Peak body representing the community-based mental health sector in WA.

Community of Practice End of Project Evaluation Report

A Collaborative Approach to the development of capacity in the NDIS WA My Way trial sites.

Peak body representing the community-based mental health sector in WA.
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Contents

1 Executive Summary

This report documents and describes the main findings and lessons learned from the Community of Practice project, which was a collaborative approach to build capacity to assist people with psychosocial disability in the NDIS My Way Trial sites in Lower South West and Cockburn/Kwinana.

The Community of Practice Project was delivered by the WA Association of Mental Health (WAAMH), between June 2015 and June 2016, in association with Jane Forward (Jane Forward Consulting) who was Project Consultant and primary author of this report.

The Community of Practice (CoP) project was a year-long project, funded by the Disability Services Commission (DSC) and led by the Western Australia Association of Mental Health (WAAMH). A CoP is defined by the process of shared learnings and information dissemination which occurs between stakeholders within a network, as well as on a broader scale (e.g. beyond to the wider community). In this case the focus of learning was the inclusion of people with a psychosocial disability (PWPD) within the WA NDIS My Way trial sites.

The project aimed to create a space for stakeholders to learn from one another, as well as identify and build their resources to access WA NDIS My Way by investing in people and systems. The CoP also aimed to provide an opportunity for stakeholders to alert the Disability Services Commission of key issue/s. In addition, the project aimed to add value by disseminating learnings from two other projects also funded by the commission that had a similar aim. This report was commissioned in order to present an end-of-project evaluation report exploring the following areas of inquiry:

1. What did the project aspire to do?
2. What happened?
3. What was the impact?
4. Future aspirations

The National Disability Insurance Scheme (NDIS) marks a significant change in the way support services are commissioned and delivered in Australia and as such is of significant interest to Community Management Mental Health organisations. In Western Australia, two versions of the scheme are being trialled. This project relates

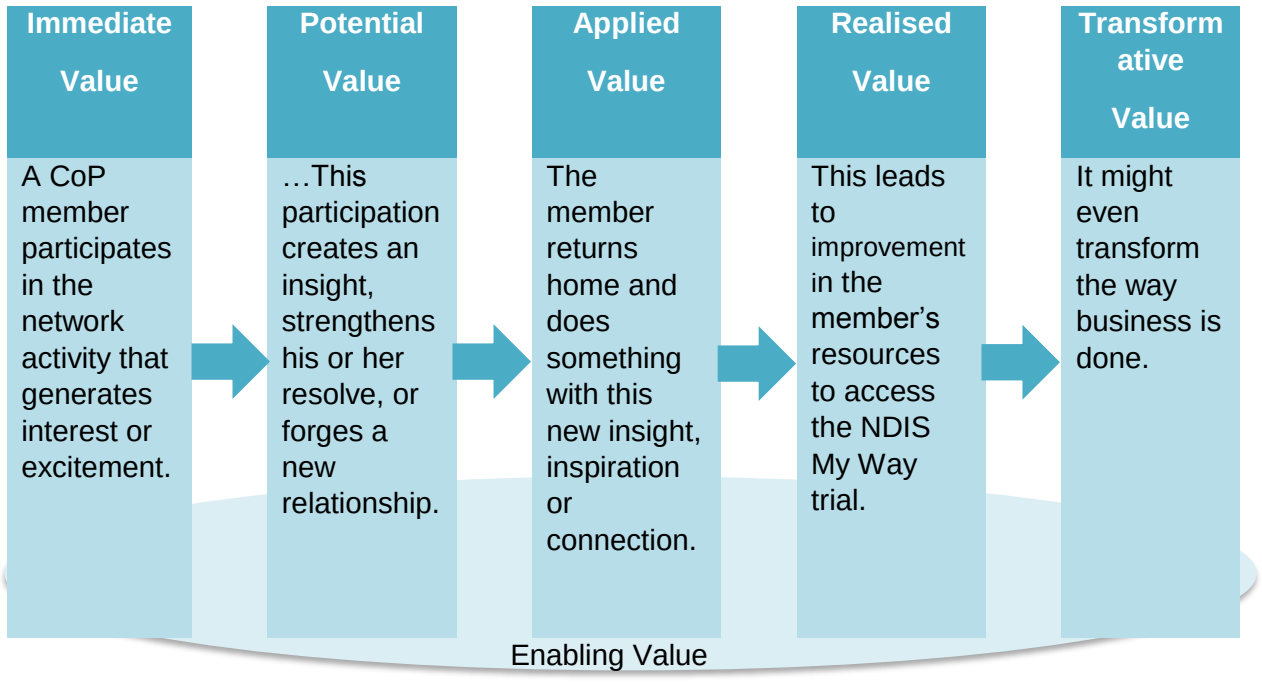
only to psychosocial disability participants and the WA NDIS My Way trial regions in the Lower South West and Cockburn/Kwinana. Activities of the project can be summarised as:

- Establishment of an active and vibrant CoP within each trial site.
- Facilitation of six CoP gatherings in each region/site.
- Capture and dissemination of project learnings.
- Value add-ons by disseminating learnings from linked projects funded by the commission.

Data collected from online questioning, story collection and end-of-session feedback presents an overwhelmingly positive regard for project methodology, design and delivery.

The end-of-project evaluation methodology draws on Beverly Wenger-Trayner's Framework for social learning in networks. The conceptual project, underpinned by a theory of change, promotes and assesses the value created in communities and networks. The framework is used to identify the type of value created at each point. The following theory of change underpins the CoP end-of-project evaluation approach:

Evaluation Framework – Theory of Change



Project learnings offer a snapshot-in-time perspective of key issues. A variance in the stages of development was noted in the regions, with the Lower South West demonstrating a mature relationship with both the scheme and other stakeholders. This observation is not surprising given the longer length of time it has been in operation, however, what was surprising is that the sites do not mirror each other and instead each trial site has a momentum of its own, evolving in response to local strengths and opportunities, often strongly influenced by the personality of leadership. With some exceptions, Cockburn/Kwinana stakeholders were generally focussed on the mechanics of the scheme, as often they were new to the role with little or no NDIS knowledge. In contrast, stakeholders in the southwest were very stable and tended to hold higher levels of experience which they were happy to share with stakeholders in the Cockburn site.

Despite the increased maturity of stakeholders and the scheme in the Lower South West, the inability to engage South West Health at the table presented a significant barrier to the project's impact and is reflective of the fragmentation which is still present in support planning of psychosocial participants within the NDIS. CoP participants were united in a belief that artificial boundaries between service systems need to be broken down for the scheme to be optimal, as participants' needs were not easy to segment into clinical and community support/intervention —instead a holistic approach is called for.

Concern continues to be expressed around the language of 'permanency' and the ideological struggle this presents within the context of recovery. These concerns have been documented in the WAAMH Board's *Position on Future Governance of the NDIS in WA* and the *Review of the NDIS Act*.

Furthermore, stakeholders continue to offer the perspective that the volume of resources in a NDIS plan relates directly to the quality/amount of advocacy a participant received. These issues have been presented by WAAMH in submissions to the National Disability Advocacy Framework, the Information, Linkages and Capacity-Building Framework and the review of the National Disability Advocacy Program. In addition, the issues were also raised in representations to state and

national committees including the NDIA's Mental Health Sector Reference Group and the WA NDIS My Way Reference Group. WAAMH actively continues to push the NDIS to effectively respond to the needs of people with psychosocial disability and that a viable network of community mental health support services is maintained for those who are not eligible for funding under the NDIS.

The CoP project began from a deficit perspective, assuming that stakeholders were lacking in knowledge and information and by providing this, capacity would be increased. Upon reflection this assumption was seen as overly simplistic and failed to recognise the significant growth and development already undertaken by many CMMHO's. The project uncovered several opportunities to enhance the mechanics of the project, such as the need for a local centralised information distribution channel, increased involvement of peers (particularly around engagement), the role of advocacy and the need to invest in 'preplanning' so that participants are better able to exercise choice and control. Equally so, the opportunity exists to begin to understand the way in which relationships are formed between planners and participants; there is potential as well for greater understanding of the effectiveness of community-based supports and their relationship with crisis presentation.

In all, 13 blog postings were posted and can be accessed via the project webpage link (see above). Topic content received positive feedback; however, stakeholders repeatedly advised of their difficulty finding the blog and once there, navigating between old and current posts proved difficult. The project trialled Asana (https://asana.com/) and DropIN (https://dropin.org.au/) free to use, online tools. Regrettably, it was assessed that neither tool was fit-for-purpose and a more suitable alternative was not identified.

A shared timeline was developed by the like projects reference group (known as the Three Projects) with the aim of coordinating activities and maximising wider stakeholder engagement. Unfortunately, due to delays in the project start-up, staff changes and challenges in the recruitment of peers, full leverage could not be achieved. The group however, was instrumental in assisting consumer and carer representation at the CoP, as well as the sharing of information and learnings.

Future Directions

Like any group work process, the CoP took a number of sessions before a rhythm was established and participants had developed trust and confidence in the process and each other. Stakeholder feedback reiterated an overwhelming desire to see the project continue, noting opportunities for development such as:

- Use forum to prototype and explore new or enhanced ways of working
- Development of a virtual CoP
- Development of a social media strategy and use of Twitter, Facebook etc. as a distribution channel
- Blog as a standalone site

2 Introduction

The Community of Practice project, delivered by the Western Australia Association of Mental Health[1] (WAAMH) and funded by the Western Australian Disability Commission, was run between July 2015 and June 2016. The project established a learning network more commonly known as a Community of Practice (CoP) within the WA NDIS My Way trial sites. The CoP[2] was defined by the process of shared learnings and information dissemination which occurs between stakeholders within the network as well as more broadly (e.g. to the wider community). In this case the focus of learning was the inclusion of people with a psychosocial disability (PWPD) within the WA NDIS My Way trial sites. The year-long project saw WAAMH facilitate a total of 12 CoP gatherings. Gatherings were typically held on the last Thursday of every month, alternating between trial sites.

The CoP aimed to create a space for stakeholders to learn from one another; it also served as a platform to identify and build their resources to access WA NDIS My Way by investing in people and systems.

The CoP also aimed to provide an opportunity for stakeholders to alert the Disability Services Commission (the commission) of key issue/s. In addition, the project aimed to add value by disseminating key learnings from other Community Managed Mental Health Organisations capacity-building projects funded by the commission, specifically:

- Richmond Fellowship of WA (RFWA), whose project aims to develop and deliver targeted and customised information for PWPD
- CoMHWA, ARAFMI (WA) and Carers WA initiative, whose project aims to provide customised community management and capacity-building strategies for consumers and carers/families (WA NDIS My Way Consumer Carer Project)

[1] The Western Australian Association for Mental Health (WAAMH) is the peak representative body for the community mental health sector in Western Australia. Its membership comprises more than 150 organisations and individuals and it works for the benefit of people with mental health issues and their families.

[2] Mandell MP, Keast R, and Brown K. *The Importance of a New Kind of Learning in Collaborative Networks*

In an effort to simplify communication to stakeholders, the CoP and the two projects noted above became known as the Three Projects.

The CoP linked closely with the commission's Information and Support Network (ISN), an internal unit established to keep all stakeholders informed, supported and connected to the WA NDIS My Way agenda. This included ISN representation on the CoP, to help facilitate a central source of accurate and up-to-date information on matters pertaining to the WA NDIS My Way trial.

This report has been commissioned in order to present an end-of-project evaluation to the commission to address the following areas of inquiry, specifically:

1. What did the project aspire to do?
2. What happened?
3. What was the impact?
4. Future aspirations

3 Background

The challenges for PWPD in accessing effective support through the NDIS have been documented at a national level by Mental Health Australia[3]. WAAMH acknowledges the state by state differences due to variations in the bilateral agreements, and that the Western Australian agreement is unique due to the decision to trial two different NDIS models across three trial sites in WA – the Commonwealth model operated in the Perth Hills by the National Disability Insurance Agency (NDIA), and the state model operated by the Disability Services Commission (the commission) in the Lower South West and Cockburn/Kwinana, known as WA NDIS My Way.

The NDIS is of significant interest to the Community Managed Mental Health (CMMH) sector which is reflected in a high level of engagement with sector organisations, consumers, carers and families. In 2014, WAAMH held two events for the mental health sector on the inclusion of psychosocial disability within the WA trial of the NDIS, which were attended by over 150 participants. Extensive consultation with the CMMH sector occurred at these events,. WAAMH also consulted the mental health sector via a survey that set out the key issues for people with psychosocial disability and proposed responses to these issues. More than 70 responses were received to the survey, with survey results documented in WAAMH's position paper *Psychosocial Disability Support through the WA NDIS My Way Trial: Key Issues and Proposed Responses*.[4]

The development of this project drew on learnings from the consultation process and was also informed by the successful CoP for psychosocial disability, which was established in the Hunter NDIS trial site by the Mental Health Coordinating Council of New South Wales.

[3] http://mhaustralia.org/publication/providing-psychosocial-disability-support-through-ndis

[4] http://waamh.org.au/assets/documents/projects/psychosocial-disability-support-through-the-wa-ndis-my-way-trials.pdf

4 The Community of Practice

4.1 Establishment Phase

The CoP project was assigned to WAAMH's sector development team. The sector development team helps develop the capability of the mental health sector to provide recovery-oriented, person centred and inclusive services, by sharing its expertise and fostering collaboration. The team has extensive networks and holds established relationships with prospective CoP members. The CoP project was able to leverage from these relationships and draw on WAAMH's existing stakeholder data base. In the lead up to the establishment of the CoP, the Sector Development Manager phoned, visited or personally emailed potential members, with the agenda to promote and drive momentum for attendance. Additionally, both project staff attended the NDIS WA My Way All Staff Planning Forum in Busselton. The forum was attended by every Planning Coordinator employed in the trial sites, and provided a great opportunity to promote the CoP and learn more about the NDIS WA My Way.

Recruitment efforts were highly successful, with 25 participants attending the first Lower South West CoP and 35 participants at the Cockburn/Kwinana trial site. At each of the initial meetings, participants were asked to identify gaps in stakeholder representation. If and when a gap was identified, project facilitators would make personal contact with the missing organisation or individual to encourage future participation. By the end of the project the details of 156 individuals were on the CoP database.

The draft project logic submitted to the commission has been reviewed and amended to reflect actual project activity and scope. The project logic presented below offers a conceptual presentation of the causal relationship underpinning the delivery of the CoP:

Table 1: Community of Practice — Program Logic

Inputs	Activities	Outputs	Initial Outcomes
• Human resources • Establishment of relationships with stakeholders • Recruitment of stakeholders • Grant revenue • Facilities to convene the group • Set up systems/methods to collect the data (write up notes from live scribe, monitor data from website, email campaign and blog etc.)	• Facilitation of 12 CoP gatherings • Design of workshop materials and tools for each CoP gathering • Minimal of 12 blog postings, reflecting a key learning from each CoP • User experience of the blog	• CoP meetings occur at regular intervals • Number of participants of the CoP • Number attending regularly • Number of relationships built • A common understanding of the application of recovery principles and how these relate to WA NDIS My Way. • The interface between the public mental health system, providers and consumers, and the challenges and learnings associated with this, are understood by CoP participants. • Supports within and outside of WA NDIS My Way are defined, understood and disseminated. • Key learnings captured and shared with stakeholders external to the CoP • CoP briefs/summaries are drafted and distributed to CoP participants which highlight the most significant areas of change observed by CoP participants, so that organisations are well-equipped to respond these changes. • Communication plan developed and implemented, inclusive of feedback loops and distribution of learnings from the CoP • Communication formats and channels established. • A self-sustaining sector response is planned and implemented, independent of commission funding.	• Joint learning and innovation from a networked CoP which encompasses mental health consumers, families and carers, community mental health and disability service providers (both Commonwealth and state), clinical providers, key government agencies and other key stakeholders (such as GPs and public mental health practitioners). • Effective interfaces are developed between all stakeholders that result in an increased ability to understand and respond to the effective inclusion of psychosocial disability in the WA NDIS My Way trial sites. • Build capacity in the NDIS My Way Trial Sites

Assumptions underpinning the program logic:

- International best practice and national policy in mental health is driven by the recovery approach. There are some unique elements of the recovery approach, such as the centrality of hope and the redefining of self, that are critical to the engagement of and the provision of support to PWPD in the NDIS. These elements are often considered not to be congruent with the My Way model.
- The relationship between psychosocial disability and mental illness, recovery, access and eligibility, recovery-oriented planning, engaging consumers, and the nature of reasonable and necessary supports likely to be needed by PWPD are not currently captured in the My Way model/processes.
- The mental health sector has a specific context which requires a tailored communication approach; for example, PWPD do not generally identify as 'disabled' and organisations that provide services to PWDP do not describe themselves as 'Disability Service Organisations'.
- Specifics of eligibility and differing approaches in supporting people between the two sectors also need attention. Further, the CMMH sector, consumers and carers have highlighted the challenges in engaging those people with mental illness likely to be eligible for the scheme, and in developing shared language about all aspects of the scheme with a particular emphasis on understanding and supporting recovery.
- The NDIS Act and Rules establish criteria for funding and provision of "*reasonable and necessary supports*", though the specific supports are not identified. The nature of supports for PWPD may be significantly different from other disabilities because of the need for recovery-oriented support and because of the interactions with different service systems. Nonetheless, there is increasing understanding of the importance of psychosocial supports. The boundaries between clinical and non-clinical support in the mental health system are structurally different to those of other disabilities, i.e. under the NDIS, "clinical" mental health supports are the responsibility of the Health systems, whereas the "clinical" supports for other disabilities are within the NDIS and considered part of what is required for the person to live a good life in the community.

4.2 Delivery Phase

The CoP project was commissioned to run for 12 months, with six gatherings to be facilitated in each trial site region. Generally, the sessions were held on the morning of the last Thursday of the month, alternating between locations, with the Cockburn site mimicking the earlier South West discussion focus. At the end of each session, the project facilitator would use a collective decision-making process to identify and establish the focus of the discussion for the following meeting. The project had been developed in response to the identified list of topics gather by WAAMH during consultation in 2014 and presented in the original project application. These topics were often referred to as a guide for selecting the next area of exploration. It had been assumed that topic discussion would be mirrored in the two sites; however, each site was found to be at different stages of development, with the South West region presenting stable attendance of a group of stakeholders familiar with each other and holding mature working relationships. In contrast, the Cockburn CoP expressed ever-changing stakeholder attendance, reflecting high levels of staff movement and job change.

The project facilitator was charged with the task of bringing a semi-structured content agenda, in order to drive and feed discussion; however, if the group chose, discussion was allowed to wander to areas of interest in order to support the methodology of collective learning. The following table outlines topic focus areas for each of the gatherings. A mixture of guest speakers, PowerPoint presentations, workshops, focus groups and discussions were held.

Table 2: Date of CoP and Discussion Focus/Topic

Lower South West	
Topic	Date
Access and eligibility	Thursday 25 June 2015
Planning and supports	Thursday 27 August 2015

Cockburn/Kwinana	
Topic	Date
Access and eligibility	Thursday 30 July 2015
Planning and supports (Panel presentation: Enable Southwest, PIR and Carer representative)	Thursday 24 September 2015

Outcome Measurement	Tuesday 27 October 2015	Outcome Measurement	Thursday 26 November 2015
Advocacy (Guest speaker: Adam Johnson, CEO, Advocacy South West)	Thursday 10 December 2015	Advocacy (Guest speaker: Samantha Jenkinson, CEO, PWD)	Thursday 11 February 2015
Implications of choice and control and the challenges of being person centred (Consumer speakers: Veronica Bruce and Beatrix Kalkman)	Thursday 25 February 2016	Implications of choice and control and the challenges of being person centred (Consumer speakers: Veronica Bruce and Beatrix Kalkman)	Thursday 31 March 2016
Change in a complex system	Thursday 5 May 2016	Change in a complex system	Thursday 26 May 2016

Feedback was gathered at the end of each session, offering a loop for continuous development and input into the organic evolution of the project. The feedback loop assisted the facilitator to establish a safe and supportive environment. All comments for improvement were acted on immediately with either email follow-up within two days, or allocation as the first item for discussion at the next gathering.

4.3 Project Blog and Other Technology

As a result of discussions during the inaugural gatherings it was agreed that technology would play a pivotal role in information distribution and future project sustainability. Specifically, it was agreed to:

- Develop a project profile page on the WAAMH website with links to Project 1 and 2.
- Set up a blog, with postings reflective of CoP insights and topical information, including links.
- Select an online tool to support group discussion, sharing and planning. This tool would be used as a virtual CoP and support the longevity of the initiative after the project.

4.3.1 Webpage

Within six weeks of the first gathering, a CoP web page was set up on the WAAMH site: https://waamh.org.au/development-and-training/community-of-practice-.aspx. The webpage is a central reference point for any interested party to learn more about the project and is a sign-up point for people wishing to receive email alerts to blog postings and monthly email newsletters.

4.3.2 Blog

In all, 13 blog postings have been posted and can be accessed via the project webpage link (see above). The blogs' topic content has received positive feedback, however, stakeholders repeatedly advised of difficulty in finding the blog and once located, navigation between old and current posts proving difficult. In response to this feedback, a new blog posting alert email is now sent to all stakeholders as well as monthly emails promoting the blog address, recent postings and updates and information on developments in the NDIS. Additionally, a full list of hyperlink postings is located on the project website.

4.3.3 Online tool

Asana (https://asana.com/) and DropIN (https://dropin.org.au/) are both free-to-use online tools which support collaborative discussion, project coordination and information exchange, which the project trialled. Regrettably, it was assessed that neither tool was fit-for-purpose and a more suitable alternative was not identified.

5 The Three Projects

As described in the introduction, the CoP aimed to add value by disseminating key learnings from other DSOs and CMMH Organisations funded by the commission. The projects that arose from these learnings became known collectively as the Three Projects:

- Project One
    - Richmond Fellowship of WA (RFWA)— aims to develop and deliver targeted and customised information for PWPD.
- Project Two
    - CoMHWA, ARAFMI (WA) and Carers WA initiative— aims to provide customised community management and capacity-building strategies for consumers and carers/families (WA NDIS My Way Consumer Carer Project).
- Project Three
    - The CoP itself.

Under the leadership of the CoP, the Three Projects coordinating group was established in June 2015 (see appendix for Terms of Reference). The purpose of the group is to optimise opportunities and the strategic alignment and coordination of each project's discrete activity and interface with each other. Group members aim to harmonise their activities and as such act in symphony with one another, maximising the strengths of each project and its membership. The group meet four times a year and at each meeting actions were recorded and the activities of each stakeholder outlined. A joint information and marketing sheet has been developed (refer appendix). This sheet was used by members to reduce confusion and facilitate clear messaging.

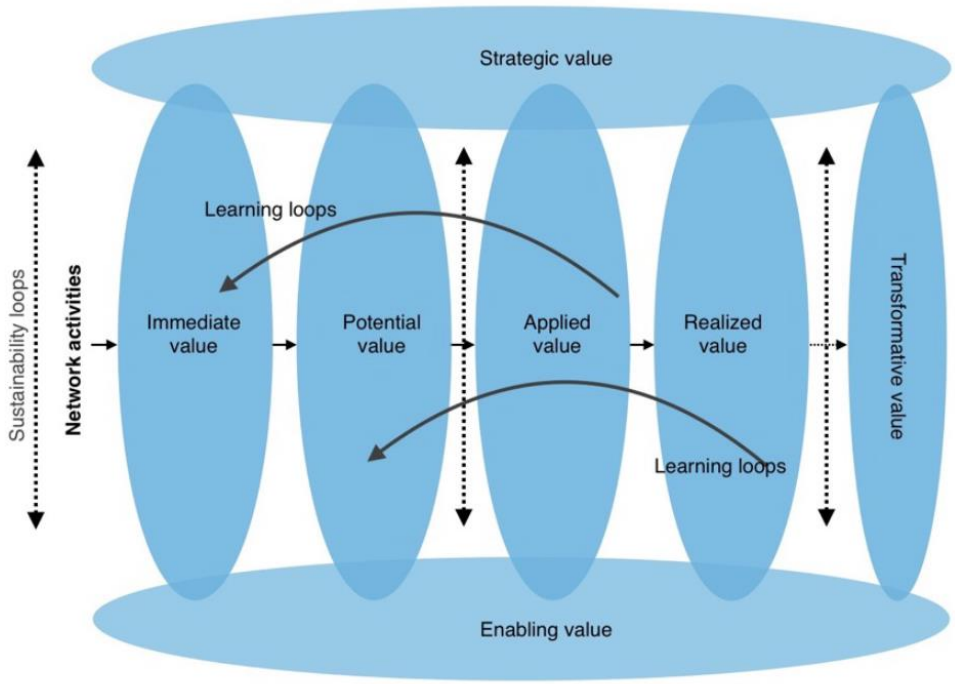
A shared timeline was developed to coordinate activities and maximise wider stakeholder engagement. Unfortunately, due to delays in project start-up, staff changes and challenges in the recruitment of peers, full leverage could not be achieved. The group, however, was instrumental in assisting consumer and carer representation at the CoP, as well as in sharing information and learnings.

6 Evaluation Approach

The CoP end-of-project evaluation approach draws on a conceptual framework developed by Beverly Wenger-Trayner (2014)[5] . The conceptual framework was developed to promote and assess the value created in communities and networks. The framework first applies theory of change methodology, presenting a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context. The approach proposes that each step in the process creates a certain type of value for network members and stakeholders. As learning flows through these steps, participants give feedback to members as to how things work in practice (or don't, as the case may be). These feedback loops are a key element of the learning process.

A visual representation of the different types of value and the learning feedback loops can be seen in the figure below:

Figure 1: Framework for Social Learning in Networks



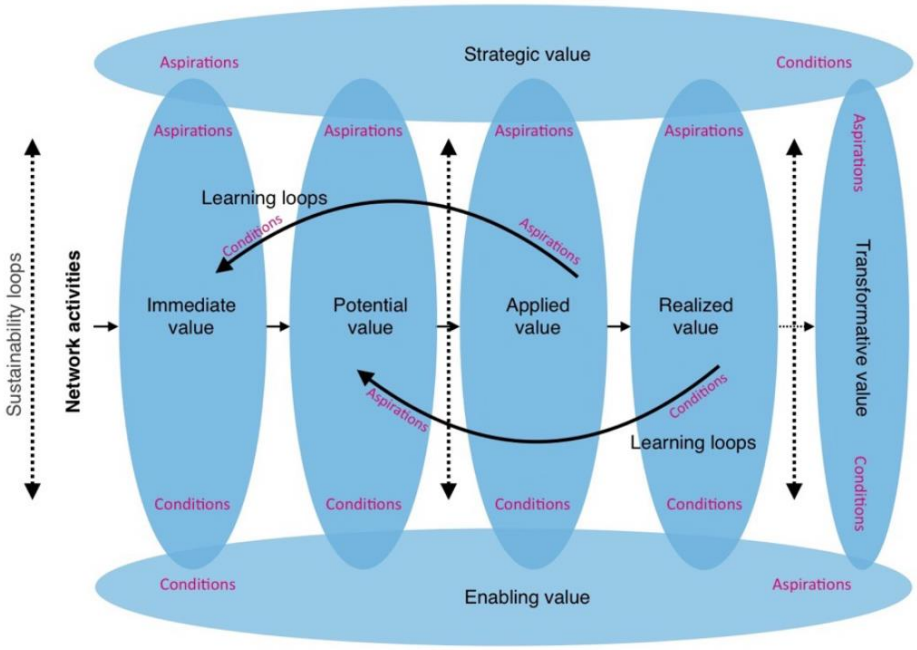
[5] Wenger, E., Trayner, B., and de Laat, M., 2011 *Promoting and assessing the value created in communities and networks: A conceptual framework*. Open University of Netherlands

The framework assesses or measures value by combining two sets of data collection methods, specifically:

1. ***Indicators*** – to show value at each cycle.
2. ***Value creation stories*** – to show how improvement or transformation can be attributed to the activity of the network (at least in part).These stories show value across cycles.

By identifying what aspirations are desired at each value cycle and the conditions necessary to achieve these, the framework can also be used prospectively to create a vision and plan future activities.

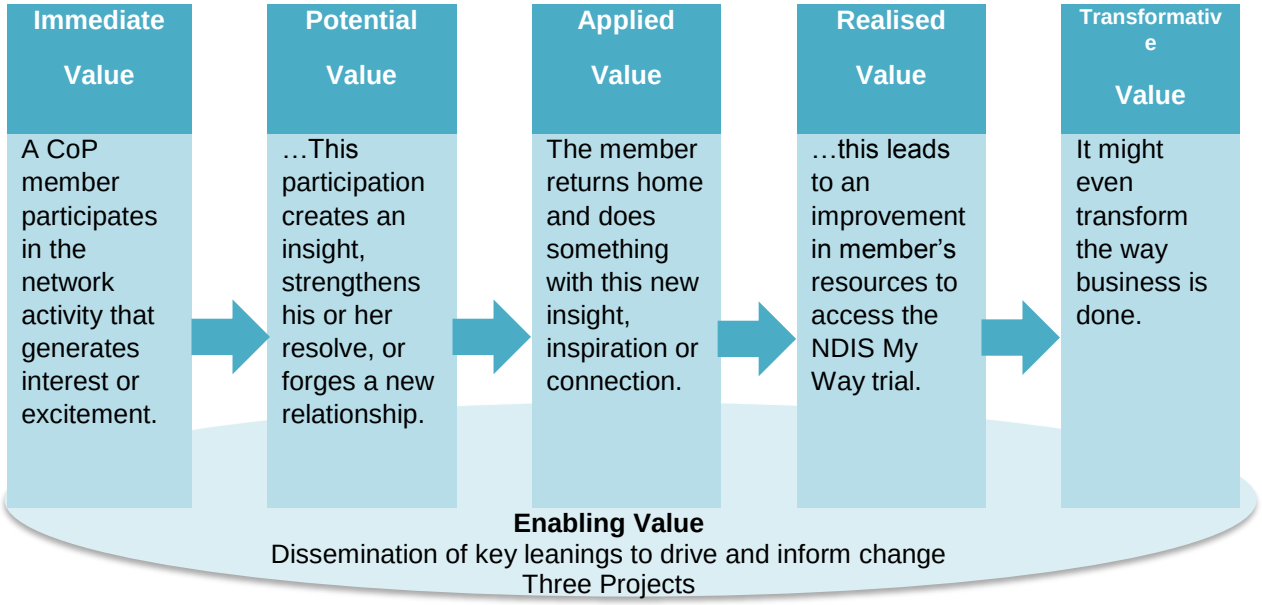
Figure 2: Using the Framework for Visioning and Planning



6.1 Evaluation Framework–Theory of Change

The following theory of change underpins the end-of-project evaluation approach:

Figure 3: Evaluation Framework – Theory of Change



7 Data Collection Methods

7.1 Indicator Results

The 12 CoP gatherings had a total of 132 people in attendance. All participants were invited to take part in an online end-of-project 'Survey Monkey' questionnaire. Questionnaire results captured the following immediate and potential value indicator data:

Table 3: Immediate Value Indicator Results

Immediate Value	Indicator	Result	
		Lower South West	Cockburn/ Kwinana
A CoP member participates in the network activity that generates interest or excitement.	Number of individual stakeholders on database (email distribution list)	**60**	**96**
	Number of sessions run	**6**	**6**
	Number in attendance/engagement	**51**	**81**
	Stakeholders who report increased capacity in…. • Knowledge of NDIS WA My Way • Ability to respond to psychosocial participants • Application of recovery principles • Clarity of boundaries/responsibilities between public mental health systems, providers and participants • Understand their role in the trial site	**57%** **14%** **43%** **43%** **43%**	**78%** **23%** **46%** **31%** **62%**
	Blog		
	Number of postings	13	
	Number of views (all postings)	594	
	Number of unique page views (visits)	290	
	CoP webpage		
	Number of views	730	
	Number of visits	419	

	Number of monthly emails sent to keep people up-to-date with what is happening in the NDIS and the NDIS My Way space. Percentage opened - average	1449 44

Table 4: Potential Value Indicator Results

Potential Value	Indicator	Result	
		Lower South West	Cockburn/ Kwinana
This participation creates an insight, strengthens his or her resolve, or forges a new relationship.	Valuable insights around access to the NDIS	**43%**	**70%**
	Valuable insight into recover principles	**29%**	**23%**
	Valuable insight into advocacy	**14%**	**46%**
	Valuable insight into person-centred practice	**14%**	**23%**
	Increased insight into the role of my organisation and our business offering to participants of the NDIS	**43%**	**31%**
	Insight into future business/service opportunities	**43%**	**54%**
	Practical knowledge around implementation of outcome measures and their value/use	**43%**	**31%**
	Resource which could help me in the future	**43%**	**77%**
	New relationships	**86%**	**77%**
	New partnerships	**43%**	**31%**

7.2

7.3 Project Learnings

The CoP methodology was applied with the aim of identifying and isolating critical considerations and issues to develop the capacity of psychosocial disability participants to use and be included in the scheme in the My Way trial regions. Collectively these items, observations or themes are referred to as learnings and are presented below.

Summary learnings presented in the six-month interim report:

- The process is not linear – each trial site has a momentum of its own and hence needs to respond to demands that the NDIS My Way model places on the system. This can be about the place, the context and the importance of relationships.
- One learning is that the Cockburn/Kwinana trial site is not as mature as the Lower South West and this could be about up-skilling and giving stakeholders the resources to understand what the NDIS My Way means to each of them as an organisation. From the first meeting in the Cockburn location, stakeholders had limited knowledge of how the NDIS My Way functioned.
- The learning from the Lower South West is about taking from the organisation an understanding about the processes and the maturity of organisations to manage the NDIS My Way in that site.
- Learning about the value of the community practice and how to utilise this mechanism as a way of learning in new trial sites. Does the CoP act as a tool which provides for greenfield sites to operate more efficiently? Can they get to maturity quicker?
- Fine tuning of the ways of working – the blogs become the “briefing papers” as topics are contextualised to what is important for the stakeholders at a particular point in time.
- The process was understood by the project team from a deficit base and this is not the case in the Lower South West – lots of opportunities to connect to resources “out there” and it is our role as facilitators to do this in a plethora of ways.
- Cockburn/Kwinana region does not have a shared language at the moment.

- The cultural context in the My Way trial sites is different in each location.

Summary learnings six to 12 months into the project:

- Service providers, carers and consumers are noting a correlation between resources assigned to individual plans and the ability of the participant and/or their supports to advocate. There is a strong belief that the correlation is not a result of need, but simply how informed, articulate or forceful a participant is.
- High percentage of providers still to define fully their business model.
- High level of misinformation, particularly in the Cockburn/Kwinana site. For example, one provider stated that none of her clients were eligible for the scheme; however, when the regional manager stated that she was not aware of any applications/presentations, it became clear that the worker had made this decision and not the scheme.
- Concern expressed by many providers of the difficulty in maintaining quality trained staff under current payment rates. Belief that this issue has yet to be fully addressed and concern that quality of service will be compromised if current standards are not maintained.
- Currently each provider or individual is left to use their own communication channels to advertise activities or events. This ad hoc approach means PWPD need to be in the right place at the right time to know what is happening. This is logistically difficult, and more so if they are unwell at the time. One suggestion is that each DSC regional office act as a central point of depository and distribution of information using a social media platform. This way all stakeholders would know where to go for local information.
- Limited engagement with PWPD who are not currently involved in the health system. It was felt that a peer workforce or outreach models are needed to address this.
- Use of language— particularly ‘permanency’— continues to be a barrier to access.
- The scheme is based on a number of assumptions which in reality could prove false. For example, ‘choice and control’ – in country/regional areas there often isn’t any real choice. The scheme is bureaucratic in design and assumes that participants are equipped to deal with this. Without adequate advocacy support

it is difficult for PWPD to assert/articulate their needs at the time that the system demands; for example, they may be unwell on the day or lack the self-empowerment skills necessary for true choice and control.

- There exists an artificial separation between clinical and community intervention, which is oppositional to the concepts of choice, control and recovery. This separation was exacerbated in the Lower South West trial site, as the South West Health service (despite repeated requests and attempts) failed to participate in the CoP, expressing a view that this was separate to their charter.
- Carer information sessions have been attended by service providers. In many examples, the friend or family carer of the PWPD were not informed of the session as the service provider assumed this role.
- There is concern for sustainability of the carer role and reduction in supports for them.
- There is a universal assumption within the scheme that consumer participation is simply about extending an invitation. The consumer engagement process with PWPD is complex and multifaceted. If they were able to simply attend there is likelihood that they would not be participants of the scheme.
- The central role of relationships is at the heart of good engagement, planning and service provision, yet cost effectiveness appears to often overlook this.
- Opportunity to use CoP to prototype and move beyond discussion.

7.4 Value creation stories

In addition to participating in the survey, a group of ten stakeholders were invited to participate in telephone interviews in order to capture a number of different perspectives. These perspectives or stories show how improvements or transformation in the sector can be attributed (in part) to the activity of the network. A value creation story has a specific genre, with something happening at each step of the framework. Two examples of value creation stories are presented below, with others located in the appendix.

The story told by Andries Pretoriusgoes, PIR Manager, Community First, goes through the main steps in the value creation genre, showing a causal link between a network

activity and an increase in psychosocial disability consumer input into service design and delivery.

The story told by Veronica, a carer, also goes through these steps in the genre, showing how her participation in the network has led to the development of new relationships and contacts. It also shows —at least in part — how the interface with providers has informed her practices as a carers' representative and deliverer of peer support training.

Immediate value	Potential value	Applied value	Realised value
I really valued hearing the consumer and carer experiences so generously shared with us by Veronica and Beatrix.	So often we become so caught up in the 'operationalized' that it was an excellent reminder that this is all about people.	We had already begun down this path but it re-enforced and strengthened our resolve to set up increased mechanisms to seek and apply consumer feedback. We now have a consumer advisory group and consumer input is integral to all that we do.	We have found that we are now advising and supporting other organisations by linking this consumer voice. For example, we have been working with South West Health as to how their emergency reception area is perceived by PWPD and the negative impact it can have on them when they come to emergency when experiencing a period of being very unwell.

Immediate value	Potential value	Applied value	Realised value
My daughter has had a psychosocial disability and until the NDIS came along she really got very little. The NDIS has changed her life. It's very new and everyone is learning. I thought	Stakeholders held the 'mechanic' knowledge but at the CoP they asked me experimental questions. Through attendance I	Attendance really joined the dots for me, and caused me to think differently. It increased my optimism that things will be better for psychosocial disability, but there	It such a big change for many of the mental health services. In some ways for those in disability it's a bit easier as they have been doing 'choice and control' for longer. It is still so new and so different, there is still such a long way to go and things like the CoP

the CoP was really good, because stakeholders were there searching for answers. They asked me a lot of questions and I think that is really valuable. They wanted to learn.	developed a lot of good contacts and was able to provide a carer perspective which is really valuable.	is still a long way to go. This changed outlook affected the way I delivered peer information session for Project 1.	offer real value as they bring us all together to learn and share. The facilitators, the topics and the people that attended were all so committed and offered so much. 

8 Findings

This section presents the evaluation findings for each value cycle. Findings are presented in a one-page summary table focussing on the following questions:

1. What did the project aspire to do?
2. What happened?
3. How to set aspirations for the next phase in the partnership?

Column 1: *What did we aspire to do*

Includes the aspirations and indicators recorded in the program logic. It also contains the conditions identified as necessary for supporting the aspirations.

Column 2: *What happened*

Summarises key achievements and shortcomings related to the cycle as well as the conditions that were fulfilled or missing. It is a brief synopsis based on project documentation, observations, interpretation of indicator data and value creation stories collected during the project.

Column 3: *How to set aspirations for the next phase*,

Proposes some questions, indicators, examples and the necessary conditions for going forward.

Table 5: Summary documentation of each value cycle

Initial aspirations *Source: original documents*		**What happened?** *Source: project documents, value creation stories, final project review meeting, observations*	**Aspirations for next phase** Examples of the type of information to be discussed	
Aspirations	Indicators	Achievements and shortcomings	Aspirations for next phase	Indicators
Conditions		Conditions fulfilled or missing	Conditions for next phase	

Table 6: Generating immediate value – Benefits of participating in activities

Aspirations

Initial aspiration		What happened?	Aspirations for next phase	
Within the network: • Hear about the experiences of stakeholders in the network. • Share good practices and innovation. • Hear about lessons learnt. • Hear about challenges and issues. **Three Projects network:** • Hear about the activities • Hear about the learnings **Outside of network:** • Hear about NDIS developments • Hear about new ways of working	**Indicators/data** • Three Project reference group established • Number stakeholders • Number of stakeholders attending CoP • Facilitate 12 CoP workshops	**Feedback about engagement from within the network** • Get to know the different ways CMMHO operate – psychosocial NDIS participants • A chance to network • Hear from others facing similar challenges • Stay up to date with good practice • Interactive sessions • Discuss challenges and issues • A chance to learn from others with more experience • Improving the capacity of stakeholders in trial sites **Feedback about engagement with Three Projects** • Delay in project commencement, changes in staff and difficulty/challenges in recruitment/engagement of consumers and carers. • Receiving same stakeholder feedback around issues and challenges of the scheme. • A chance to understand and interact with carers and consumers. **Feedback about interaction outside of network** • A chance to hear about Agency and My Way developments • A chance to hear about international trends/research (e.g. Recovery framework, self-direction care) **Monitoring of indicators by project consultant** • Blog postings capture key insights from each workshop (gathering) • Reflection and development conversation at end of each workshop (developmental evaluation approach) • Six month and end-of-project online survey	**Aspirations** *What are your aspirations for the direct experience that people will have when engaging with the network?* *Examples:* • *Specific activities and projects* • *Ability to go beyond the rhetoric* • *Ability to prototype new ways of working* • *Interactive sessions* • *Ability to address hard issues/challenges* • *Solving problems together*	**Indicators/data** *What indicators would suggest this is happening?* *Examples:* • *Levels of attendance* • *Participation and commitment* • *Depth of discussion* • *Number of prototypes* • *Mistakes and failures* • *Positive comments*

Conditions

CoP • Stakeholder engagement. • Capacity of stakeholders to attend. Including consumer/carer payment. • Consultant to design, resource and facilitate workshops (gatherings). • Briefing papers. **Resources** • Online engagement and communication system identified. • Workshop design and support materials. • Development of new tools. **Three Projects** • Recruitment channel • Partnership to empower/support consumer/carer participation.	**CoP** • Stakeholder engagement, with additional targeted focus -South West Health, South West Aboriginal Medical Service, Consumers and Carers. • Capacity of stakeholders to attend. • Consultant to design resource and facilitate workshops (gatherings). • Blog postings. **Resources** • Online engagement and communication systems identified • Workshop design and support materials **Three Projects** • Direct recruitment and provision of limited in-house support.	

Table 7: Generating **potential** value — Insights, ideas, methods, skills, documents, relationships

Initial aspirations →	**What happened?** →	**Aspirations for next phase**

Aspirations

• Increase knowledge of psychosocial disability • Strengthen relationships within the network • Provide feedback to commission and wider stakeholders • Develop stakeholder resources by investing in people and systems • Adoption of recovery-oriented practice which aligns to scheme • Produce quality briefing papers (capture learnings) • Leverage Three Projects	**Indicators/data** • Number of new relationships • Number of briefing papers • Delivery of recovery framework workshop	**Partnerships** We developed a lot of good contacts and were able to learn from the perspective of others **Recovery** So often we become so caught up in the 'operationalized' that it was an excellent reminder that this is all about people. **Blog** The blog supports effective distribution of learnings and insight, offering an effective communication strategy. **Feedback loop** The forum provided a safe space in which I could hear directly about the way stakeholders were feeling/experiencing the rollout and if and when necessary, we could change or modify the way we were doing things.	**Aspirations** *What potentially useful things to you want the network to produce?*	**Indicators/data** *What indicators would suggest the network is producing what you hope it will?*

Conditions

• Stakeholder active participation • All three projects operational • Communication strategy	• Workshop content: relevant and informative • Feedback and blog postings provided in a timely manner	*Under what conditions will the network be able to produce these things?*

Table 8: Generating **applied** value—Plans into practice, implementation or resolutions, inspiration that changes practice

	Initial aspirations		What happened?	Aspirations for next phase	
Aspirations	• Apply learnings in the interest of their CMMH organisation • Solve problems • Create innovation • Harmonise and standardise language • Implementation of quality safeguards • Increase application of recovery and person-centred principles	**Indicators/data** Percentage reported insight into recovery principles; person-centred practice	**Strengthen the future** The insights and knowledge we gained from attending the CoP were discussed at length with my colleagues, and have influenced our practice, business model and work. **Consumer participation** Hearing from consumers and carers was one of the most enriching experiences of the CoP and reinforced the : • Role of peers • Need for active consumer participation • Embedding co-design	**Aspirations** *How can learnings be used to create/influence change?* *How can learnings be used to prototype new ways?* *How much risk should members take in trying new network ideas and experimenting?* *Examples: do you want to see:* • *Improved practice?* • *Integrated practice* *collaboration?*	**Indicators/data** *What are indicators that would suggest that application is happening?* *What is their impact?* *Which of the initial set of indicators are still relevant?*
Conditions	CMMH organisation investment		Change and transformation requires a whole-of-organisation approach. Change and transformation require ‘systems’ to come together.	*Under what conditions will it be possible for members to apply what the network has produced?*	

Table 9: Generating **realised** value – Creating a change in the WA NDIS My Way psychosocial landscape

	Initial aspirations		What happened?	Aspirations for next phase	
Aspirations	• Effective interfaces between stakeholders (breaking down of sector silos/fragmentation) • Increased ability to understand and respond to inclusion of psychosocial disability supports within and outside WA NDIS My Way		**Relationships** Participation in the CoP has led to the development of new relationships **Interface** Despite all of our efforts, the inability to engage with South West Health reflects the inability to truly increase capacity of the trial site to include psychosocial disability participants. Until we start having discussions around what the real core business of tertiary mental health services are, we cannot progress.	**Aspirations** *If the network is successful what should be different – for consumers? For the scheme? For the organisation?* *What undesirable outcomes should the network help prevent?* *Are the initial set of aspirations still the right ones? Are there new ones?*	**Indicators** *What impact does the network want to have? Are there additional indicators of realised value specific to the network?*
Conditions			Adequate time and opportunity to go beyond discussion.	*What are the conditions you think must be in place for these outcomes to be likely? Are there factors that would prevent the network having an effect on relevant outcomes?*	

Table 10: Generating **transformative** value — A transformation in the way 'business' is done

	Initial aspirations		What happened?	Aspirations for next phase	
Aspirations	Improve stakeholder responsiveness to the daily living support needs of individuals with psychosocial disability within the WA NDIS My Way trial sites.		It is still so new and so different, there is still such a long way to go and things like the CoP offer real value as they bring us all together to learn and share. The facilitators, the topics and the people that attended were all so committed and offered so much.	Aspirations *Transformative effects are hard to plan. But where do you think there is the greatest potential for surprising outcomes that could transform the broader landscape of practices, the attitude of government and the expectations of the public?*	Indicators *Adoption of universal measures.* *Understanding of impact and touch points.*
Conditions	Suitability of CoP beyond project funding. Use of technology platform.			What are conditions that would make transformative effects more likely? What are the risks?	

Table 11: Generating **enabling** value — Building capacity for sustaining learning

Initial aspirations	What happened?	Aspirations for next phase

Aspirations	Adoption of technological platform to sustain CoP		Suitable product still to be identified	**Aspirations** *What kind of support would you need ideally? How can you be sure that it fits with your strategic imperatives?*	**Indicators** *What are some indicators that would suggest the right level of support is available?*
Conditions	Existence of suitable product. Stakeholder adoption.		WAAMH to have necessary capability	*Under what conditions would this support be more likely to become available?*	

9 Conclusion

The CoP aimed to create a space for stakeholders to learn and build resources, provide an opportunity for stakeholders to alert the Disability Services Commission of key issues, and to disseminate learnings from the projects known as Project 1 and 2. The end-of-project evaluation approach demonstrates project impact through the collection of data indicators and story harvesting.

Analysis of the indicators illustrates wide stakeholder engagement, high participation rates, and high levels of user satisfaction with the CoP project and its methodology. There is a consistent message being noted in the genre of each of the value creation stories, demonstrating a link between the network and capacity building within stakeholders in the context of psychosocial participants and the NDIS My Way trial sites. Application of these metrics concludes that the project was effective and has had an impact on the capacity of stakeholders in the trial sites.

The learnings captured offer a snapshot-in-time perspective of key issues and are presented to assist the Disability Services Commission in its endeavours to enhance the functioning of the scheme and support increased uptake of psychosocial participants. A variance in the stages of development was noted in the regions, with the Lower South West demonstrating a mature relationship with both the scheme and other stakeholders. This observation is not surprising given the longer length of time it has been in operation; however, what was surprising is that the sites did not mirror each other and instead each trial site has a momentum of its own, evolving in response to local strengths and opportunities, often strongly influenced by the personality of leadership. With some exceptions Cockburn/Kwinana stakeholders were generally focussed on the mechanics of the scheme, as often they were new to the role, with little or no NDIS knowledge. In contrast, stakeholders in the Lower South West were very stable and tended to hold higher levels of experience which they were happy to share with stakeholders in the Cockburn site.

Despite the increased maturity of stakeholders and the scheme in the Lower South West, the inability of WAAMH, the My Way Regional Manager or any other stakeholder to bring South West Health to the table presented a significant barrier to the project's impact. As Michael Fin, from Enable South West states:

'Despite all of our efforts, the inability to engage with South West Health reflects the inability to truly increase capacity of the trial site to include psychosocial disability participants. Until we start having a discussion around what the real core business of tertiary mental health services is, we cannot progress.'

In many ways the inability to engage South West Health is reflective of the fragmentation which is still present in support planning of psychosocial participants within the NDIS. CoP participants were united in a belief that artificial boundaries between service systems need to be broken down for the scheme to be optimal, as participants' needs are not easy to segment into clinical and community support/intervention; rather, a holistic approach is called for.

Concern continues to be expressed around the language of 'permanency' and the ideological struggle this presents within the context of recovery. These concerns have been documented in the WAAMH Board's *Position on Future Governance of the NDIS in WA* and the *Review of the NDIS Act*. Furthermore, stakeholders continue to offer the perspective that the volume of resources in a plan relates to the quality/amount of advocacy a participant received. These issues have been presented by WAAMH in submissions to the National Disability Advocacy Framework, the Information, Linkages and Capacity-Building Framework, and review of the National Disability Advocacy Program. In addition, the issues were also raised in representations on state and national committees including the NDIA's Mental Health Sector Reference Group and the WA NDIS My Way Reference Group. WAAMH actively continues to push the NDIS to effectively respond to the needs of people with psychosocial disability and that a viable network of community mental health support services is maintained for those who are not eligible under the NDIS.

The CoP project began from a deficit perspective, assuming that stakeholders were lacking in knowledge and information and by providing this, capacity would be increased. Upon reflection this assumption was overly simplistic and failed to recognise the significant growth and development already undertaken by providers and consumers, particularly in the South West, and that relationships and context are at the core. The project uncovered several opportunities to enhance the mechanics of the project, such as the need for a local centralised information distribution channel, increased involvement of peers (particularly around engagement), the role of

advocacy and the need to invest in ‘preplanning’ so that participants are better able to exercise choice and control. Equally so, opportunity exists to begin to understand the way in which relationships are formed between planners and participants and greater understanding of the effectiveness of community-based supports and their relationship with crisis presentation. Lower South West CoP participants were informed by the NDIS My Way regional manager that South West Health Mental Health have advised of a reduction in crisis presentations of scheme participants but as yet, exactly what is contributing to this decline is yet to be fully understood.

9.1 Future Directions

Like any group work process, the CoP took a number of sessions before a rhythm was established and participants had developed trust and confidence in the process and each other. Stakeholder feedback indicated an overwhelming desire to see the project continue, noting opportunities for development such as:

- Use the forum to prototype and explore new or enhanced ways of working
- Development of a virtual CoP
- Development of a social media strategy and use of twitter, Facebook etc. as a distribution channel
- Blog as a standalone site
- Transition of CoP to a local reference network with the purpose of continued experience sharing.

10 Appendix A: Terms of Reference – Three Projects Reference Group

1. Context

The NDIS is the new way of providing individualised support for eligible people with permanent and significant disability, their families and carers. All members of this coordinating group consider the NDIS to be an important, long overdue reform and welcome the inclusion of people with psychosocial disability into the scheme. They also recognise that there are unique principles of service, history, context and language in mental health that will need to be recognised and responded to for the scheme to operate effectively for people with psychosocial disability.

This Joint Project Coordinating Group (the Group) is made up of three member projects, commonly referred to as Projects 1, 2 and 3. Each project is currently funded to deliver specific responses to support the uptake and use of NDIS by psychosocial participants. The group is cognisant that this activity is occurring in an environment of change and that there exists the risk that stakeholders will become fatigued from information overload and/ or multiply change demands.

2. Purpose

This coordinating group aims to optimise opportunity as well as strengthen the strategic alignment and coordination of each project's discrete activity and interface with each other. Group members aim to harmonise their activity and as such act in symphony with one another, maximising the strengths of each project and its membership.

3. Role of the Joint Project Coordinating Group

The operations of the Joint Project Coordinating Group are relatively unstructured and dynamic, with an internal focus on information exchange, identification of leverage opportunities and the coordination of activities. In addition, the group will develop strategies to present consistent external messaging and reduce duplication.

4. Code of Conduct

The group understands that to fulfil its role effectively, it is important that its members adhere to the following principles at all times:

- Treat people with respect, courtesy, honesty and fairness
- Respect different values, beliefs, cultures, religions and social and economic status
- Value and acknowledge the contribution of others and engage cooperatively
- Maintain confidentiality of information
- Act with honesty and integrity
- Declare any potential for conflict of interest and stand aside when a conflict of interest issue exists or is perceived to exist
- Act in a professional manner with care and diligence.

5. General

5.1 Membership

The Joint Project Coordinating Group shall be comprised of:

- WAAMH
- CoMHWA
- Carers Association of Western Australia
- Richmond Wellbeing

5.2 Convenor/Chair

Coralie Flatters, Sector Development Manager, WAAMH, shall convene the group meetings.

If the designated Chair is not available, then Jane Forward (referred to as the Acting Chair) will be responsible for convening and conducting that meeting. The Acting

Chair is responsible for informing the Chair as to the salient points/decisions raised or agreed to in the minutes.

5.3 Agenda Items

All agenda items must be forwarded to the Chair by C.O.B. two (2) working days prior to the next scheduled meeting.

The group agenda, with attached meeting papers, will be distributed at least one (1) working day prior to the next scheduled meeting.

5.4 Action Notes and Meeting Papers

The action notes of each group meeting will be taken and circulated by WAAMH. Full copies of the action notes, including attachments, shall be provided to all Task Group members.

By agreement of the group, out-of-session decisions will be deemed acceptable. Where agreed, all out-of-session decisions shall be recorded in the action notes of the next scheduled group meeting.

5.5 Frequency of Meetings

The Task Group will meet every 6 to 8 weeks at the offices of the Western Australian Mental Health Association, City West Lotteries House, 2 Delhi Street West Perth, for the life of the projects.

5.6 Proxies to Meetings

Members of the group shall not nominate a proxy if unable to attend a meeting.

5.7 Quorum Requirements

All members are required to be in attendance for the meeting to be recognised as an authorised meeting and therefore recommendations or resolutions to be valid.

12 Appendix B: Three Projects Flyer

Information and Support for People with Psychosocial Disability and their Family/Carers accessing NDIS MyWay

1

Targeted and customised information sessions for people who may be eligible for the Scheme and their carers

Contact Lindsay Harlow, Project Officer, Richmond Wellbeing on 9350 8800 or Lindsay.Harlow@rw.org.au

2

Peer Led Consumer and Carer Network for participants in the Scheme

Contact Danielle Lobo, Project Officer, Consumers of Mental Health WA (CoMHWA) on 0421 228 328 or dlobo@comhwa.org.au

3

A Community of Practice for Service Providers to learn from participants, their family/carers and each other

Contact Coralie Flatters, Manager Sector Development, Western Australian Association of Mental Health (WAAMH) on 9420 7279 or CFlatters@waamh.org.au

Carers WA Australia

helpingminds Mental Health Services & Carer Support Formerly Anglicare

CoMHWA Consumers of Mental Health WA [Inc]

WAAMH Western Australian Association for Mental Health

Richmond Wellbeing

Government of Western Australia

Disability Services Commission

13 Appendix C: Value Creation Stories

Immediate value	Potential value	Applied value	Realised value
The Lower South West gatherings attracted a wide range of consumers, carers, providers, PIR representation and us. I felt that the gatherings were of real value, because they brought such a wide range of stakeholders together in a meaningful way.	The forum provided a safe space in which I could hear directly about the way stakeholders were feeling/experiencing the rollout and if and when necessary, we could change or modify the way we were doing things.	The CoP environment enabled me to clarify and seek out information about things we were unsure about or that needed validation. The CoP clarified information which I was able to take back, and use to plug information or knowledge gaps that we had. We had said from the beginning that we wanted to consult with people during the rollout, and this activity re-enforced this. It was an effective interface and opportunity to ensure that knowledge and information was getting through.	We now have 200 psychosocial participants on plans. WACHS informs us that they are seeing less crisis presentations, and attribute that to the NDIS. It would be ideal to understand from a consumer perspective more about the way we develop plans and also the effect or relationship between increased community and social supports and reduction in crisis presentation. The CoP has supported the work that the commission has and is doing to increase the uptake of psychosocial disability participants.

Immediate value	Potential value	Applied value	Realised value
On 27 October 2015, we discussed the topic of outcome measures. It was a good discussion but like many of the other topics was left unresolved. In this instance we expressed different views and experiences and shared our learning but what	In this instance the immediate value would be the establishment of a baseline and the potential value would be the movement, positive or negative.	The applied value would be the use of the data to more broadly inform best practice, effective use of resources etc.…	The true realised value would be the use of data to better service the client, not the interest of the organisation. I enjoyed the opportunity to participate in the CoP, but it was a talk-fest which had not yet got

lacked for me was to truly achieve realised value.			to the application of the topics, as I have outlined.

Immediate value	Potential value	Applied value	Realised value
My daughter has a psychosocial disability and until the NDIS came along she really got very little. The NDIS has changed her life. It's very new and everyone is learning. I thought the CoP was really good, because stakeholders were there searching for answers. They asked me a lot of questions and I think that is really valuable. They wanted to learn. 	Stakeholders held the 'mechanic' knowledge but at the CoP they asked me experimental questions. Through attendance I developed a lot of good contacts and was able to provide a carer perspective which is really valuable.	Attendance really joined the dots for me, and caused me to think differently. It increased my optimism that things will be better for psychosocial disability, but there is still a long way to go. This changed outlook affected the way I delivered peer information session for Project 1.	It is such a big change for many of the mental health services. In some ways for those in disability it's a bit easier as they have been doing 'choice and control' for longer. It is still so new and so different; there is still such a long way to go and things like the CoP offer real value as they bring us all together to learn and share. The facilitators, the topics and the people that attended were all so committed and offered so much.

Immediate value	Potential value	Applied value	Realised value
What we really valued was hearing the consumer and carer	So often we become so caught up in the 'operationalized' that it was	We had already begun down this path but it re-enforced and	We have found that we are now advising and supporting other

experiences so generously shared with us by Veronica and Beatrix. Community First Live Life Better	an excellent reminder that this is all about people.	strengthened our resolve to set up increased mechanisms for consumer feedback. We now have a consumer advisory group and consumer input is integral to all that we do.	organisations by linking this consumer voice. For example, we have been working with South West Health as to how their emergency reception area is perceived by PWPD and the negative impact it can have on them when they come to emergency when experiencing a period of being very unwell.

Immediate value	Potential value	Applied value	Realised value
I attended the Kwinana/Cockburn gathering on 11 February on the topic of advocacy. The session was an opportunity for me to hear first-hand of consumer, carer and provider experiences. Additionally, I was able to inform the group of recent work which WAAMH had undertaken and take feedback and comment. WAAMH Western Australian Association for Mental Health	During the session, a carer spoke of how transport had been removed from her daughter's plan but as the carer and someone familiar with the system, after advocating for her daughter she was able to eventually get this reinstated. This example strengthened my knowledge of the issues and challenges facing systemic advocacy and how in the context of psychosocial disability being so new, the difference advocacy can make in the formation of a plan.	The insights and knowledge which I gained from attending the CoP were discussed at length with my colleagues, and our subsequent submission to the National Disability Advocacy Program drew extensively on the CoP gathering.	The learning gained from attending the CoP has been a significant influence in the development of WAAMH's key messaging. It is this messaging which we promote, share and advocate for in all aspects of the work that we do.

Immediate value	Potential value	Applied value	Realised value
Great networking opportunity, which allowed me to hear of people's stories/experience.	I was able to take the stories back to the team, noting areas of concern or those which were perceived to be working well. This fed into our quality improvement agenda.	Through hearing stories, I was able to make contact with individuals or networks and address misunderstanding/communication around psychosocial eligibility. Because stakeholders were unclear, we were able to break it down into components, and advise of what documents we need. We spoke with CMMO and even doctors, outlining exactly what was needed.	Previously we had people present who did met criteria and those that did without the necessary documentation. This process enables us to be more specific about whom and what is required. We were able to develop our network and be really clear about our communication. 'There was a lot of incorrect information/understanding out there'...

Immediate value	Potential value	Applied value	Realised value
Opportunity to network and gain firsthand experience from providers, consumers, carers and those with experience of operating in the Lower South West trial site; and the provision of supporting information e.g.: Hunter Valley trial, NDIS updates.	Face to face contact with local providers and those from the Lower South West, have provided my team with valuable insight and information which we have used for planning and service design. Additionally, the sharing of experience has provided us with ideas and suggestion to move forward.	For individuals: • Ability to better inform clients. • Increased ability to provide targeted support e.g.: with clients' permission, we could advise the planner, that this is how it looks on a good day and this is how it looks on a bad day.	The process as supported us to increase our connection and relationship with CMMHO. We have realised that we are the treatment of last resort, which means that complexity and areas beyond CMMHO capacity return to us. This realisation as supported us to take a proactive approach, and plan accordingly.

		• Support clients and their carers with negative imagine to engage in process. Advise that you can personally select. • Provide support with interviewing of providers. • Concept of 'Banking hours', and how to ask for and apply this. How to apply as a crisis reduction support. For our agency: • Better understand the capacity of the sector to provide.	