ANNUAL REPORT

2013–2014

Mental Health Council of Australia

WHO WE ARE

The peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians.

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HIGHLIGHTS OF 2013-2014

The 2013-14 financial year was a busy one, with many key achievements across all areas of the organisation.

SOME OF THE KEY HIGHLIGHTS FOR THE YEAR ARE LISTED BELOW

Advocacy

- Close engagement with the National Mental Health Commission's (NMHC) Review of Mental Health Services and Programmes including 3 formal submissions
- Engagement with the Review of Australia's Welfare System
- Regular meetings with Government Ministers, the opposition, crossbenchers and minor parties
- 10 policy submissions developed on key mental health reform items
- Federal Budget 2014-15 Submission

Engagement

- Successful World Mental Health Day campaign with over 2,300 mental health promises posted to the website along with national distribution of 160,000 postcards, 20,000 posters and 5,000 wrist bands
- Membership growth with a total of 132 full and associate members
- 89% increase in Twitter followers and 53% increase in Facebook audience
- 213% increase in subscriptions to the CEO Weekly Update
- Establishment of a National Disability Insurance Scheme (NDIS) network with over 600 subscribers
- 22 media releases distributed nationally
- Launch of strategic publication 'Perspectives: Mental Health and Wellbeing in Australia'

Collaboration

- 4 major sector collaboration events involving members and other key stakeholders
- Member contribution to a range of policy submissions and other key reports
- Participation in many working groups and collaborations
- Partnership with the NMHC to launch the National Mental Health Leaders Program

Corporate

- Strong member endorsement of a new Constitution following an intensive consultation period
- Development of a new three year Strategic Plan
- First staff engagement survey showed all staff are satisfied or very satisfied with the MHCA as an employer and staff are all engaged or highly engaged in their work
- Development of a Reflect Reconciliation Action Plan
- Establishment of a fundraising program

Financial

- Unqualified audited financial statements
- Reduced deficit from $44,377 to $9,604
- Receipt of operating grants totalling $3,689,678 representing 77% of total revenue

FROM THE CHAIR AND CEO

This year, the election of a new Federal Government, followed closely by the announcement of a Review of Mental Health Services and Programmes by the National Mental Health Commission, provided us with an opportunity to focus on the way this country supports mental illness.

Immediately, we welcomed the new Government's review. We live in complex and challenging times and mental health presents some complex policy challenges. The real success of this review will be measured by the difference that it makes in both the lives of Australians who experience mental illness and those who care for them. We all need, as a community, to take responsibility for ensuring that meaningful and lasting mental health reform is not just an idea in a dusty report, but is something that transforms the lives of real people.

We have dedicated much of 2013-14 to this important work. Our new strategic vision of mentally healthy people and mentally healthy communities provides us with the inspiration, and our new mission of co-designing the best mental health system in the world defines the task at hand.

We set ourselves the task of identifying the key elements needed to achieve lasting reform, and have embarked on projects to describe them. We have outlined key structural barriers to mental health reform, and processes to overcome them. Any analysis of the submissions we have made to the NMHC's review will find concrete and practical steps that governments can take to improve our current "system".

This annual report outlines much of this work. Our aim is to ensure the review has lasting impact where others have not.

But our work on the review has not brought an end to important work in other areas. We have spent considerable effort looking deeply into the NDIS in particular. We are focused on ensuring this scheme is effective for people with psychosocial disabilities, originally left out of the scheme itself and our members and stakeholders have been closely engaged with us in this process.

MEANINGFUL AND LASTING MENTAL HEALTH REFORM IS NOT JUST AN IDEA

We have continued our work in developing a new national peak for consumers and our work with the National Mental Health Consumer and Carer Forum (NMHCCF) and National Register has helped us to ensure that the voice of consumers and carers features in everything that we do.

Our commitment to facilitating a voice for consumers and carers and making sure their views are heard by those decision makers, both in the bureaucracy and government, remains strong, and is reflected in all our work.

We remain engaged with the Federal Parliament, meeting with all sides of politics and ensuring mental health remains top of mind. We will continue to strive towards achieving a bi-partisan vision for mental health in every conversation we have.

We have also directed much of our efforts this year to expanding our communications with members and stakeholders. Successful events like World Mental Health Day, the Council of Non-Government Organisations on Mental Health (CONGO) and our Members Policy Forum continue to give us opportunities to listen and share information with those with specialised knowledge in our sector and beyond.

New products like our Weekly Media Summary and bi-monthly online magazine Perspectives have allowed us a two way conversation with our members and have provided more opportunities for members to engage with each other.

In the midst of all this we also returned a strong financial result, successfully changed our company structure, our constitution and name with the support of members. All this is merely a platform for the important work ahead, but it's a strong platform.

It's an exciting time in the mental health sector and we have much to share and do.

Come November 2014 the NMHC review will be over. Our focus for the year ahead must move from imagining the high performing system of the future to implementing it. And surely this is what people who live each day with mental illness have been waiting for.

Jennifer Westacott
Chair

Frank Quinlan
CEO

A NEW STRATEGIC FOCUS

Strategic planning was a strong focus throughout 2013 following the wrap up of the MHCA's previous strategic framework. The establishment of a new plan provided an opportunity for the organisation to reassess our priorities and objectives for the next three years.

We launched our new Strategic Plan 2013-16 at the Members Policy Forum in October 2013. The plan includes a new vision: ***Mentally healthy people, mentally healthy communities*** *and mission:* ***To co-design the best mental health system in the world.***

The new plan focuses on delivering clear objectives that fit into five key focus areas encompassing the work of the entire organisation.

OUR FOCUS AREAS

CO-DESIGNING	MONITORING	ENCOURAGING	ENGAGING	MANAGING
To co-design a model for the best mental health system in the world in conjunction with consumers and carers, members, governments and other stakeholders	*To monitor and evaluate the performance of mental health systems and the progress of national reform, including the interface between the mental health system and other services and programs*	*To advocate for policies, services and systems that work effectively and efficiently together*	*To help the mental health sector to share information and work together*	*To ensure the MHCA is an influential, innovative, financially secure, robust, and well governed organisation*

OUR OBJECTIVES

- Australia has a world class mental health system co-designed by consumers, carers and key stakeholders
- The voices of consumers and carers, members and other stakeholders guide the reform process
- Reform is achieved with consensus on key priorities amongst consumers and carers, members, governments and other key stakeholders

- Comprehensive information is available on:
  - » government spending and activities
  - » system performance, interfaces and integration
  - » consumer and carer experiences and outcomes
  - » workforce capacity and wellbeing

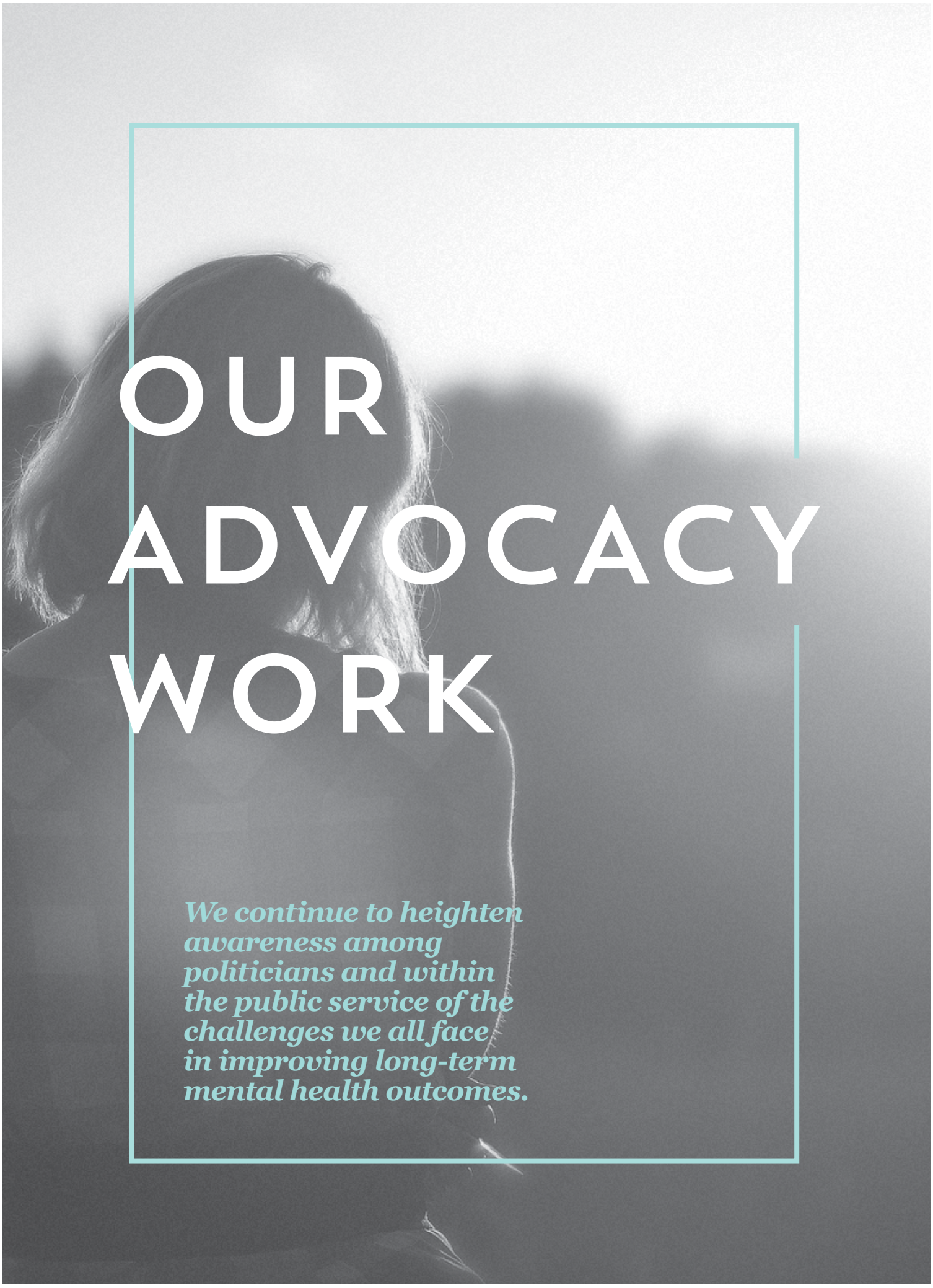
- Mental health reform maintains momentum and delivers real outcomes
- Seamless interfaces between key system components, including:
  - » the NDIS
  - » housing and homelessness
  - » physical health
  - » employment
- Reforms to a broad range of government policy and programs support improvements in mental health

- Members and stakeholders share information and resources to improve outcomes for people who experience mental illness and their carers. This would include exchanges between:
  - » MHCA and members, stakeholders, consumers and carers and governments
  - » MHCA and the public
  - » MHCA members

- The MHCA is:
  - » well-funded and financially secure
  - » diverse in its funding sources
  - » well managed and governed
  - » an employer of choice
  - » focused on the mental and physical wellbeing of staff

OUR VISION

MENTALLY HEALTHY PEOPLE, MENTALLY HEALTHY COMMUNITIES



OUR ADVOCACY WORK

We continue to heighten awareness among politicians and within the public service of the challenges we all face in improving long-term mental health outcomes.

A new government always brings both risks and opportunities. Despite the loss of a dedicated mental health Minister following the federal election, we have continued to ensure the voice of mental health is heard 'on the hill'. We have established excellent relationships with a number of new Ministers within the Abbott Government while maintaining contact with the opposition and crossbenchers.

In keeping with the whole-of-life nature of mental illness, we have been working with Ministers, advisers and agencies across Government, including the health, social services and employment relations portfolios and central agencies. We continue to heighten awareness among politicians and within the public service of the challenges we all face in improving long-term mental health outcomes.

One of the most important opportunities to influence and shape the future in mental health is the NMHC's review, which the Government commissioned consistent with its election commitments.

Other Government initiatives with clear implications for people with mental illness include:

- The National Commission of Audit
- The Review of Australia's Welfare System (the 'McClure' Review)
- The Federation White Paper

Details on our contributions to these and other processes can be found in Section 5 ('Our Key Focus Areas'). A full list of our policy submissions can also be found here: **http://mhaustralia.org/resources/submissions.**

While continuing to engage with the Government and contribute to formal consultation opportunities surrounding these initiatives, the MHCA also has a strong, long-term advocacy program that is described in detail in our new strategic plan.

The objectives outlined in the plan coalesced over the past year through our efforts, in collaboration with members and stakeholders to encourage governments to endorse national, whole-of-life, outcome-based targets and indicators to drive long-term mental health reform.

THE MHCA IS ON THE RIGHT PATH TO ACHIEVING BETTER MENTAL HEALTH OUTCOMES.

Adopting targets and indicators that have broad support from governments, the non-government sector and, most importantly, consumers and carers is the first step on the path to better mental health outcomes. The MHCA will continue to make this case as we further our advocacy efforts over the coming months and years.

OUR KEY FOCUS AREAS

CO-DESIGNING

To co-design a model for the best mental health system in the world in conjunction with consumers and carers, members, government and other stakeholders.

Focus Area 1: Co-designing

To co-design a model for the best mental health system in the world in conjunction with consumers and carers, members, government and other stakeholders.

A multitude of reviews, evaluations and reports over many decades have described the shortcomings of the mental health 'system' in delivering what consumers and carers need and want. Despite the efforts of many alongside substantial investment by governments, we are yet to see a vision for mental health reform and a path to achieving that vision.

A world leading mental health system

There are many stakeholders, policies and service interactions that contribute to an ideal mental health system. Given the scale and complexity of these arrangements, it is nearly impossible to develop and articulate a single framework that is at the same time comprehensive and action-oriented.

Creating a detailed blueprint for the mental health system as a whole is not necessarily the right first step to long-term reform. Doing so would duplicate previous efforts, which have generally proven ineffective in delivering lasting improvements across the board – despite notable achievements in particular areas.

Over the past year, the MHCA has sought in consultation with consumers and carers, members, government and other stakeholders, to identify the common barriers and structural factors which continue to impede reform. Our ultimate objective through this work is to build a clear, practical and achievable reform plan.

The need to outline how we can work together to achieve this vision has become more pressing in the context of the NMHC's review.

We hope to identify the key elements of a world-leading mental health system – and the steps required to put us on track towards achieving that vision – to inform the Commission's work over 2014.

National Mental Health Commission's Review of Mental Health Services and Programmes

Following its election in September 2013, the Australian Government tasked the NMHC with conducting a review of Australia's mental health services and programmes. The NMHC is due to provide their final report to the Government by 30 November 2014.

The MHCA **welcomed the review** and began work to develop a long-term vision for national mental health reform, as described above.

In November 2013, we made an initial submission to the Chair of the NMHC and offered the assistance of the MHCA and ideas on early directions for the review.

Our **second submission**, in April 2014, was a comprehensive document that identified structural and system levers for reform. Our recommendations were based on our vision of a world-class mental health system characterised by several fundamental features to drive better consumer and carer outcomes, prevention and early intervention, a recovery focus, service integration, and increased participation and inclusion of mental health consumers and carers.

Following a period of intense consultation throughout the sector, we delivered a **third submission** in June 2014. This submission built on previous submissions by:

- Describing the characteristics of a high-performing mental health system, emphasising the interdependency of clinical, psychosocial and other issues which contribute to the capacity of individuals to lead a contributing life
- Discussing some broader contextual factors which are critical to improving outcomes in the long-term, with reference to the National Commission of Audit, the 2014-15 Federal Budget, the Review of Australia's Welfare System, the Federation White Paper, and the NDIS
- Considering the challenges in achieving better coordination and integration within and across systems that people with mental health issues may encounter
- Describing the practical steps required to lay the structural foundations for reform
- Identifying other immediate priorities for action which are consistent with a long-term vision for reform

National Mental Health Consumer and Carer Forum

A fundamental aspect of a world leading mental health system is the need for consumers and carers to play a key leadership role and to ensure their voices are heard. The National Mental Health Consumer and Carer Forum (NMHCCF) plays a key role in the development of mental health policy and is a combined national voice for consumers and carers. The NMHCCF is auspiced by the MHCA.

Through its membership, the NMHCCF gives mental health consumers and carers the opportunity to meet, form partnerships and be involved in the development and implementation of mental health reform.

Membership of the NMHCCF comprises one consumer representative and one carer representative nominated by each state/territory government and representatives from eight national health consumer and carer organisations. During 2013-14 the Forum included one Culturally and Linguistically Diverse (CALD) consumer representative, one CALD carer representative and one Aboriginal and Torres Strait Islander (ATSI) consumer representative. The CALD representatives have participated on behalf of Mental Health in Multicultural Australia. The NMHCCF met four times in 2013-14.

Throughout the year NMHCCF representatives continued to provide consumer and carer perspectives on national mental health reform initiatives being progressed through national committees and events.

NMHCCF submissions were made to the following consultations:

- Draft Proposed National Framework for Reducing the use of Restrictive Practices in the Disability Service Sector (joint submission with the MHCA)
- Australian Commission on Safety and Quality in Health Care (ACSQHC) Discussion Paper – Consumers, the Health System and Health Literacy: Taking Action to Improve Safety and Quality
- NMHC Review of Mental Health Services and Programmes
- Australian Law Reform Commission Issues Paper 44, Equality Capacity and Disability in Commonwealth Laws (joint submission with the MHCA)
- Australian Law Reform Commission Equality, Capacity and Disability in Commonwealth Laws Discussion Paper

Also in 2013-14, NMHCCF members published two new advocacy briefs:

- CALD Mental Health
- Borderline Personality Disorder

Four existing advocacy briefs were also updated:

- Homelessness
- Privacy and Confidentiality
- Mental Health Facts and Figures
- Smoking and Mental Health

The NMHCCF has a strong focus on psychosocial disability and the implementation of the NDIS and wrote an article on people with severe, enduring mental illness, psychosocial disabilities and their carers which was published in the MHCA publication, Perspectives – Mental health and Wellbeing in Australia. This publication is discussed further in Focus Area 4: Engaging.

The NMHCCF also had an article on psychosocial disability published in the Health Issues Journal Summer 2014 edition.

All NMHCCF publications and submissions are available at **www.nmhccf.org.au**

National Register of Mental Health Consumer and Carer Representatives

The National Register is made up of 60 mental health consumer and carer representatives from around Australia. Members provide expertise to organisations requiring consumer and carer representatives who can work effectively at the national level.

During 2013-14 the consumer and carer selection panel (NMHCCF co-chairs and the consumer and carer representatives on the MHCA Board) selected representatives from the NMHCCF and National Register for 24 consumer and 21 carer representative positions for the following new opportunities across national mental health reform, health workforce development and mental health service planning initiatives:

- Medibank Private and beyondblue – mental health reform workshop
- Suicide Prevention Australia – annual conference
- Reconnexion – national anxiety and depression conference

- MHCA DisabilityCare stakeholder workshop
- MHCA DisabilityCare – project advisory group
- WA clinical senate meeting – presentation
- Psychotherapy and Counselling Federation of Australia (PACFA) Conference – organising committee
- Melbourne Social Equity Institute – lived experience advisory group
- Mental Health Nurse Incentive Program – expert reference group
- Partners in Recovery – capacity building project
- NMHC on behalf of the Mentally Healthy Workplace Alliance – stakeholder advisory group
- Disability Advocacy Network Australia (DANA) Conference – presentation
- 9th National Seclusion and Restraint Reduction Forum – participation
- National Mental Health Workforce Strategy and Planning workshop
- Disability Employment Services – consumer days
- Australian Mental Health Outcomes and Classification Network (AMHOCN) and Community Mental Health Australia (CMHA) – technical advisory group
- Australian Electoral Commission – disability advisory committee
- PACFA Conference – participation
- MHCA National Mental Health Consumer Organisation Establishment Project – stakeholder workshop
- NMHC National Mental Health Leaders Project induction and training workshop – presentation
- The Royal Australian College of General Practitioners (RACGP) – learning package review group
- Suicide Prevention Australia – lived experience symposium

Annual National Register and NMHCCF Issues Forum/Workshop

The annual National Register and NMHCCF workshop was held on 22-23 May 2014 and was attended by 65 consumers and carers. The workshop focused on opportunities and challenges for advocates and building the effectiveness of consumer and carer advocacy efforts in 2014-15. Key agenda items included peer workforce, trauma informed care and practice, the NDIS and the National Recovery Framework.

National Mental Health Leaders Program

The MHCA partnered with the NMHC, with the support of the NMHCCF, to further develop a new cohort of consumer and carer mental health leaders and find and develop the next generation of leaders.

In November 2013, the NMHC sought nominations from people with lived experience of mental illness and their families and carers, who had the capabilities, experience and/or potential to operate at the national level and to work with and contribute to the NMHC's vision and mission. The selection process concluded in March 2014 with eleven people selected for the program.

Program participants were offered a range of opportunities including:

- Contributing at a national level to mental health policy advice, advocacy and reporting associated with the Commission's mandate.
- Individual mentoring and participation in the national leadership development program, which included training workshops and ongoing learning, networking and mentoring opportunities.

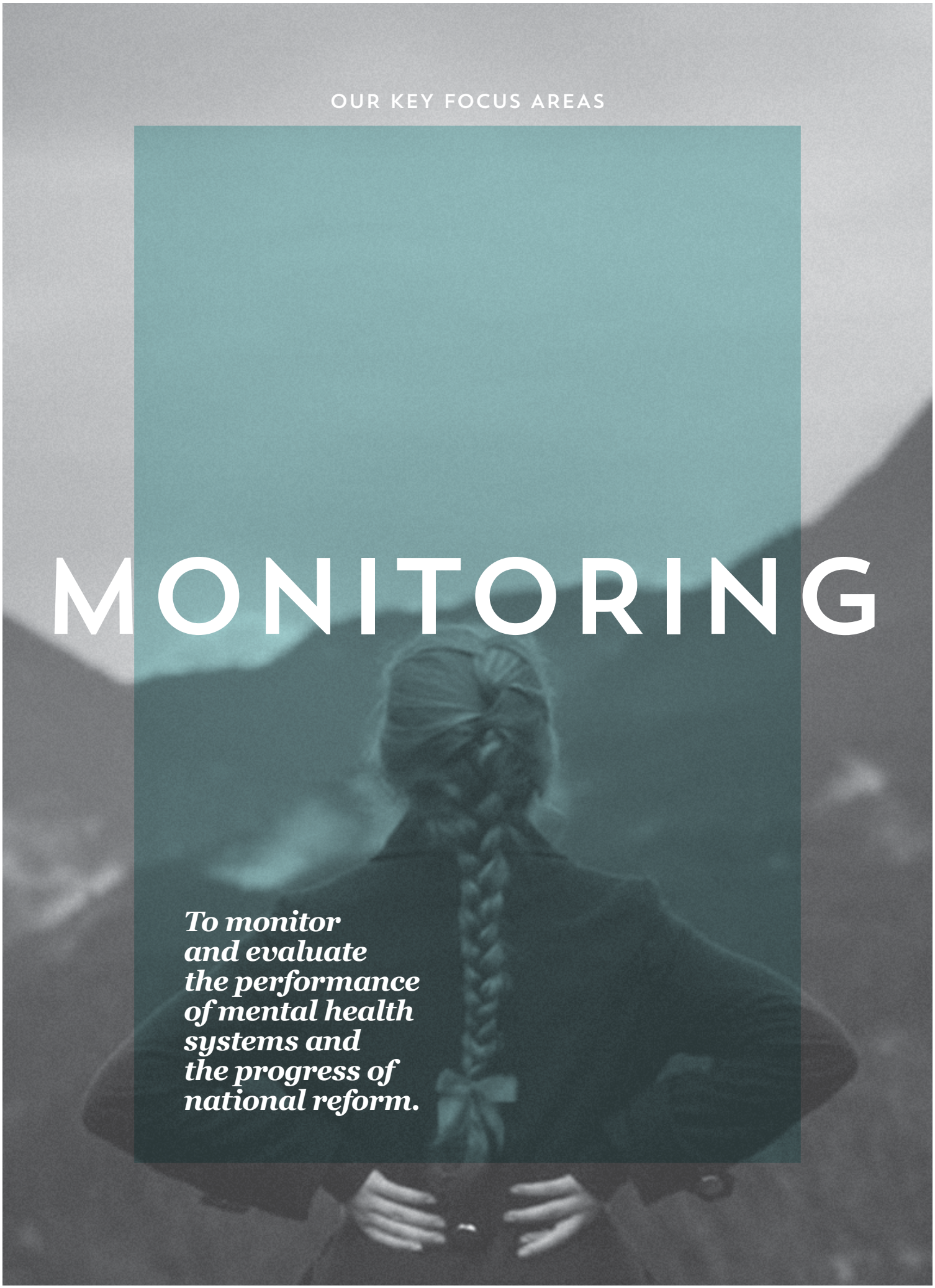
An induction and training workshop for the eleven participants was held in May 2014. At this two and a half day residential workshop, participants shared experiences and heard from guest presenters about a range of topics including leadership, communication and influence, and the mental health landscape. A workshop communique was developed by participants and is available on the **Commission's website.**

The workshop was the first part of the project, with further development opportunities throughout 2014, including two additional workshops, access to a resource and activity web portal, leadership development plans, mentoring, and opportunities to attend national level meetings and networking events.

Further information about the project is available from the **NMHC website**.

OUR KEY FOCUS AREAS

MONITORING



To monitor and evaluate the performance of mental health systems and the progress of national reform.

Focus Area 2: Monitoring

To monitor and evaluate the performance of mental health systems and the progress of national reform, including the interface between the mental health system and other services and programs.

Monitoring national reform

The MHCA has continued its leadership role in the mental health sector with a number of high profile policy submissions containing recommendations for meaningful and achievable reform.

Targets and Indicators

Following the inaugural CONGO meeting in October 2012, the NMHC and the MHCA have worked closely to gather the views of consumers, carers, the non-government sector and other experts on targets and indicators that would drive long-term reform in mental health for the benefit of consumers and carers. In July 2013 we delivered **our consultation report** on behalf of the mental health sector. It was clear from our discussions that the broader mental health sector understood the importance of, and wished to embrace, the rare opportunity to align government action with consumer and carer aspirations and the support of the non-government sector. This report went to the Commission's Expert Reference Group (ERG) on Targets and Indicators, which the ERG used as the basis for its own recommendations to the Ministerial Working Group on Mental Health Reform.

In February 2014, we led a campaign to support our member organisations to encourage Commonwealth and state/territory governments to endorse national, whole-of-life, outcome-based targets and indicators to drive long-term mental health reform. Using information provided by the MHCA, many members took the opportunity to contact government decision-makers ahead of the March 2014 meeting of the Australian Health Ministers Advisory Council.

We will continue to advocate for COAG to adopt the targets and indicators as a critical driver of reform in the interests of consumers and carers.

Submission to the 2014-15 Federal Budget

Our s**ubmission to the 2014-15 Federal Budget** proposed a series of no-cost, low-cost and long-standing recommendations that will help build an Australian mental health system is holistic, integrated and delivers better support for people with a lived experience of mental illness and their carers.

The MHCA met with key government Ministers and advisors in the lead-up to the delivery of the Federal Budget in May and provided a summary of the impact of announced budget measures for people who experience mental illness. An email summary of the budget outcomes was sent to all members along with a short video and was the most popular and most shared piece of correspondence to members during the year.

Submission to the NMHC Review of Mental Health Services and Programmes

The NMHC review has been a particular focus for the entire mental health sector throughout the year. In the previous section (Focus Area 1: Co-designing) you can read about our submissions to the review process.

Welfare Reform

In February 2014, the MHCA met with Patrick McClure and members of the team conducting the Government's Review of Australia's Welfare System. Changes to the welfare system are likely to have significant impacts on people with a lived experience of mental illness and their carers. The MHCA has worked closely with other non-government organisations with an interest in the welfare system, including the Australian Council of Social Services, the Australian Federation of Disability Organisations and the National Welfare Rights Network and we aim to provide a detailed submission to the review team in August 2014.

Employment services

The MHCA received funding from the (then) Department of Education, Employment and Workplace Relations to undertake a project to promote Disability Employment Services (DES) to mental health consumers and carers, seek feedback about their experiences with DES and their suggestions for employment services reform. This involved providing information about the DES program and bringing consumer and carer representatives together to discuss their experiences with the disability employment system.

In addition, the MHCA supported Jobs Australia's 2015 Project, which aims to promote an alternative model for the future of employment services in collaboration with other non-government organisations, in the context of the Australian Government's review of the employment services system beyond 2015.

Participation on key advisory groups and committees

The MHCA is a member of many national mental health advisory groups and committees, demonstrating its leadership role in representing the mental health sector on issues that are of interest to members and other stakeholders.

Examples include:

- Expert Working Group on Targets & Indicators convened by the NMHC
- Australian National Council on Drugs
- Human Services Strategy and Innovation Council
- Mental Health Information Strategies Standing Committee
- Safety and Quality Partnerships Standing Committee and various subcommittees
- Health Workforce Australia – Mental Health Advisory Group
- Disability Support Pension Impairment Tables Advisory Group
- NDIS Eligibility and Assessment Expert Group
- Independent Hospital Pricing Authority Stakeholder Advisory Group on Activity Based Funding
- Department of Human Services Council on Strategy and Innovation
- Mindframe Communications Advisory Group
- Mental Health Nurse Incentive Program Expert Reference Group
- Partners in Recovery Expert Reference Group
- Partners in Recovery Capacity Building Project Reference Group
- Suicide Prevention Australia's Working Group on planning for World Suicide Prevention Day
- Mentally Healthy Workplace Alliance
- National Complex Needs Alliance

National Disability Insurance Scheme

Over the past year our has worked closely with members and stakeholders in NDIS trial sites and played a key role in identifying the implications of the transition to the NDIS for the mental health sector.

Many of the issues raised by mental health stakeholders, and subsequently conveyed by the MHCA to the National Disability Insurance Agency (NDIA) and policy-makers, have the potential to make significant negative impacts on mental health consumers, carers and service providers, and some required urgent attention. A summary of these issues can be found in the **MHCA's December 2013 position paper.**

In recognition of the urgency of these concerns, in early 2014, the Board of the NDIA invited us to develop a proposal on how they could be addressed.

The proposal, developed in confidence at the request of the NDIA, was subsequently released for sector consultation in March 2014.

The proposal advocates slowing down the implementation of the scheme to ensure that the key barriers to effective implementation are addressed first.

Some of the most important issues now facing the mental health sector include:

- identifying what Tier 2 supports will look like, as this is likely to impact on many more people with psychosocial disability than those in Tier 3.
- establishing mechanisms for monitoring the 'continuity of care' guarantee already agreed by governments, to ensure that no person currently eligible for psychosocial supports will miss out on services as an unintended consequence of the transition to the NDIS.

The MHCA is pleased that the NDIA has recently recognised the importance of the distinctive issues faced by the mental health sector as it prepares for the NDIS, including the appointment of a special adviser on mental health matters. The MHCA regards this as an important outcome of its ongoing policy and advocacy work to realise the full potential of the NDIS to improve quality of life for people with psychosocial disability. Throughout 2013-14, the MHCA was also engaged to conduct an NDIS Capacity Building Project to engage the mental health sector. A full report on this project is provided in the next section – Focus Area 3: Encouraging.

Policy Submissions

The MHCA developed a number of high quality submissions throughout the 2013-14 financial year, covering a range of national mental health and related issues. All submissions can be downloaded from the **MHCA website.**

August 2013

Submission to the 5th Community Pharmacy Agreement Mid-Point Consultation with Stakeholders

The MHCA described the key role that community pharmacies can play in the provision of consumer medicine information and the facilitation of consumer understanding about medicines, their benefits, effects and how they can be managed. The MHCA also called for broader consultation with the mental health sector in developing a stronger role for community pharmacies in supporting mental health consumers and carers.

November 2013

Submission to the National Commission of Audit 2013

This submission recommended that the Commission of Audit defer any specific action in relation to mental health (beyond possibly lending its support to the need for substantial review) to the more detailed NMHC review.

January 2014

Submission to the Australian Law Reform Commission issues paper into equal recognition of people with disability before the law - Mental health and insurance 2014

This submission to the Australian Law Reform Commission described how people with experience of mental illness often do not have access to insurance on reasonable terms. The MHCA argued that the exemptions that providers of insurance currently enjoy under the *Disability Discrimination Act (1992)* be reviewed and amended, and that an independent actuarial study be conducted on the data insurers use to assess the risks associated with mental illness. The submission also called for a number of improvements to industry practice, including to insurance products, guidelines, forms and processes, and staff training.

February 2014

Submission to Australian Law Reform Commission inquiry into equal recognition of people with disability before the law - NDIS 2014

The central principles of the NDIS of consumer choice and control go to the heart of the Australian Law Reform Commission's inquiry into equality before the law of people with disability. In this submission, the MHCA outlined concerns around equal recognition for people with psychosocial disability through the NDIS, including in relation to scheme design, service quality and safeguards, and supported decision-making.

February 2014

Joint NMHCCF and MHCA submission to the Australian Law Reform Commission Issues Paper - Equality, Capacity and Disability in Commonwealth Laws 2014

In this joint submission, the NMHCCF and the MHCA discussed human rights and equal recognition before the law for people with mental illness and psychosocial disability. The submission made a series of recommendations about nationally consistent approaches to legal capacity, supported decision-making, advance care planning, mental health legislation and restrictive practices.

February 2014

Submission to the 2014-2015 Federal Budget

The MHCA's 2014-15 budget submission proposed a range of no-cost, low-cost and long-standing recommendations that will help build an Australian mental health system that is holistic, integrated and that delivers better support for people with a lived experience of mental illness and their carers.

February 2014

Submission to the NMHC Review of Mental Health Services and Programmes 2014

Following the release of the Terms of Reference, the MHCA wrote to Professor Allan Fels, Chair of the NMHC, to offer support and assistance to their Review of Mental Health Services and Programmes. In doing so, the MHCA also highlighted a number of issues that must be given high priority throughout the course of the review.

March 2014

Submission to the Senate Standing Committee on Economics Inquiry into Affordable Housing 2014

The MHCA provided a submission to the Senate Inquiry into Affordable Housing. In the submission the MHCA recommended that people with lived experience of mental illness be recognised as a priority group in future housing and homelessness agreements; that the National Partnership Agreement on Homelessness be re-funded for a further five years; and endorsed the continuation of current strategies aimed at growing the community housing sector to ensure there are increased housing options available for people with lived experience of mental illness.

April 2014

Submission to the National Mental Health Commission's Review of Mental Health Services and Programmes 2014

This second submission formed the MHCA's response to the NMHC's call for submissions as part of its formal consultation to inform its review. The submission identified structural and systemic levers for reform, while making recommendations for actions that were practical and achievable in a reasonable timeframe.

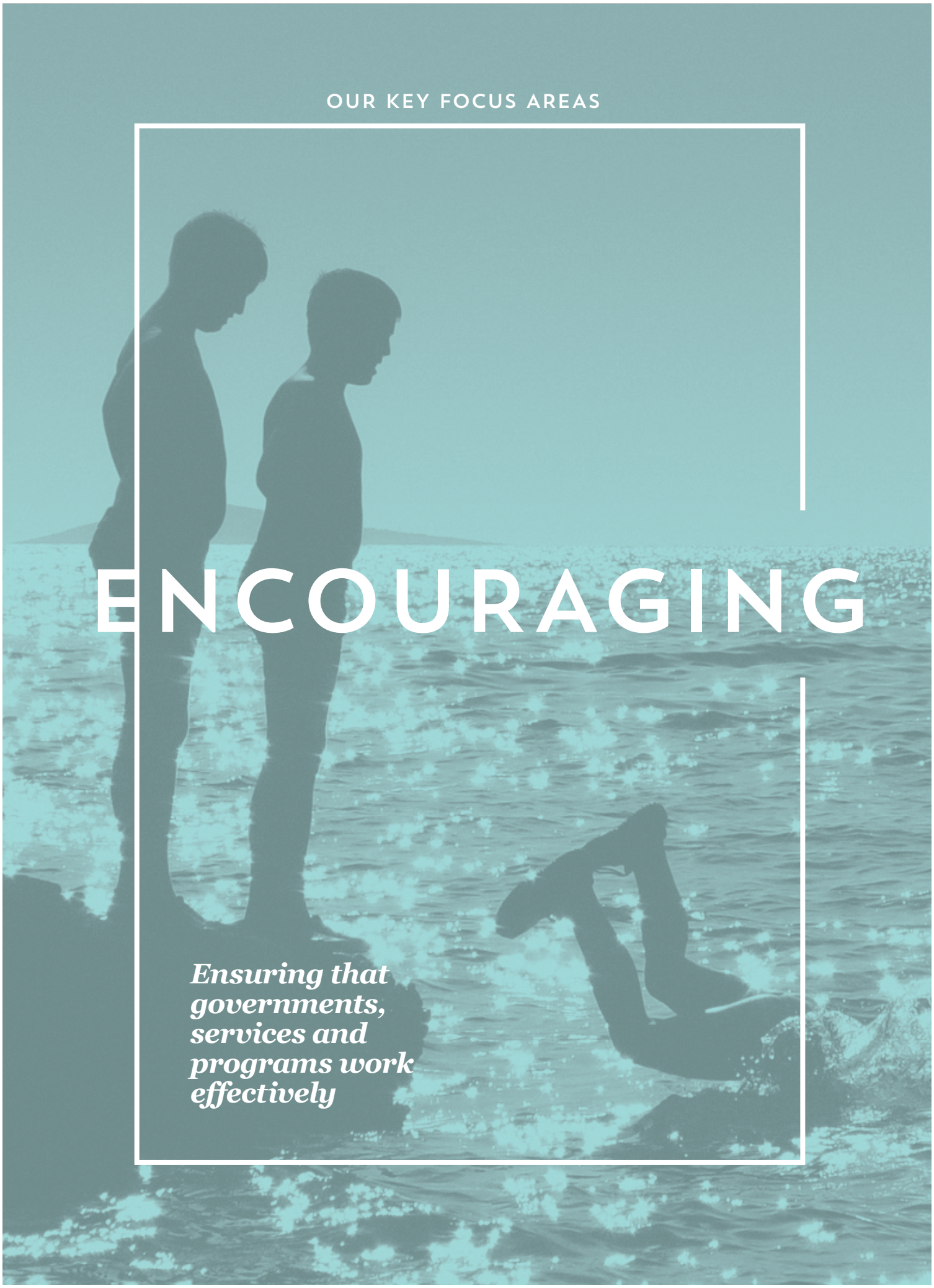
June 2014

Submission to the National Mental Health Commission's Review of Mental Health Services and Programmes 2014

This third submission from the MHCA to the NMHC's review articulated the MHCA's priorities for the mental health system going forward. It provided detailed analysis on: the characteristics of a high-performing mental health system; the role for governments; structural foundations for long-term reform; and the boundary between mental health and other systems.

OUR KEY FOCUS AREAS

ENCOURAGING



Ensuring that governments, services and programs work effectively

Focus Area 3: Encouraging

To advocate for policies, services and systems that work effectively and efficiently together.

NDIS Capacity Building Project

The NDIA funded the MHCA to help build the capacity of the mental health sector to engage with the NDIS. The subsequent NDIS Capacity Building Project generated considerable interest amongst mental health stakeholders, from the NDIS trial sites to the national level. It brought together a wide range of stakeholders and established advisory structures on specific issues. The network built through the project includes over 600 stakeholders. The NDIS Capacity Building Project was the most visited section of the MHCA website over the reporting period.

During this period, the MHCA undertook the following activities:

- A position paper that drew from the findings of consultations and articulated the sector's concerns about the design of the NDIS, the status of existing services, the likely impact on future mental health programs and some potential solutions
- Development of an online information portal on NDIS issues relevant to the mental health sector
- Organisational readiness forums for service providers in each state and territory
- Convened a national stakeholder forum
- A CONGO meeting that was dedicated to NDIS issues
- Formal and informal discussions with the NMHCCF
- Visits to active trial sites
- Convening a Project Advisory Group along with specialist working groups to identify key issues relevant to the mental health sector and provide on-going advice and oversight of the project
- Presentations and discussions at dozens of events and conferences
- Feedback through the MHCA's NDIS network
- Consumer and carer fact sheets
- An interim report on the progress of the capacity building work

The project has also created opportunities to engage with other stakeholders affected by the NDIS, such as the housing sector, the broader disability sector and organisations representing people from Indigenous and culturally diverse backgrounds, to address issues relevant to psychosocial disability.

During 2014 the MHCA also worked closely with the NDIA to ensure that the expertise and knowledge within the sector is used to inform implementation. This relationship is expected to continue, with the MHCA playing a key role in the future to support mental health sector participation in the NDIS. The MHCA will do this by providing information and support, undertaking capacity building activities, feeding advice from the sector to government, and facilitating mechanisms to include stakeholders in developing solutions to the many challenges in implementing the NDIS for people with psychosocial disability.

National Mental Health Consumer Organisation Establishment Project

Since 2012, the MHCA and the Consumer Reference Group (CRG) have been working together to establish an independent and sustainable national mental health consumer organisation.

The new organisation will be governed by and for people with lived experience of mental illness. It will focus on human rights and social justice approaches to mental health consumer issues and interests, and influence mental health reform and practice in Australia.

As the project nears completion, we face uncertainty about whether government funding will be available for the new organisation once established. This uncertainty has had an impact on project activity, and a number of key project milestones, including Board and CEO recruitment, have been delayed.

The CRG and the MHCA met three times in 2013-14. Project achievements this year included:

- Development of vision and mission statements for the new organisation
- Development of the draft constitution, with a focus on good governance. This process included advice from the CRG, the MHCA Board, governance and legal experts, and comprehensive community consultation.
- The MHCA Board endorsed a series of recommendations from the CRG about the structure of the new organisation, including:
  - » a hybrid membership structure of both individuals and organisations, ensuring that people with lived experience are voting members
  - » a Board composed of nine directors, six of whom must have lived experience, including the Chair
  - » the new organisation will seek to be a Health Promotion Charity
- Finalisation of the engagement and communication strategy and implementation of a range of project communication and engagement activities, including presenting at TheMHS Conference, a community consultation on the constitution, monthly updates from CRG members, meeting communiques, and creating a project Facebook page.
- Discussion of the positioning of the new organisation at a national mental health consumer peak workshop hosted by the CRG and the MHCA. Twelve mental health consumer-focused peaks were represented.

Additional information about the project is available on the project website **mhconsumer.org.au**

OUR KEY FOCUS AREAS

ENGAGING

To help the mental health sector to share information and work together.

Focus Area 4: Engaging

To help the mental health sector to share information and work together.

Communications channels

The MHCA has a commitment to improving sector knowledge and capacity through the dissemination of information and the provision of a platform to reduce stigma in the community. This is achieved through a number of innovative channels.

The MHCA CEO sends a weekly email update to a wide range of members and stakeholders, keeping them informed of the work being done by the MHCA and alerting them to items of key interest in the sector. The weekly email was moved to a new template and platform in December 2013 and promotion was boosted. Since the change the number of people subscribing to the update has increased by 213%.

All publications, media releases and policy statements are distributed to members, uploaded to the website and advertised through updates, social media and email notifications. Our following on social media continues to grow with the audience on Twitter and Facebook increasing by 89% and 53% respectively throughout the reporting period.

A direct benefit of membership is a Weekly Media Summary, which features mental health-related stories from Australia and overseas including Hansard extracts and media releases from Members of Parliament.

The new MHCA website and membership database went live in November 2013. The redevelopment of the site evolved throughout the year with the site receiving 199,227 page views during the reporting period.

Strategic Publication – 'Perspectives: Mental Health and Wellbeing in Australia'

In August 2013, the MHCA launched a strategic publication – 'Perspectives: Mental Health and Wellbeing in Australia'. Perspectives provided a snapshot of an important moment for the mental health sector in Australia, a time of real and meaningful reform. The publication was about building a stronger mental health sector, through collaborative reform, based on a coordinated approach to services and policy, creating an inclusive system where individuals are able to live a contributing life. The publication included thirty-one articles from experts in homelessness, economics, workforce participation and education. The entire publication can be downloaded from **our website**.

Following the launch of the hard copy publication, a new online bi-monthly magazine was launched in June 2014. Also called Perspectives, this magazine allows the MHCA to provide an in-depth analysis of some of the key issues facing the mental health sector. As an added member benefit, members are invited to contribute articles to the publication.

World Mental Health Day – 10 October

October 2013 saw an extremely successful national campaign for World Mental Health Day. The campaign focused on three themes, reducing stigma, encouraging help seeking and bringing communities together. Utilising a new interactive concept and online platform, the campaign called on everyone to make a mental health promise to themselves, regardless of their personal mental health history.

The campaign achieved the following highlights:

- Launched on Weekend Sunrise
- Celebrity endorsement of the campaign including Firass Dirani, Shane Jacobson, John Waters, Chrissy Swan, Jane Hall, Peter Overton, Hugh Riminton, Andrew O'Keefe, Joe Roff, Jonathan Welch, Jamie Harnwell and Jessica Rowe.
- Successful social media cross promotion through MHCA members and stakeholders including R U OK?, Lifeline, beyondblue, SANE Australia and the NMHC
- Minister for Health, The Hon Peter Dutton MP and MHCA CEO Frank Quinlan held a press conference at Parliament House
- The MHCA posted 199 tweets and 300 Facebook posts relating to WMHD between 16 September and 11 October 2013
- The campaign went global, reaching and engaging audiences in America, England, New Zealand and Asia
- 2,300 mental health promises published on **1010.org.au** by Friday 11 October 2013
- The Promise Wall was the most popular page receiving 17,678 page views throughout the four week campaign
- There were 101 events added to the event map – surpassing the total of 70 events listed in 2012
- 23 radio interviews were conducted by Jessica Rowe, Peter Overton, Jonathon Welch, and Professor Helen Christensen, totalling 20 hours of radio airtime
- Public Information Messages (PIM) were produced for radio with TV journalists and presenters Jessica Rowe and Peter Overton, AFL footballer Harry O'Brien, youth mental health expert Professor Pat McGorry, and founder of the School of Hard Knocks Jonathon Welch
- A specific 30-second and 60-second PIM were recorded by Indigenous musician and broadcaster Warren H. Williams for broadcast on Indigenous radio stations
- More than 160,000 postcards, 20,000 posters and 5,000 wristbands were produced and distributed across the country

In early 2014, we were approached by a production company who filmed a documentary for ABC 2 with comedian Felicity Ward. This TV show will air on 6 October 2014, and aligns with and supports the second year of the campaign, further boosting its reach and impact.

Grace Groom Memorial Oration

The Grace Groom Memorial Oration in October 2013 was an excellent opportunity for members to network and listen to an inspirational speech from MHCA Chair Jennifer Westacott. Focused on reform, the Chair shared some of her personal story including why she accepted the position of Board Chair as well as the Board's vision for the next decade in mental health. A key message from the speech was the call for a social movement to change the way society views mental health and to drive the establishment of integrated, people centred services and programs.

Minister for Health The Hon Peter Dutton also addressed the audience and joined Jennifer onstage for a Q&A session hosted by ABC journalist Lyndal Curtis.

Members Policy Forum

The MHCA convened two Members Policy Forums over the course of the 2013-14 financial year, in October 2013 and April 2014.

The October 2013 forum included addresses by Minister Dutton, Greens Senator Penny Wright and ALP Senator Jacinta Collins. Members were given the opportunity to address questions and provide input to all three politicians.

The April 2014 forum discussed a range of issues including the NMHC review, the welfare system review and a presentation on the new strategic focus of co-designing the best mental health system in the world. A Special General Meeting was held during the day during which members ratified the move to become a Company Limited by Guarantee and voted to change the organisation's name to Mental Health Australia. More information on this is provided in Section 7 – Governance. A member and stakeholder dinner was held on the evening before the forum and guests were entertained by comedian Bryan Dawe.

Council of Non-Government Organisations on Mental Health

Following on from the success of previous meetings in October 2012 and May 2013, the third CONGO meeting was held on 10 April 2014. This event provided key non-government organisations with the chance to influence the NDIS agenda and included sessions on:

- Feedback from the trial sites
- Discussion of the MHCA's **proposal** for the NDIA *'Developing a framework for providing psychosocial disability support through the NDIS'*
- Key emerging issues:
  - » coverage and eligibility
  - » assessing impairment and support needs
  - » outreach, early intervention and high support needs
  - » transition and integration with existing programs
  - » the capacity of consumers and carers to engage effectively with the NDIS
  - » the capacity of mental health service providers and the mental health workforce to adapt to the NDIS
  - » monitoring, accountability and evaluation

The meeting was highly successful with feedback from all attendees indicating that the CONGO format is valued and should continue into the future.

Media and Public Relations

Media remains a key plank of information delivery and advocacy, especially in connection with key campaigns and issues. In addition, the MHCA has begun a targeted program of reporting on member and stakeholder activities to raise the profile of the sector in general.

The MHCA has continued to build the profile of its CEO to become a recognised and trusted face of mental health in Australia. In addition, the talent and reach of high profile individuals such as Jessica Rowe, Peter Overton and Jonathan Welch has also been utilised. Through this, we will further our impact on policy development and raise the profile of members and the work of the sector.

Media output has risen by over 12.5% in this reporting period. This included 22 media releases, MHCA staff being interviewed on national television, radio and opinion pieces being published on national news platforms and in nationally circulated newspapers.

Mentally Healthy Workplace Alliance

The Alliance brought together a range of organisations through the NMHC and is committed to working with businesses to create mentally health workplaces. The MHCA is one of the founding members and our CEO sits on the Alliance's Steering Committee.

The Alliance promoted opportunities for all Australian workplaces to take active steps to create mentally healthy workplaces and fully realise the benefits to their people, their business and the community.

The Alliance has launched a call for good practice and will use the information obtained to develop practical, national resources for businesses for release later in 2014.

Pharma Collaboration

The MHCA Pharma Collaboration provided an opportunity for the mental health sector to maintain a relationship with the medicines industry. AstraZeneca Australia Pty Ltd; Janssen-Cilag Australia Pty Ltd; Lundbeck Australia Pty Ltd.; Pfizer Australia Pty Ltd.; and Medicines Australia (the peak body for the prescription medicines sector) and the MHCA form the partners of the collaboration.

The MHCA Pharma Collaboration met several times during the period and agreed on a work plan that covered:

- Provision of consumer and carer support to attend World Mental Health Day activities
- Support for input to national medicines policy via MHCA representation on key mental health policy advisory committees
- Development of an economic case for mental health promotion, mental illness prevention and early intervention.

The Pharma Collaboration generously supported other activities throughout the year, including World Mental Health Day.

National Suicide Prevention Alliance

The MHCA is proud to be part of the National Suicide Prevention Alliance, which is led by Suicide Prevention Australia (SPA) and has embraced the goal of halving the national suicide rate in ten years – an ambition we hope to see governments endorse through COAG as they consider long-term targets to drive mental health reform.

As part of this relationship, MHCA staff attended the National Suicide Prevention Conference in Melbourne in July 2013, a broad cross sector SPA planning day in August 2013 in the lead up to the 2013 World Suicide Prevention Day, and an April 2014 planning workshop for the 2014 World Suicide Prevention Day campaign. This workshop included representatives from a range of mental health and suicide prevention organisations, including many MHCA members.

Mend Medicare Coalition

The MHCA joined forces with the Australian Nursing & Midwifery Federation, Catholic Health Australia, Consumers Health Forum of Australia, and the Public Health Association Australia to call on all political parties ahead of the September 2013 Federal Election to outline plans to ensure Medicare is able to meet the needs of all Australians into the future. The Mend Medicare Coalition released a report presenting the latest figures on the cost of health care and access to services which highlights the concern that the most vulnerable in our community are the ones missing out on quality healthcare. The Mend Medicare Coalition also called on all political parties to acknowledge the growing barriers to care and restore what is meant to be a universal health system.

Mental Health Conference Funding Program

The MHCA received funding from the Australian Government Department of Health for the Mental Health Conference Funding Program to provide financial assistance to support mental health and/or suicide prevention themed conferences and events.

The purpose of the program is to promote the involvement of mental health consumers and carers at mental health and suicide prevention themed conferences, and support the delivery of those conferences with a mental health clinical/professional focus.

The program is very popular and highly competitive with some funding rounds attracting more than 30 applicants. The funds applied for often exceed funds available for allocation and the reach of the program is quite diverse with funded conference topics covering issues such as:

- Suicide prevention
- Grief
- Post-Traumatic Stress Disorder
- Borderline Personality Disorder
- Indigenous Mental Health
- Regional Mental Health
- Inner City Mental Health
- Attachment and Trauma Informed Practice
- Youth Mental Health
- LBGTI Mental Health
- Eating Disorders

OUR KEY FOCUS AREAS

Ensuring the MHCA is an influential, innovative, financially secure, robust, and well governed organisation.

MANAGING

Focus Area 5: Managing

To ensure the MHCA is an influential, innovative, financially secure, robust, and well governed organisation.

Workforce

Our workforce grew around 5% to 20 employees for the period 2013-2014. During the year we also engaged two Business Administration Trainees.

Equity and workforce diversity

Our commitment to Equal Employment Opportunity (EEO) and Diversity continues to be reflected in our 5 year EEO Management Plan, created in 2013. The plan was developed to guide programs that identify and remove barriers relating to employment and the promotion of EEO groups.

Initiatives successfully undertaken during the second year of the plan included:

- development of an Equal Opportunity, Discrimination and Harassment Policy
- collection of diversity data to inform our diversity strategies and outcomes
- introduction of purchased additional leave that further enhances our existing employment policies and practices to meet the diverse needs of our employees
- ongoing training and development of the Equity and Diversity Officer to handle employee enquiries regarding workplace discrimination, harassment, victimisation and bullying

Representation of our workforce

The MHCA is a small organisation and the representation of our workforce demonstrates a strong commitment to Equal Employment Opportunity (EEO).

WORKPLACE PROFILE	COMMUNITY SERVICES – MENTAL HEALTH COUNCIL OF AUSTRALIA											
Occupational	**Full time**		**%**	**Part time**		**%**	**Casual**		**%**	**Total Employees**		**%**
Category	*Female*	*Male*	*Female*	*Female*	*Male*	*Female*	*Female*	*Male*	*Female*	*Female*	*Male*	*Female*
Board	4	6	40	0	0	0	0	0	0	4	6	40
Executive Management	1	3	25	1	0	100	0	0	0	2	3	40
Management	1	0	100	5	0	100	1	0	100	7	0	100
Project Officers	1	1	50	1	0	100	0	0	0	2	1	67
Administration Staff	3	1	75	1	0	100	0	0	0	4	1	80
Total	10	11	48	8	0	100	1	0	100	19	11	63

EEO (STATISTICS)	% WORKFORCE
Female	75%
Minority group	6%
Person with a Disability	6%
Lived experience as a mental health carer	26%
Lived experience as a mental health consumer	42%

Work Health and Safety

The organisation had another excellent result this year with no lost time due to injuries or workers compensation claims.

No Bullying Policy/Program

A No Bullying Policy aimed at preventing and managing bullying at work was successfully introduced, defining what inappropriate behaviour is, knowing the parameters and learning how to resolve and report bullying behaviour. While there will continue to be a strong emphasis on appropriate workplace behaviour, the No Bullying Program is now evolving to focus on how people conduct themselves in the workplace and the values and attributes we are proud of.

Health in Mind Program

The Health in Mind Program is our employee health promotion program. During 2013-2014, all employees had the opportunity to be involved in one or more of the following program activities – on-site free influenza vaccination, corporate subsidy for individual health and fitness activities, Care Aware campaign, employee briefings on communication skills and interpersonal dynamics at work, ergonomic assessments, nutrition and arranged activities on national health observance days.

Employee support

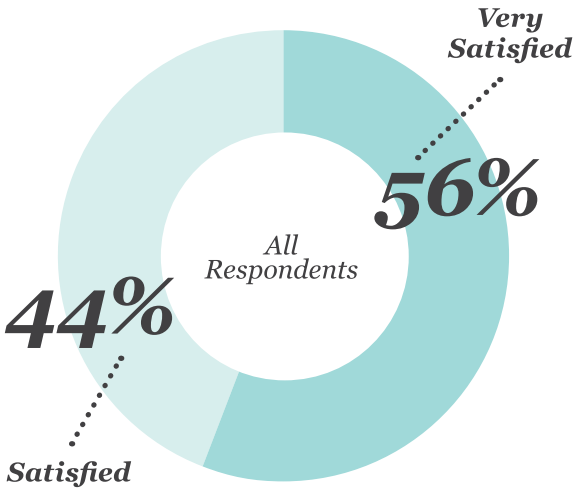
The MHCA is conscious of the challenges facing employees today and provides different forms of employee support. We have continued our partnership with Canberra Psychology Clinic, as our Employee Assistance Program provider, to give employees and their families professional counselling on general lifestyle management and issues that impact on work. Family friendly policies include flexible working arrangements, paid maternity and paternity leave and study assistance.

Measuring our organisational health

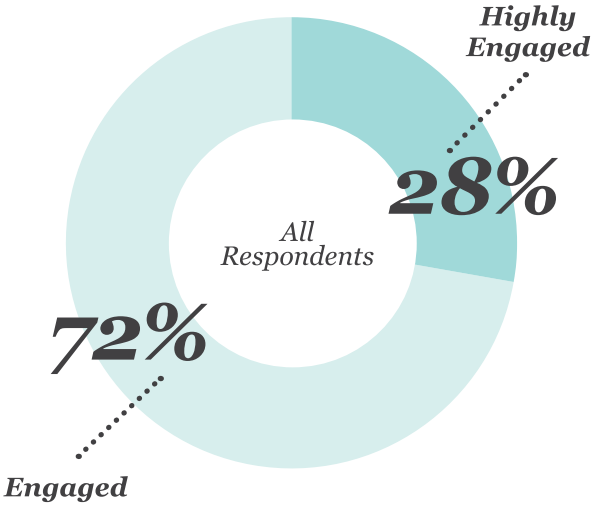
This year, the MHCA conducted its first Employee Engagement Survey. The results of the survey were very encouraging. Some of the highlights included:

- 94% of employees participated in the survey
- Employees are either satisfied or very satisfied with the MHCA as an employer
- All employees are engaged or highly engaged in their work

Employee Satisfaction Graph



Employee Engagement Graph



Action planning from survey findings

The survey results have helped us to understand the views and concerns of our employees and this feedback is being used to identify specific actions to be taken to address opportunities and issues impacting on the organisation's engagement and culture.

Reflect Reconciliation Action Plan

The MHCA is committed to making a real contribution to reconciliation through the development of a Reflect Reconciliation Action Plan (RAP). The Reflect RAP, once launched, will be implemented over 12 months with a focus on creating meaningful relationships, enhancing respect and promoting sustainable opportunities for Aboriginal and Torres Strait Islander peoples within our organisation and more broadly.

Our commitment to developing a Reflect RAP was confirmed on 9 October 2013, when the Board endorsed and signed a 'Statement of Commitment to Develop a Reconciliation Action Plan'. The Reflect RAP has been built into our Strategic Plan and a working group was established in October 2013 to guide its development.

We have consulted with Reconciliation Australia on the processes needed to develop a Reflect RAP. Staff have also been consulted and provided with information sessions on issues of historical and contemporary significance for Aboriginal and Torres Strait Islander peoples and communities, and the processes of reconciliation. In May 2014, staff participated in a morning tea and a screening of the 2007 National Apology to the Stolen Generation in recognition of Reconciliation Week.

The Reflect RAP will be launched in the latter half of 2014.

Fundraising program

In 2013-14 the Board identified the need to seek a more diverse funding stream to help ensure the sustainability of the MHCA. They affirmed this commitment through the development of an initial business sustainability plan, establishing a fundraising program for the organisation.

This program has begun the complex process of establishing fundraising priorities for the MHCA.

MEMBERS

The MHCA values the support and input received from our member organisations, all of whom play a direct role in achieving our strategic priorities.

THE MHCA WOULD LIKE TO ACKNOWLEDGE AND THANK ALL OUR MEMBERS FOR THEIR SUPPORT.

Full Members

Adults Surviving Child Abuse (ASCA)
Alzheimer's Australia
ANU Centre for Mental Health Research
Australasian Society of Psychiatric Research
Australian Association of Development Disability Medicine
Australian Association of Social Workers
Australian College of Mental Health Nurses
Australian Counselling Association
Australian Infant Child Adolescent and Family Mental Health Association
Australian Medical Association
Australian Psychological Society
Australian Rotary Health
Australian Society of Psychological Medicine
beyondblue
Black Dog Institute
Brain & Mind Research Institute
Carers Australia
Catholic Health Australia
Catholic Social Services Australia
Dietitians Association of Australia
dNet – People Like Us
Grow
headspace
Inspire Foundation
International Association of Infant Massage, Australia Inc
Lifeline Australia
Mental Health Carers ARAFMI Australia
Mental Health Coalition of South Australia
Mental Health Community Coalition of the ACT
Mental Health Coordinating Council
Mental Health Council of Tasmania
Mental Health First Aid Australia
Mental Health Foundation Australia
Mental Health Professionals Network
Mental Health Research Institute
Mental Illness Fellowship of Australia Inc
Mind Australia
National Aboriginal Community Controlled Health Organisation
National Anxiety Disorders Organisations Network (NADON)
National Council of Intellectual Disability
National LGBTI Health Alliance
National Rural Health Alliance
NEAMI Limited
Northern Territory Mental Health Coalition
Occupational Therapy Australia
On the Line
ORYGEN Youth Health Research Centre
Ostara Australia
Pharmaceutical Society of Australia
Post and Antenatal Depression Association (PANDA)
Private Mental Health Alliance
Private Mental Health Consumer Carer Network (Australia)
Psychiatric Disability Services of Victoria (VICSERV)
Psychosis Australia Trust
Psychotherapy and Counselling Federation of Australia (PACFA)

Queensland Alliance

Queensland Centre for Mental Health Research

Ramsay Health Care

Relationships Australia

Richmond Fellowship of Australia

Royal Australian College of General Practitioners

SANE Australia

Suicide Prevention Australia

The Butterfly Foundation

TheMHS Learning Network Inc

The Pharmacy Guild of Australia

The Royal Australian and New Zealand College of Psychiatrists

WA Association for Mental Health

Associate Members

ACT Mental Health Consumer Network

Anxiety Recovery Centre Victoria

ARAFMI Queensland

Artius Pty Ltd

ASPIRE

blueVoices

Break Thru People Solutions

Care Connect

CatholicCare NT

Centacare Catholic Diocese of Ballarat Inc

Centacare Catholic Family Services

Central Coast Family Suppprt Services Inc

CHESS EMPLOYMENT & Support Services (CHESS)

Club Haven

Converge International incorporating ResolutionsRTK

Dulwich Centre Foundation

Eating Disorders Foundation of Victoria Inc

Exercise and Sports Science Australia (ESSA)

Fernhills Clinic

Finding Workable Solutions

Gold Coast Centre Against Sexual Violence Inc

Graceville Centre

Homecare Services Pty Ltd

JobCo Employment Services Inc

Junaya Family Development Services

Karakan Hostels

Lamp Inc

Lives Lived Well

McAuley Community Services for Women

Melaleuca Refugee Centre, Torture and Trauma Survivor Service NT

Mental Health Association NSW

Mental Health Carers Arafmi WA

Mental Illness Education ACT

Mental Illness Fellowship of North Queensland Inc

Mental Illness Fellowship of Queensland

Mentally Healthy WA

MLC Community Foundation

Mothers Against Drugs

Movember

Newcastle Family Support Services Inc

NSW Consumer Advisory Group - Mental Health Inc

Open Minds

Pathways Southwest Inc

Peer Support Foundation Ltd

Peninsula Support Services Inc

Permanent Care and Adoptive Families

Perth Central East Metro Medicare Local

Post Placement Support Service

Queensland Voice for Mental Health

Reconnexion – a service of EACH

Richmond Fellowship of WA

Richmond Fellowship Queensland

Ruah Mental Health

Social Firms Australia

Supported Options in Lifestyle and Access Services Inc

The Australasian Centre for Rural & Remote Mental Health

The Compassionate Friends VIC Inc

Tully Support Centre

UCare Gawler Inc

WISE Employment Ltd

WISHIN Inc

Workability

Youth and Family Service (Logan City) Inc

GOVERNANCE

Our governance structure ensures that the Board, staff and member organisations collaborate effectively to support our vision of mentally healthy people and mentally healthy communities.

Board

The MHCA is governed by a Board of up to ten members. The Board consists of up eight delegates from member organisations, including consumer and carer members and an additional two independent, skills based members who are drawn from outside the membership.

The Board members in June 2014 were:

Chair Ms Jennifer Westacott

Independent Member

Jennifer has been Chief Executive of the Business Council of Australia since 2011, bringing extensive policy experience in both the public and private sectors. For over 20 years Jennifer occupied critical leadership positions in the New South Wales and Victorian governments. She was the Director of Housing and the Secretary of Education in Victoria, and most recently was the Director-General of the New South Wales Department of Infrastructure, Planning and Natural Resources. From 2005 to 2011 Jennifer was senior partner at KPMG, heading up the firm's Sustainability, Climate Change and Water practice and its NSW State Government practice.

Jennifer has a Bachelor of Arts (Honours) from the University of New South Wales, where she is an Adjunct Professor at the City Research Futures Centre. She was a Chevening Scholar at the London School of Economics. Jennifer is a National Fellow of the Institute of Public Administration Australia and a Fellow of the Australian Institute of Company Directors, and since 2013 has been a Non-Executive Director of Wesfarmers Limited.

Deputy Chair Professor Lyn Littlefield OAM

Full member representative

Lyn is the Executive Director of the Australian Psychological Society, which represents the largest mental health workforce in Australia. She is a Registered Psychologist and Member of the Australian Psychological Society Colleges of Clinical, Counselling, Community and Organisational Psychologists with over 20 years of experience in mental health in hospital and community settings. Lyn has devoted much of this time to improving mental health services in these contexts. She is a Fellow of the Australian Institute of Company Directors and the Australian Institute of Management.

Member Ms Clare Guilfoyle

Consumer member

Clare Guilfoyle is the Chief Executive Officer of Grow Australia. Grow has operated for over 50 years and was established and developed by people living with a mental illness. Clare is committed to promoting consumer leadership and advocates for greater participation by people with experience of mental illness in planning, policy and service delivery. Clare has worked in the health and community sector for over 25 years. Clare has a degree in Science (Nursing) and has experience that extends from the clinical setting, policy development, governance and strategic business development, education and research.

Member Mr Tony Fowke AM

Carer member

Tony is the Vice President of Mental Health Carers Arafmi Australia which is the only body at the national level that solely represents mental health carers. Tony has been a mental health carer for more than 30 years. Whilst he has retired from active practice as a lawyer he sits on the Mental Health Review Board in Perth and provides pro bono advice on mental health issues. On Australia Day 2003 Tony was appointed to be a Member of the Order of Australia for his role as an advocate for the advancement of mental health services in Australia and to the community. In October 2012 Tony was awarded the McCusker Charitable Foundation Award for Excellence in the Mental Health Sector and The Family and Carers Involvement and Engagement Award

Member Mr Arthur Papakotsias

Full member representative

Arthur has been Chief Executive Officer of Neami National for 23 years. He is Chair of the MHCA Audit and Compliance Committee, as well as the Chair of Housing Choices Australia and has completed post graduate studies in management at RMIT and a Strategic Perspectives as well as an Authentic Leadership Development Course at Harvard Business School. From a background in Psychiatric Nursing and Psychiatric Disability Recovery Service management, Arthur is a member of the Australian Institute of Company Directors (MAICD) and all state based mental health peak bodies. In 2013 Arthur contributed a chapter for the Oxford University Press, Third Edition of 'Mental Health in Australia'.

Member Dr Caroline Johnson

Full member representative

Caroline is a General Practitioner in Melbourne. Her interest in primary mental health care grew out of her experience providing professional development activities for GPs at the RACGP Victorian Faculty from 1996 until 2002. This led to a lecturer position at the Department of General Practice, University of Melbourne, where Caroline has had the opportunity to teach GPs at undergraduate, vocational and postgraduate levels. While at the university, she has also undertaken research on monitoring mental health conditions in the GP setting. She still teaches medical students at the University of Melbourne and also trains GP registrars as a Medical Educator at the Victorian Metropolitan Alliance (VMA). She is the Clinical Lead in Mental Health, RACGP National Standing Committee – Quality Care and has represented the RACGP on a variety of committees related to mental health, including the Mental Health Professionals Association.

Member Mr Geoff Harris

Full member representative

Geoff is the Executive Director of the Mental Health Coalition of SA Inc which is the peak body for mental health in South Australia. With over 15 years of experience working in health and mental health, Geoff has also served on a range of Boards including the Health Performance Council (SA) and the SACOSS Policy Council. Through previous work in central Australia, Geoff gained an understanding of many rural and remote mental health, social and wellbeing issues.

Member Mr Jack Heath

Full member representative

Jack is the Chief Executive Officer of SANE Australia, a national charity helping all Australians affected by mental illness lead a better life. In 1997 Jack founded the Inspire Foundation with the idea of using the internet to prevent youth suicide. Jack was Inspire Australia's Executive Director from 1997 to 2007, Inspire's Global CEO from 2008-09 and Inspire USA's CEO from 2010-11. While working with Inspire USA, Jack was appointed to the Executive Committee of the US National Action Alliance for Suicide Prevention, a position he still holds.

Member Mr Jonathan Nicholas

Full member representative

Jonathan is the Chief Executive Officer of the Inspire Foundation. With a background in child psychology and human rights he completed an Honours Degree in Psychology and a Masters in Public Health. Having helped build *ReachOut.com* to be Australia's leading youth mental health service when he was Director of Programs for Inspire Foundation in Australia, Jono was pivotal in establishing Inspire Ireland in 2009. Jono has also provided training in Indonesia on the Convention on the Rights of the Child, and co-authored a report for UNICEF on the situation of children and women living in Cambodia.

Member The Hon Craig Knowles

Independent Member

Craig is the former Minister for Health, Planning and Infrastructure, Housing and Natural Resources in the NSW Government. He holds a range of Board and advisory positions as well as serving on a number of not for profit and charitable Boards. He is a Fellow of the Australian Property Institute.

Constitutional change

This year, the members decided to move the organisation to a Company Limited by Guarantee, starting in July 2014. Previously the MHCA has been incorporated as an Association in the ACT, however the organisation would be more appropriately governed under a national regulatory model. The move to a Company Limited by Guarantee truly reflects the MHCA's role as the national peak for the mental health sector.

The work to undertake this important change was considerable, and involved a carefully designed change management plan over the 2013-14 financial year. The organisation appointed the Deputy CEO as the new Company Secretary, who worked with the Communication and Stakeholder Engagement Manager to ensure members engaged with the change and the transition was smooth. The result was a successful vote at a Special General Meeting in April, with the membership supporting the change to a new Constitution for the MHCA. In addition, the members voted to change the name of the organisation to Mental Health Australia, also starting on 1 July 2014.

PATRONS AND PARTNERS

We are pleased to have the support of eminent Australians who share our vision of quality mental health for everyone.

Throughout the year our Patrons have provided much appreciated advice and assisted with the promotion of mental health issues to the media and the Australian people.

Our Patrons are:

Ms Jessica Rowe

Mr Peter Overton

Mr Jonathan Welch

Mr David Galbally QC

We would also like to thank the organisations who have partnered with us throughout the year and provided financial support for our activities:

- The Australian Government Department of Health
- The Australian Government Department of Social Services
- The National Mental Health Commission
- The MLC Community Foundation
- Primary Communications
- iSentia
- The Royal Commission into Institutional Responses to Child Sexual Abuse
- AstraZeneca Australia
- Lundbeck Australia
- Pfizer Australia
- Janssen Cilag Australia

OUR STAFF

Our success depends on the experience and dedication of our staff. The team combined skills in business, financial and program management, policy development, planning, accounting, communications and administration.

STAFF AT 30 JUNE 2014 WERE:

Mr Frank Quinlan
Chief Executive Officer

Ms Melanie Cantwell
Deputy Chief Executive Officer

Mr Josh Fear
Director, Policy and Projects

Ms Kylie Wake
Director, Consumer and Carer Programs

Mr Chris Wagner
Director of Communications

Ms Mardi Savill
Finance Manager

Ms Emily Clay
Manager Policy and Projects

Ms Sarah Morrison
Online Manager

Ms Joanne Huxley
Manager Communications and Stakeholder Engagement

Ms Shelley McKinnon
Corporate Services Manager

Ms Delia Witney
Human Resources Manager

Ms Liz Ruck
Senior Policy Officer

Mr Travis Gilber
Policy Officer

Ms Jodie Fisher
Project Manager – NMHCO

Ms Kathryn Sequoia
Executive Officer – NMHCCF and National Register

Ms Kim Harris
Admin/Project Officer – NMHCCF and National Register

Mr Peter O'Rourke
PR and Events Coordinator

Ms Keah Woodgate
Admin/Project Officer – NMHCO

Ms Sandra Mortimore
Executive Assistant/Corporate Support Officer

Ms Amy Byrne
Finance/HR Officer

AUDIT & COMPLIANCE COMMITTEE REPORT

The MHCA's Audited Financial Statements for the year ended 30 June 2014 have been finalised and are available for download at **www.mhaustralia.org**.

The reports were prepared as General Purpose Reports. The Auditors have stated that the reports are a 'true and fair view' of the Council's financial position as at that date. The Auditors have issued an unqualified audit report.

For the 2013/14 financial year, total revenue was $3,982,329 and total expenditure was $3,991,932, compared to revenue of $4,148,890 and expenditure of $4,104,514 for the 2012/13 financial year. The result was a deficit of $9,604 (2012/13 deficit $44,377).

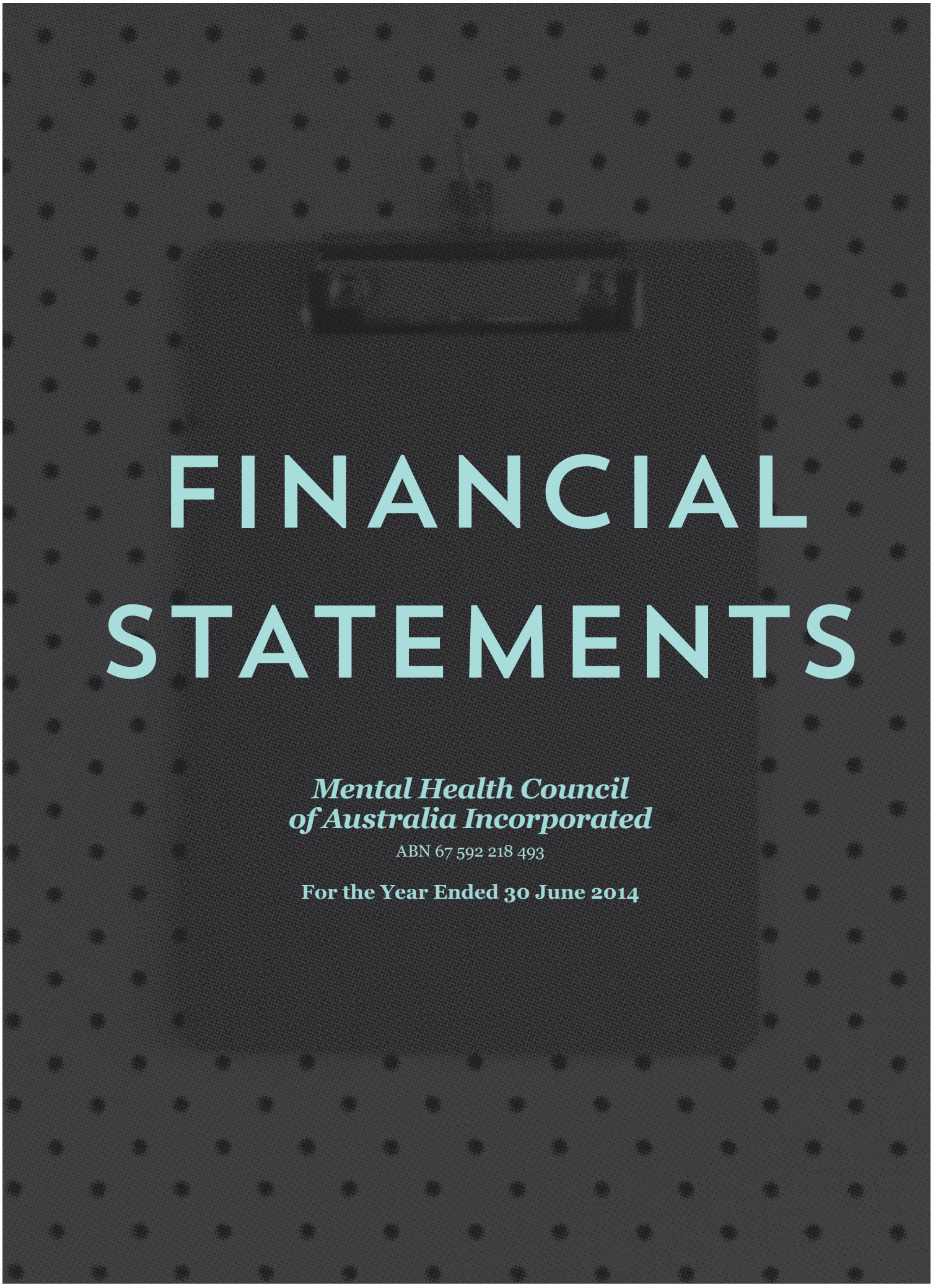
As at 30 June 2014, the Council's Total Assets were $2,961,274 (2012/13 $3,151,845) and Total Liabilities were $1,187,431 (2012/13 $1,368,398). Total Equity was $1,773,843 (2012/13 $1,783,447), represented by working capital of $1,556,562 (2013 $1,526,578), Grace Groom Memorial Foundation funds of $38,950 (2013 $35,978), Property, Plant and Equipment of $217,281 (2012/13 $238,807), and Non-Current Liabilities (provision for employee entitlements) of $16,570 (2012/13 $17,916).

In the 2013/14 financial year, operating grants received of $3,689,678 (2012/13 $3,826,591) represented 77% (2012/13 92%) of the total revenue received. These funds were received from the Australian Government Departments of Health and Social Services; the National Mental Health Commission; the Pharma Collaboration; and state governments supporting the NMHCCF to undertake contracted activities. These funds were expended to achieve the outcomes required in the various contracts.

The CEO, Deputy CEO and other staff have worked tirelessly and effectively during the past twelve months to work towards the provision of the best mental health services so desperately needed by consumers and carers and to ensure their voice is heard through the MHCA. The Audit and Compliance Committee congratulate them on an excellent result.

Arthur Papakotsias

Chair, Audit and Compliance Committee



FINANCIAL STATEMENTS

Mental Health Council of Australia Incorporated

ABN 67 592 218 493

For the Year Ended 30 June 2014

Mental Health Council of Australia Incorporated

ABN 67 592 218 493

For the Year Ended 30 June 2014

CONTENTS

Mental Health Council of Australia Incorporated

ABN 67 592 218 493

Board Members' Report

For the Year Ended 30 June 2014

Your board members submit the financial statements of the Association for the financial year ended 30 June 2014.

1. General information

Board Members

The names of the board members throughout the year and at the date of this report are:

Ms Jennifer Westacott	Chairperson
Professor Lyn Littlefield	Deputy Chairperson
Mr Tony Fowke AM	
Ms Clare Guilfoyle	
Mr Geoff Harris	
Mr Jack Heath	
Dr Caroline Johnson	
The Hon Craig Knowles	
Mr Arthur Papakotsias	
Mr Jonathan Nicholas	Appointed: 9 October 2013

Principal Activities

The principal activities of the Association during the financial year were to promote quality mental health for everyone in Australia as well as represent and promote the interests of the Mental Health sector.

Significant Changes

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

Mental Health Council of Australia Incorporated resolved to transfer the net assets of the Association to Mental Health Australia on 1st July 2014. Accordingly, these are the final accounts of the Association.

2. Operating Results

The profit (loss) of the Association for the financial year amounted to $ (9,604) (2013: $ 44,377).

Signed in accordance with a resolution of the Members of the Board:

Board Member: .....
Ms Jennifer Westacott

Board Member: .....
Mr Arthur Papakotsias

Mental Health Council of Australia Incorporated

ABN 67 592 218 493

Statement by Members of the Board

In the opinion of the Board the financial statements as set out on pages 3 to 29:

1. Present a true and fair view of the financial position of the Mental Health Council of Australia Incorporated as at 30 June 2014 and its performance for the year ended on that date in accordance with Australian Accounting Standards (including Australian Accounting Interpretations) of the Australian Accounting Standards Board.

2. There are reasonable grounds to believe that the Mental Health Council of Australia Incorporated will be able to pay its debts as and when they fall due.

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

Board Member: .....
Ms Jennifer Westacott

Board Member: .....
Mr Arthur Papakotsias

Dated: 2 September 2014

Mental Health Council of Australia Incorporated

ABN 67 592 218 493

Statement of Profit or Loss and Other Comprehensive Income

For the Year Ended 30 June 2014

	Note	2014 $	2013 $
Revenue	9	**3,982,329**	4,148,890
Administrative expenses	10	**(468,420)**	(433,404)
Grant payments		**(297,644)**	(427,876)
Other operating grants expenditure		**(1,044,035)**	(1,524,589)
Employee benefits expense		**(2,130,223)**	(1,679,998)
Depreciation expense		**(51,611)**	(38,646)
Profit (loss) before income tax		**(9,604)**	44,377
Income tax expense		**-**	-
Profit (loss) for the year		**(9,604)**	44,377
Total comprehensive income for the year		**(9,604)**	44,377

Mental Health Council of Australia Incorporated

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Statement of Financial Position

As At 30 June 2014

	Note	2014 $	2013 $
ASSETS			
CURRENT ASSETS			
Cash and cash equivalents	2	**2,584,642**	2,442,589
Trade and other receivables	3	**70,458**	364,432
Other financial assets	4	**48,015**	48,015
Other assets	5	**40,878**	58,002
TOTAL CURRENT ASSETS		**2,743,993**	2,913,038
NON-CURRENT ASSETS			
Property, plant and equipment	6	**217,281**	238,807
TOTAL NON-CURRENT ASSETS		**217,281**	238,807
TOTAL ASSETS		**2,961,274**	3,151,845
LIABILITIES			
CURRENT LIABILITIES			
Trade and other payables	7	**1,093,720**	1,278,148
Short-term provisions	8	**77,141**	72,334
TOTAL CURRENT LIABILITIES		**1,170,861**	1,350,482
NON-CURRENT LIABILITIES			
Long-term provisions	8	**16,570**	17,916
TOTAL NON-CURRENT LIABILITIES		**16,570**	17,916
TOTAL LIABILITIES		**1,187,431**	1,368,398
NET ASSETS		**1,773,843**	1,783,447
EQUITY			
Retained earnings		**1,773,843**	1,783,447
TOTAL EQUITY		**1,773,843**	1,783,447

Mental Health Council of Australia Incorporated

ABN 67 592 218 493

Statement of Changes in Equity

For the Year Ended 30 June 2014

2014

	Note	Retained Earnings $	Total $
Balance at 1 July 2013		**1,783,447**	**1,783,447**
Loss attributable to members of the entity		**(9,604)**	**(9,604)**
Balance at 30 June 2014		**1,773,843**	**1,773,843**

2013

	Note	Retained Earnings $	Total $
Balance at 1 July 2012		1,739,070	1,739,070
Profit attributable to members of the entity		44,377	44,377
Balance at 30 June 2013		1,783,447	1,783,447

Mental Health Council of Australia Incorporated

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Statement of Cash Flows

For the Year Ended 30 June 2014

	Note	2014 $	2013 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts from customers		**4,388,900**	4,708,785
Payments to suppliers and employees		**(4,275,491)**	(4,435,272)
Interest received		**58,729**	62,607
Net cash provided by (used in) operating activities	14(b)	**172,138**	336,120
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of held-to-maturity investments		**-**	(7,898)
Purchase of property, plant and equipment		**(30,085)**	(115,571)
Net cash used in investing activities		**(30,085)**	(123,469)
Net increase (decrease) in cash held		**142,053**	212,651
Cash and cash equivalents at beginning of financial year		**2,442,589**	2,229,938
Cash and cash equivalents at end of financial year	14(a)	**2,584,642**	2,442,589

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

The financial statements cover Mental Health Council of Australia Incorporated as an individual entity. Mental Health Council of Australia Incorporated is an Association incorporated in the Australian Capital Territory under the *Associations Incorporation Act 1991* (ACT).

The financial statements were authorised for issue on 2 September 2014 by the board members of the Association.

1 Summary of Significant Accounting Policies

(a) Basis of Preparation

These general purpose financial statements have been prepared in accordance with the *Associations Incorporation Act 1991* (ACT) and Australian Accounting Standards and Interpretations of the Australian Accounting Standards Board. The Association is a not-for-profit entity for financial reporting purposes under Australian Accounting Standards. Material accounting policies adopted in the preparation of these financial statements are presented below and have been consistently applied unless stated otherwise.

The financial statements, except for the cash flow information, have been prepared on an accruals basis and are based on historical costs, modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities. The amounts presented in the financial statements have been rounded to the nearest dollar.

(b) Subsequent Events

Mental Health Council of Australia Incorporated resolved to transfer the net assets of the Association to Mental Health Australia on 1 July 2014. Accordingly, these are the final accounts of the Association.

The going concern basis has not been applied in the preparation of this financial report. The liquidation basis has been adopted in the measurement of financial information provided.

(c) Cash and Cash Equivalents

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

(d) Trade and Other Receivables

Trade and other receivables include amounts due from customers for goods sold and services performed in the ordinary course of business. Receivables expected to be collected within 12 months of the end of the reporting period are classified as current assets. All other receivables are classified as non-current assets.

Trade and other receivables are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. Refer to Note 1(l) for further discussion on the determination of impairment losses.

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

1 Summary of Significant Accounting Policies (continued)

(e) Property, Plant and Equipment

Each class of property, plant and equipment is carried at cost or fair value as indicated, less, where applicable, any accumulated depreciation and impairment losses.

Plant and equipment

Plant and equipment are measured on the cost basis and are therefore carried at cost less accumulated depreciation and any accumulated impairment losses.

In the event the carrying amount of plant and equipment is greater than the estimated recoverable amount, the carrying amount is written down immediately to the estimated recoverable amount and impairment losses are recognised either in profit or loss or as a revaluation decrease if the impairment losses relate to a revalued asset. A formal assessment of recoverable amount is made when impairment indicators are present (refer to Note 1(f) for details of impairment).

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

Depreciation

The depreciable amount of all fixed assets is depreciated on a straight-line basis over the asset's useful life to the Association commencing from the time the asset is available for use.

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

Fixed asset class	Depreciation rates
Office equipment	20-33.33%
Leasehold improvements	7.5%

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

Gains and losses on disposals are determined by comparing proceeds with the carrying amount. These gains or losses are recognised in profit or loss in the period in which they arise.

(f) Impairment of Assets

At the end of each reporting period, the Association assesses whether there is any indication that an asset may be impaired. The assessment will include the consideration of external and internal sources of information. If such an indication exists, an impairment test is carried out on the asset by comparing the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, to the asset's carrying amount. Any excess of the asset's carrying amount over its recoverable amount is recognised immediately in profit or loss.

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

1 Summary of Significant Accounting Policies (continued)

(f) Impairment of Assets (continued)

Where the future economic benefits of the asset are not primarily dependent upon the asset's ability to generate net cash inflows and when the Association would, if deprived of the asset, replace its remaining future economic benefits, value in use is determined as the depreciated replacement cost of an asset.

Where it is not possible to estimate the recoverable amount of an individual asset, the Association estimates the recoverable amount of the cash-generating unit to which the asset belongs.

(g) Trade and Other Payables

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

(h) Provisions

Provisions are recognised when the Association has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured. Provisions recognised represent the best estimate of the amounts required to settle the obligation at the end of the reporting period.

(i) Employee Provisions

Short-term employee provisions

Provision is made for the Association's obligation for short-term employee benefits. Short-term employee benefits are benefits (other than termination benefits) that are expected to be settled wholly before 12 months after the end of the annual reporting period in which the employees render the related service, including wages and salaries. Short-term employee benefits are measured at the (undiscounted) amounts expected to be paid when the obligation is settled.

Other long-term employee provisions

Provision is made for employees' long service leave and annual leave entitlements not expected to be settled wholly within 12 months after the end of the annual reporting period in which the employees render the related service. Other long-term employee benefits are measured at the present value of the expected future payments to be made to employees. Expected future payments incorporate anticipated future wage and salary levels, durations of service and employee departures, and are discounted at rates determined by reference to market yields at the end of the reporting period on government bonds that have maturity dates that approximate the terms of the obligations. Upon the remeasurement of obligations for other long-term employee benefits, the net change in the obligation is recognised in profit or loss as a part of employee benefits expense.

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

1 Summary of Significant Accounting Policies (continued)

(i) Employee Provisions (continued)

The Association's obligations for long-term employee benefits are presented as non-current employee provisions in its statement of financial position, except where the Association does not have an unconditional right to defer settlement for at least 12 months after the end of the reporting period, in which case the obligations are presented as current provisions.

(j) Leases

Leases of fixed assets where substantially all the risks and benefits incidental to the ownership of the asset, but not the legal ownership, are transferred to the Association are classified as finance leases. Finance leases are capitalised by recording an asset and a liability equal to the present value of the minimum lease payments including any guaranteed residual values. Leased assets are depreciated on a straight-line basis over their estimated useful lives where it is likely that the Association will obtain ownership of the asset. Lease payments are allocated between the reduction of the lease liability and the lease interest expense for the period.

Lease payments for operating leases, where substantially all of the risks and benefits remain with the lessor, are recognised as expenses on a straight-line basis over the lease term. Lease incentives under operating leases are recognised as a liability and amortised on a straight-line basis over the life of the lease term.

(k) Unexpended Grants

The Association 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 Association to treat grant monies as unexpended grants in the statement of financial position where the Association 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.

(l) Financial Instruments

Initial recognition and measurement

Financial assets and financial liabilities are recognised when the Association becomes a party to the contractual provisions to the instrument. For financial assets, this is equivalent to the date that the Association commits itself to either the purchase or sale of the asset (i.e. trade date accounting is adopted).

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

Classification and subsequent measurement

Mental Health Council of Australia Incorporated

ABN 67 592 218 493

Notes to the Financial Statements

For the Year Ended 30 June 2014

1 Summary of Significant Accounting Policies (continued)

(l) Financial Instruments (continued)

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

Amortised cost is calculated as the amount at which the financial asset or financial liability is measured at initial recognition less principal repayments and any reduction for impairment, and adjusted for any cumulative amortisation of the difference between that initial amount and the maturity amount calculated using the *effective interest method*.

The *effective interest method* is used to allocate interest income or interest expense over the relevant period and is equivalent to the rate that discounts estimated future cash payments or receipts (including fees, transaction costs and other premiums or discounts) through the expected life (or when this cannot be reliably predicted, the contractual term) of the financial instrument to the net carrying amount of the financial asset or financial liability. Revisions to expected future net cash flows will necessitate an adjustment to the carrying amount with a consequential recognition of an income or expense item in profit or loss.

(i) *Financial assets at fair value through profit or loss*

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

(ii) *Loans and receivables*

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market and are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

(iii) *Held-to-maturity investments*

Held-to-maturity investments are non-derivative financial assets that have fixed maturities and fixed or determinable payments, and it is the Association's intention to hold these investments to maturity. They are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

(iv) *Available-for-sale investments*

Available-for-sale investments are non-derivative financial assets that are either not capable of being classified into other categories of financial assets due to their nature or they are designated as such by management. They comprise investments in the equity of other entities where there is neither a fixed maturity nor fixed or determinable payments.

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

1 Summary of Significant Accounting Policies (continued)

(l) Financial Instruments (continued)

They are subsequently measured at fair value with any remeasurements other than impairment losses and foreign exchange gains and losses recognised in other comprehensive income. When the financial asset is derecognised, the cumulative gain or loss pertaining to that asset previously recognised in other comprehensive income is reclassified into profit or loss.

Available-for-sale financial assets are classified as non-current assets when they are expected to be sold within 12 months after the end of the reporting period. All other available-for-sale financial assets are classified as current assets.

(v) *Financial liabilities*

Non-derivative financial liabilities other than financial guarantees are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial liability is derecognised.

Impairment

At the end of each reporting period, the Association assesses whether there is objective evidence that a financial asset has been impaired. A financial asset or a group of financial assets will be deemed to be impaired if, and only if, there is objective evidence of impairment as a result of the occurrence of one or more events (a 'loss event'), which has an impact on the estimated future cash flows of the financial asset(s).

In the case of available-for-sale financial assets, a significant or prolonged decline in the market value of the instrument is considered a loss event. Impairment losses are recognised in profit or loss immediately. Also, any cumulative decline in fair value previously recognised in other comprehensive income is reclassified to profit or loss at this point.

In the case of financial assets carried at amortised cost, loss events may include indications that the debtors, or a group of debtors, are experiencing significant financial difficulty, default or delinquency in interest or principal payments, indications that they will enter into bankruptcy or other financial reorganisation and changes in arrears or economic conditions that correlate with defaults.

For financial assets carried at amortised cost (including loans and receivables), a separate allowance account is used to reduce the carrying amount of financial assets impaired by credit losses. After having undertaken all possible measures of recovery, if the management establishes that the carrying amount cannot be recovered by any means, at that point the written-off amounts are charged to the allowance account or the carrying amount of impaired financial assets is reduced directly if no impairment amount was previously recognised in the allowance account.

When the terms of financial assets that would otherwise have been past due or impaired have been renegotiated the Association recognises the impairment for such financial assets by taking into account the original terms as if the terms have not been renegotiated so that the loss events that have occurred are duly considered.

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

1 Summary of Significant Accounting Policies (continued)

(l) Financial Instruments (continued)

Derecognition

Financial assets are derecognised where the contractual rights to receipt of cash flows expire or the asset is transferred to another party whereby the Association no longer has any significant continuing involvement in the risks and benefits associated with the asset. Financial liabilities are derecognised where the related obligations are discharged, cancelled or have expired. The difference between the carrying amount of the financial liability extinguished or transferred to another party and the fair value of consideration paid, including the transfer of non-cash assets or liabilities assumed is recognised in profit or loss.

(m) Fair Value of Assets and Liabilities

The Association measures some of its assets and liabilities at fair value on either a recurring or non-recurring basis, depending on the requirements of the applicable Accounting Standard.

Fair value is the price the Association would receive to sell an asset or would have to pay to transfer a liability in an orderly (ie unforced) transaction between independent, knowledgeable and willing market participants at the measurement date.

As fair value is a market-based measure, the closest equivalent observable market pricing information is used to determine fair value. Adjustments to market values may be made having regard to the characteristics of the specific asset or liability. The fair values of assets and liabilities that are not traded in an active market are determined using one or more valuation techniques. These valuation techniques maximise, to the extent possible, the use of observable market data.

To the extent possible, market information is extracted from either the principal market for the asset or liability (ie the market with the greatest volume and level of activity for the asset or liability) or, in the absence of such a market, the most advantageous market available to the Association at the end of the reporting period (ie the market that maximises the receipts from the sale of the asset or minimises the payments made to transfer the liability, after taking into account transaction costs and transport costs).

For non-financial assets, the fair value measurement also takes into account a market participant's ability to use the asset in the highest and best use or to sell it to another market participant that would use the asset in its highest and best use.

The fair value of liabilities and the Association's own equity instruments (excluding those related to share-based payment arrangements) may be valued, where there is no observable market price in relation to the transfer of such financial instruments, by reference to observable market information where such instruments are held as assets. Where this information is not available, other valuation techniques are adopted and, where significant, are detailed in the respective note to the financial statements.

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

1 Summary of Significant Accounting Policies (continued)

(n) Revenue and Other Income

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

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

Revenue recognition relating to the provision of services is determined with reference to the stage of completion of the transaction at the end of the reporting period and where the outcome of the contract can be estimated reliably. Stage of completion is determined with reference to the services performed to date as a percentage of total anticipated services to be performed. Where the outcome cannot be estimated reliably, revenue is recognised only to the extent that related expenditure is recoverable.

Revenue from the sale of goods is recognised at the point of delivery as this corresponds to the transfer of significant risks and rewards of ownership of the goods and the cessation of all involvement in those goods.

Donations are recognised as revenue when received. Interest revenue is recognised using the effective interest method. Membership income is recognised on a receipts basis as it is voluntary in nature.

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

(o) Income Tax

No provision for income tax has been raised as the Association is exempt from income tax under Div 50 of the *Income Tax Assessment Act 1997*.

(p) Goods and Services Tax (GST)

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

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

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

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

1 Summary of Significant Accounting Policies (continued)

(q) Comparative Figures

When required by Accounting Standards, comparative figures have been adjusted to conform with changes in presentation for the current financial year.

When the Association retrospectively applies an accounting policy, makes a retrospective restatement or reclassifies items in its financial statements, an additional statement of financial position as at the beginning of the preceding comparative period, in addition to the minimum comparative financial statements, must be disclosed.

(r) Critical Accounting Estimates and Judgments

The board members evaluate estimates and judgments incorporated into the financial statements based on historical knowledge and best available current information. Estimates assume a reasonable expectation of future events and are based on current trends and economic data, obtained both externally and within the Association.

Key estimates - Impairment

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

(s) Economic Dependence

Mental Health Council of Australia Incorporated is dependent on Australian Government funding from various government departments for the majority of its revenue used to operate the business. At the date of this report the board members have no reason to believe the Australian Government will not continue to support Mental Health Council of Australia Incorporated via its funding agreements with various government departments.

(t) New Accounting Standards and Interpretations

The AASB has issued new and amended Accounting Standards and Interpretations that have mandatory application dates for future reporting periods. The Association has decided against early adoption of these Standards. The following table summarises those future requirements, and their impact on the Association:

Mental Health Council of Australia Incorporated

ABN 67 592 218 493

Notes to the Financial Statements

For the Year Ended 30 June 2014

1 Summary of Significant Accounting Policies (continued)

(t) New Accounting Standards and Interpretations (continued)

Standard Name	Effective date for entity	Requirements	Impact
AASB 9 Financial Instruments AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2009)AASB 2012-6 Amendments to Australian Accounting Standards - Mandatory Effective Date of AASB 9 and Transitional Disclosures AASB 2013-9 Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments	30 June 2018	Significant revisions to the classification and measurement of financial assets, reducing the number of categories and simplifying the measurement choices, including the removal of impairment testing of assets measured at fair value. The amortised cost model is available for debt assets meeting both business model and cash flow characteristics tests. All investments in equity instruments using AASB 9 are to be measured at fair value.	The available-for-sale investments held will be classified as fair value through OCI and will no longer be subject to impairment testing. Other impacts on the reported financial position and performance have not yet been determined.
AASB 2012-3 Amendments to Australian Accounting Standards - Offsetting Financial Assets and Financial Liabilities [AASB 132]	30 June 2015	This Standard adds application guidance to AASB 132 to address inconsistencies identified in applying some of the offsetting criteria of AASB 132, including clarifying the meaning of 'currently has a legally enforceable right of set-off' and that some gross settlement systems may be considered equivalent to net settlement.	The adoption of this standard will not change the reported financial position and performance of the entity, there are no impact on disclosures as there are no offsetting arrangements currently in place.
AASB 2013-3 Amendments to AASB 136 - Recoverable Amount Disclosures for Non-Financial Assets	30 June 2015	This standard amends AASB 136 to require additional disclosures about the fair value measurement when the recoverable amount of impaired assets is based on fair value less costs of disposal. In addition, a further requirement has been included to disclose the discount rates that have been used in the current and previous measurements if the recoverable amount of impaired assets based on fair value less costs of disposal was measured using a present value technique.	There are no changes to reported financial position or performance from AASB 2013-3, however additional disclosures may be required.

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

1 Summary of Significant Accounting Policies (continued)

(t) New Accounting Standards and Interpretations (continued)

Standard Name	Effective date for entity	Requirements	Impact
AASB 2013-9 Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments AASB 2014-1 Amendments to Australian Accounting Standards	30 June 2015	This standard withdraws the substantive content in AASB 1031 and provides signpost references to materiality in other Australian Accounting Standards. AASB 2014-1 makes amendments to particular Australian Accounting Standards to delete their references to AASB 1031 Materiality as each standard is amended for another purpose.	There is not expected to be any changes to the reported financial position, performance or cash flows of the entity.

2 Cash and Cash Equivalents

	Note	2014 $	2013 $
CURRENT			
Cash on hand		**200**	106
Cash at bank		**2,584,442**	2,442,483
	14, 15	**2,584,642**	2,442,589

3 Trade and Other Receivables

	Note	2014 $	2013 $
CURRENT			
Trade receivables	15	**70,458**	364,432
Total current trade and other receivables		**70,458**	364,432

(a) Provision for Impairment of Receivables

Current trade receivables are generally on 30-day terms. These receivables are assessed for recoverability and a provision for impairment is recognised when there is objective evidence that an individual trade receivable is impaired. No provision for impairment was required at year end.

Mental Health Council of Australia Incorporated

ABN 67 592 218 493

Notes to the Financial Statements

For the Year Ended 30 June 2014

3 Trade and Other Receivables (continued)

(b) Credit risk - Trade and Other Receivables

The Association has no significant concentration of credit risk with respect to any single counterparty or group of counterparties other than those receivables specifically provided for and mentioned within Note 3. The main source of credit risk to the Association is considered to relate to the class of assets described as 'trade and other receivables'.

The following table details the Association's trade and other receivables exposed to credit risk (prior to collateral and other credit enhancements) with ageing analysis and impairment provided for thereon. Amounts are considered as 'past due' when the debt has not been settled within the terms and conditions agreed between the Association and the customer or counterparty to the transaction. Receivables that are past due are assessed for impairment by ascertaining solvency of the debtors and are provided for where there are specific circumstances indicating that the debt may not be fully repaid to the Association. The balances of receivables that remain within initial trade terms (as detailed in the table) are considered to be of high credit quality.

			Past due but not impaired (days overdue)				
	Gross amount	Past due and impaired	< 30	31-60	61-90	> 90	Within initial trade terms
	$	$	$	$	$	$	$
2014							
Trade and other receivables	**70,458**	**-**	**-**	**-**	**-**	**200**	**70,258**
2013							
Trade and other receivables	364,432	-	-	-	-	29,700	334,732

4 Other Financial Assets

	Note	2014 $	2013 $
CURRENT			
Held-to-maturity financial assets	4(a)	**48,015**	48,015
Total Current Assets		**48,015**	48,015

(a) Held-to-maturity investments comprise:

Fixed interest securities - current	15	**48,015**	48,015
		48,015	48,015

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

5 Other Assets

	Note	2014 $	2013 $
CURRENT			
Prepayments		**40,878**	58,002
		40,878	58,002

6 Property, Plant and Equipment

	Note	2014 $	2013 $
Office equipment			
At cost		**233,310**	203,225
Accumulated depreciation		**(163,401)**	(132,194)
Total office equipment		**69,909**	71,031
Leasehold improvements			
At cost		**272,054**	272,054
Accumulated depreciation		**(124,682)**	(104,278)
Total leasehold improvements		**147,372**	167,776
Total property, plant and equipment		**217,281**	238,807

(a) Movements in Carrying Amounts

Movement in the carrying amounts for each class of property, plant and equipment between the beginning and the end of the current financial year:

	Office Equipment $	Improvements $	Total $
Balance at the beginning of year	**71,031**	**167,776**	**238,807**
Additions	**30,085**	**-**	**30,085**
Depreciation expense	**(31,207)**	**(20,404)**	**(51,611)**
Carrying amount at the end of 30 June 2014	**69,909**	**147,372**	**217,281**
Balance at the beginning of year	29,846	132,036	161,882
Additions	60,643	54,928	115,571
Depreciation expense	(19,458)	(19,188)	(38,646)
Carrying amount at the end of 30 June 2013	71,031	167,776	238,807

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

7 Trade and Other Payables

	Note	2014 $	2013 $
CURRENT			
Unsecured liabilities			
Trade payables		**159,940**	248,812
Accrued expenses		**201,894**	56,837
Deferred income		**657,707**	881,800
GST payable		**74,179**	90,699
		1,093,720	1,278,148

(a) Financial liabilities at amortised cost classified as trade and other payables

	Note	2014 $	2013 $
Trade and other payables			
- Total Current		**1,093,720**	1,278,148
Less:			
GST payable		**(74,179)**	(90,699)
Deferred income		**(657,707)**	(881,800)
Financial liabilities as trade and other payables	15	**361,834**	305,649

8 Provisions

	Note	2014 $	2013 $
CURRENT			
Annual leave entitlements		**77,141**	72,334
		77,141	72,334
NON-CURRENT			
Long service leave entitlements		**16,570**	17,916
		16,570	17,916

Analysis of total provisions

	Note	2014 $	2013 $
Current		**77,141**	72,334
Non-current		**16,570**	17,916
		93,711	90,250

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

8 Provisions (continued)

	Long service leave entitlements	Annual leave entitlements	Total
	$	$	$
Opening balance at 1 July 2013	**17,916**	**72,334**	**90,250**
Additional provisions	**929**	**127,666**	**128,595**
Amounts used	**-**	**(122,859)**	**(122,859)**
Unused amounts reversed	**(2,275)**	**-**	**(2,275)**
Balance at 30 June 2014	**16,570**	**77,141**	**93,711**

Employee Provisions

Employee provisions represent amounts accrued for annual leave and long service leave.

The current portion for this provision includes the total amount accrued for annual leave entitlements and the amounts accrued for long service leave entitlements that have vested due to employees having completed the required period of service. Based on past experience, the association does not expect the full amount of annual leave or long service leave balances classified as current liabilities to be settled within the next 12 months. However, these amounts must be classified as current liabilities since the association does not have an unconditional right to defer the settlement of these amounts in the event employees wish to use their leave entitlement.

The non-current portion for this provision includes amounts accrued for long service leave entitlements that have not yet vested in relation to those employees who have not yet completed the required period of service.

9 Revenue and Other Income

	Note	2014 $	2013 $
Revenue			
- operating grants		**3,689,678**	3,826,591
- member subscriptions		**19,949**	20,137
- donations		**17,371**	13,465
- sales		**6,543**	9,144
- other trading revenue		**192,167**	214,838
- interest received		**56,621**	64,715
Total Revenue		**3,982,329**	4,148,890

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

10 Profit (loss) for the Year

	Note	2014 $	2013 $
Profit (loss) includes the following specific expenses:			
Administrative expenses			
Corporate services		**316,440**	253,377
Governance		**62,496**	83,552
Marketing, communications and fundraising		**89,484**	35,753
State consultation workshops		**-**	60,722
Total administrative expenses		**468,420**	433,404
Rental expense on operating leases			
Minimum lease payments		**232,337**	207,031

11 Auditors' Remuneration

	Note	2014 $	2013 $
Remuneration of the auditor of the Association for:			
- auditing or reviewing the financial statements		**6,950**	6,750
- other services		**440**	445

12 Capital and Leasing Commitments

(a) Operating Lease Commitments

Non-cancellable operating leases contracted for but not recognised in the financial statements:

	Note	2014 $	2013 $
Payable - minimum lease payments:			
- not later than 12 months		**236,189**	223,211
- between 12 months and 5 years		**74,504**	276,872
		310,693	500,083

The property lease is a non-cancellable lease with a 3 year term expiring on 17 September 2015, with rent payable monthly in advance. Contingent rental provisions within the lease agreement require the minimum lease payments shall be increased by 4% per annum. An option exists to renew the lease at the end of the 3 year term for an additional 3 years.

The other operating leases are non-cancellable leases with 1-4 year terms and with fixed monthly payments.

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

12 Capital and Leasing Commitments (continued)

(b) Service Contract Expenditure Commitments

	Note	2014 $	2013 $
Payable:			
- not later than 12 months		**29,365**	21,575
		29,365	21,575

13 Key Management Personnel Compensation

Any person(s) having authority and responsibility for planning, directing and controlling the activities of the Association, directly or indirectly, including any board member is considered key management personnel.

The totals of remuneration paid to key management personnel of the Association during the year are as follows:

	Note	2014 $	2013 $
Short-term benefits		**670,352**	644,834
		670,352	644,834

Three board member positions receive honoraria for work performed in relation to the Association's affairs. No other board members, or parties related to them, received any remuneration from the Association during the year other than reimbursement for expenses incurred.

14 Cash Flow Information

(a) Reconciliation of cash

	Note	2014 $	2013 $
Cash at the end of the financial year as shown in the statement of cash flows is reconciled to items in the statement of financial position as follows:			
Cash and cash equivalents	2	**2,584,642**	2,442,589
		2,584,642	2,442,589

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

14 Cash Flow Information (continued)

(b) Reconciliation of Cash Flow from Operations with Profit (loss) after Income Tax

	Note	2014 $	2013 $
Profit (loss) for the year		**(9,604)**	44,377
Non-cash flows in profit (loss)			
- Depreciation		**51,611**	38,646
Changes in assets and liabilities			
- (Increase)/decrease in trade receivables		**293,974**	526,830
- (Increase)/decrease in prepayments		**17,124**	(9,747)
- Increase/(decrease) in deferred income		**(224,093)**	(326,552)
- Increase/(decrease) in trade payables and accruals		**39,665**	58,210
- Increase/(decrease) in provisions		**3,461**	4,356
Cash flow from operations		**172,138**	336,120

(c) Credit Standby Arrangements with Banks

Credit facility	**54,000**	54,000
Amount utilised	**(6,252)**	(11,833)
	47,748	42,167

The Association has credit card facilities setup with their banks with general terms and conditions. Interest rates are variable and subject to adjustment.

(d) Non-cash Financing and Investing Activities

There were no non-cash financing or investing activities during the year.

15 Financial Risk Management

The Association's financial instruments consist mainly of deposits with banks, short-term investments, accounts receivable and payable.

The carrying amounts for each category of financial instruments, measured in accordance with AASB 139 as detailed in the accounting policies to these financial statements, are as follows:

Mental Health Council of Australia Incorporated

ABN 67 592 218 493

Notes to the Financial Statements

For the Year Ended 30 June 2014

15 Financial Risk Management (continued)

	Note	2014 $	2013 $
Financial Assets			
Cash and cash equivalents	2	**2,584,642**	2,442,589
Loans and receivables	3	**70,458**	364,432
Other financial assets	4	**48,015**	48,015
Total Financial Assets		**2,703,115**	2,855,036
Financial Liabilities			
Financial liabilities at amortised cost			
Trade and other payables	7(a)	**361,834**	305,649
Total Financial Liabilities		**361,834**	305,649

Financial Risk Management Policies

The board members' risk management strategy seeks to assist the Association in meeting its financial targets whilst minimising potential adverse effects on financial performance. Risk management policies are approved and reviewed by the board members on a regular basis. These include credit risk policies and future cash flow requirements.

Specific Financial Risk Exposures and Management

The main risks the Association is exposed to through its financial instruments are credit risk, liquidity risk and market risk relating to interest rate risk.

There have been no substantive changes in the types of risks the Association is exposed to, how these risks arise, or the board's objectives, policies and processes for managing or measuring the risks from the previous period.

(a) Credit risk

Exposure to credit risk relating to financial assets arises from the potential non-performance by counterparties of contract obligations that could lead to a financial loss to the Association.

Credit risk is managed through the maintenance of procedures ensuring to the extent possible, that customers and counterparties to transactions are of sound credit worthiness. Such monitoring is used in assessing receivables for impairment. Credit terms are generally 30 days from the invoice date.

Risk is also minimised through investing surplus funds in financial institutions that maintain a high credit rating.

Credit Risk Exposures

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

15 Financial Risk Management (continued)

The maximum exposure to credit risk by class of recognised financial assets at the end of the reporting period, excluding the value of any collateral or other security held, is equivalent to the carrying value and classification of those financial assets (net of any provisions) as presented in the statement of financial position.

The Association has no significant concentration of credit risk with any single counterparty or group of counterparties. Details with respect to credit risk of Trade and Other Receivables are provided in Note 3.

Trade and other receivables that are neither past due nor impaired are considered to be of high credit quality. Aggregates of such amounts are as detailed at Note 3.

Credit risk related to balances with banks and other financial institutions is managed by the board members. The following table provides information regarding credit risk relating to cash and money market securities based on Standard & Poor's counterparty credit ratings.

	Note	2014 $	2013 $
Cash and cash equivalents			
- AA Rated	2	**2,584,442**	2,442,483
		2,584,442	2,442,483
Held-to-maturity securities			
- AA Rated	4	**48,015**	48,015
		48,015	48,015

(b) Liquidity risk

Liquidity risk arises from the possibility that the Association might encounter difficulty in settling its debts or otherwise meeting its obligations related to financial liabilities. The Association manages this risk through the following mechanisms:

- preparing forward looking cash flow analysis in relation to its operational, investing and financial activities;
- monitoring undrawn credit facilities;
- maintaining a reputable credit risk profile;
- managing credit risk related to financial assets;
- only investing surplus cash with major financial institutions; and
- comparing the maturity profile of financial liabilities with the realisation profile of financial assets.

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

15 Financial Risk Management (continued)

The table below reflects an undiscounted contractual maturity analysis for financial liabilities. Cash flows realised from financial assets reflect management's expectation as to the timing of realisation. Actual timing may therefore differ from that disclosed. The timing of cash flows presented in the table to settle financial liabilities reflects the earliest contractual settlement dates.

Financial liability and financial asset maturity analysis

	Within 1 Year		1 to 5 Years		Total Contractual Cash Flow	
	2014	2013	2014	2013	2014	2013
	$	$	$	$	$	$
Financial liabilities due for payment						
Trade and other payables (excluding deferred income and GST payable)	**361,834**	305,649	**-**	-	**361,834**	305,649
Total contractual outflows	**361,834**	305,649	**-**	-	**361,834**	305,649
Total expected outflows	**361,834**	305,649	**-**	-	**361,834**	305,649
Financial assets - cash flows realisable						
Cash and cash equivalents	**2,584,642**	2,442,589	**-**	-	**2,584,642**	2,442,589
Trade, term and loans receivables	**70,458**	364,432	**-**	-	**70,458**	364,432
Held-to-maturity investments	**48,015**	48,015	**-**	-	**48,015**	48,015
Total anticipated inflows	**2,703,115**	2,855,036	**-**	-	**2,703,115**	2,855,036
Net (outflow)/inflow on financial instruments	**2,341,281**	2,549,387	**-**	-	**2,341,281**	2,549,387

(c) Market risk

Interest rate risk

Exposure to interest rate risk arises on financial assets and financial liabilities recognised at the end of the reporting period whereby a future change in interest rates will affect future cash flows or the fair value of fixed rate financial instruments. The Association is also exposed to earnings volatility on floating rate instruments.

Sensitivity Analysis

The following table illustrates sensitivities to the Association's exposures to changes in interest rates. The table indicates the impact on how profit or loss and equity values reported at the end of the reporting period would have been affected by changes in the relevant risk variable that management considers to be reasonably possible. These sensitivities assume that the movement in a particular variable is independent of other variables.

Mental Health Council of Australia Incorporated

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Notes to the Financial Statements

For the Year Ended 30 June 2014

15 Financial Risk Management (continued)

	Profit	Equity
	$	$
Year Ended 30 June 2014		
+/- 2% in interest rates	**52,000**	**52,000**
Year Ended 30 June 2013		
+/- 2% in interest rates	50,000	50,000

There have been no changes in any of the assumptions used to prepare the above sensitivity analysis from the prior year.

Fair Values

Fair value estimation

The fair values of financial assets and financial liabilities approximate their carrying values as presented in the statement of financial position and notes to the financial statements. Fair value is the amount at which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arm's length transaction.

Fair values derived may be based on information that is estimated or subject to judgment, where changes in assumptions may have a material impact on the amounts estimated. Areas of judgment and the assumptions have been detailed below.

Differences between fair values and carrying amounts of financial instruments with fixed interest rates are due to the change in discount rates being applied by the market since their initial recognition by the Association. Most of these instruments which are carried at amortised cost are to be held until maturity and therefore the fair value figures calculated bear little relevance to the Association.

The fair values of financial assets and financial liabilities as disclosed in the statement of financial position and in the notes to the financial statements have been determined based on the following methodologies: Cash and cash equivalents, trade and other receivables and trade and other payables are short-term instruments in nature whose carrying value is equivalent to fair value. Trade and other payables exclude deferred income and GST payable which are not considered to be financial instruments.

16 Capital Management

The board members control the capital of the Association to ensure that adequate cash flows are generated to fund its operations and that returns from investments are maximised within tolerable risk parameters. The board members ensure that the overall risk management strategy is in line with this objective.

The Association's capital consists of financial liabilities, supported by financial assets.

The board members effectively manage the Association's capital by assessing the Association's financial risks and responding to changes in these risks and in the market. These responses may include the consideration of debt levels.

Mental Health Council of Australia Incorporated

ABN 67 592 218 493

Notes to the Financial Statements

For the Year Ended 30 June 2014

16 Capital Management (continued)

There have been no changes to the strategy adopted by the board members to control the capital of the Association since the previous year.

The gearing ratios for the years ended 30 June 2014 and 30 June 2013 are as follows:

	Note	2014 $	2013 $
Total borrowings		**-**	-
Less Cash and cash equivalents	2	**(2,584,642)**	(2,442,589)
Net debt		**(2,584,642)**	(2,442,589)
Equity		**1,773,843**	1,783,447
Total capital		**(810,799)**	(659,142)
Gearing ratio		**- %**	- %

17 Association Details

The principal place of business of the Association is:
Mental Health Council of Australia Incorporated
(from 1 July 2014, Mental Health Australia,
as a not-for-profit company limited by guarantee)
ALIA House, Level 1
9-11 Napier Close
Deakin ACT 2600

Hardwickes
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6 Phipps Close Deakin ACT 260
PO Box 322 Curtin ACT 260
T 02 6282 599
F 02 6282 593
E info@hardwickes.com.a
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Hardwicke
ABN 35 973 938 18

Hardwickes Partners Pty L
ABN 21 008 401 53

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Independent Auditor's Report

To the members of Mental Health Council of Australia Incorporated

Report on the Financial Report

We have audited the accompanying financial report of Mental Health Council of Australia Incorporated, which comprises the statement of financial position as at 30 June 2014, the statement of profit or loss and other 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 statement by members of the board.

Board Members' Responsibility for the Financial Report

The board members are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards and the *Associations Incorporation Act 1991 (ACT)*, and for such internal control as the board members determine is necessary to enable the preparation of the financial report that 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 judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Association'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 Association's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the board members, 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.

Hardwickes
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Independent Auditor's Report

To the members of Mental Health Council of Australia Incorporated

Opinion

In our opinion, the financial report gives a true and fair view of the financial position of Mental Health Council of Australia Incorporated as at 30 June 2014, and of its financial performance and its cash flows for the year then ended in accordance with Australian Accounting Standards and the *Associations Incorporation Act 1991 (ACT)*.

Emphasis of Matter

Without modifying our opinion, we draw attention to Note 1(b) Subsequent events in the financial report, which discloses the transfer of the net assets of the Association to Mental Health Australia on 1 July 2014.

Hardwickes
Chartered Accountants

Hardwickes
R Johnson

Robert Johnson FCA
Partner

Canberra

Dated: 2 September 2014

Mental Health
Council of Australia