mental health coordinating council

2013-2014 Annual Report

Policy, Advocacy and Reform

Sector and Workforce Development

Learning and Development

Organisational Development

Strategic Engagement

Research and Evaluation

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ORGANISATIONAL PROFILE

The Mental Health Coordinating Council (MHCC) is the peak body for non-government mental health community-managed organisations (CMOs) across New South Wales (NSW). MHCC has 120 voting member organisations which provide a diversity of psychosocial and clinical services. MHCC advocates recovery oriented and trauma informed practice and works closely with its members and other stakeholders to build capacity and improve mental health service delivery to people with lived experience of mental health conditions, their families and carers in NSW.

MHCC takes a leadership role in advocating the vital importance of the mental health community managed sector. We participate extensively in policy reform and work in partnership with State and Commonwealth Governments to build cross sectoral collaboration and understanding.

We initiate, manage and conduct research and sector development projects on behalf of and in partnership with the sector and build capacity through partnerships, collaboration, and workforce development.

MHCC is a Registered Training Organisation providing accredited mental health and leadership training and professional development.to community sector workers and other stakeholders.

MHCC is also a founding member of Community Mental Health Australia (CMHA), a coalition of the eight state and territory peak bodies across Australia, representing over 800 organisations nationally.

OUR 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.

ABOUT OUR SECTOR

Mental Health CMOs are a crucial part of the entire mental health and human service system in NSW. Our members contribute to improved outcomes for people experiencing – or at risk of developing mental health conditions and psychosocial disability, and play a key role in prevention, early intervention and providing the supports that assist people to stay well in the community. Our sector is flexible and responsive and promotes the principles of trauma-informed recovery orientation as central to its philosophy of practice. One of the sector's key strengths is the meaningful inclusion of people affected by mental health issues and their families and carers, in the planning and development of services and government strategic reforms.

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

If you've missed an issue of *View fom the Peak*, you can download copies online.

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 accredited training through MHCCs Registered Training Organisation
- Discounts to seminars and conferences
- Access to trauma-informed recovery-orientated practice resources.

Inform and stay informed

- MHCC keeps members up to date with information affecting the sector and informed about evidence based best practice from the latest research
- MHCC provides opportunities to share the experience of other organisations through working and advisory groups, participation at forums and through contributions to the sector's quarterly publication, View from the Peak.

THE PEOPLE BEHIND MHCC

MHCC BOARD

KAREN BURNS
(Chair)
UnitingCare
Mental Health
attended 7 of 8 meetings

SUE SACKER
(Treasurer)
Schizophrenia Fellowship
attended 7 of 8 meetings

LEONE CRAYDEN
(Vice Chair)
On Track Community
Programs
attended 7 of 8 meetings

JOHN MALONE
(Secretary)
Aftercare
attended 7 of 8 meetings

JUDI HIGGIN
New Horizons Enterprises
attended 7 of 8 meetings

SYLVIA GRANT
Neami National
attended 6 of 8 meetings

PAM RUTLEDGE
RichmondPRA
attended 6 of 8 meetings

PERI O'SHEA
NSW CAG
attended 3 of 8 meetings

DR CATHY KEZELMAN
ASCA
attended 4 of 8 meetings

DEBORARH BANKS
Lou's Place
attended 7 of 8 meetings

THE PEOPLE BEHIND MHCC

MHCC STAFF

CEO Jenna Bateman

POLICY & SECTOR DEVELOPMENT

Corinne Henderson - Senior Policy Advisor (Acting CEO 6 months from 7/4/14)
Tully Rosen, Senior Policy Officer (Acting Deputy CEO 6 months from 7/4/14)
Tina Smith - Senior Policy Advisor – Sector Development
Stephanie Maraz - Partnership Projects: Development & Coordination
Lucy Corrigan - Policy Assistant (2/7/12 – 16/8/13)

ADMINISTRATION

Erika Hewitt - Operations & HR Manager
Colleen Mosch - Reception & Office Administration
Ian Bond - IT & Equipment Officer
Jill Dimond - Finance Officer
Jean Robinson - Finance Assistant (Commenced 19/11/13)

QUALITY & COMMUNICATIONS

Carrie Stone - Community Engagement Officer
Lenny Pelling - Promotions Officer
Sheena Lee - Compliance & Quality Officer
Craig Healy - Volunteer

PROJECT STAFF

Deb Tipper - CMHDARN Project Officer

LEARNING & DEVELOPMENT (LD)

Simone Montgomery - Manager LD
Chris Keyes - Project Liaison & Development Team Leader
Jacqueline Moreno Ovidi - Training Services Team Leader

COURSE COORDINATION

Lorna Downes - Short Course Coordinator

ADMINISTRATION

Joanne Timbs - Senior Administration Officer
Kat Fardian - Online Learning Officer
Lisa Van Praag - Training Logistics Coordinator
Christine Kam - Student Support & Administration Officer (1/2/12 – 28/11/13)
Liesl Homes - Administration Officer – Aboriginal Projects
Melinda Shipp - Administration Assistant (commenced 16/7/13)
Nicole Cother - Student Support & Administration Officer
Simona Adochiei - Administration Officer
Rainbow Yuen - Administration Assistant

CHAIR's REPORT

This has been a busy year for MHCC, as the team continue to provide leadership and representation for the sector, call for policy development and build sector capacity through partnerships, collaboration and workforce development. MHCC has continued to advocate for the community managed mental health sector, as it collaborates in reform processes and faces dynamic and structural changes.

This year also saw the continued engagement of MHCC in the Aboriginal Careers in Mental Health program - an innovative model that builds the capacity of community mental health organisations to train, employ and support Aboriginal workers. This was a positive experience for both host organisations and the trainees themselves, with stated benefits related to access to quality education and training whilst in paid employment, increasing future job prospects within the mental health sector and increasing the capacity for organisations to support Aboriginal people in the workplace, including the improvement of related internal policies and procedures.

There have been many achievements by MHCC in sector development over the last 12 months, including the ongoing partnership between MHCC and the NSW Mental Health Commission in seeking information and supporting organisations within the Hunter NDIS pilot site. One of the highlights has been the Hunter NDIS and Mental Health Community of Practice Forums which allows for sharing and reflection on the experience of people with a mental illness/ psychosocial disability, their families and carers and the organisations that provide services to them within the Hunter NDIS trial site. This forum has attracted well over 100 community sector workers from the Hunter and over 50 workers from outside the Hunter.

MHCC continues to be an active member of Community Mental Health Australia, which is a coalition of the eight peak community mental health organisations from each State and Territory, and aims to provide a voice and represent the sector in national initiatives related to mental health and social inclusion.

MHCC Learning and Development had a specific focus on designing and delivering specialised workforce development training, which included training for Partners in Recovery Organisations, assisting PIR Organisations to make the shift from traditional case management to a co-ordinated approach to support facilitation. There has also been significant development of the Certificate IV in Mental Health Peer Work, to meet the needs of the emerging and growing peer workforce. MHCC is the lead agency for Community Mental Health Australia for the course. The Board of MHCC acknowledges the innovation of the Learning and Development team and thank them for their hard work over the last 12 months.

I would like to thank my fellow Board members for their commitment to the sector and willingness to debate challenging issues over the past year, in a time of dynamic change. This year the Board increased its focus on governance standards and MHCC continues to pursue effectiveness and transparency.

I would like to thank Jenna Bateman, Chief Executive Officer of MHCC for her responsiveness to the needs of member organisations in a changing environment and leadership of the organisation. Jenna has taken long service leave this year since April 2014, which provided an opportunity for other staff within MHCC to take on the leadership role for six months. I would also like to acknowledge both Corinne Henderson and Tully Rosen, who shared the role over this period, which saw the re-negation of MHCC KPIs with the NSW Ministry for Health, re-alignment of the organisation with changing budget allocations and provided direction for the MHCC team over this period.

Karen Burns

CEO's REPORT

MHCC Chair Karen Burns has highlighted in her report some of the projects and initiatives undertaken this year by MHCC that represent some of our more visible contributions to sector development. Alongside these endeavours has been activity that impacts in less overt ways but is nevertheless crucial to our role in promoting and supporting the community managed sector.

Of particular note is the work we have done in advocating integrated care approaches through, for example, advocacy of the community hub model (currently being trialled as 'Like Minds'); promotion of consortia approaches across and between sectors; and our series of projects funded by the NSW Health Institute and Training Institute (HETI) designed to support placement and supervision of clinically trained staff in CMOs.

Other activities worth noting include the review and update of the Mental Health Rights Manual; the advocacy MHCC has continued to do around the importance of supported decision making within the human services and legal systems for people with mental health conditions; research into physical health strategies and programs underway in the MH CMO sector; and analysis of the applicability of a recovery-orientated approach for young people.

At the national level our skills and experience in CMO data, outcomes and workforce issues has been sought particularly in relation to the NDIS. At the state level, advice to the NSW MH Commissions Strategy and Plan has been a key area of our focus.

Perhaps the most significant issue for MHCC over the last year however has been the Partnerships for Health agenda run by NSW Health. This initiative will continue to be our key focus as we come into the 2015 state election. There is much for us to learn through the experience of

similar 'recommissioning' undertakings in states such as Victoria and WA. In NSW the recent review of the NSW Homelessness sector under 'Going Home Staying Home' gives indications of the losses in 'value adding' and expertise that can occur if full assessment of current outcomes from services are not conducted.

This year has been an uncertain one for MHCC members on a number of fronts and this is likely to continue into 2015. Partnerships for Health, the NDIS, the transition of Medicare Locals to Primary Health Networks and implications of the government's response to the Commissions Strategic Plan are all to varying degrees unknown quantities at this point. MHCC is committed to providing information and guidance to members to the degree we are able and to advocate for resources to support reform processes.

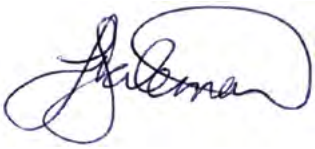
MHCC retains skilled and dedicated individuals across the policy and learning and development portfolios. These individuals are well supported by our communications and admin teams and I would like to thank them all for their many contributions this year. Special thanks to Erika Hewitt who very capably steers MHCC operations.

Top row: MHCC Policy team
Middle: MHCC Core and Communications team
Bottom: MHCC Learning and Development team

Special thanks also to Deb Tipper who has managed the CMO MH and DA research network (CMHDARN) so effectively. This partnership between MHCC, NADA and the NSW MH Commission is raising CMO capacity in this crucial area.

My long service leave this year saw Corinne Henderson take up the MHCC reins supported by Tully Rosen in a created Deputy CEO role. My thanks to them both for their achievements and commitment to their respective positions over the period of my leave. Also thanks to Senior Policy Advisor Tina Smith and Learning and Development Manager Simone Montgomery for continued outstanding work in their respective portfolios.

The MHCC Board attracts a very knowledgeable and experienced group of people whose advice guides MHCC directions. My thanks to Karen Burns for her continued solid chairing of the Board.



Jenna Bateman

Chief Executive Officer

OUR WORK OVER THE PAST YEAR

What follows is a snapshot of MHCC activity during 2013-2014 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

MHCC advocates the importance of sector capacity to meet population health needs at a state and Commonwealth level. MHCC's contributions to sector development encompass initiatives in workforce education and training; supervision practices; data collection and reporting; evaluation and outcomes; research into practice; service coordination; and organisational collaboration models.

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 2013/14, we represented Community Mental Health Australia (CMHA) on the Health Workforce Australia (HWA) Mental Health Workforce Reform Project Advisory Group.

MHCC had previously represented CMHA on the Mental Health Standing Committee's (MHSC) Mental Health Workforce Advisory Committee (MHWAC). Following the demise of MHWAC in December 2012 there has been continuing uncertainty about directions for mental health workforce development. The new national Mental Health Drug and Alcohol Principal Committee (MHDAPC) now has accountability for the implementation plan for the National Mental Health Workforce Strategy and Plan (NMHWSP) developed by MHWAC. The NMHWSP 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. There is no community sector representation to the MHDAPC and this will likely need to be addressed as we move into 2014/15.

MHCC has also worked on behalf of CMHA to progress our partnership with the National Mental Health Commission to develop the Certificate IV Mental Health Peer Work learning and assessment materials.

During 2013/14 MHCC continued to chair CMHA's Workforce Development Working Group although its activities have been limited. 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 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, including but not limited to implementation of the National Disability Insurance Scheme (NDIS).

MHCC is still playing a key role in representing the sector as part of the CS&HISC review of the Community Services Training Package CHC08. Additionally we participate on behalf of CMHA on the National Training Package Advisory Committee convened by Community Services and Health.

Learning and Development Overview

As a leader in community mental health sector workforce development MHCC LD continued to prioritise workforce initiatives to enhance sector capability and build capacity through professional development and qualifications across the mental health and human service sectors

Peer Work

In partnership with the National Mental Health Commission (NMHC), Community Mental Health Australia (CMHA) was funded to develop national learning and assessment resources for the Certificate IV in Mental Health Peer Work CHC42912. MHCC coordinated this project on behalf of CMHA. In partnership with a robust governance framework of the National Consumer and Carer Peer Work Qualification Reference Group, the Consumer and Carer Technical Reference Group and the National Management Steering Committee MHCC was able to produce high quality learning and assessment resources for national distribution by the NMHC. This will enable peer workers to access the course from a variety of Registered Training Organisations (RTOs) nationally, as well as utilise the resources for informal training, or to support mentoring and professional development.

These resources validate the knowledge base of peer work and cement the peer workforce as an occupational group in mental health.

Stage 2 of the project is to develop materials for a 3 day Peer Leadership Skills Set training. This is targeted at peer workers who are in senior, leadership or mentoring roles. Development is now underway and will be finalised and available from the NMHC in January 2015.

Supporting Partners in Recovery (PIR)

MHCC has undertaken substantial work since 2011 to better understand the practice skills required for effective care and service coordination. This work was based on consultation with consumers, carers and service providers to close an identified knowledge gap regarding service coordination as a recovery oriented practice skill set. On the basis of this work, MHCC undertook an analysis of the Support Facilitator role against what the literature and consumers, carers and service providers told us was effective care and service coordination practice. In August 2013 MHCC invited representatives from PIR organisations, including lead agencies and consortia members to participate in an industry focus group to design a training suite that directly relates to the work of the PIR Support Facilitators.

Out of this group came a framework for an induction package for Support Facilitators based on a needs analysis and identification of key role competencies.

Over the year MHCC trained 245 people and conducted 17 courses.

Aboriginal Careers in Mental Health (ACIMH)

Aboriginal Careers in Mental Health (ACIMH) was a state-wide initiative that sought to build the Aboriginal mental health workforce in NSW between 2012 and 2014. Key stakeholders across community mental health organisations, the Department of Education and Communities and the Department of Prime Minister and Cabinet came together to support 46 new Aboriginal Mental Health trainees to provide much needed support to people around NSW.

As a state-wide initiative, ACIMH trainees were well spread around NSW with 40% based in rural NSW, 11% based in Newcastle and 49% based in Sydney. Significantly ACIMH attracted and recruited a large number of young people with 48% of all trainees aged between 20-29 years. The gender balance of trainees was also fairly even with 42% men and 58% women coming into the sector.

ACIMH has been evaluated by an independent evaluator, EJD Consulting and the final report is available on the MHCC website.

> Overwhelmingly, the majority of stakeholders felt that ACIMH has had a significant and positive impact on the employment and support of Aboriginal staff.

Further, 46% of stakeholders felt there had been a significant change in host organisation general interest and commitment to Aboriginal employment. Significantly, ACIMH boasts a 70% retention and completion rate, with 32 trainees completing the program. The true essence and success of ACIMH is clearly articulated through its trainees:

"The experience I have had in my time as an Indigenous trainee at Neami has been great, and with that experience has come the confidence to grow not only as a support worker but also as a person. I was blessed to be given this opportunity after being unemployed for several months and losing my drive to be in the workforce. Now thanks to this traineeship I am future driven with my sights set on further study and security within the mental health recovery field."

Mark Richards, Trainee, Neami

CREATING A FRAMEWORK FOR PRACTICE RECOGNITION

MHCC has continued to advocate directions for strengthening the recognition of psychosocial disability and recovery support practice. Discussions have occurred with both CMHA and the Mental Health Council of Australia (MHCA) concerning the value of a national direction in this regard.

Directions continue to emerge related to the likely certification/accreditation/registration of workers funded through the NDIS who may not be Australian Health Practitioner Agency (AHPRA) regulated health professionals (i.e., vocationally qualified or unqualified workers – both peer and non-peer). In May, MHCC prepared a submission to the Australian Health Ministers' Advisory Council in regard to their discussion paper about a proposed National Code of Conduct for Health Care Workers. The code of conduct applies to unregulated community sector workers assisting people with mental health conditions.

There are also continuing 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.

NDS are preparing a discussion paper that is to be used by the Commonwealth Department of Social Service to inform a National Disability Strategy/NDIS strategic workforce development direction. MHCC continues to highlight the concern that this may not be valuing or inclusive of the skills required for recovery-oriented and trauma-informed psychosocial disability and recovery support work.

IMPROVING SERVICE EFFECTIVENESS AND QUALITY

The Trauma-Informed Care and Practice Organisational Toolkit (TICPOT): An organisational change process resource

The Trauma-Informed Care and Practice Organisational Toolkit (TICPOT), is one element of a broader national initiative promoting the integration of trauma-informed care and practice (TICP) principles across service systems and programs in Australia. The development of TICPOT stems from one of the recommendations described in MHCC's position paper: *Trauma-Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia – A National Strategic Direction,* 2013.

TICPOT is due for completion by the end of 2014. It will provide guidance towards the organisational change processes necessary to embed TICP principles into every aspect of an organisation and its service delivery approach. It is targeted at a diversity of organisations across mental health and human service sectors including community managed mental health, primary health, and public services including mental health inpatient settings.

TICPOT is a quality improvement tool that centres on reflective practice, and includes information and resources needed to assist organisations begin their journey or build on existing trauma-informed policies and practices. Importantly TICPOT contains a brief overview of the assessment processes necessary to inform an organisational change process and sustainable quality improvement.

The objective is to better enable an organisation and its workforce to be responsive to the needs of service users impacted by experiences of trauma; as well as embed a sustainable trauma-informed organisational culture that appropriately supports staff.

ROSSAT Stage 2: Validation and Refinement

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.

In 2013, a Stage 2 ROSSAT project commenced with the aims of determining the face validity, content validity and response process validity of the ROSSAT toolkit. With the blossoming of literature on recovery orientation and recovery quality processes, the ROSSAT literature review has been updated and a set of consultations were held to provide data for the validation process. The ROSSAT *Tool for Organisations* (T4O) and *Tool for Workers* (T4W) have been reviewed in detail following this process to make it briefer and easier to use. The tools have been found to have extremely high levels of validity.

Along with the National Mental Health Standards, ROSSAT is also cross-referenced with MHCC's Trauma-Informed Care and Practice Organisational Toolkit (TICPOT), in order for organisations to streamline their use of the two quality improvement resources.

MHCC will release an updated ROSSAT toolkit and user guide in line with the recommended changes at the end of 2014.

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 is important for ensuring contemporary evidence-based and recovery-oriented practice.

The *MHCC Organisation Builder (MOB) Policy Resource* available on MHCC's website 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 are mapped to a range of frameworks to support accreditation processes and the policy resource itself is continuously quality improved.

The Recovery Oriented Language Guide that underpins the Policy Resource has been very well received across the mental health and broader community sectors. During 2013/14 a second edition of the guide was published in partnership with the Mental Health Commission of NSW.

MHCC Recovery Oriented Language Guide because language matters.

ENHANCING PRACTICE APPROACHES

National Recovery Framework

The national framework for recovery-oriented mental health services was developed under

the guidance of the Mental Health, Drug and Alcohol Principal Committee, oversighted by the Safety and Quality Partnership Standing Committee, on which MHCC represents CMHA. MHCC worked closely with the authors particularly to ensure that the framework included identifying the necessity for trauma-informed principles and practice to influence the design and development of innovative service models and systems of care with the participation of people with lived experience of mental illness and trauma.

Trauma-Informed Care and Practice (TICP): towards a cultural shift and policy reform across mental health and human services in Australia – A National Strategic Direction

MHCC and member organisation Adults Surviving Child Abuse (ASCA) continue to advocate at a state and national level across service systems, and although the National Trauma-Informed Care and Practice (NTICP) Advisory Working Group completed the work it originally set out to accomplish, it maintains regular contact informing members about activities in each state.

In November 2013, the Mental Health Commission of NSW partnered with MHCC and ASCA to host a forum to bring together senior managers and practitioners from agencies across service sectors in NSW, to share knowledge and information around the evidence, principles, policy and practice needed for the broad uptake of TICP across mental health and human service systems.

MHCC promotes TICP on a range of state and Commonwealth advisory groups where relevant to influence policy and program development, as well as promotion of workforce and sector capacity building across mental health and human service sectors. MHCC continues to develop TICP training tailored to the needs of particular service settings as recommended in the strategic directions paper.

CREATING NEW SERVICE MODELS

During 2013/2014 the Minister announced support for a three year pilot program in two locations, where for the first time people in NSW would have access to a comprehensive range of health care and support services under the one roof.

> These 'Community Hubs' were established to provide a 'one-stop-shop' for people with mental health conditions to access a diversity of services and supports to assist them in their recovery journeys within the community.

The proposed model is innovative and, with genuine partnership and commitment underpinning its operation, has the potential to revolutionise the experience of consumers and carers seeking support for mental health conditions. It makes sense that the structure of services fits with current understanding of what supports the recovery of people with mental health conditions. Under an integrated and co-located service, symptom management

and medication, physical health screening, psychological counselling, vocational support, social and leisure connections, family interventions, housing support and peer support and advocacy are some of the service choices able to be built into a single integrated support plan. Under the Integrated Services Model the reality of 'no wrong door' is more fully achieved. People seeking support enter a service where there is a person-centred coordinated assessment and plan which sets out to meet all of their needs.

INTEGRATING SERVICE DELIVERY

Similarly, in line with the international push to integrate care and improve health services, particularly for people with complex health and psychosocial needs, NSW Health is investing in approaches to integrate care and progress towards a health system that routinely provides seamless, effective and efficient care that responds to all of a person's health needs across physical and mental health. MHCC has supported these initiatives, as an integrated health system will better support people with complex health needs, support people to stay well in the community and be more sustainable in the long run.

During the year NSW announced an integrated care strategy providing funding over four years to progress the journey toward improved integrated care. Locally led integration of care is at the heart of the strategy, with funding provided from Local Health Districts (LHDs) in partnerships between for example CMOs and Medicare Locals, who are collaborating to develop and progress integrated care in their regions.

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. Stage one of this work was to undertake a literature review and develop a framework for thinking about care coordination practice as a subset of psychosocial rehabilitation and recovery support practice. Stage two was consumer, carer and service provider consultations to better understand the skills that result in effective, client self-directed service coordination and continuity of care. We also explored how poorly embedded these skills are in the Community Services Training Package with the exception of the mental health related qualifications despite them being required by a range of community service and health workers. The Community Services and Health Industry Skills Council included content about these matters in their 2014 E-Scan and included the content in a submission to the National Mental Health Commission review of mental health services and programs. Our work in the Hunter NDIS trail site has further validated that these skills are poorly recognised, valued and remunerated (if remunerated at all).

The work undertaken in 2013/14 by MHCC to develop the PIR induction training, 'Navigating Support Facilitation', can form the basis for service/care coordination training for a broader audience of community service and health workers, along with other advocacy and promotion of the skills required for effective care coordination.

Meet Your Neighbour

During 2013 MHCC continued to hold its Meet Your Neighbour events around NSW to encourage organisations to meet, learn more about each other and find ways to work better together. These events continue to elicit positive responses and to demonstrate that these events are creating newly established referral pathways, with consumers and carers being better matched to programs and services in their area. MHCC invites member organisations to host a Meet Your Neighbour event so that they can get to know their neighbouring services. During this year MHCC held twelve events across NSW.

2013-14 Host Organisation	Location	Date
Uniting Care MH	Penrith	17/07/13
WentWest	Blacktown	05/11/13
Wayside Chapel	Sydney	06/12/13
Evergreen Life Care Aged Care Facility	Central Coast	20/01/14
Richmond PRA	Nowra	06/02/14
Mission Australia	Marrickville	13/02/14
Uniting Care MH	Parramatta	18/02/14
ACON	Newcastle	24/02/14
Warrina Refuge in partnership with Housing NSW	Coffs Harbour	04/03/14
Family Drug Support	Willoughby	12/3/14
Anglicare	Maroubra	1/4/14
Interrelate	Lismore	11/4/14

BUILDING SECTOR INFRASTRUCTURE

Work Integrated Learning (WIL) Supervision Project

The WIL Supervision Project is a 2014 initiative between MHCC, the University of Sydney and the NSW Health Education and Training Institute (HETI) Sydney Interdisciplinary Clinical Training Network (ICTN). It seeks to build on the successful activities of three 2013 Sydney ICTN projects to enhance capacity for health student placements, namely the: MHCC *'Community Managed Mental Health Sector Practice Placement Project'*; Sydney Local Health District Centre for Education and Workforce Development *'Growing Clinical Supervision Capacity in the Sydney ICTN through the Implementation of 'Teaching on the Run' Training'* (ToTR); and St Vincent's Health Network *'Supervision Training and Readiness (STAR) Project'*. MHCC is the lead agency for the project which is funded through HWA, HETI and the NSW ICTN. This project also aims to increase both quality and capacity of the NSW community services and health industry to undertake professional entry health student practice/'clinical' placements. Two community sector trials of ToTR training were completed in April and May. This was followed by the development of a draft framework for peer mentor group supervision that will be trialled later in the year. The final project report is due in November.

Practice Placement Project

The 2014 Practice Placement Project (PPP) is also a partnership between MHCC, HETI and the University of Sydney. It is funded through the HWA and the NSW ICTN.

> It seeks to build on the earlier 2013 MHCC PPP and to continue to enhance the capacity of the community sector to undertake professional entry health student practice placements.

From early 2014 we have been working to increase the number of community sector organisations and programs in the *Practice Placement Listing.* This includes reapproaching the MHCC membership and also approaching the NSW Network of Alcohol and Other Drug Agencies (NADA) membership. In addition, contact has been made with all 12 universities across NSW to develop relationships and a directory of all key academic contacts in the health professions (i.e., medicine, nursing, psychology, occupational therapy, social work, sports/exercise physiology and dietetics/nutrition). The final *Project Report* to HETI in November will be inclusive of the findings and recommendations arising from the 2013 PPP, especially with regard to the key drivers required to build community sector practice placement capacity and further developments of the proposed community sector inter-professional practice supervision model.

2. POLICY LEADERSHIP, INFLUENCE AND REFORM

Central to providing leadership to our members and the community managed mental health sector is our voice as an influential advocate for legislative reform and policy development, at both a state and Commonwealth level. MHCC's objective in this is to bring about a better resourced community sector able to support recovery and keep people out of hospital and living well in the community. This involves facilitating effective linkages between government, community managed and private sectors, promoting trauma-informed recovery orientated practice approaches, quality and accountability frameworks and innovative service and funding models.

RESPONDING FLEXIBLY TO POLICY REFORM

MHCC builds on its knowledge base through engaging in research and consultation with members, consumers, carers and other stakeholders. MHCC regularly responds to key issues that represent the interface between mental health, the legislation and cross sectoral policy matters.

During the year MHCC has authored numerous submissions and position papers in response to Commonwealth and State inquiries, as well as providing feedback on policy reform and implementation directly to government and other agencies.

Following, is a selection highlighting the breadth of work undertaken. MHCC's public submissions are published on the MHCC website.

"Partnerships for Health" – NSW Health NGO Grant Program Reform

'Partnerships for Health' (P4H) is the NSW Ministry of Health response to the Grants Management Improvement Program (GMIP), which included a major review of the form and function of CMO grant funding at all levels of NSW Health. One of the main outcomes of the P4H response is the reorientation of NSW Health from "contributory" grants funding toward clearly defined service provider contracts. This is a challenging reform for CMOs to understand and respond to, as some traditionally funded organisations deliver services that are difficult to conceptualise within a business-style "service" metric. The Ministry initially intended to end all grant funding in mid-2014 and immediately tasked Local Health Districts (LHDs) with formal CMO service contracting.

MHCC joined with other peak bodies and community stakeholders to challenge the timeframe and assumptions of this transition; major concerns were raised around purchasing priority decision-making, LHD knowledge and capacity, CMO readiness and potential changes to overall funding levels. Thanks to a concerted campaign across the community sector, the Ministry for Health decided to transitionally fund current CMOs within the NGO Grant Program through to mid-2015. This has allowed both NSW Health and CMOs to prepare for the new contracting relationships with a greater level of planning and readiness.

Key submissions:

- Australian Commission on Safety & Quality in Health Care (ACSQHC), Consumers and health system and health literacy: Taking action to improve safety and quality. Health Literacy
- Australian Law Reform Commission (ALRC): Equality, Capacity & Disability in Commonwealth Laws: Discussion Paper 81
- Mental Health Council of Australia (MHCA). Providing Psychosocial Disability Support Through the NDIS – a proposal
- Review of the NSW Mental Health Act 2007: Report for NSW Parliament
- Families, Community Services and Indigenous Affairs, Disability Reform: Early intervention and the NDIS
- NSW Office of Fair Trading: Model Rules under the NSW Associations Incorporation Act 2009: Division 2 s35
- Families, Community Services and Indigenous Affairs, NDIS Rules Consultation Paper
- Department of Family and Community Services. Reforming NSW Disability Support: Legislative Structure and Content. Discussion Paper
- NSW Government, Issues arising under the NSW Mental Health Act 2007: Discussion Paper
- Community Services & Health Industry Skills Council Environmental Scan 2013
- Independent Commission against Corruption. Funding NGO Delivery of Human Services in NSW: A period of transition
- National Primary Health Care Strategic Framework: Consultation Draft
- Select Council on Disability Reform: Eligibility and reasonable and necessary support under an NDIS
- 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

HUMAN RIGHTS AND ACCESS TO DEMOCRACY

MHCC consulted with the NSW Electoral Commission (NSWEC) on the development of the 2014-2016 NSWEC Equal Access to Democracy Disability Action Plan. In this context we have identified where some challenges exist, and what may be some of the barriers to access for electors with psychosocial disability not currently recognised by the Commission. We have worked with the Commission to provide information concerning alternative methods of exerting the democratic right to vote and highlighting possible avenues for engagement for people with lived experience of mental health conditions.

The NSW Mental Health Rights Manual Edition IV (MHRM)

The current version of the Mental Health Rights Manual Edition 3 (MHRM) launched in 2011, speaks to a diverse mental health community, and was developed specifically for people with a mental health condition, their carers and families; and the non-legal community service providers in NSW.

In partnership with the NSW Mental Health Commission, MHCC is in the process of updating the online resource to ensure the new edition incorporates the latest legislative reform and government directives, standards and guidelines. The aim is to include material that reflects legislative changes such as amendments to the NSW MH Act and the Forensic Provisions as well as other legislation and environmental changes such as the amalgamation of NSW Tribunals under a Super Tribunal (NSW Civil and Administrative Tribunal), the formation of National and State Commissions; and Commonwealth initiatives such as the National Disability Insurance Scheme (NDIS).

> The MHRM is one of MHCC's most frequently used online resources – with approximately 85,000 plus hits a year (7,000 per month).

BUILDING & SUSTAINING STRATEGIC RELATIONSHIPS

MHCC continues to build strategic relationships across sectors and service systems with the objective of increasing awareness and understanding that the mental health CMO sector represents a leading provider of quality services in the community. We sustain and enhance our strategic relationships through consistent participation and engagement in government policy and program review concerning mental health matters as they interface with: physical health, disability, ageing, human rights, the legislation and the criminal justice system at a State and Commonwealth level.

In March 2014 MHCC signed a MOU with National Disability Services Limited (NDS) in order to establish a collaborative working relationship aimed at securing optimal outcomes for people with psychosocial disability in relation to the implementation of the National Disability Strategy 2010-2020.

MHCC's current representation on external committees, reference, research and advisory groups is extensive, cross sectoral and broad-based. Likewise we facilitate consultations, meetings and maintain dialogue with consumers, carers, public, private and community representatives with regard to systemic issues and service delivery priorities.

At a 'grass roots' level MHCC's *Meet Your Neighbour* initiative continues to support networking and promote service coordination and referral pathways between MHCC members and a diversity of service providers across sectors.

These face to face events, held across the state invite organisations to learn more about each other and find improved ways to collaborate. Ongoing relationship building with Medicare Locals, the Aged Care sector and the annual MHCC Regional Forums are also working to promote the CMO sector and support strategic partnership development.

National Mental Health Commission

MHCC responded both directly in its own submission, and via feedback to the Mental Health Council of Australia to a wide ranging review being undertaken by the National Mental Health Commission. This review set out to fulfil a Coalition election commitment which the Government stated was aimed at delivering mental health services and programmes more efficiently and effectively. This review has sought to "examine existing mental health services and programmes across the government, private and non-government sectors". The focus of the review is to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill health and their families to lead contributing lives in the community. Discussion with reference to this review is still in progress.

MHCC also provided input into the National Contributing Life Project which built on the National Mental Health Commission's first *National Report Card on Mental Health and Suicide Prevention* (2012).

Mental Health Council of Australia (MHCA)

MHCC maintains a close working relationship with MHCA providing submissions and advice to MHCA on various national policy and reform initiatives. Currently a major focus of the relationship relates to the National NDIS Capacity Building Project. MHCC sits on MHCA's overarching NDIS Program Advisory Group, and also participates in the Workforce, Scheme Design and

Accountability working groups. MHCA has successfully partnered with MHCC on a number of NDIS events and forums in Sydney and the Hunter NDIS launch site. This relationship is expected to remain strong as the National Disability Insurance Agency develops an ongoing work-plan with MHCA for NDIS-related capacity building over the next two years. MHCC also consults with MHCA and the National Consumer and Carer Mental Health Forum for national sector development projects delivered through CMHA such as the Peer Work Qualification Project.

Mental Health Commission of NSW (MHC)

MHCC has fostered a close relationship with the Mental Health Commission of NSW since its establishment in 2012.

> Our policy team has been in close consultation on a range of issues particularly with regards to the development of the Strategic Plan for Mental Health in NSW.

The Commission has worked in partnership with us on a number of projects including the Community Mental Health Drug and Alcohol Research Network (CMHDARN). CMHDARN is a partnership project between MHCC, NADA and the Commission and was established to broaden involvement of drug and alcohol and mental health community organisations in practice-based research.

Another partnership initiative between MHCC and the Commission has been to understand psychosocial disability in the context of the NDIS Hunter Launch site. This was made possible by situating a MHCC senior analyst in the trial site to gather 'on the ground' information and influence perspectives of the NDIA and other stakeholders.

The Commission has also made it possible for MHCC to continue to enable and enhance access to up-to-date information concerning mental health and human rights via the online NSW Mental Health Rights Manual.

GP NSW & Medicare Locals

MHCC have worked in collaboration with GP NSW to build engagement and cultivate partnerships between the Medicare Locals (MLs) and CMOs.

> Importantly during various joint activities, CMO's attending were able to clearly articulate the need to drive the consumer voice into the performance improvement cycle of MLs.

This included advocating recovery orientated and trauma informed practice and concepts of self-directed care. MLs are regular participants at MHCC events including conferences, seminars and forums, as well as *Meet Your Neighbour* networking opportunities around the state, and communities of practice. MHCC has strongly promoted the value of CMOs in providing services for health and wellbeing in the community to MLs, emphasising service-coordination based on a partnership approach to improving linkages and referral pathways.

Aged Care

Both the mental health and aged care sectors face challenges in appropriately addressing the complex needs associated with mental illness and ageing. Australia's demographic has been shifting for some years to reflect greater numbers of people requiring a diversity of age related mental health and physical health care needs. There is now growing recognition of the increasing numbers of older people with mental health and coexisting conditions having poor access to the support and care they need. Building on relationships established since 2012, when MHCC together with the Aged and Community Services Association of NSW and ACT (ACS) held the *Mental Health of Older People: Connecting Sectors Forum*, we have continued to highlight the need for greater focus on this area.

MHCC participates on a number of state-wide reference groups, facilitated by the Mental Health and Drug and Alcohol Office (MHDAO), including the Older People's Mental Health Working Group; and the Specialist Mental Health Service for Older People (SMHSOP) Community Model of Care Project, which has been investigating best practice in this context.

> MHCC has been particularly vocal in raising issues concerning the heightened risk of re-triggering trauma in elderly consumers and advocating for a more therapeutic approach to care than behaviour management and medication.

MHCC has also been involved in consultations in relation to the Older People's Drug & Alcohol Project, which involves the range of key stakeholders in care and support for older people with drug and alcohol issues, and capturing homelessness issues. MHCC has also been involved in Aged Health collaborative work, commenting on the Framework for Integrated Health Care of the Older Person with Complex Health Needs and a future focus on education/workforce development in the context of dementia, delirium, depression and drug & alcohol issues.

Community Mental Health Australia (CMHA)

MHCC is a founding member of CMHA, the alliance of state and territory mental health peak bodies. Through participation in CMHA, national and interstate relationships have been strengthened in a range of national projects, committees, and advisory groups.

MHCC, representing CMHA, is heavily involved in the Council of Australian Governments (COAG) and the Australian Health Ministers' Advisory Council (AHMAC) advisory council structures. MHCC sits on the Safety, Quality and Partnerships Standing Committee (SQPSC), and in 2014 was nominated by CMHA to represent the community sector on their newly formed Mental Health Workforce Working Group. MHCC also provides advice to CMHA's representative on the Mental Health Information Strategy Standing Committee (MHISSC).

This year MHCC also began to represent CMHA on the Independent Hospital Pricing Authority (IHPA) Activity Based Funding Working Group. MHCC, for CMHA, completed development of the Certificate IV in Mental Health Peer Work for the National Mental Health Commission, and also released the final report for the CMHA National CMO Outcome Measurement Project. MHCC continues to develop new national initiatives with its CMHA partner organisations in the areas of the NDIS, Peer Workforce and Information Strategy.

Health Workforce Australia (HWA)

Throughout 2013/14, MHCC on behalf of CMHA have continued to work closely with Health Workforce Australia (HWA) on their Mental Health Workforce Reform Project Advisory Group and related working groups. This involved three specific projects. The Mental Health Workforce Project report *Mental Health Workforce Study: Mental Health Workforce Planning Data Inventory* became publicly available in December. It highlighted the paucity of cohesive mental health workforce data collections and emphasised the paucity of data for vocationally qualified mental health workers, the community sector workforce and the peer workforce across all mental health work settings.

The reports and related recommendations for both the HWA Mental Health Capabilities Project and the Mental Health Peer Workforce Project will be available in July 2014. The *'National Mental Health Core Capabilities'* apply to all workers in all mental health and some other primary healthcare settings. They focus on four levels of capabilities required across six domains: values; whole of person focus; professional, ethical and legal approach; collaborative practice; provision of care; and, life-long learning.

The Peer Workforce Project was undertaken in partnership with the National Mental Health Commission. It made available a *Mental Health Peer Workforce Literature Scan* and *Mental Health Peer Workforce Study* project report making 15 recommendations for peer workforce development across six key areas. One of the recommendations regarding the need to establish National Mental Health Peer Workforce Development Guidelines for use in a range of settings, was progressed by HWA in the form of a draft document prior to their demise in June.

Once again, future directions for mental health workforce development now lie with the Mental Health and Drug and Alcohol Principal Committee (MHDAPC) and Commonwealth Department of Health and Ageing.

Safety and Quality Partnership Standing Committee (SQPSC)

MHCC represents CMHA on this national committee tasked to progress the mental health safety and quality agenda as a component of the COAG Standing Council on Health. A key role of the SQPSC is the provision of expert technical advice and recommendations on the development of national policy and strategic directions for safety and quality in mental health taking into consideration the National Mental Health Strategy, the current Fourth National Mental Health Plan, and mainstream health initiatives. The SQPSC has a watching brief in relation to safety and quality in mental health and provides advice on emerging issues of concern and related quality and safety initiatives.

> MHCC have provided input into a number of initiatives including the development of the National Standards for Mental Health Services and the National Framework for Recovery Oriented Mental Health Services.

MHCC has also promoted the principles of Trauma-Informed Care and Practice at a national level through the SQPSC and through the National Mental Health Commission's Seclusion and Restraint Project.

The newly established SQPSC Workforce Development Working Group has a specific focus on implementation of the *National Practice Standards for the Mental Health Workforce* and the Mental Health Professional Online-Development (MH-POD) resource.

National CMO Outcome Measurement Project

The Final Report of the National CMO Outcome Measurementment Project was published in November 2013. MHCC delivered this major report on behalf of CMHA and in partnership with the Australian Mental Health Outcomes and Classification Network (AMHOCN).

Following broad interest and further requests for support from the sector, MHCC and AMHOCN are developing a guidebook to supplement the project report and support CMOs planning to implement routine outcome measurement across programs.

The report is also being designed to aid funders to understand the work of CMOs; how and why outcome measurement should be used, and the various issues that need to be considered when negotiating use of outcome tools and resulting data. The guidebook is being written in consultation with a national Technical Advisory group including subject matter experts from across the community, government, academic and private sectors. Consumer and carer representatives are also involved. The guidebook will be released in the second half of 2014.

National NGO Establishments Minimum Data Set

MHCC continues to support and promote the development of the Australian Institute of Health and Welfare (AIHW) NGO Establishments National Minimum Data Set (NGOE NMDS). The NGOE NMDS was developed by the AIHW in partnership with MHCC, representing CMHA. When fully collected and reported it will for the first time provide a national picture of the community managed mental health services being provided across jurisdictions and service types. 2014 has been a turbulent year for the NGOE NMDS. Major reforms such as the NDIS and state purchasing programs jeopardised it's endorsement as a data set to collect by 2015/16. However following national deliberation the Mental Health and Drug and Alcohol Principal Committee (MHDAPC) has endorsed its roll-out. The AIHW continues to aim for a 2016 national report and mental health peak bodies continue to make use of the NGOE NMDS data set specifications to inform sector planning activities, such as the NSW Sector Benchmarking Project conducted by MHCC.

CONTRIBUTING TO THE DEVELOPMENT AND IMPLEMENTATION OF PLANNING AND RESOURCING FRAMEWORKS

Outcomes of the 2010 Sector Mapping Project

The 2010 NSW Community Managed Sector Mapping Project, and related *Capacity Building Literature Review* and framework, made 11 recommendations for sector development and capacity building that were to be progressed over three years and their outcomes evaluated in 2013/14. The content also helped to inform directions for our *2012/15 Strategic Plan*. The table below summarises the key outcomes achieved through progressing the recommendations of the Sector Mapping Project.

Recommendation	Outcomes
A clear framework will be produced by NSW Health which will structure its relationship with the mental health CMO sector.	Agreement in-principle to develop a framework from NSW Health. This is now being pursued through the NSW Mental Health Commission and conjunction with activities relevant to the NSW Health 'Partnerships for Health' funding reforms.
Seven core community-managed mental health service areas (functions) to be accessible within each local area. The amount of support available is population-based with needs-based variation parameters.	The *Sector Benchmarking Project* was completed in 2013. The findings informed development of the National Mental Health Service Planning Framework and are being used to inform NSW community sector mental health planning.
Mental health consumers have access to the range of CMO service types and experience continuity of care between components of the mental health service system.	The *Sector Benchmarking Project* and *Service Coordination Strategy* were used to progress this recommendation. With regard to the later, MHCC has consulted with consumers, carers and service providers to close a literature gap about the skills required for effective service coordination and will use this knowledge to inform next steps for the *Service Coordination Strategy.*
The CMO sector will: develop a recovery-oriented audit mechanism for CMOs; and, develop a CMO equivalent of MH-CoPES.	*The Recovery Oriented Service Self-Assessment Toolkit* (ROSSAT) has been well received and helped to inform directions for development of the National Mental Health Recovery Practice Framework. Development of a CMO MH-CoPES now being pursued through the NSW Mental Health Commission and national directions in developing consumer and carer experience of care measures.
CMOs develop and adopt a Care Coordination Strategy that will promote pathways and linkages across the mental health sector.	The Service Coordination Strategy has been progressed to further our understanding of coordinated and integrated service delivery, including identification of the skills required by all community services and health professionals for effective care coordination practice.
Infrastructure Grants be provided to the CMO sector to facilitate ongoing capacity building.	Infrastructure grants have included the *Infrastructure Grants Program, Mental Health Drug and Alcohol Research Grants, and Community Mental Health Drug and Alcohol Research Network (CMHDARN) Seeding Grants.* CMHDARN is now working closely with the NSW Mental Health Commission to pursue our shared research and development directions.

Recommendation	Outcomes
Workforce Development continues to be strengthened as a critical factor in sector development.	Continuing leadership in collaborative, recovery-oriented and trauma informed community mental health workforce development through MHCC's *Learning and Development activities* and as CMHA's representative a wide range of state and national workforce development groups.
Streamline procurement processes and introduce outcome focused funding and performance agreements.	Participation on the NSW Health NGO Advisory Committee and in the NGO Grants Management Improvement Program. MHCC is engaged with MHDAO on options for purchasing models under the NSW Health' Partnerships for Health'
An Agreed Data Set to be adopted by NSW mental health CMOs and government funding bodies. De-identified data is generated from CMOs to: build a clearer picture of the size and functionality of the CMO sector; and, enable CMO sector evaluation and planning.	The MHCC Sector Mapping and Data Management projects have informed the development of the MHEstablishment NGO NMDS national service taxonomy and minimum data set that is to be introduced in 2015/16. This work was also progressed through the national Community Sector Mental Health Outcome Measurement Project.
A broad Community Mental Health Research Network is to be developed.	The *Community Mental Health Drug and Alcohol Research Network* (CMHDARN) is now operated by MHCC and NADA in partnership with the Mental Health Commission of NSW.
Evaluate the outcomes of the recommendations arising from the *Sector Mapping Project* and review capacity of the NSW mental health CMO sector in 2013.	Evaluation has been ongoing and has now been completed in 2013/14.

NSW Community Managed Mental Health Sector Benchmarking Project

MHCC has now completed and delivered final reports for the NSW Community Managed Mental Health Sector Benchmarking Project to the Ministry of Health, including all LHD Directors of Mental Health. This project was funded by the NSW Ministry of Health and is integral to future planning and purchasing priorities for funders of community mental health services across the state. The project report successfully established population need estimates and planning targets across a range of service types, based on the epidemiology and modelling methods of the Ministry's Mental Health Clinical Care and Prevention (MH-CCP) Model. It was designed to provide evidence and justification to enable more equitable program funding decisions by funders in a language that they can understand. The findings, especially around gaps and program targets have been very informative.

It was not hard to establish that no LHD is over-serviced, and we have been able to confirm that many programs are not being funded in a way that makes an awful lot of sense at a broad population level.

Many gaps have been highlighted to the Ministry and profiles will be delivered to each LHD to encourage them to focus on service areas where they may have a significant lack of community support available. The planning targets really throw down the gauntlet to local planners to aim for a level of resourcing to the sector that would roughly double the amount of community managed service provision that is currently funded. This is generally in line with the estimates being developed by the Ministry of Health for the National Mental Health Service Planning Framework, and takes into account planning targets for hospital and acute services.

National Disability Insurance Scheme (NDIS)

During 2013/14, MHCC worked in partnership with the NSW Mental Health Commission within the NSW NDIS Hunter trial site to explore the situation for people with mental health issues/ psychosocial disability. An important outcome of this activity is establishment of the *Hunter NDIS and Mental Health Community of Practice Forum*. At the end of June the forum had a total of 224 participants with an average of 70 people attending each of the four events held during 2013/14. Participants are mostly from the community sector and a large number of Hunter New England Mental Health (HNEMH) staff also attend. The National Disability Insurance Agency (NDIA) and Mental Health Council Australia also attend and provide regular updates along with HNEMH. It is estimated that 1,300 people with high levels of psychosocial disability related to mental health conditions may have access to Tier 3 funded NDIS recovery support services by the end of the NSW trial in June 2016. By the end of June 2014, just 159 people were accessing NDIS funded supports (i.e., 12% of the target). At full roll-out in 2018, the NDIS may be assisting 19,000 people in NSW with psychosocial disability.

> Considerable learning towards establishing Tier 3 eligibility/ access and care planning/ review benchmarks is occurring for consumers, carers, service providers and the NDIA/ NDIS. This has required a greater understanding of the impact of psychosocial disability in people's lives.

Structures have and are being established in the Hunter to maximise the learning and opportunities presenting and MHCC has been able to represent the community sector in these early implementation/ evaluation structures. The NSW Mental Health Commission will continue this partnership with MHCC in 2014/15 in order to continue to pursue the many opportunities presenting through the NDIS to improve the lives of people affected by mental health issues.

Josh Fear/MHCA, Suzanne Punshon/NDIA, Tina Smith/MHCC, and Sage Telford, Mental Health Commission of NSW, at the Hunter NDIS and Mental Health COP Forum in January 2014.

Six Monthly Updates on Mental Health NDIS Trial Site Activity are available to download on MHCC's website.

3. RESEARCH & DEVELOPMENT

Research into evidence-based practice is critical to the ongoing innovation and sustainability of the mental health community managed sector, and critical to the success and recognition of service delivery approaches.

It is essential that our sector sustain proactive building of the research agenda enhanced through collaborative engagement with other human service sectors. MHCC has played a significant role in building the evidence base for the mental health community managed sector by cross disciplinary engagement with universities, academics, legal and disability professionals and medical practitioners, and continues to build on these relationships through its research partnerships. This includes its ongoing work on ROSSAT; CMHDARN; through the development of an organisational change process toolkit in the context of trauma-informed care and practice; the physical health research project; the child and youth mental health recovery project; and through its practice placement and supervision projects with Health Education Training Institute (HETI-ICTN).

CMOs in NSW need to and are constantly finding new ways to demonstrate their value through outcome frameworks, performance indicators and other types of performance and quality reviews that are being developed and implemented to help meet the demand for increased accountability from funders, government and local communities. These factors are vital to our maintaining our principles of recovery oriented practice and continuing to maintain our professionalism and vision in a political environment that seeks ever increasing 'efficiencies'. Whilst the research dollar has become ever more elusive, MHCC and its partners in research have achieved much during this year.

FACILITATING AN EVIDENCE BASED PRACTICE RESEARCH AND EVALUATION DIRECTION FOR THE SECTOR

Physical Health Research Project

In January 2014, MHCC in partnership with the University of Sydney completed a 6 month scoping study and review funded by the Mental Health and Drug and Alcohol Office (MHDAO) in which physical health related practices currently provided by NSW mental health community organisations were explored and compared to best practice internationally.

The study explored perspectives of mental health workers and consumers and carers in regards to the benefits, strengths and weaknesses of programs currently available in NSW.

The outcomes highlighted in the study demonstrate both innovative one-off programs and ongoing activities being delivered in line with international best practice. Clearly articulated is the need for more systematic and sustainable practices in supporting consumers to address their physical health needs, as well as enhancing methods of knowledge sharing and experience across the sector. Whilst it is clear from this study that some CMOs have progressed work in this context, there is still much to be done at both workforce training and programmatic levels, as well as embedding a cultural shift that ensures that physical health care is appropriately considered in the context of trauma-informed, recovery oriented, person-centred care. This study builds on the earlier work conducted by the MHCC Physical Health Industry Reference Group (PHIRG) directly addressing the key recommendations of their earlier physical health scoping and literature review. The recommendations of this study will assist MHCC advocate for further initiatives to enable the sector to make a meaningful and long term contribution to improving consumer physical health.

Child and Youth Mental Health Recovery Project

As a consequence of determined efforts by the consumer movement and the community mental health sector, recovery-oriented practice is now embedded across numerous Australian mental health policy frameworks and practice standards. However, there is little evidence that work has been undertaken to define 'recovery' specifically from the perspective of young people. There has been a tendency in youth mental health services as well as child and adolescent mental health services (CAMHS) to use language in their models of care which does not easily align to the 'recovery' literature.

> It is timely to explore how the concept of 'recovery' applies to children and young people. There is growing recognition that recovery is not an approach that applies equally across the life stages.

Supported by a small grant from the NSW Ministry of Health, and with the collaboration of MH-Children and Young People, MHCC has established a reference group which consists of a diversity of participants from child and youth mental health services across public, and community managed sectors. The aim of the study is to review practices in CAMHS and consult with parents and carers about their experiences as carers of these young people and in their engagement with services. The project also sets out to investigate the main themes identified in the adult personal recovery literature and to discuss and explore the utility and relevance of these recovery processes for young people and their families. Our aim is to identify areas for further study and provide recommendations for recovery orientation in child and youth mental health services. The project is expected to be completed second half 2014.

YOUTH 'RECOVERY' PROJECT

Improving outcomes for young people with mental health conditions

PROMOTING THE EVIDENCE BASE FOR COMMUNITY MANAGED APPROACHES: RESEARCH INTO PRACTICE

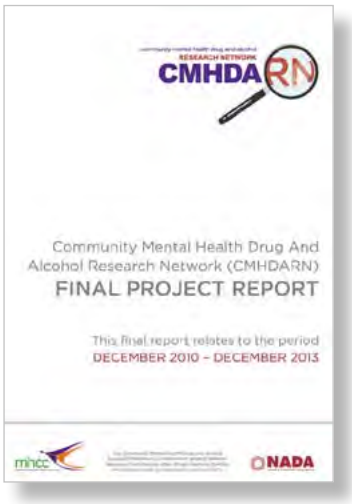
Community Mental Health Drug and Alcohol Research Network

The Community Mental Health Drug and Alcohol Research Network (CMHDARN) was established by MHCC and Network of Drug and Alcohol Agencies (NADA) to broaden involvement of the community mental health and drug and alcohol sectors in practice-based research. It aims to promote the value of research and the use of research evidence in practice, to facilitate research capacity building across the sectors and to improve service delivery to consumers of services. During 2013-14 a new partnership commenced between the Mental Health Commission of NSW, MHCC and NADA. Throughout this past year, CMHDARN has been solidly supported through members of its project Reference Group, as well as many other external people, who contributed as presenters, facilitators, and resource and information providers.

In early 2014, CMHDARN and the National Drug and Alcohol Research Centre (NDARC), Centre for Research Excellence in Mental Health and Substance Use (CREMS) initiated the *CMHDARN Mentoring Program*, which links CREMS post-doctoral students with workers in CMOs. Following an Expression of Interest process this program commenced in May 2014, with 10 mentees matched with 8 mentors, on work related projects.

Associate Professor Anthony Shakeshaft, Deputy Director, National Drug and Alcohol Research Centre presents at the CMHDARN Rural Research Forum in Orange, June 2013.

CMHDARN
RESEARCH NETWORK



For more information about CMHDARN activities or to read the CMHDARN project report visit www.cmhdaresearchnetwork.com.au

4. ORGANISATIONAL DEVELOPMENT

MHCC has been focused this year on ensuring our processes and systems are working towards our future sustainability across all arms of the organisation.

MHCC celebrated its 30th anniversary of *working for mental health* this year and with a gala dinner and a publication highlighting MHCC's achievements over the past 30 years. The document was compiled through numerous interviews with those in and around the organisation and demonstrates just how far the community managed mental health sector has come in those 30 years.

This year MHCC commenced work towards our inaugural reconciliation action plan (RAP) which we are working towards having endorsed by Reconciliation Australia (RA) later in 2014. To date we have held a full day workshop facilitated by RA and attended by all staff and a Board representative. It is our hope that through the development and implementation of our RAP we will enhance the knowledge of MHCC staff around Aboriginal and Torres Strait Islander people's culture and history. Once we have implemented our inaugural RAP which is focusing internally on MHCC staff, practices and processes that we will then commence work on a RAP with more of any external, sector focus.

REVIEWING SYSTEMS FOR MHCC GOVERNANCE, MANAGEMENT AND OPERATIONS

The review of the internal meeting structure of MHCC has enabled further opportunity for cross organisational decision making including a greater transfer of knowledge between core and LD staff.

This year we reviewed our Governance policy and Board matters schedule to ensure the Board have the resources and data needed to make informed decisions about the overall governance and management of MHCC.

IMPROVING MHCC QUALITY IMPROVEMENT PROCESSES

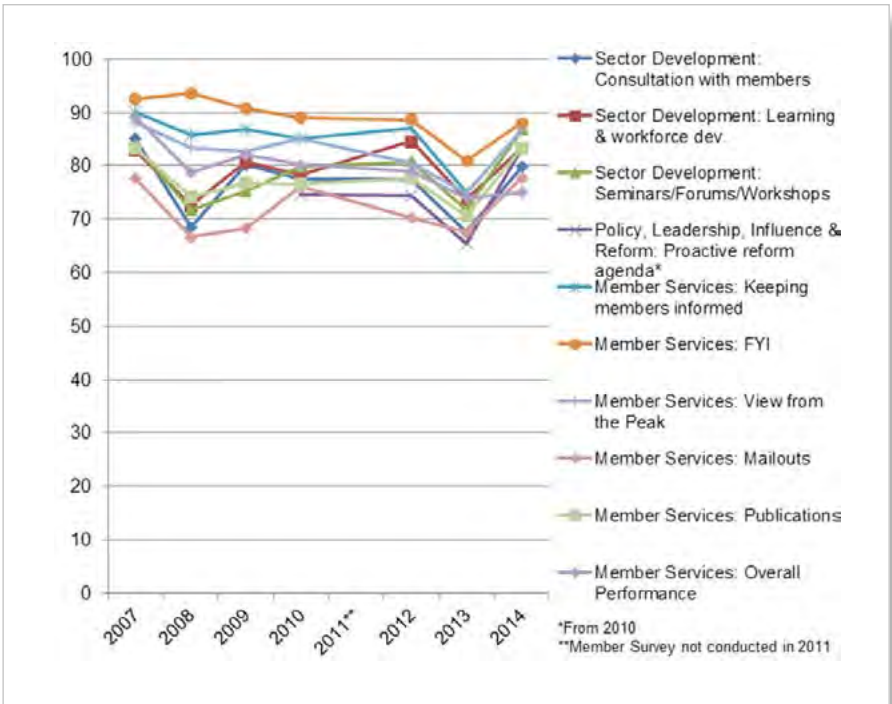
Accreditation

After completing the first full accreditation cycle with the Australian Council of Healthcare Standards (ACHS) which commenced in 2009, MHCC initiated the first phase of the succeeding four year accreditation cycle in 2013 where MHCC processes were reviewed and rated against the revised EQuIP5 standards. In 2014, MHCC engaged in the organisation-wide survey from external auditors as part of phase 2 of the cycle, and received re-accreditation in April. MHCC is currently preparing for the internal desktop survey to be completed in 2015.

MHCC Member Survey

The MHCC 2013-14 Member Survey was conducted from 9 September to 29 September 2014. This year's survey was promoted through emails to members and newsletter alerts.

MHCC received 90.48% *Agree to Strongly Agree* responses for having outstanding performance for the past year, providing an average score of 75.00%. Among the services provided, 'Seminars/Forums/ Workshops' received the highest average score of 86.90%, with 95.24% *Good* to *Excellent* ratings. The initiatives that received the highest usefulness scores are 'Recovery Oriented Language Guide' and 'Community Mental Health and Drug & Alcohol Research Network (CMHDARN),' both receiving the average score of 85.53%, with 85.00 and 75.00% of the respective responses falling into *Somewhat Useful* and *Very Useful* ratings.



Left: Data for trending questions across members surveys conducted from 2007-2014 indicate MHCC is continuing to improve in many key areas.

CONSOLIDATING THE BUSINESS VIABILITY OF THE LD

To ensure the long term business viability of the MHCC LD we are constantly reviewing the needs of the sector and monitoring emerging trends. To ensure continued relevance and currency we continue to review existing resources and invest in the development of new products such as our online learning framework Capacit-e being launched in early 2015.

Right: *Understanding Mental Health Recovery*, the first of the Capacit-e™ mental health e-learning product range.

MEMBERSHIP

Following is a list of Ordinary and Associate members of MHCC as of June 2014.

For more details please visit www.mhcc.org.au

ACON - Darlinghurst	Good Grief Ltd	Rape & Domestic Violence Services Australia
Action Foundation for Mental Health Inc.	GROW NSW	RichmondPRA
Adults Surviving Child Abuse	Heal for Life Foundation	Roam Communities
Aftercare	Home in Queanbeyan	Rosemount Good Shepherd Youth & Family Services
Alcohol & Drug Foundation NSW	Hope Street	Samaritans
Anglicare	Hornsby Ku-ring-gai Association	Schizophrenia Fellowship of NSW
ARAFMI NSW (Mental Health Carers ARAFMI NSW Inc.)	Independent Community Living Australia Ltd	South Eastern Sydney Medicare Local
Australian Kookaburra Kids Foundation Inc.	Interrelate Family Centres	South West Women's Housing
B Miles Women's Foundation	Jewish House Limited	Southern Community Welfare Inc.
Baptist Community Services (NSW & ACT)	JewishCare - Fischl House	St Luke's Anglicare
Benelong's Haven Ltd	Justice Action	St Vincent de Paul Society - NSW
Billabong Clubhouse	Kamira Alcohol & Other Drug Treatment Services	St Vincent's Mental Health Service
Black Dog Institute	Kedesh Rehabilitation Service	Stepping Out Housing Program
Blue Mountains Food Services	Keepwell (Aust) - Melbourne	Suicide Prevention Australia Inc.
Bobby Goldsmith Foundation	Life Without Barriers	Support, Opportunity and Care Inc.
Break Thru People Solutions	Link-Up (NSW) Aboriginal Corporation	Survivors & Mates Support Network
Brown Nurses	Liverpool Youth Accommodation Assistance Company	Sydney Women's Counselling Centre
Care Connect Ltd	Lou's Place	Ted Noffs Foundation
Carers NSW Inc.	Make a Difference	The ARC Group NSW Inc.

Castle Personnel Services Ltd	Mandala Community Counselling Service	The Benevolent Society
Catholic Healthcare	Manly Drug Education & Counselling Centre	The Disability Trust
Catholic Social Services NSW/ACT	Manning Mental Health Service	The Limegreen Solutions
CatholicCare - Ageing, Dementia & Disability Care	Mental Health Association NSW	The Lorna Hodgkinson Sunshine Home
Centacare - Community Lifestyle Support	Mind Australia	The Mental Health Recovery Institute
Centacare - New England North West	Mission Australia - NSW	The Oolong Aboriginal Corporation
Centacare - Wagga	Mission Australia - Triple Care Farm	The Salvation Army
Central Coast Disability Network	Mountains Community Resource Network	The Station Ltd
Central Queensland Medicare Local	Murrumbidgee Medicare Local	The Wayside Chapel
Central Queensland Medicare Local	NALAG Centre for Loss & Grief Dubbo	Transcultural Mental Health Centre
Cessnock Community Healthcare	Neami National	Uniting Care - Institute of Family Practice
CHESS Head Office (Coffs Harbour Employment Support Service)	New Horizons	Uniting Care Mental Health
Club Speranza	Newtown Neighbourhood Centre	UnitingCare - Children Young People and Families
CO AS IT	NSW Consumer Advisory Group (CAG)	Wagga Women's Health Centre
Community Care Northern Beaches	Oakdene House Foundation	WAYS Youth Services
Community Links Wollondilly	Official Visitors Program NSW Ministry of Health	Weave Youth and Community Services Inc.
Community Options Illawarra Inc. - Wollongong	On Track Community Programs	Wesley Mission
Counsellors & Psychotherapists Assn NSW Inc. (CAPA)	One Step at a Time Counselling	Wesley Mission - Mental Health Support Services
CRANES Community and Support Programs	ONE80TC	Western Sydney Medicare Local (Wentwest)
Education Centre Against Violence (ECAV)	Open Minds	WHOS (We Help Ourselves)
Exodus Foundation	Peer Support Foundation Limited	Wollongong West Street Centre
Family Drug Support	Pegasus Care	

In 2013, MHCC marked 30 years supporting the NSW community managed mental health sector.

1. Fay Jackson, Lorna Downes and Tully Rosen.
2. The party gets underway at Slide Bar on November 12th 2013.
3. Judi Higgin and Jenna Bateman with the lollipop cake.
4. Tony Humphrey. 5. Edi Condack and John Malone. 6. Rob Stirling, Susan Gamola and Deb Tipper. 7. Mardi Diles and Janelle Ghazi.
8. Arthur Papakotsias and Emma McTaggart. 9. The 2013 Board sing a rousing rendition of 'Happy Birthday' to MHCC - Leone Crayden, Cathy Kezelman, Deborah Banks, Sue Sacker, Pam Rutledge, Karen Burns, Peri O'Shea and Judi Higgin. 10. Lynda Hennessey and Peri O'Shea. 11. Simone Montgomery, Erika Hewitt and Chris Keyes.
12. Lucy Corrigan, Tina Smith, Corinne Henderson and Debbie Greene. 13. Carrie Stone and Lenny Pelling. 14. Chris Kam, Nicole Cother, Stephanie Maraz, Colleen Mosch, Lucy Corrigan, Jacqui Moreno-Ovidi and Rainbow Yuen.

2013-2014 FINANCIALS

O'Neill & O'Brien Pty Limited

Accountants and Auditors

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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 2014

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 2014, 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 2014 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 22nd **day of** October **2014.**

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

To the Directors of MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED

I declare that, to the best of my knowledge and belief, in relation to the audit of MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED for the year ended 30 June 2014 there have been;

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

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

.....

Bruce Lawrence

Dated this 22nd **day of** October **2014**

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
ABN: 59 279 168 647
Statement by Members of The Board
For the Year Ended 30 June 2014

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 2014 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 26th day of September 2014

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
Statement of Comprehensive Income
For the Year ended 30 June 2014

	Note	2014 $	2013 $
Revenue	2	3,513,730	3,812,727
Finance Costs	4	959	927
Employee Benefits Expense	3	1,992,097	2,009,442
Depreciation and Amortisation	3	26,903	29,864
Other Expenses	3	1,603,672	1,876,267
Profit (Loss)	5	(109,901)	(103,776)
Total Comprehensive Income		(109,901)	(103,776)

The accompanying notes form part of these financial statements.

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
Statement of Financial Position
As at 30 June 2014

	Note	2014 $	2013 $
Current Assets			
Cash and Cash Equivalents	6	3,378,664	3,592,532
Trade and Other Receivables	8	880,106	535,262
Total Current Assets		4,258,770	4,127,794
Non-Current Assets			
Property, Plant and Equipment	9	119,132	115,673
Total Non-Current Assets		119,132	115,673
Total Assets		4,377,902	4,243,467
Current Liabilities			
Trade and Other Payables	10	128,287	236,967
Short-Term Financial Liabilities	11	115,655	58,125
Provisions	12	549,043	561,391
Other	13	1,274,016	966,182
Total Current Liabilities		2,067,001	1,822,665
Total Liabilities		2,067,001	1,822,665
Net Assets		2,310,901	2,420,802
Equity			
Retained Profits	14	2,310,901	2,420,802
Total Equity		2,310,901	2,420,802

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 2014

	2014 $	2013 $
Opening Balance	2,420,802	2,524,578
Retained Earnings		
Profit Attributable to Shareholders	(109,901)	(103,776)
	(109,901)	(103,776)
Closing Balance	2,310,901	2,420,802
Reconciliation of Retained Earnings		
Opening Balance	2,420,802	2,524,578
Profit Attributable to Shareholders	(109,901)	(103,776)
Closing Balance	2,310,901	2,420,802
Total Equity	2,310,901	2,420,802

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 2014

	Note	2014 $	2013 $
CASH FLOWS FROM OPERATING ACTIVITIES			
LDU - Course Payment (inclusive of GST)		2,097,079	2,176,000
Seminar Revenue (inclusive of GST)		31,420	20,947
Receipts from Members (inclusive of GST)		64,716	54,272
Government & Other Grants Received(inclusive of GST)		1,409,560	1,679,780
Consultancy & co-ord fee (inclusive of GST)		94,474	95,953
Payments to Suppliers & Employees (inclusive of GST)		-4,031,490	-4,968,876
Interest Received		99,037	148,838
Other Receipts		51,760	3,023
Net Cash Provided by Operating Activities		**-183,444**	**-790,063**
CASH FLOW FROM INVESTING ACTIVITIES			
Payments for Property, Plant & Equipment		42,724	12,250
Proceeds from Sale of Property, Plant & Equipment		-12,300	
Net Cash Used in Investing Activities		**30,424**	**12,250**
CASH FLOW FROM FINANCING ACTIVITIES			
Net Cash Used in Financing Activities			
Net Increase (Decrease) in Cash Held		-213,868	-802,313
Cash at the Beginning of the Financial Year		3,592,532	4,394,845
Cash at the End of the Financial Year		**3,378,664**	**3,592,532**

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
Notes to the Financial Statements
For the Year ended 30 June 2014

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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 loss 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 goods 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.

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

(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 and management fees from 2012 to 2014 amount to $142,262.50. 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 2014

	2014 $	2013 $
2. Revenue		
Government & Other Grants	1,281,418	1,527,074
	1,281,418	1,527,074
Other Income		
Interest Received	99,037	148,838
LDU Course Payments	1,906,436	1,978,182
Membership Subscriptions	58,833	49,338
Co-ord Fee	40,000	24,545
Seminars and Sundry Income	33,204	22,066
Consultancy Income	45,886	62,684
Sale of Training Packages & Publications	47,120	
Net Loss on sale Non Current Assets	(61)	
	2,230,455	2,285,653
	3,511,873	3,812,727
3. Expenses		
Employee Benefits Expense	1,976,597	2,023,067
Depreciation and Amortisation Expenses	26,903	29,864
Advertising	10,181	14,415
Bank Charges	917	737
Insurance	25,446	28143
Library	1,726	728
Postage	10,314	14,403
Printing & Stationery	65,938	93,407
Repairs & Maintenance	5,168	7,339
Telephone	21,322	19,223
Other Expenses	1,476,303	1,684,250
	3,620,815	3,915,576
4. Finance Costs		
Bank Card Charges	959	927
	959	927
5. (Loss)Profit for the Year	**(109,901)**	**(103,776)**
Profit from continuing operations includes the following specific expenses:		
Charging as Expense		
Finance Costs	959	927

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 2014

	2014 $	2013 $
Movements in Provisions		
Depreciation		
- Depreciation of Property, Plant and Equipment	29,603	29,864
Net Expenses Resulting from Movement in Provisions	29,603	29,864
Bad & Doubtful Debts:-		
- Bad debts written off	463	327
	463	327
Remuneration of the Auditor:-		
- Audit & review of financial reports	6,460	6,500
	6,460	6,500
Crediting as Income:		
Interest from :		
- Other Corporations	99,037	148,838
Total Interest Revenue	99,037	148,838

6. Cash and Cash Equivalents

Deposits	2,670	4,050
Cash Management Account	112,082	48,536
Cash on Hand	300	300
Security Deposit	700	200
Business Day Term Deposit	3,262,912	3,539,446
	3,378,664	3,592,532
Cash Reconciliation		
Cash and Cash Equivalents	3,378,664	3,592,532
	3,378,664	3,592,532

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 2014

	2014 $	2013 $
7. Cash Flow Information		
Reconciliation of Cash Flow from Operations with Profit after Income Tax		
Profit (Loss)	(109,901)	(103,776)
Adjustments for Non-Cash Components in Profit:		
Depreciation	26,903	29,864
Net Loss on Disposal Property, Plant & Equipment	61	
Changes in Assets and Liabilities		
Increase in Trade and Other Receivables	(344,843)	(336,675)
Increase in Trade and Other Payables	256,684	(391,754)
Decrease in Provisions	(12,348)	12,278
Net Cash Provided by Operating Activities	(183,444)	(790,063)
8. Trade and Other Receivables		
Current		
Trade Debtors	866,480	535,262
Prepayments	13,626	0
Total Trade and Other Receivables	880,106	535,262
9. Property, Plant and Equipment		
Plant and Equipment		
Plant & Equipment	188,173	188,173
Less Accumulated Depreciation	134,838	125,269
	53,335	62,904
Motor Vehicles	54,127	72,173
Less Accumulated Depreciation	22,712	37,960
	31,415	34,213
Computer Equipment	106,443	80,125
Less Accumulated Depreciation	72,061	61,569
	34,382	18,556
Total Plant and Equipment	119,132	115,673

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 2014

	2014 $	2013 $
10. Trade and Other Payables		
Current		
PAYG Withholding Tax Payable	19,893	24,130
Trade Creditors	108,394	212,837
Total Trade and Other Payables	128,287	236,967
11. Financial Liabilities		
Current		
GST Creditor	115,655	58,125
	115,655	58,125
Total Financial Liabilities	115,655	58,125
12. Provisions		
Current		
Provision for Holiday Pay	151,645	134,460
Provision for Long Service Leave	24,716	54,249
Provision for Training Venue	372,682	372,682
	549,043	591,391
Total Provisions	549,043	561,391

An amount of $372,682 has been set aside for the renting and fitting out premises for a social enterprise conference and training centre.

13. Other		
Current		
Accrued Charges	80,950	0
Deferred Income	823,227	870,984
Income in Advance	369,839	95,198
	1,274,016	966,182
14. Retained Earnings		
Retained Earnings at the Beginning of the Financial Year	2,420,802	2,524,578
Less		
Net Loss attributable to members of the company	109,901	103,776
Retained Earnings at the End of the Financial Year	2,310,901	2,420,802

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 2014

	2014 $	2013 $
15. **Auditors Remuneration**		
BRUCE LAWRENCE was the auditor of MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED		
- Audit & review of financial reports	6,460	6,500
	6,460	6,500

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 2014

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 1/7/13	34,213	62,904	18,556	115,673
Additions	16,406		26,318	42,724
Disposals and Loss on Disposal	12,361			12,361
Depreciation Expense (Note 3)	6,843	9,569	10,492	26,904
Carrying Amount at 30/6/14	**31,415**	**53,335**	**34,382**	**119,132**

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 2014

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.

MENTAL HEALTH CO-ORDINATING COUNCIL INCORPORATED
ABN: 59 279 168 647
Notes to the Financial Statements
For the Year Ended 30th June 2014

(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 2014 $	Non Interest Bearing 2014 $	Total 2014 $
Financial Assets			
Cash	3,378,664		3,378,664
Receivables		880,106	880,106
	3,378,664	880,106	4,258,770
Financial Liabilities			
Trade and Other Payables		243,942	243,942
Deferred Income		1,274,016	1,274,016
	0	1,517,958	1,517,958
Net Financial Assets/ Liabilities	3,378,664	-637,852	2,740,812

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 2014

NOTE 19: FINANCIAL INSTRUMENTS (cont'd)

	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 Liaiblities			
Trade and Other Creditors		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

Reconciliation of Net Financial Assets to Net Assets

	2014 $	2013 $
Net Financial Assets as above	2,740,812	2,866,520
Property, Plant & Equipment	119,132	115,673
Provisions	-549,043	-561,391
Net Assets as per Statement of Financial Position	2,310,901	2,420,802

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, 2014.

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 2014

NOTE 21: REMUNERATION OF BOARD MEMBERS

	2014 $	2013 $
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:

$	$	2014	2013
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

Resigning Members
Cathy Kezelman
Peri O'Shea
John Malone

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

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 2014

NOTE 23: EMPLOYEE ENTITLEMENTS	2014 $	2013 $
Employee Entitlement Liabilities:		
Provision for Employee Entitlements-Current (Note 12)	176,361	188,709
Aggregate Employee Entitlement Liability	**176,361**	**188,709**

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 2014

	2014 $	2013 $
Revenue		
Government & Other Grants	1,281,418	1,527,074
Membership Subscriptions	58,833	49,338
Seminar	28,564	19,043
Consultancy Income	45,886	62,684
Sundry Income	4,640	3,023
Sale of Training Packages & Publications	47,120	-
Interest Received		
- Other Corporations	99,037	148,838
LDU Course Payments	1,906,436	1,978,182
AC IMH Co ord Fee	40,000	24,545
Profit on Sale of Non-current Assets	1,796	-
Loss on Sale of Non-current Assets	(1,857)	-
	3,511,873	3,812,727
Expenditure		
Accommodation	55,418	48,826
Administration Costs	138,823	192,287
Advertising	10,181	14,415
Accreditation Expenses	12,511	127
Auditor's Remuneration		
- Audit & review of financial reports	6,460	6,500
Bad Debts Written Off	463	327
Bank Charges	917	737
Bank Card Charges	959	927
Catering	61,693	56,256
Cleaning	6,674	5,646
Consultancy Fees	339,021	315,306
Courier Expenses	7,065	10,083
Computer Software	37,418	20,892
Depreciation	26,903	29,864
Equipment Purchases	8,994	4,498
Filing Fees	2,146	680
Fringe Benefits Tax	9,114	9,222
Grants Paid	211,455	219,023
Insurance	25,446	28,143
Internet Expense	46,002	24,807
Library	1,726	728
Motor Vehicle Expenses	12,452	14,579
Postage	10,314	14,403
Printing & Stationery	65,938	93,407
Provision for Annual Leave	17,185	5,643
Provision for Long Service Leave	(29,533)	6,634
Repairs & Maintenance	5,168	7,339
Recruitment Expenses	1,742	8,547
Scholarships	104,746	253,638
Security Costs	405	1,245

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 2014

	2014	2013
	$	$
Sitting Fees	35,347	-
Staff Amenities	5,842	5,846
Subsidies Paid	-	4,815
Subscriptions	17,266	18,527
Sundry Expenses	2,150	2,833
Superannuation Contributions	165,097	163,067
Telephone	21,322	19,223
Trainers	208,163	317,390
Training	11,443	18,910
Travelling Expenses	79,092	50,100
Utilities	5,006	6,376
Venue Hire	45,433	44,534
Wages	1,818,006	1,841,877
Waste Disposal	1,201	1,103
Web Design	8,600	27,173
	3,621,774	3,916,503
Loss before Income Tax	(109,901)	(103,776)

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

Mental Health Coordinating Council

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mhcc
mental health coordinating council