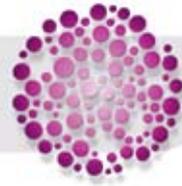


# 2012

## Annual Report

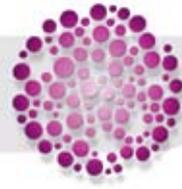




# Contents

|                                  |    |
|----------------------------------|----|
| Contents                         |    |
| 2011/12 at a glance              | 4  |
| Chairman's foreword              | 5  |
| Chief Executive Officer's report | 6  |
| MHPN Interdisciplinary Networks  | 8  |
| Network Activities               | 12 |
| Online Professional Development  | 15 |
| Information on Directors         | 20 |
| Financial Report                 | 23 |





# 2011/12 at a glance

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## Networks

- 449 networks
- 44 percent regional/rural/remote
- 92 special interest networks
- 1,255 network meetings held
- 9,158 network members
- 14,416 network meeting attendances

## Webinars

- 2,373 attendees
- 7,444 registrations
- 14,024 views of webinar recordings

## Website

- 6,398 MHPN Online members
- 25,900 e-newsletter subscribers

## Introduction

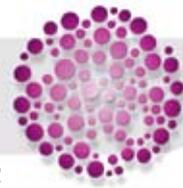
The Mental Health Professionals Network (MHPN) aims to improve consumer outcomes by encouraging collaborative care in Australia's primary mental health sector.

The project involves developing local interdisciplinary mental health networks and online professional development activities aimed at enhancing interdisciplinary practice and collaborative care.

MHPN is a not-for-profit organisation funded by the Australian Government Department of Health and Ageing. MHPN has four member organisations and three partner organisations: Australian Psychological Society, The Royal Australian College of General Practitioners, The Royal Australian and New Zealand College of Psychiatrists, the Australian College of Mental Health Nurses, Australian Association of Social Workers, Occupational Therapy Australia and The Royal Australasian College of Physicians.

We appreciate the support of all our partners.





# Chairman's foreword

**John McGrath AM**  
Chairman



**In our last report, the Department of Health and Ageing (DoHA) was still considering our proposal for funding of a three year extension to the project. I am delighted to say that agreement to the proposal came through shortly after the 2011 annual report went to press.**

DoHA rightly wants to see the best possible outcomes for their support. These include improved mental health for all Australians, a more efficient and informed mental health system, and integration of clinicians into a culture of interdisciplinary practice and collaboration.

The award of the additional three year funding is ample testimony to the validity of our working model. Its thesis is that we can better achieve those boosted mental health outcomes through interdisciplinary collaborative networks rather than through individuals in isolation.

We continue to enjoy a relationship with the Department based on transparency, trust and most importantly, regular communications.

The same can be said of our relationships with our member and partner organisations. The respective colleges and associations that represent our professional clinicians remain committed to the partnership.

Now in our fourth year, time and experience are showing that the clinicians themselves are beginning to feel the benefits of this collaborative networking approach through greater awareness of resources. In both metropolitan and rural, regional and remote settings, communications campaigns have uncovered an eagerness to participate in networking that can diminish isolation and promote mutual development.

Network numbers remain steady, even with consolidations as smaller networks seek sustainable support from larger groups. Encouragingly, our online presence has performed even better than expected, witnessed by the increasing popularity of the

webinar series. In this lies our wider vision—a mental health care framework performing at peak functionality for all its constituents. The vision will continue to be buoyed by excellent people and refined technology.

Consumers of mental health services remain the core of our purpose and focus. Their voices, for so long muted, are now heard in the variety of forums MHPN supports physically and electronically. As more and more Australians listen to their stories through our networks, so the stigma of mental illness will lessen.

I would like to acknowledge our CEO Chris Gibbs for his outstanding leadership, and our senior executive team of Stewart Potten, Bronwyn Morris-Donovan, Tanya Reardon, Trevor Donegan, Nicky Bisogni and Amanda Osciak. I am continually impressed by the executive team as they drive the project forward, resulting in an impressive year.

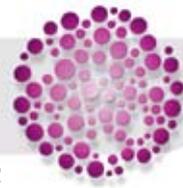
I also extend my thanks to my fellow Board Directors whose individual and collective contributions have guided us and provided discipline-specific perspectives when required. I appreciate their time commitment, energy and participation in debate that has contributed to the success of this project. In addition I thank those Board Members who have accepted additional responsibilities, especially our Company Secretary Kim Ryan for the many responsible tasks she performs on our behalf.

As we progress through Phase 3 we still face significant challenges, if we are to ensure that what we have established to date is sustainable in the long term. With continued commitment from our impressive staff and many other stakeholders, I can see a strong future for MHPN and its role in primary mental health care.

Finally, thank you to Minister Mark Butler for his leadership in Mental Health and in particular his support for, and encouragement of MHPN. We also appreciate the valuable support and assistance from the Officers in the Department of Health and Ageing.

**John McGrath AM**  
Chairman





# Chief Executive Officer's report



## Chris Gibbs

Chief Executive Officer

### **It is with satisfaction that I provide this report on the third full year of operations of MHPN.**

In the relatively short time that MHPN has been active, it has become clear that there is significant interest around Australia in community mental health to meet and share professional development experiences. Participation across all forms of activity—network meetings, website visits and webinars—is energetic and has grown.

MHPN has the primary purpose of promoting interdisciplinary practice and collaborative care and it has done this by supporting local community mental health networks and online professional development through a monthly webinar program.

This year over 9,000 clinicians across mental health disciplines participated in networks. This participation was voluntary and the content and membership of the networks was locally driven. The participation rate supports the premise that knowing your fellow health workers leads to quicker and more informed care for individuals who need assistance.

Central to the ongoing success of a network is the network coordinator, and we acknowledge the efforts of the many coordinators who foster network activity.

In the same year, 20,000 clinicians participated directly or downloaded podcasts for the nine webinars hosted by MHPN. This represents a remarkable contribution to professional development for clinicians working in the area of community mental health care. It is also an acknowledgement of the panellists who have created well-informed and interactive content that is integral to the webinars.

This year has also seen the emergence of three new themes:

## Special Interest Networks

As MHPN matures and consolidates, over 90 of the 450 established networks identify as special interest networks. This tells us that clinicians across the board have not only taken the central principle of interdisciplinary collaboration to heart, but have concentrated them into fields appealing to people from a range of disciplines prepared to learn from each other. The range of special interest networks is extensive including youth mental health, of which there are 17, perinatal mental health, child and adolescent issues, culturally and linguistically diverse (CALD), eating disorders and autism.

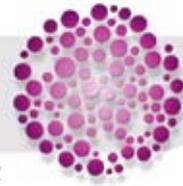
MHPN continues to explore possibilities for expanding the reach of special interest networks into other practice areas such as diabetes and mental health, problem gambling and psycho-oncology. Unsurprisingly, most special interest networks are found in metropolitan locations where the diversity of mental health practitioners is greater than elsewhere. With this in mind, we are excited about using online technology to help these networks expand their reach to rural and remote based clinicians.

## Co-morbidity

It is increasingly apparent that good health is often compromised when another condition is shadowed by the primary diagnosis. This can be the case where the focus is on a physical illness and underlying mental illness is not addressed, or vice versa. The end result has a significant impact on recovery.

We have seen a rise in the number of special interest groups with a focus on co-morbidity and the popularity of webinars that are devoted to one of these issues. In every way these developments reflect our purpose. Encouraging and facilitating interdisciplinary collaboration, peer support and cross referrals is the core theme for MHPN and we can be confident that as our base of networks matures, this will feature a number of networks focused on co-morbidities. This is a positive development.





## Virtual technology

The use of online technology has not been limited to webinars. In the last year there have been experiences in working with online options to enable remote clinicians to participate in network meetings. Together with video conferencing, we expect this to grow.

We are pleased to report that a number of networks have taken the opportunity to introduce a consumer and/or carer perspective to network meetings and the webinar program has achieved similar outcomes through direct participation on panels.

MHPN has been funded to June 2014 and will aim to consolidate the activities that it has undertaken and continue to find ways to support interdisciplinary practice in the community.

## Partnerships

I would like to acknowledge the ongoing support of our partner organisations, the Australian Psychological Society (APS), the Royal Australian & New Zealand College of Psychiatrists (RANZCP), the Royal Australian College of General Practitioners (RACGP), the Australian College of Mental Health Nurses (ACMHN), the Australian Association of Social Workers (AASW), Occupational Therapy Australia (OT Australia), the Australian College of Rural and Remote Medicine (ACRRM) and stakeholders including beyondblue, headspace and Children of Parents with a Mental Illness (COPMI).

## Note of Appreciation

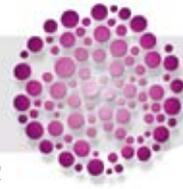
I couldn't report this progress without the vision of our Chairman, John McGrath AM, and the support and expertise of the Board, whom I gratefully thank.

Similar praise is due to MHPN staff who have worked expertly and with great enthusiasm.

### **Chris Gibbs**

Chief Executive Officer





# MHPN Interdisciplinary Networks

**The Mental Health Professionals Network (MHPN) aims to improve interdisciplinary collaboration between professionals working in the primary mental health sector by fostering local networks across Australia.**

The networks support GPs, psychiatrists and allied mental health clinicians to expand their referral networks, broaden knowledge of local services and providers, deepen their professional development, and thereby improve consumer outcomes.

At June 30 2012, MHPN had 449 networks located in metropolitan, regional, rural, and remote locations nation-wide. Of that number, 44 percent are located in non-metro settings. As well, MHPN was active in forming online virtual networks and Special Interest Networks which focus on a particular aspect of mental health. To June 30, there had been 92 special interest networks established.

Network attendance figures continued to climb. Interest in joining existing networks or establishing new ones was steady.

An important initiative in June this year was the introduction of member directories, giving network members regularly updated contact details of local clinicians.

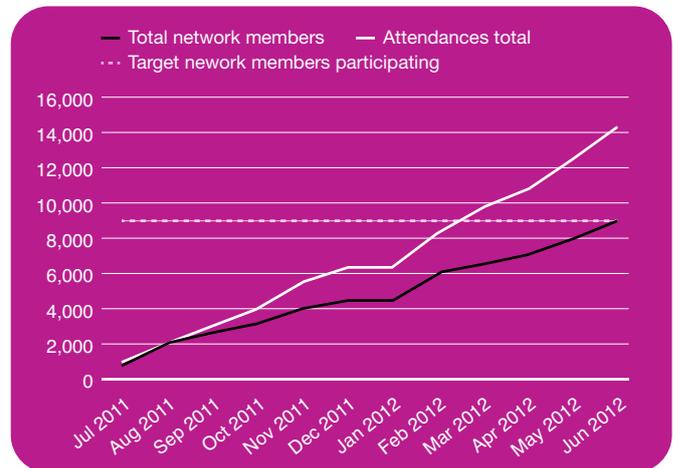
## Network participation

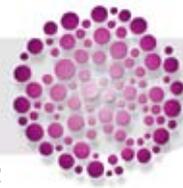
**Participation in MHPN networks has been on an upward trend this year.**

Networks registered 14,416 clinician attendances at 1,255 meetings. There were a total of 9,158 individual members who attended network meetings during the year.

Understandably, the timing and frequency of network meetings was affected by school and public holidays. The busiest months were February and May respectively when 1,797 and 1,647 attendances were recorded. July 2011 and January 2012 were the quietest periods.

## Network participation financial year 2011/12





## Networks Consolidation

### **This year saw the consolidation of many networks and the emergence of special interest networks.**

The past year has witnessed a period of consolidation and a strong push to identify opportunities to establish new networks. In many cases the locations of networks have recalibrated to reflect the profile of clinicians in particular areas and their practice interests. The following provides a snapshot of activity for the last year and some of the key achievements.

The number of networks was 449 at June 30, 2012. Forty four percent of networks were located in regional, rural or remote Australian Standard Geographical Classification–Remoteness Areas system (ASGC–RA) 2-5. This was well ahead of the project target of 35 percent.

MHPN achieved an improvement in the ratio of returned network attendance data. At the end of June it stood at 96 percent, well beyond the target of 85 percent. These numbers were achieved as a result of system improvements and database capability which has streamlined the distribution of attendance lists and the linking of certificates of attendance to the return of data.

The project added 85 new networks to our total.

#### **New Member Campaign**

A Network Member Registration form was developed to assist with the recruitment of new members to existing networks and to identify opportunities for new networks and coordinators. The member registration form was linked to a Survey Monkey questionnaire that provided clinicians the opportunity to nominate networks in their local area they wish to join or to express an interest in launching a new network.

The survey takes approximately five minutes to complete and has been effective on all fronts.

#### **Network Profiles**

Network profiles were developed and linked to the network meeting calendar on the website. Combined with the new member registration form, this gave clinicians access to more information about the networks operating locally. In addition, a new registration system enabled clinicians to register online for upcoming network meetings.

#### **Network Members Directory**

MHPN introduced an additional incentive for clinicians to join MHPN networks. Network member directories were introduced for every network. The privacy-protected, local member directories list all members of a current network, and are distributed to members of the local MHPN network only.

Their purpose is to share members' contact details to foster referrals and collaboration within the local network. The directories are also useful tools for coordinators to communicate directly with the members of their network.

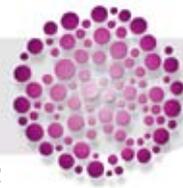
The directories are secure and updated on a regular basis. The biggest difference between these and other clinical resource directories is that they contain local, real-time information that is refreshed after every meeting.

#### **Virtual Networks**

MHPN has made notable progress in establishing community mental health networks that are relevant to local mental health service providers.

In the last year, interest in the employment of technology to link clinicians has advanced. Where clinicians cannot attend meetings in person, we support networks with webconferencing technology to link in people remotely via computer. Options include network to network, individual to network, and guest speaker to network online communication. In this way, we aim to bring together people regardless of geographical setting.





## Special Interest Networks

### As MHPN has matured and consolidated, 92 of the 449 established networks identify as special interest networks.

This tells us that clinicians across the board have not only taken the central principle of interdisciplinary collaboration to heart, but have concentrated them into fields appealing to people from a range of disciplines prepared to learn from each other.

The range of special interest (SI) networks is extensive including youth mental health, perinatal mental health, child and adolescent issues, culturally and linguistically diverse (CALD), eating disorders and autism.

With co-morbidity high on the agenda, the reach of special interest networks has expanded into other practice areas such as diabetes and mental health, and psycho-oncology.

SI networks have considerable appeal to clinicians practicing in more specialised domains as they provide unique opportunities for collaborative interaction between clinicians and community stakeholders working in primary mental health.

Perhaps not surprisingly most SI networks are located in metropolitan and outer metro areas of capital cities where there is likely to be greater diversity of professional mix and clinicians practising in more specialised domains. To date there are only five SI groups in RA3— three in New South Wales and two in Queensland; and none in RAs 4 and 5. This is to be expected given the availability of certain professions and distribution of the workforce in regional, rural and remote areas.

In many cases practice is generalist in nature and the emphasis is about providing a service to a population with a broad range of needs. In acknowledgement of these differences in practice and service delivery, the MHPN webinar series has been a key way of promoting special interest topics in rural and remote areas.

With this in mind, we are excited about using online technology to help these networks expand their reach to rural and remote based clinicians.

### Special interest networks

The most popular special interest groups include youth, peer support/Balint, perinatal, child and adolescent, culturally and linguistically diverse, and eating disorders.

There are similar features between SI networks and those with a generic mental health focus that determine whether they are likely to succeed. Anecdotal feedback strongly suggests that consistent leadership and participation of a core group of clinicians are the foundations for networks to maintain momentum and remain active.

MHPN expanded the reach of some SI networks in areas using webinar technology to provide collaborative networking opportunities for rural and remote mental health clinicians. MHPN played a critical role coordinating and organising these groups and promoting opportunities for clinicians to become involved and shape the direction and development of ideas. Furthermore it has provided the vehicle and opportunities for clinicians to build links that encourage collaborative interaction and discussion around a range of co-morbidities between chronic disease and mental health.

## Co-morbid mental health and chronic disease

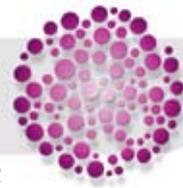
### The focus on co-morbidity has become more pronounced in the last six months.

Co-morbidity is the occurrence of more than one condition at the same time, and is common among those with mental illness. Many people with chronic physical health conditions have mental health issues, and the coexistence of mental and physical conditions can lead to reduced quality of life. Better integration of mental health support with primary care services and chronic disease management programs is essential to improving consumer care.

New networks have recently emerged with a co-morbid focus, usually as a result of a local link with a peak body representing the physical health aspects. Diabetes, drug and alcohol, and psycho-oncology attracted significant interest.

MHPN has utilised the webinar platform to explore co-morbid topics in an interdisciplinary format. Two webinars were held around co-morbidity: substance abuse and mental health presentations, and mental health and diabetes, both drawing on expertise from the physical and mental health fields. MHPN plans to expand this range of topics in the future.





## Network Membership

### Membership to MHPN networks is voluntary.

Members can attend as many or few meetings as they wish, can swap networks or opt out without any penalty. This provides challenges to networks and MHPN project officers in maintaining the sustainability of networks. Where meetings are cancelled due to low numbers, the network can be put at risk if members do not meet for long periods of time. MHPN works closely with coordinators to create and adhere to a schedule of meetings. We assist with administrative tasks such as sending invitations, booking venues and catering, and collating RSVPs. Other tasks may include arranging guest speakers, marketing the network to other clinician groups, and helping to define the network's meeting agenda.

Networks aim to include general practitioners, psychiatrists, psychologists, mental health nurses, occupational therapists, and social workers. Other allied primary mental healthcare practitioners, Indigenous health workers and relevant community workers are encouraged to join where their inclusion will enhance consumer outcomes.

Overall the core professions were well represented at network meetings during the past 12 months. Psychologists head the list of professionals who are members of MHPN (35 percent), followed by social workers (nine percent), GPs (eight percent), and mental health nurses (seven percent).

Additionally, 36 percent of network meetings included a mix of three or more disciplines providing primary mental health care services under the Medicare Benefits Schedule.

#### Network coordination

Network Coordinators remain essential to network sustainability.

Each network is voluntarily coordinated by a member of the network. Coordinators are integral to the success and longevity of networks. They play a key role in supporting interdisciplinary collaboration and meaningful networking opportunities for members. Throughout the last 12 months the top three professions performing the role have remained consistent. These are: psychologists, mental health nurses and social workers.

At June 30 2012, there were 500 people undertaking the coordination role for 449 networks. Some networks have decided to share coordination responsibility. This is resolved at a local level and has enabled some networks to achieve stability and reduce turnover.

Of the Other component in the table in column two above, a large number were mental health program managers and coordinators, headspace managers and administrators, counsellors and students.

| Coordinator profession | Totals     | %          |
|------------------------|------------|------------|
| Psychologist           | 206        | 41         |
| Other                  | 101        | 20         |
| Social worker          | 57         | 11         |
| Psychiatrist           | 18         | 4          |
| Mental health nurse    | 65         | 13         |
| General practitioner   | 41         | 8          |
| Occupational therapist | 11         | 2          |
| Paediatrician          | 1          | 1          |
| <b>Grand total</b>     | <b>500</b> | <b>100</b> |

#### GP Engagement

The involvement of general practitioners is the cornerstone of fostering interdisciplinary practice and their participation in MHPN is well regarded by network members.

This year, 44 percent of network meetings registered attendance by one or more GPs.

A number of strategies were implemented or maintained to increase GP engagement. GPs featured in all MHPN webinars and also had the role of facilitation. Communications to GPs remained a focus and were strengthened by the support of the RACGP communications and membership departments.

#### Psychiatrist Initiative

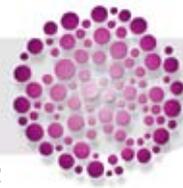
In February 2011, MHPN introduced an initiative to increase the participation rate of psychiatrists in networks. This was developed on the basis that psychiatrists have consistently been identified as a drawcard for clinicians and in particular, engagement with GPs. The Psychiatrist Initiative offers networks an opportunity to access a psychiatrist as a guest speaker at a network meeting.

In 2011/12, 166 psychiatrists attended meetings as expert guest speakers. Of these 126 claimed remuneration and 40 presented for free. In a few cases, psychiatrists joined networks as regular members after their initial engagement as a guest speaker.

The initiative has continued to present useful opportunities to networks to access input from psychiatrists. In an expansion of the concept, online technology has also been utilised to link psychiatrists into remote and regional networks.

On other fronts, MHPN has continued to encourage participation by psychiatrists in networks. Eighteen networks are coordinated by psychiatrists, predominantly in metropolitan and larger regional centres. The greatest number of psychiatrists participating in network meetings has occurred in Victoria. The Royal Australian and New Zealand College of Psychiatrists maintained support of the initiative.





# Network Activities

## Cancer psychiatrist urges closer GP links

**Encouraging psychiatrists and psychologists to form closer links with cancer patients' GPs will go a long way to addressing cancer's impact on mental health, says Dr Jeremy Couper, Head of Psychiatry at Melbourne's renowned Peter MacCallum Cancer Centre ('Peter Mac').**

Dr Couper has worked in psycho-oncology at Peter Mac for six years. He heads a team of psychiatrists who work in research and cooperate with a corresponding group of psychologists in clinical mental health delivery.

### **Psycho-oncology group an Australian first**

His exposure to MHPN came about through colleague and fellow researcher, Professor Sidney Bloch, retired Professor Emeritus of Psychiatry at the University of Melbourne. The subsequent formation of an interdisciplinary Mental Health Professionals Network with a special interest in psycho-oncology is a first for Australia.

The network's first meeting in Melbourne in June, which Dr Couper addressed, attracted more than 60 GPs, psychologists, psychiatrists, nurses, counsellors, occupational therapists, social workers and dieticians. It also had support from other cancer-related organisations including Cancer Council Victoria, Cabrini Hospital and Western Health.

For such an invasive and fearful condition, Dr Couper said the awareness of and action on the connection between cancer and mental illness had been slower than with other life-threatening diseases.

## **New cancer centre accelerates interest in mental health**

However, the construction of the Victorian Comprehensive Cancer Centre (VCCC) had accelerated interest. Clinicians were paying greater attention to the need for research into, and therapies for, mental health disorders accompanying the diagnosis and treatment of cancer.

The VCCC is a \$1 billion world class facility bringing together Peter Mac and seven other Australian institutes at the forefront of cancer research.

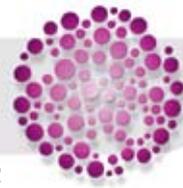
Breast cancer has been in the vanguard of attention for its physical and mental impact on women for more than a decade. Interest in the mental effects of prostate cancer on men was now growing too, he said.

New areas in cancer care that require attention to mental health issues include Peter Mac's Familial Cancer Centre (FCC) which takes an early intervention approach to cancer diagnosis. The FCC works with potentially at-risk relatives of cancer patients who are encouraged to come forward for genetic testing for cancer susceptibility and, if necessary, prophylactic treatment.

Like organ transplant technology 20 years ago, the prophylactic approach to cancer treatment has led to novel psychological challenges for a new group of patients that didn't exist before, he said.

The bulk of the psychiatric and psychological unit's work centred on helping people cope with the diagnosis, investigation, treatment planning and management of their cancer and its aftermath. On top of psychological components of therapeutic management, palliative care issues for patients facing a poor prognosis could introduce a need for psychiatric help.





### GPs better informed than specialists

Most people undergoing cancer treatment did so through their local GP. Often the GP would have been one of the few clinicians to have known the patient prior to the discovery of the cancer, and might well have been involved in the diagnosis.

Dr Couper said that GPs were probably better informed about the patients' mental health than the specialist oncologists in cancer centres. With long waiting lists and the urgency surrounding the specifics of the cancer itself, patients tended not to share their psychological or psychiatric issues with their cancer specialist, preferring to reserve them for their GP.

After the inaugural MHPN meeting Dr Couper said he would like to see a greater collaboration between psychologists and GPs who refer to one another.

'The MHPN format was successful and had the potential to generate more groups. They needed a community focus and a closer liaison between psychiatrists, psychologists and GPs involved in cancer treatment', he said.

### A psychiatrist, a teacher and a student walk into a room

It may sound like the beginning of a joke, but it is the way many of the former Coffs Harbour Youth Suicide Prevention Committee, now Youth Mental Health and Wellbeing Network, meetings start.

Under the banner of the Youth Mental Health and Wellbeing Network and that of the Mental Health Professionals Network (MHPN), a diverse range of clinicians and mental health professionals from the local community meet with a common goal—to promote resilience, mental health literacy, early recognition and help-seeking for youth mental health issues.

In Coffs Harbour, MHPN has become a vehicle for community development in mental health. The Youth Mental Health and Wellbeing Network, powered by commitment and passion on a local level, set out to engage the community.

'Raising public awareness of mental health literacy is helping us to dismantle the barriers blocking young people from accessing the support they need, often when they need it the most,' says Jesse Taylor, Manager Mid North Coast headspace, Coffs Harbour.

In November 2011 the committee organised the **Opening Minds for a Better Future** forum. Through headspace Mid North Coast, the network was able to engage psychiatrist Professor Pat McGorry AO, a champion of preventative and youth mental health reform, as a keynote speaker.

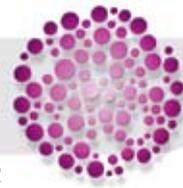
A presentation by Professor McGorry is an achievement for any forum. For a regional area such as Coffs Harbour it was a great opportunity for clinicians to meet a man who has fundamentally shifted the way youth mental health is perceived in Australia. In turn Professor McGorry saw a great opportunity to engage with a community that was fundamentally shifting how youth mental health was seen in their region. He has now become one of the many committed individuals who are members of the Youth Mental Health and Wellbeing Network.

A region such as Coffs displays the impact that collaborative practice can have. Through local commitment and national support from MHPN, the momentum of this committee has spread and there are now multiple networks in Coffs Harbour working towards better mental health.

As Jesse says 'MHPN gave us the help we needed to get moving... hosting three large youth suicide awareness community events (last year) ...

'Being accountable to the people we serve is a massive responsibility; for service providers to offer a comprehensive and appropriate service framework that empowers our clients to gain their self-sufficiency, we need to work together. MHPN is a supportive vehicle for this meaningful engagement.'





## Primary care network delivers triad treatments

Tamworth Eating Disorders Special Interest Group (SIG) is one of the Mental Health Professionals Network's most active. It's probably no surprise that its record in treating eating disorders is ahead of the national averages.

Never wavering from its focus, the group's roots go back 17 years to a collaboration between a Tamworth Hospital dietician, Deanne Harris, and local GP, Dr Miriam Grotowski. They recognised the growing influence of, and mortality behind eating disorders and set up an alliance. Both women are still active in the field and in the MHPN network.

Tamworth Hospital ran a program three years ago called Nourishing Networks. It aimed at providing information and education for health professionals confronted by eating disorders. A second aim—promoting the intentions of the MHPN special interest group—was to help those same health professionals interact for expanded knowledge and referrals.

As a result of the initiative, a partnership formed with the Butterfly Foundation. The foundation recently asked the Tamworth group to take part in its pilot eating disorder survey in regional areas.

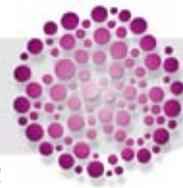
The network includes as members school counsellors, GPs, social workers, psychologists, mental health nurses and dieticians and occasional visits from paediatricians and psychiatrists. It is aligned to the Tamworth Eating Disorder Awareness committee which raises funds for information packages. The packs are for GPs to distribute to people newly diagnosed with eating disorders and their families and carers.

### Triad treatment

The network's main measure of success is delivering 'triad' treatment to patients. The triad system combines care from a psychologist, dietician and GP and is viewed as the most effective course of therapy. All Tamworth's patients—an average of about 20 a year, exclusively female and in the age range of 10 to 50—receive triad treatment.

Coordinator, Sally Moy, says treatment in Tamworth is effective because of the experience and collaborative approach of the clinicians. As a result recovery from eating disorders is above the national average and deaths are well below.





# Online Professional Development

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## MHPN provides a range of online learning and networking opportunities for people working in primary mental health care.

*'I was impressed with the willingness to take a collaborative/multidisciplinary approach by the three presenters. It's important that as practitioners we value what each profession can bring to the care of the patient.'* Webinar participant

### Webinars

MHPN hosts a series of regular, free webinars. The webinars feature facilitated panels of respected mental health clinical experts and consumers and their advocates. They tackle case studies in an interactive forum that encourages audience participation. The objective of the webinars is to demonstrate and encourage a collaborative approach to the assessment, diagnosis, treatment and support of patients with mental health issues. Topics are often selected based on the presentations that emerge from GP practice.

Clinicians across Australia have participated and demand has exceeded places available. In the last financial year MHPN hosted nine webinars resulting in 2,373 attendees and 14,024 podcast hits. With such positive endorsement by the clinical community, MHPN ensures it exploits the latest online technology to extend and refine the webinars' reach to wider audiences. The MHPN platform has a capacity for 250 participants and most webinars worked to maximum capacity.

### Discipline representation

Webinars have drawn on general practitioners, nurses, allied mental health clinicians, and consumer representatives as presenters. Psychiatrists were represented in all but one webinar, and while the spread was even across other disciplines, a priority is to increase the range of speakers. All webinars were facilitated by Dr Michael Murray, a GP and medical educator from Townsville.

### Podcasts

MHPN webinar recordings are available to clinicians on the MHPN website for download at anytime in video or audio format, and can be streamed from the website. Over 14,000 views of webinar recordings occurred during 2011/12.

### Future of the webinars program

The webinar program continues to be an important aspect of the MHPN project. A further 10 webinars are scheduled in 2012/13, and interest from other organisations in partnering on webinar delivery promises to unfold.

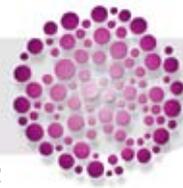
### Testimonial quotes from webinar participants

*'Presentation informative, comprehensive and realistic. Openness of presenters and their professionalism and sharing of experience greatly appreciated.'*

*'An excellent presentation both because of the quality and breadth of input, and also because of its accessibility.'*

*'I hope this clinical education model will continue long into the future. It is especially helpful for sole practitioners working in a high level of isolation.'*





## Online education reduces isolation, lifts clinical learning

*'As the Mental Health Professionals Network's main webinar facilitator, Dr Michael Murray knows as well as anyone the power of integrated communication. And as a career-long regional and rural doctor, he is profoundly aware of the isolation and restrictions to learning that GPs in the far corners of Australia endure.'*

### By Dr Michael Murray

Contrary to expectations, direct feedback from webinar exit surveys reveals that many city clinicians, like their bush counterparts, also feel isolated from specialist expertise.

For some, the isolation comes through the pressure of busy practices, or through a lack of awareness of expert forums which could be made available.

Since MHPN launched its webinar program in December 2010, I have led 12 of the 15 online events staged so far. Although I had no experience of facilitation at the beginning of the series, I was keen to get involved.

I see online teaching and interaction as the way of the future for specialised learning, and not only for rural and remote practitioners.

## Webinars more intimate than traditional methods

Compared to traditional face-to-face teaching, I see online information sharing as more intimate than listening to a presentation in a traditional lecture theatre or hotel conference room. Styles of learning are changing and people accept that online education is just as important and relevant as traditional methods.

For regional, rural and remote clinicians, no longer having to travel for hours or days to attend a conference, of which only a part might be relevant, is now a reality. It is beginning to emerge that people are gaining a great deal more than they would have.

They can look forward to monthly (or more frequent) webinars of great relevance as opposed to an annual event over a day or two that may not cover anywhere near the same ground.

## Proof in numbers

The proof is in the number of applicants wishing to participate. MHPN webinars frequently attract many hundreds, with the most recent generating more than 1,200 registrations. The number consistently grows with successive webinars.

The most important ingredient to a successful event is the quality of the platform, or the technology and the skills behind it. A good platform can disguise minor faults, but a bad platform will impede the webinar from getting off the ground. Of great importance too is the quality of the facilitator and the presenters.

Where these components are abundant, participants enjoy a successful and informative event. In the case of the MHPN webinars to date, the quality of presenters has been uniformly excellent.

What makes MHPN webinars different? For a start, the expert panel is drawn from different mental health disciplines, rather than one only. That attracts an interdisciplinary audience. This, and the case study approach encourages interaction between the panellists and audience, which in turn promotes collaboration.

I envision the future of mental health education as aligning with television technology, but in an even more sophisticated way than today.

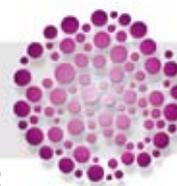
## Incentives for collaboration

Choice of subject, depth of content, frequency of presentation, and simplicity of technology will all continue to improve. As they do, so the incentives for collaboration will build as clinicians further grasp the value of sharing.

As a doctor in general practice myself, I acknowledge that GPs can be difficult to engage, especially in educational and CPD applications. I recommend professional colleges and associations offer more of the 'carrot' of earning CPD points with less of the 'stick' of unnecessary or complicated administrative processes.

In this way, online learning, webinars and virtual networks will have an even brighter future.

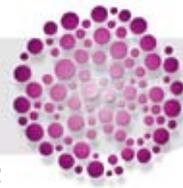




## MHPN Webinar Series 2011/12

| Topic   |  | Registrations | Participants | Podcast downloads |
|---|--|---------------|--------------|-------------------|
| <b>Psychosis</b><br>Tues 5 July 2011<br>6.30pm  | Dr John Farhall, clinical psychologist<br>Prof. Alan Rosen, psychiatrist<br>Alan Hainsworth, mental health nurse<br>Facilitator: Dr Michael Murray, GP and medical educator  | 783           | 233          | 1738              |
| <b>Complex trauma</b><br>Tues 20 Sept 2011<br>7.15pm  | Dr Cathy Kezelman, consumer advocate<br>Ursula Benstead, psychologist<br>Prof. Warwick Middleton, psychiatrist<br>Facilitator: Dr Michael Murray, GP and medical educator  | 831           | 263          | 2910              |
| <b>Collaborative care in mental health and diabetes</b><br>Wed 16 Nov 2011<br>7.45pm            | Prof. Tim Lambert, psychiatrist<br>Dr Ralph Audehm, GP<br>Prof. Prasuna Reddy, health psychologist<br>Catherine Prochilo, credentialled diabetes educator<br>Facilitator: Dr Michael Murray, GP and medical educator           | 300           | 132          | 722               |
| <b>Bipolar mood disorder</b><br>Mon 5 Dec 2011<br>7.45pm  | Ingi Barr, consumer advocate<br>Assoc. Prof. Greg Murray, clinical psychologist<br>Prof. David Castle, psychiatrist<br>Dr Mary Emeleus, GP<br>Facilitator: Dr Michael Murray, GP and medical educator                          | 800           | 240          | 1869              |
| <b>Substance abuse presentations</b><br>Tuesday 7 Feb 2012<br>7.15pm                            | Assoc. Prof. Lynne Magor-Blatch, forensic psychologist<br>Dr Benny Monheit, GP<br>Prof. Dan Lubman, psychiatrist<br>Facilitator: Dr Michael Murray, GP and medical educator  | 730           | 291          | 1984              |
| <b>Perinatal mental health</b><br>Monday 19 Mar 2012<br>6.30pm                                  | Prof. Jeannette Milgrom, clinical psychologist<br>Stacey Noble, consumer representative<br>Prof. Bryanne Barnett AM, psychiatrist<br>Assoc. Prof. Morton Rawlin, GP<br>Facilitator: Dr Michael Murray, GP and medical educator | 950           | 306          | 2320              |
| <b>Autism and mental health</b><br>Wednesday 4 April 2012<br>7.30pm                             | Prof. Sylvia Rodger, occupational therapist<br>Dr Cheryl Dissanayake, psychologist<br>Prof. Andrew Cashin, mental health nurse<br>Dr John Wray, paediatrician<br>Facilitator: Dr Michael Murray, GP and medical educator       | 1050          | 302          | 427               |
| <b>Older people with mental health issues</b><br>Wednesday 9 May 2012<br>7.15pm                 | Dr Rod McKay, psychiatrist<br>Ms Julianne Whyte, social worker<br>Dr Nancy Pachana, clinical psychologist<br>Facilitator: Dr Michael Murray, GP and medical educator   | 800           | 299          | 880               |
| <b>Collaborative care for eating disorder presentations</b><br>Wednesday 13 June 2012<br>7.45pm | Mr Chris Thornton, clinical psychologist<br>Dr Jan Orman, GP<br>Dr Andrew Court, psychiatrist<br>Facilitator: Dr Michael Murray, GP and medical educator   | 1200          | 307          | 1174              |
| <b>TOTAL</b>  |  | <b>7,444</b>  | <b>2,373</b> | <b>14,024</b>     |





## MHPN Website

### Upgrade to the site

The website has been refined as new aspects of the program have been developed. The success of the webinars was the basis for several changes to the website during the year as the high volumes of webinar recordings previously hosted on the website were moved to a cloud-based storage system.

Improvements were also made to site navigation to improve flow and focus on key areas, as well as to allow for developments such as network profiles and video testimonials.

### MHPN Online

MHPN Online membership grew from 2,827 members at the same time last year to 6,398 members at June 30, 2012, an increase of 126 percent.

## Data collection

In August 2011 MHPN migrated all of its data on network activity and clinicians to an Access database. These were previously stored on spreadsheets numbering in the hundreds and created a slow, manual procedure for managing network membership and meetings. The build of the database and migration of data was a major task involving an external database developer, key senior MHPN staff and all MHPN project officers.

The new database provides the essential functionality to support project teams in carrying out administrative tasks and has significantly reduced time spent on manual tasks. It offers a range of tools and functions that improve the effectiveness in managing networks and reporting to DoHA through access to real time data.

Over the course of the year, enhancements were made to the database to support operational and reporting requirements. Automated functions were created for distributing network meeting invitations, certificates of attendance, network member directories, as well as a range of reports. The database has improved internal productivity and enhanced our reporting capabilities.

## Overview of Communications

The Communications team manages a broad portfolio that influences and supports many dimensions of the project, including the webinar program, MHPN Online, national stakeholder engagement and promotion and branding of the MHPN project.

### Brand recognition

A strategic and dynamic communications strategy resulted in an organisational transition from no brand identity to a highly recognized entity in the primary mental health care landscape.

A major challenge has been to keep the promotion of MHPN in line with, and not in front of achievements.

The positive response to, and high participation in, the webinar program has been a key component to boosting brand identity among both individuals and organizations.

Other strategies which have led to this positive brand recognition include a regular feed of stories to the press, promotion of the website, targeted marketing to clinicians, presence at mental health conferences, engagement of key stakeholders and effective use of clinician testimonials.

New developments include a new corporate brochure, and creation of an Honour Board to recognise long-serving coordinators and long-standing networks.

### Webinars and Online Networking

The integration of online technologies and social marketing into various components of our marketing strategy has been rewarding as members adopt these new media for networking and professional development. MHPN developed a secure online networking portal within the website to enable virtual networking between members. There are 449 online groups who engage in varying degrees of interactivity.

### Social media

During the year MHPN launched a social media campaign, using Twitter and Facebook.

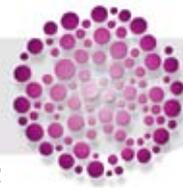
### Promotion of MHPN outcomes

The promotion of network activity has been fundamental to the success of MHPN. MHPN has been able to transition from promising an outcome to sharing our success stories, backed up by clinicians' testimonials.

Communication pathways with member organisations were established early and utilised to full effect. Expansion to broader health-related journals captured a larger market, whilst targeted local network stories were published in local newspapers.

The MHPN e-newsletter has provided a cost effective method for regular, timely dissemination of good news stories and upcoming MHPN events to MHPN stakeholders.





Stories of successful networks stimulate other groups to think about the types of topics and speakers they would like at their meetings. MHPN regularly interviewed network coordinators about the factors that help their network to thrive. These articles, featuring quotes on why collaboration in primary care is integral, feature in MHPN's e-news and partner publications where possible.

Last year we embarked on our first video testimonial by a coordinator and headspace manager. It sends a strong message about the link between local community services, individual clinicians and MHPN working together to improve consumer services locally. We intend to produce more testimonials of this nature.

## Ministerial launch for Phase 3

The Minister for Mental Health and Ageing, Mark Butler, launched the third phase of the Mental Health Professionals Network (MHPN) project in Adelaide on April 5. The event was hosted by the Royal Australian College of General Practitioners in their Adelaide office.

In a media release accompanying the event, Minister Butler said the Gillard Government was funding MHPN to support better training and professional development for the primary mental health care workforce and collaboration across clinical disciplines.

'Support for local mental health networks is part of the Government's broader agenda to develop a truly integrated mental health system. This additional funding will allow additional local mental networks to be established, and support and grow the existing networks,' Mr Butler said.

'Over the life of this project, around 14,000 clinicians – from general practice, psychiatry, psychology, mental health nursing, occupational therapy and social work – will be able to meet for professional training and support at networks around four times each year, with additional training available online.

'These clinicians will also be able to hear from leading mental health experts and carer and consumer representatives through a series of web based seminars, or "webinars", on topics of clinical interest to the mental health workforce.

'A well trained mental health workforce is important to the delivery of quality mental health services and this project will result in improved referral pathways, increased knowledge of local services providers and better care coordination for people with mental health needs,' Mr Butler said.

Other speakers at the event included MHPN Chair John McGrath AM, Dr Anne Sved-Williams, a perinatal and infant psychiatrist working in Adelaide, Sarah Farrell, coordinator

of the MHPN Broome and Derby networks who attended remotely via web conference, and Janne McMahon OAM, Independent Chair of the Private Mental Health Consumer Carer Network (Australia).

Guests included a multidisciplinary mix of clinicians and leaders in the mental health community. The event was followed by a media release from Minister Butler's office in Canberra.

Press releases and letters were circulated to MHPN stakeholders and relevant health media announcing the approval of Phase 3 of MHPN. Letters were sent to coordinators acknowledging and thanking them for their contribution.

## Partnerships

**MHPN received strong support from partner organisations with advice, access to databases, and cooperation in joint promotion of common interests.**

MHPN developed strong links with partner organisations, Divisions of General Practice and other stakeholders, effectively utilising all available communications channels in primary mental health care. We also partnered with lead organisations in the mental health arena to promote collaboration within mental health service delivery, including with Beyond Blue, headspace, Peter MacCallum, Partners in Depression and Diabetes Australia.

MHPN fielded requests from organisations involved in mental health care to promote messages to our member base and to selectively co-promote where appropriate. The growth of goodwill in the sector is something we will continue in Phase 3.

### Conferences

MHPN had active roles at several conferences during the year.

We attended:

- ACMHN Mental Health Nursing in Primary Care Conference
- AHPA National Allied Health Conference
- RANZCP 2012 Congress
- 13th International Mental Health Conference

## Evaluation of MHPN Project

At the commencement of Phase 3, the Board endorsed three evaluation projects that collectively inform MHPN's internal operations and strategic planning around ongoing network support. The projects are:

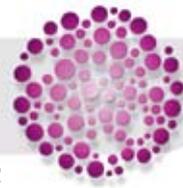
Project 1: Network sustainability

Project 2: Evaluation of the MHPN webinar program.

Project 3: Impact of participation in MHPN networks.

The projects are scheduled to be completed in the 2012/2013 financial year.





## Information on Directors

### Mr John McGrath AM

#### *Special Responsibilities*

- Chairman of MHPN,
- Chair of the MHPN Executive Committee,
- Chairman of the MHPN Project Advisory Group,
- Member of the MHPN Finance and Audit Committee,
- Member of the MHPN Evaluation Committee.

#### *Experience*

- Former National Party MLA for Warrnambool in Victorian Parliament,
- Former Chairman of the Victorian Ministerial Expert Advisory Committee on Mental Health,
- Board member for headspace
- Former board member of Crisis Support Services,
- Inaugural Chairman of The Mental Health Council of Australia,
- Carer of a family member with mental illness and,
- Past Deputy Chairman and Board member of beyondblue.

### Associate Professor Morton Rawlin

BMed, MMedSci, FRACGP, FACRRM, DipPractDerm, DipMedHyp, DipFP, DipBusAdmin, MAICD

#### *Experience*

- Currently in full-time clinical general practice,
- Chair of the Victoria Faculty of the RACGP, Faculty of Specific Interests and an RACGP Board Member,
- Adjunct Associate Professor in General Practice at the University of Sydney,
- Chair of the Rural Placement Committee of the Royal Workforce Agency, Victoria (RWAV),
- Member of the Committee of Presidents of Medical Colleges (CPMC) Education subcommittee,
- Chair, General Practice Mental Health Standards Collaboration (GPMHSC).

### Anne Buck B.A.(Hons)

#### *Experience*

- Policy Officer, Australian College of Mental Health Nurses,
- Former Australian Public Service Officer in Department of Education, Employment and Workplace Relations.

### Professor Kathleen Moore

MAPS, BA, GradDip AppPsych, GradDip ClinMentHlth (Hypnosis), MSc, PhD (Retired 28 February 2012)

#### *Special Responsibilities*

- Chair of the MHPN Finance and Audit Committee, resigned 28 February 2012.

#### *Experience*

- Professor of Psychology at Charles Darwin University,
- Member of the APS Professional Development and Accreditation Committee,
- President of the Stress and Anxiety Research Society,
- President of the Asian Psychological Association (APSA),
- Past Board member and Chair of Finance and Investment Committee of the Australian Psychological Society (APS),
- Past Treasurer of Australian National Association of Mental Health (ANAMH).

### Professor Lyndel Littlefield OAM, FAPS, FACID, FAIM

#### *Special Responsibilities*

- Chair of the MHPN Quality Assurance and Clinical Education Committee,
- Member of MHPN Executive Committee.

#### *Experience*

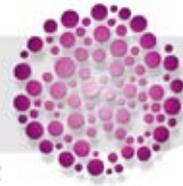
- Executive Director of the Australian Psychological Society (APS) and a Professor of Psychology at La Trobe University. Lyn is a clinical psychologist and has worked in both the public and private sectors during her career,
- Chair of the Mental Health Professionals Association (MHPA)
- Lyn is currently, or has recently been, a member of a number of Federal Government Ministerial advisory and reference groups, including the:
  - Mental Health Expert Working Group,
  - National Advisory Council on Mental Health,
  - National Mental Health Workforce Advisory Group,
  - National Primary Health Care Strategy Taskforce.

Lyn has also had extensive involvement in the development and implementation of the Better Outcomes in Mental Health Care and the Better Access to Mental Health Care – Medicare initiatives.

### Dr. Johanna Lammersma MBBS, FRANZCP

#### *Experience*

- Psychiatrist (Private Practice).



### Ms Kim Ryan

RN, Adj. Assoc. Prof. FACMHN

#### *Special Responsibilities*

- MHPN Company Secretary,
- Member of MHPN Finance and Audit Committee (Acting chair from 28 February 2012),
- Member of MHPN Executive Committee.

#### *Experience*

- Chief Executive Officer of the Australian College of Mental Health Nurses,
- Adjunct Associate Professor,
- Former Chair of the Mental Health Professionals Association,
- Chair of the Coalition of National Nursing Organisation.

### Dr. Anne Ellison

PhD, PDM (Mktg), B.A (Hons), MAICD

#### *Special Responsibilities*

- Member of the MHPN Evaluation Committee,
- Member of the MHPN Quality Assurance and Clinical Education Committee

#### *Experience*

- General Manager – Practice, Policy and Projects – RANZCP.

### Dr. Zena Burgess

PhD – Psychology, MBA, Master of Education,  
Grad Dip – Educational Psychology, BA.

#### *Experience*

- Chief Executive Officer of the RACGP – appointed in 2008,
- Organisational and Clinical Psychologist,
- Past State and Federal Government roles in The Family Court Counselling Service,
- Tribunal member for Victorian Civil and Administrative Appeals,
- Past Board Member of the Country Fire Authority,
- Post secondary education experience at Latrobe University, Swinburne University and at Australian Catholic University.

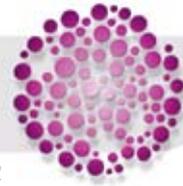
### Harry Lovelock RN, MSS, Grad Dip Health Admin

#### *Special Responsibilities*

- Chair of the MHPN Evaluation Committee.

#### *Experience*

- Executive Manager, Strategic Development and Public Interest,
- Director of Policy, RANZCP,
- Senior Policy Adviser Victorian Department of Human Services,
- Representative on:
  - Mental Health Practice Standards Committee,
  - HWA Professions Standing Committee,
  - National Primary Health Care Partnership,
  - Mental Health Professionals Association.



## Executive Committee (first meeting March 2012)

John McGrath AM (Chair)  
 Prof. Lyn Littlefield (APS)  
 Kim Ryan (ACMHN)  
 Chris Gibbs (MHPN)

## Finance and Audit Committee

Dr Kate Moore (APS—Chair until February 2012)  
 John McGrath AM (MHPN Chair)  
 Kim Ryan (ACMHN—Acting Chair from February 2012—  
 appointed Chair in April 2012)  
 Chris Gibbs (MHPN)  
 Trevor Donegan (MHPN)

## Evaluation Committee

Harry Lovelock—Chair (APS)  
 Deepika Ratnaike (external advisor)  
 Dr Barbara Murphy (external advisor)  
 Dr Anne Ellison (RANZCP)  
 John McGrath AM (MHPN Chair)  
 Chris Gibbs (MHPN)  
 Stewart Potten (MHPN)  
 Bronwyn Morris-Donovan (MHPN)  
 Tanya Reardon (MHPN)  
 Amanda Osciak (MHPN)

## Quality Assurance and Clinical Education Committee

(QACEC—commenced in February 2012) formerly  
 Clinical Reference Group

Prof. Lyn Littlefield (CRG Chair) APS  
 Peta Marks (ACMHN)  
 Assoc. Prof. David Pierce  
 (Director, University of Melbourne, Dept of Rural Health)  
 Dr Rebecca Matthews (APS)  
 Dr Anne Ellison (RANZCP)  
 Emeritus Professor Sidney Bloch  
 (RANZCP Nominee—from June 2012)  
 Chris Gibbs (MHPN)  
 Stewart Potten (MHPN)  
 Nicky Bisogni (MHPN)  
 Tanya Reardon (MHPN)  
 Amanda Osciak (MHPN)

### Mental Health Professionals Network Ltd

Emirates House  
 Level 8, 257 Collins Street  
 Melbourne VIC 3000

Tel: 1800 209 031 or (03) 8662 6600

Email: [contactus@mhpn.org.au](mailto:contactus@mhpn.org.au)

Web: [www.mhpn.org.au](http://www.mhpn.org.au)

A not-for-profit organisation, MHPN is funded by the Commonwealth Government Department of Health and Ageing.

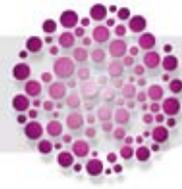
### Member organisations

The Royal Australian College of General Practitioners  
 The Royal Australian and New Zealand College of Psychiatrists  
 Australian Psychological Society  
 Australian College of Mental Health Nurses

### Partner organisations

Occupational Therapy Australia  
 Australian Association of Social Workers  
 The Royal Australasian College of Physicians





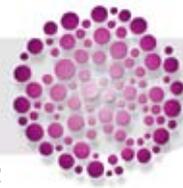
# Financial Report

## For the year ended 30 June 2012

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### Contents

|                                    |    |
|------------------------------------|----|
| Directors' Report                  | 24 |
| Auditor's Independence Declaration | 26 |
| Statement of Comprehensive Income  | 27 |
| Statement of Financial Position    | 28 |
| Statement of Changes in Equity     | 29 |
| Statement of Cash Flows            | 30 |
| Notes to the Financial Statements  | 31 |
| Directors' Declaration             | 37 |
| Independent Auditor's Report       | 38 |



## Directors' Report

The directors of Mental Health Professionals Network Ltd (MHPN) present their report together with the financial report of the company for the financial year ended 30 June 2012 and auditor's report thereon.

### Directors

The names of the directors in office at any time during or since the end of the year are:

| <b>Name of Director</b> | <b>Appointment</b> | <b>Resignation</b> |
|-------------------------|--------------------|--------------------|
| John McGrath            | 7/8/2008           |                    |
| Kim Ryan                | 12/6/2008          |                    |
| Joanna Lammersma        | 12/6/2008          |                    |
| Morton Rawlin           | 12/6/2008          |                    |
| Kathleen Moore          | 12/6/2008          | 28/2/2012          |
| Lyndel Littlefield      | 12/6/2008          |                    |
| Anne Buck               | 26/8/2011          |                    |
| Zena Burgess            | 27/6/2011          |                    |
| Harry Lovelock          | 28/2/2012          |                    |
| Anne Ellison            | 18/4/2011          |                    |

The directors have been in office since the start of the financial year to the date of this report unless otherwise stated.

### Company Secretary

The following person held the position of company secretary at the end of the financial year:

Kim Ryan – appointed company secretary on 12/6/2008.

### Results

The deficit of the company for the financial year amounted to \$551,503 (2011: \$1,234,487).

### Review of Operations

The company continued to engage in its principal activities, the results of which are disclosed in the attached financial statements. The company entered into a contract with the Department of Health and Ageing (DoHA) on 31 October 2011 which extends the life of the project through to 30 June 2014.

### Significant Changes in State of Affairs

There were no significant changes in the company's state of affairs during the financial year not otherwise disclosed in this report or the financial statements.

### Company Objectives

The company has been established to promote the quality of patient care by:

- Supporting and sustaining across Australia clinical interdisciplinary groups of mental health professionals working in the primary care sector, and
- Development of a national interactive website that supports ongoing networking of mental health clinicians.

### Principal Activities

The principal activities of the Mental Health Professionals Network Ltd during the financial year were:

- a) to provide mental health stakeholder support and a coordinated, collaborative forum for issues affecting the following four key professional groups – The Royal Australian and New Zealand College of Psychiatrists (RANZCP), The Royal Australian College of General Practitioners (RACGP), The Australian Psychological Society Ltd (APS) and The Australian College of Mental Health Nurses Inc (ACMHN); and
- b) to develop an integrated education and training package in support of collaborative care arrangements in the delivery of primary mental health care. This education and training package is aimed at the key professional groups who are involved in primary mental health care, namely: psychiatrists, general practitioners, psychologists, mental health nurses, paediatricians, occupational therapists and social workers.

No significant change in the nature of these activities occurred during the financial year.

### Company Performance

Against the two major objectives the company achieved the following:

- By June 2012 a national platform of 450 interdisciplinary community mental health networks had been established and sustained, and
- MHPN online provides interactive web based professional development activities in addition to the provision of an online communications network with participating clinicians and network coordinators.

### After Balance Date Events

No matters or circumstances have arisen since the end of the financial year that have significantly affected, or may significantly affect the operations of the company, the results of those operations or the state of affairs of the company in future financial years.

### Likely Developments

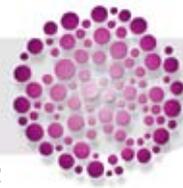
The directors believe that there are no likely developments that will significantly adversely affect the company in the coming year.

### Environmental Issues

The company's operations are not regulated by any significant environmental regulation under a law of the Commonwealth or of a State or Territory.

### Dividends Paid or Recommended

The constitution prohibits the payment of dividends to members of the company. No dividends were paid or declared since the start of the financial year. No recommendation for payment of dividends has been made.



### Directors' meetings including committee meetings

The number of meetings of directors (including meetings of the Committees of Directors) held during the year and the numbers of meetings attended by each Director were as follows.

|                                    | Directors meetings |                    | Finance & Audit |                    | Evaluation |                    |
|------------------------------------|--------------------|--------------------|-----------------|--------------------|------------|--------------------|
|                                    | Attended           | Eligible to attend | Attended        | Eligible to attend | Attended   | Eligible to attend |
| J McGrath                          | 9                  | 9                  | 9               | 9                  | 4          | 6                  |
| A Buck (From 26 August 2011)       | 7                  | 8                  | -               | -                  | -          | -                  |
| Z Burgess                          | 1                  | 9                  | -               | -                  | -          | -                  |
| A Ellison                          | 9                  | 9                  | -               | -                  | 4          | 6                  |
| J Lammersma                        | 7                  | 9                  | -               | -                  | -          | -                  |
| L Littlefield                      | 8                  | 9                  | -               | -                  | -          | -                  |
| H Lovelock (From 28 February 2012) | 3                  | 3                  | -               | -                  | 2          | 2                  |
| K Moore (To 28 February 2012)      | 6                  | 6                  | 6               | 6                  | -          | -                  |
| M Rawlin                           | 5                  | 9                  | -               | -                  | -          | -                  |
| K Ryan                             | 9                  | 9                  | 9               | 9                  | -          | -                  |

|                                    | Directors Executive |                    | Quality Assurance & Clinical Education |                    |
|------------------------------------|---------------------|--------------------|--|--------------------|
|                                    | Attended            | Eligible to attend | Attended                               | Eligible to attend |
| J McGrath                          | 2                   | 2                  | -                                      | -                  |
| A Buck (From 26 August 2011)       | -                   | -                  | -                                      | -                  |
| Z Burgess                          | -                   | -                  | -                                      | -                  |
| A Ellison                          | -                   | -                  | 1                                      | 2                  |
| J Lammersma                        | -                   | -                  | -                                      | -                  |
| L Littlefield                      | 2                   | 2                  | 1                                      | 2                  |
| H Lovelock (From 28 February 2012) | -                   | -                  | -                                      | -                  |
| K Moore (To 28 February 2012)      | -                   | -                  | -                                      | -                  |
| M Rawlin                           | -                   | -                  | -                                      | -                  |
| K Ryan                             | 2                   | 2                  | -                                      | -                  |

### Indemnification of officers

During or since the end of the year, the company has given indemnity or entered an agreement to indemnify, or paid or agreed to pay insurance premiums in order to indemnify the directors of the company against legal liability which it may incur through the conduct of its activities or the provision of services.

Further disclosure required under section 300(9) of the corporation's law is prohibited under the terms of the contract.

### Indemnification of auditors

No indemnities have been given or insurance premiums paid, during or since the end of the year, for any person who is or has been an auditor of the company.

### Auditor's Independence Declaration

A copy of the auditor's independence declaration, as required under section 307C of the Corporations Act 2001 in relation to the audit for the financial year is provided with this report.

### Proceedings on behalf of the company

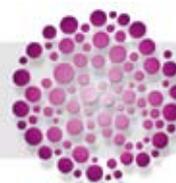
No person has applied for leave of Court to bring proceedings on behalf of the company.

Signed in accordance with a resolution of the Board of Directors.

John McGrath AM  
Director

Kim Ryan  
Director

Dated: 15 August 2012  
Melbourne



## AUDITOR'S INDEPENDENCE DECLARATION



**PITCHER PARTNERS**

An independent Victorian Partnership  
ABN 27 975 255 196

**MENTAL HEALTH PROFESSIONALS NETWORK LTD  
A.B.N. 67 131 543 229**

**AUDITOR'S INDEPENDENCE DECLARATION  
TO THE DIRECTORS OF MENTAL HEALTH PROFESSIONALS NETWORK LTD**

In relation to the independent audit for the year ended 30 June 2012, to the best of my knowledge and belief there have been:

- (i) No contraventions of the auditor independence requirements of the *Corporations Act 2001*; and
- (ii) No contraventions of any applicable code of professional conduct.

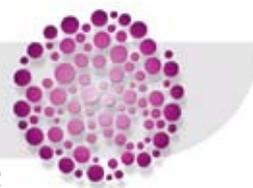
N R BULL

Partner

15 August 2012

PITCHER PARTNERS

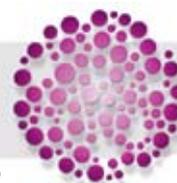
Melbourne



## STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 30 JUNE 2012

|                                    | Notes | 2012<br>\$         | 2011<br>\$         |
|------------------------------------|-------|--------------------|--------------------|
| Revenue                            | 5     | 2,901,618          | 2,777,594          |
| Less Expenses                      |       |                    |                    |
| Employee Benefits                  | 5     | (2,401,448)        | (2,580,593)        |
| Workshop Expenses                  |       | (251,526)          | (289,602)          |
| Occupancy and Member Related Costs |       | (538,466)          | (569,695)          |
| Administrative Expenses            |       | (115,832)          | (380,113)          |
| Depreciation Expense               | 5     | (6,129)            | (8,663)            |
| Other Expenses                     |       | (139,720)          | (183,415)          |
| <b>Total Expenses</b>              |       | <b>(3,453,121)</b> | <b>(4,012,081)</b> |
| Deficit before income tax expense  |       | (551,503)          | (1,234,487)        |
| Income tax expense                 | 3     | –                  | –                  |
| Deficit from continuing operations |       | (551,503)          | (1,234,487)        |
| Other comprehensive income         |       | –                  | –                  |
| <b>Total comprehensive loss</b>    |       | <b>(551,503)</b>   | <b>(1,234,487)</b> |

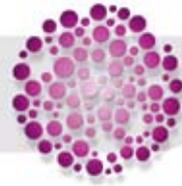
The accompanying notes form part of these financial statements.



## STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2012

|                                  | Notes | 2012<br>\$      | 2011<br>\$     |
|----------------------------------|-------|-----------------|----------------|
| <b>CURRENT ASSETS</b>            |       |                 |                |
| Cash and cash equivalents        | 6     | 305,209         | 846,135        |
| Receivables                      | 7     | 888             | 18,953         |
| <b>TOTAL CURRENT ASSETS</b>      |       | <b>306,097</b>  | <b>865,088</b> |
| <b>NON-CURRENT ASSETS</b>        |       |                 |                |
| Plant and equipment              | 8     | 2,003           | 8,132          |
| <b>TOTAL NON-CURRENT ASSETS</b>  |       | <b>2,003</b>    | <b>8,132</b>   |
| <b>TOTAL ASSETS</b>              |       | <b>308,100</b>  | <b>873,220</b> |
| <b>CURRENT LIABILITIES</b>       |       |                 |                |
| Payables                         | 9     | 261,643         | 293,513        |
| Provisions                       | 10    | 80,157          | 61,904         |
| <b>TOTAL CURRENT LIABILITIES</b> |       | <b>341,800</b>  | <b>355,417</b> |
| <b>TOTAL LIABILITIES</b>         |       | <b>341,800</b>  | <b>355,417</b> |
| <b>NET ASSETS</b>                |       | <b>(33,700)</b> | <b>517,803</b> |
| <b>EQUITY</b>                    |       |                 |                |
| Retained surplus / (deficit)     | 11    | (33,700)        | 517,803        |
| <b>TOTAL EQUITY</b>              |       | <b>(33,700)</b> | <b>517,803</b> |

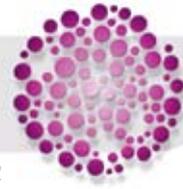
The accompanying notes form part of these financial statements.



## STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 30 JUNE 2012

|  | 2012<br>\$      | 2011<br>\$     |
|--|-----------------|----------------|
| Total equity at the beginning of the financial year  | 517,803         | 1,752,290      |
| Deficit for the year                                 | (551,503)       | (1,234,487)    |
| Total recognised income and expenses for the year    | (551,503)       | (1,234,487)    |
| <b>Total equity at the end of the financial year</b> | <b>(33,700)</b> | <b>517,803</b> |

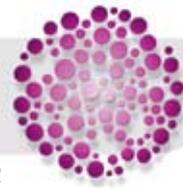
The accompanying notes form part of these financial statements.



## STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2012

|   | Notes | 2012<br>\$  | 2011<br>\$  |
|---|-------|-------------|-------------|
| <b>CASH FLOWS FROM OPERATING ACTIVITIES</b> |       |             |             |
| Grant receipts                              |       | 3,162,361   | 3,000,000   |
| Payments to employees                       |       | (2,468,138) | (2,593,889) |
| Payments to suppliers                       |       | (1,265,100) | (1,803,859) |
| Interest received                           |       | 29,951      | 55,782      |
| Net decrease in cash held                   |       | (540,926)   | (1,341,966) |
| Cash at the beginning of the financial year |       | 846,135     | 2,188,101   |
| Cash at the end of the financial year       | 6     | 305,209     | 846,135     |

The accompanying notes form part of these financial statements.



## NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The financial report is a general purpose financial report that has been prepared in accordance with Australian Accounting Standards / Reduced Disclosure Requirements, Interpretations and other authoritative pronouncements of the Australian Accounting Standards Board and the Corporations Act 2001.

The financial report was approved by the directors as at the date of the directors' report.

The financial report is for the entity Mental Health Professionals Network Limited as an individual entity. Mental Health Professionals Network Limited (MHPN) is a company limited by guarantee, incorporated and domiciled in Australia.

The following is a summary of the material accounting policies adopted by the company in the preparation of the financial report. The accounting policies have been consistently applied, unless otherwise stated.

### (a) Basis of preparation of the financial report

#### *Historical Cost Convention*

The financial report has been prepared under the historical cost convention, as modified by revaluations to fair value for certain classes of assets as described in the accounting policies.

### (b) New accounting standards and interpretations

A number of accounting standards and interpretations have been issued at the reporting date but are not yet effective. The directors have not yet assessed the impact of these standards or interpretations.

### (c) Rounding of amounts

All amounts shown in the financial statements are expressed to the nearest dollar.

### (d) Revenue

Grant revenue is recognised in the statement of comprehensive income when it is controlled. When there are conditions attached to grant revenue relating to the use of those grants for specific purposes it is recognised in the statement of financial position as a liability until such conditions are met or services provided.

Interest revenue is recognised as interest accrues using the effective interest method.

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

### (e) Unexpended grants

The company receives grant monies to fund projects either for contracted periods of time or for specific projects irrespective of the period of time required to complete those projects. It is the policy of the company to treat grant monies as unexpended grants in the statement of financial position where the company is contractually obliged to provide the services in a subsequent financial period to when the grant is received or in the case of specific project grants where the project has not been completed.

### (f) Impairment of assets

At each reporting date, the company reviews the carrying values of its tangible and intangible assets to determine whether there is any indication that those assets have been impaired. If such an indication exists, the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, is compared to the asset's carrying value. Any excess of the asset's carrying value over its recoverable amount is expensed to the statement of comprehensive income.

### (g) Goods and services tax (GST)

Revenues, expenses, assets and liabilities are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office. In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of an item of the expense. Receivables and payables in the statement of financial position are shown as inclusive of GST. Cash flows are presented in the statement of cash flows on a gross basis, except for the GST component of investing and financing activities, which are disclosed as operating cash flows.

### (h) Comparative figures

Where required by Australian Accounting Standards, comparative figures have been reclassified and repositioned for consistency with the current financial year disclosures.

### (i) Plant and equipment

Assets with a cost in excess of \$1,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost over their estimated useful lives using the straight-line method. The following table indicates the expected useful lives of non-current assets on which the depreciation charges are based:

| Class of fixed assets | Useful lives | Depreciation basis |
|-----------------------|--------------|--------------------|
| Plant & Equipment     | 4 years      | Straight Line      |

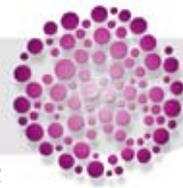
### (j) Payables

These amounts represent liabilities for goods and services provided prior to the end of the financial year and which are unpaid. The normal credit terms are usually 30 days.

### (k) Employee benefits

#### Short-term employee benefit obligations

Liabilities arising in respect of wages and salaries, annual leave, accumulated sick leave and any other employee benefits expected to be settled within twelve months of the reporting date are measured at their nominal amounts based on remuneration rates which are expected to be paid when the liability is settled. The expected cost of short-term employee benefits in the form of compensated absences such as annual leave is recognised in the provision of the employee benefits. All other short-term employee benefit obligations are presented as payables.



## NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (cont'd)

### (l) Income tax

The company has been granted exemption from Income Taxation under Subdivision 50-B of the Income Assessment Act 1997.

### (m) Going concern

The financial report has been prepared on a going concern basis which assumes that the company will have access to sufficient cash funds to meet its financial obligations and extinguish its liabilities in the normal course of operations.

During the year ended 30 June 2012, the company incurred a deficit from ordinary activities of \$551,503 (2011: \$1,234,487) and generated net operating cash outflows of \$540,926 (2011: \$1,341,966). As at that date the company's total liabilities exceeded total assets by \$33,700 (2011 total assets exceeded total liabilities by \$517,803).

The adoption of the going concern basis for the preparation of the Financial Report has been made after consideration of the following matters:

- The company has received a Letter of Intention from the Department of Health and Ageing (DoHA) formally noting DoHA's intention to vary the existing funding agreement with the company for the Mental Health Interdisciplinary Networks (MHIN) Project to realign the schedule of payments under the contract to better reflect the company's expenditure patterns.
- Payments under the contract will still be linked to the acceptance of project deliverables, however it is DoHA's intention to bring funds forward to ensure that the company has sufficient funds to manage the on-going expenses related to the MHIN Project.

As at the date of this report, the Directors expect the Deed of Variation to be executed and as a result consider the going concern basis of accounting appropriate for the company.

## NOTE 2: MEMBERS' GUARANTEE

The company is incorporated under the Corporations Act 2001 as a company limited by guarantee. If the company is wound up, the constitution states that each member is required to contribute a maximum of \$100 each towards meeting any outstanding debts and obligations of the company. At 30 June 2012 the number of members was four.

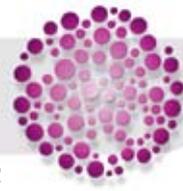
## NOTE 3: INCOME TAX

The company, a charitable institution, is endorsed to access the following concessions:

- Income Tax exemption under Subdivision 50-B of the Income Tax Assessment Act 1997,
- GST concessions under Division 176 of A New Tax System (Goods and Services) Act 1999 and,
- FBT rebate under section 123E of the Fringe Benefits Tax Assessment Act 1986.

## NOTE 4: ECONOMIC DEPENDENCY

The company is reliant on grant funding from the Commonwealth Government. At the date of this report, the company had a contract with the Commonwealth Department of Health and Ageing (DoHA) for grant funding from November 2011 to June 2014.

2012  
\$2011  
\$

## NOTE 5: REVENUE & DEFICIT FROM CONTINUING OPERATIONS

Operating deficit for the year has been determined after:

(a) Revenue from operating activities

|                   |           |           |
|-------------------|-----------|-----------|
| Government grants | 2,874,873 | 2,727,273 |
|-------------------|-----------|-----------|

(b) Revenue from non-operating activities

|                  |        |        |
|------------------|--------|--------|
| Interest revenue | 26,745 | 50,321 |
|------------------|--------|--------|

|                      |                  |                  |
|----------------------|------------------|------------------|
| <b>Total Revenue</b> | <b>2,901,618</b> | <b>2,777,594</b> |
|----------------------|------------------|------------------|

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(c) Deficit has been determined after:

Employee benefits:

|                    |           |           |
|--------------------|-----------|-----------|
| Salaries and Wages | 2,237,815 | 2,396,337 |
|--------------------|-----------|-----------|

|                |         |         |
|----------------|---------|---------|
| Superannuation | 163,633 | 184,256 |
|----------------|---------|---------|

|                                |                  |                  |
|--------------------------------|------------------|------------------|
| <b>Total Employee Benefits</b> | <b>2,401,448</b> | <b>2,580,593</b> |
|--------------------------------|------------------|------------------|

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|                                     |       |       |
|-------------------------------------|-------|-------|
| Depreciation of plant and equipment | 6,129 | 8,663 |
|-------------------------------------|-------|-------|

## NOTE 6: CASH AND CASH EQUIVALENTS

|              |                |                |
|--------------|----------------|----------------|
| Cash at bank | 305,209        | 846,135        |
|              | <b>305,209</b> | <b>846,135</b> |

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## NOTE 7: RECEIVABLES

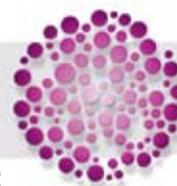
CURRENT

|                |   |        |
|----------------|---|--------|
| GST refundable | – | 14,859 |
|----------------|---|--------|

|                |     |       |
|----------------|-----|-------|
| Accrued income | 888 | 4,094 |
|----------------|-----|-------|

|  |            |               |
|--|------------|---------------|
|  | <b>888</b> | <b>18,953</b> |
|--|------------|---------------|

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|                                    | 2012<br>\$   | 2011<br>\$   |
|------------------------------------|--------------|--------------|
| <b>NOTE 8: PLANT AND EQUIPMENT</b> |              |              |
| Plant and Equipment                |              |              |
| At cost                            | 26,855       | 26,855       |
| Less accumulated depreciation      | (24,852)     | (18,723)     |
|                                    | <b>2,003</b> | <b>8,132</b> |

**(a) Movement in carrying amounts**

Movement in the carrying amount for each class of plant and equipment between the beginning and the end of the current financial year is set out below:

|                                       |              |              |
|---------------------------------------|--------------|--------------|
| Plant and Equipment                   |              |              |
| Carrying amount at beginning          | 8,132        | 16,795       |
| Additions                             | –            | –            |
| Depreciation expense                  | (6,129)      | (8,663)      |
| <b>Carrying amount at end of year</b> | <b>2,003</b> | <b>8,132</b> |

The company assessed at 30 June 2012 whether there is any indication that any of the above assets may be impaired. There is no indication that an impairment loss is present, that is, where the carrying amount of an asset exceeds its recoverable amount.

**NOTE 9: PAYABLES**

## CURRENT

|                            |                |                |
|----------------------------|----------------|----------------|
| Amounts payable to members | 65,462         | 47,258         |
| Other payables             | 196,181        | 246,255        |
|                            | <b>261,643</b> | <b>293,513</b> |

Other payables are non-interest bearing and are settled within 30 days. The company pays within the allocated settlement period when prompt payment discounts are available.

**NOTE 10: PROVISIONS**

## CURRENT

|                   |               |               |
|-------------------|---------------|---------------|
| Employee benefits | 80,157        | 61,904        |
|                   | <b>80,157</b> | <b>61,904</b> |

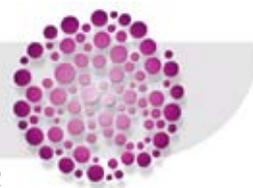
Due to the project not having a funding agreement beyond 30 June 2014, no calculation for Long Service Leave has been made.

**NOTE 11: RETAINED SURPLUS / (DEFICIT)**

|   |                 |                |
|---|-----------------|----------------|
| Retained surplus at beginning of financial year             | 517,803         | 1,752,290      |
| Net Deficit attributable to members of the entity           | (551,503)       | (1,234,487)    |
| <b>Retained surplus/ (deficit) at end of financial year</b> | <b>(33,700)</b> | <b>517,803</b> |

The company is limited by guarantee, does not have share capital and is incorporated in Australia.

If the company is wound up, the constitution states that each member is required to contribute a maximum of \$100 each towards meeting any outstanding debts and obligations of the company. At 30 June 2012 the number of members was four.

2012  
\$2011  
\$

## NOTE 12: KEY MANAGEMENT PERSONNEL COMPENSATION

Key Management Personnel (KMP) are those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any Director of that Entity. KMP has been taken to comprise the Directors and the members of the Executive Management responsible for the day to day financial and operational management of MHPN.

### (i) Names of Directors:

J McGrath  
 A Buck (from 26 August 2011)  
 Z Burgess  
 A Ellison  
 J Lammersma  
 L Littlefield  
 H Lovelock (from 28 February 2012)  
 K Moore (to 28 February 2012)  
 M Rawlin  
 K Ryan

The directors have been in office since the start of the financial year unless otherwise stated.

### (ii) Names of Executives:

C Gibbs (Chief Executive Officer)  
 S Potten (National Project Manager)

### Compensation of KMP

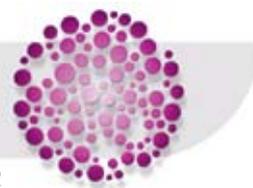
Aggregated compensation of KMP was as follows:

|                              |                |                |
|------------------------------|----------------|----------------|
| Short-term employee benefits | 382,616        | 417,765        |
| Long-term employee benefits  | –              | –              |
|                              | <b>382,616</b> | <b>417,765</b> |

## NOTE 13: AUDITOR'S REMUNERATION

Amounts received or due and receivable by Pitcher Partners for:

|                     |               |               |
|---------------------|---------------|---------------|
| – audit services    | 30,000        | 20,000        |
| – taxation services | –             | 2,600         |
| – consultancy       | 3,825         | 4,860         |
| – other             | 57            | 188           |
|                     | <b>33,882</b> | <b>27,648</b> |

2012  
\$2011  
\$

## NOTE 14: RELATED PARTIES

Transactions between related parties are on normal commercial terms and conditions no more favourable than those available to other parties unless otherwise stated.

Transactions with related parties:

### (a) Members – provision of services

|        |                |                |
|--------|----------------|----------------|
| ACMHN  | 219,674        | 190,946        |
| APS    | 287,088        | 296,576        |
| RACGP  | 11,256         | 53,054         |
| RANZCP | 172,970        | 182,707        |
|        | <b>690,988</b> | <b>723,283</b> |

### (b) Directors – provision of services

|            |   |       |
|------------|---|-------|
| D. Murphy* | – | 2,415 |
|            | – | 2,415 |

\* Darra Murphy was a director of MHPN until 22 May 2011

## NOTE 15: CONTINGENT ASSETS

The company has a \$75,124 contingent asset owing from DoHA as at balance date. This relates to the finalisation of the Phase 2 audit as at 30 June 2011.

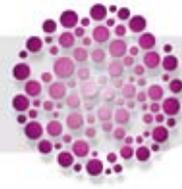
## NOTE 16: EVENTS SUBSEQUENT TO REPORTING DATE

There has been no matter or circumstance, which has arisen since 30 June 2012 that has significantly affected or may significantly affect:

- (a) The operations, in financial years subsequent to 30 June 2012, of the company, or
- (b) The results of those operations, or
- (c) The state of affairs, in financial years subsequent to 30 June 2012, of the company.

## NOTE 17: SEGMENT REPORTING

The business operates in the mental health industry, predominantly in Australia.



## DIRECTORS' DECLARATION

The directors of the company declare that:

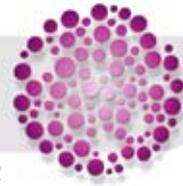
1. the financial statements and notes, as set out on pages 27 to 36, are in accordance with the Corporations Act 2001:
  - i) comply with Accounting Standards in Australia and the Corporations Regulations 2001, and
  - ii) give a true and fair view of the financial position as at 30th June 2012 and of the performance for the year ended on that date of the company.
2. in the directors' opinion there are reasonable grounds to believe that the company will be able to pay its debts as and when they become due and payable.

This declaration is made in accordance with a resolution of the Board of Directors.

John McGrath AM  
Director

Kim Ryan  
Director

Dated: 15 August 2012  
Melbourne



## INDEPENDENT AUDITOR'S REPORT



**PITCHER PARTNERS**

An independent Victorian Partnership  
ABN 27 975 255 196

**MENTAL HEALTH PROFESSIONALS NETWORK LTD  
A.B.N. 67 131 543 229**

**INDEPENDENT AUDITOR'S REPORT  
TO THE MEMBERS OF MENTAL HEALTH PROFESSIONALS NETWORK LTD**

We have audited the accompanying financial report of Mental Health Professionals Network Ltd, which comprises the statement of financial position as at 30 June 2012, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the directors' declaration.

*Directors' Responsibility for the Financial Report*

The directors of the company are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards – Reduced Disclosure Requirements and the *Corporations Act 2001*, and for such internal control as the directors determine is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

*Auditor's Responsibility*

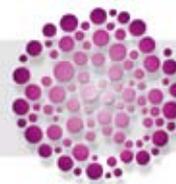
Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. Those standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about 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 judgement, including the assessment of the risks of material misstatement in the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the company's preparation of the financial report that gives a true and fair view 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 company's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial report.

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 the *Corporations Act 2001*.



**PITCHER PARTNERS**

An independent Victorian Partnership  
ABN 27 975 255 196

**MENTAL HEALTH PROFESSIONALS NETWORK LTD  
A.B.N. 67 131 543 229**

**AUDITOR'S INDEPENDENCE DECLARATION  
TO THE DIRECTORS OF MENTAL HEALTH PROFESSIONALS NETWORK LTD**

In relation to the independent audit for the year ended 30 June 2012, to the best of my knowledge and belief there have been:

- (i) No contraventions of the auditor independence requirements of the *Corporations Act 2001*; and
- (ii) No contraventions of any applicable code of professional conduct.

N R BULL

Partner

15 August 2012

PITCHER PARTNERS

Melbourne