABN: 59 279 168 647
## Notes to the Financial Statements
## For the Year Ended 30 June 2013

NOTE 19: FINANCIAL INSTRUMENTS (cont'd)

| | 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 Creditors | | 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** |

**Reconciliation of Net Financial Assets to Net Assets**

| | 2013 $ | 2012 $ |
|---|---|---|
| Net Financial Assets as above | 2,866,520 | 2,940,404 |
| Property, Plant & Equipment | 115,673 | 133,287 |
| Provisions | -561,391 | -549,113 |
| **Net Assets as per Statement of Financial Position** | **2,420,802** | **2,524,578** |

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, 2013.

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

# MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
## ABN: 59 279 168 647
## Notes to the Financial Statements
## For the Year Ended 30 June 2013

### NOTE 21: REMUNERATION OF BOARD MEMBERS

| | 2013 $ | 2012 $ |
|---|---|---|
| Income paid or payable, or otherwise made available, to board members by the assocaition 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:

| $ | $ | 2013 | 2012 |
|---|---|---|---|
| 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:

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

**New Members**
The following board members were elected at the Association's Annual General Meeting:

Karen Burns
Leone Crayden
Judi Higgin
Sylvia Grant
Pam Rutledge
Sue Sacker
Deborah Banks

**Resigning Members**
The following board members stood for re-election at the Association's Annual General Meeting.

Karen Burns
Leone Crayden
Judi Higgin
Sylvia Grant
Pam Rutledge
Sue Sacker
Deborah Banks

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

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

# MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
## ABN: 59 279 168 647
## Notes to the Financial Statements
## For the Year Ended 30 June 2013

| NOTE 23: EMPLOYEE ENTITLEMENTS | 2013 $ | 2012 $ |
|---|---|---|
| Employee Entitlement Liabilities: | | |
| Provision for Employee Entitlements-Current (Note 12) | 188,709 | 176,431 |
| **Aggregate Employee Entitlement Liability** | **188,709** | **176,431** |

### 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

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

# MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
## Income and Expenditure Statement
## For the Year ended 30 June 2013

| | 2013<br>$ | 2012<br>$ |
|---|---|---|
| **Revenue** | | |
| Government & Other Grants | 1,527,074 | 1,070,395 |
| Membership Subscriptions | 49,338 | 38,583 |
| Seminar | 19,043 | 7,205 |
| Consultancy Income | 62,684 | - |
| Sundry Income | 3,023 | 6,651 |
| Interest Received | | |
| - Other Corporations | 148,838 | 198,178 |
| LDU Course Payments | 1,978,182 | 3,333,500 |
| AC IMH Co ord Fee | 24,545 | - |
| | 3,812,727 | 4,654,512 |
| **Expenditure** | | |
| Accommodation | 48,826 | 34,734 |
| Administration Costs | 192,287 | 97,949 |
| Advertising | 14,415 | 11,634 |
| Accreditation Expenses | 127 | 8,799 |
| Auditor's Remuneration | | |
| - Audit & review of financial reports | 6,500 | 7,000 |
| Bad Debts Written Off | 327 | 2,000 |
| Bank Charges | 737 | 873 |
| Bank Card Charges | 927 | 935 |
| Catering | 56,256 | 41,544 |
| Cleaning | 5,646 | 5,800 |
| Consultancy Fees | 315,306 | 316,424 |
| Courier Expenses | 10,083 | 10,209 |
| Computer Software | 20,892 | 43,438 |
| Depreciation | 29,864 | 40,248 |
| Equipment Purchases | 4,498 | 7,201 |
| Filing Fees | 680 | 91 |
| Fines | - | 212 |
| Fringe Benefits Tax | 9,222 | 14,677 |
| Grants Paid | 219,023 | 10,000 |
| Insurance | 28,143 | 27,031 |
| Internet Expense | 24,807 | 19,522 |
| Library | 728 | 1,609 |
| Motor Vehicle Expenses | 14,579 | 16,921 |
| Postage | 14,403 | 7,824 |
| Printing & Stationery | 93,407 | 58,821 |
| Provision for Annual Leave | 5,643 | 19,672 |
| Provision for Long Service Leave | 6,634 | 15,419 |
| Repairs & Maintenance | 7,339 | 4,053 |
| Recruitment Expenses | 8,547 | 30,247 |
| Scholarships | 253,638 | 258,677 |
| Security Costs | 1,245 | 1,173 |
| Speaker & Seminar Expenses | - | 13,267 |
| Staff Amenities | 5,846 | 6,087 |

*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 2013

| | 2013 $ | 2012 $ |
|---|---|---|
| Subsidies Paid | 4,815 | - |
| Subscriptions | 18,527 | 15,124 |
| Sundry Expenses | 2,833 | 3,062 |
| Superannuation Contributions | 163,067 | 159,846 |
| Telephone | 19,223 | 17,905 |
| Trainers | 317,390 | 359,452 |
| Training | 18,910 | 7,941 |
| Travelling Expenses | 50,100 | 88,373 |
| Utilities | 6,376 | 235 |
| Venue Hire | 44,534 | 69,438 |
| Wages | 1,841,877 | 1,820,611 |
| Waste Disposal | 1,103 | 1,890 |
| Web Design | 27,173 | 5,685 |
| | 3,916,503 | 3,683,653 |
| **Loss before Income Tax** | (103,776) | 970,859 |

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

## CONTACT US

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