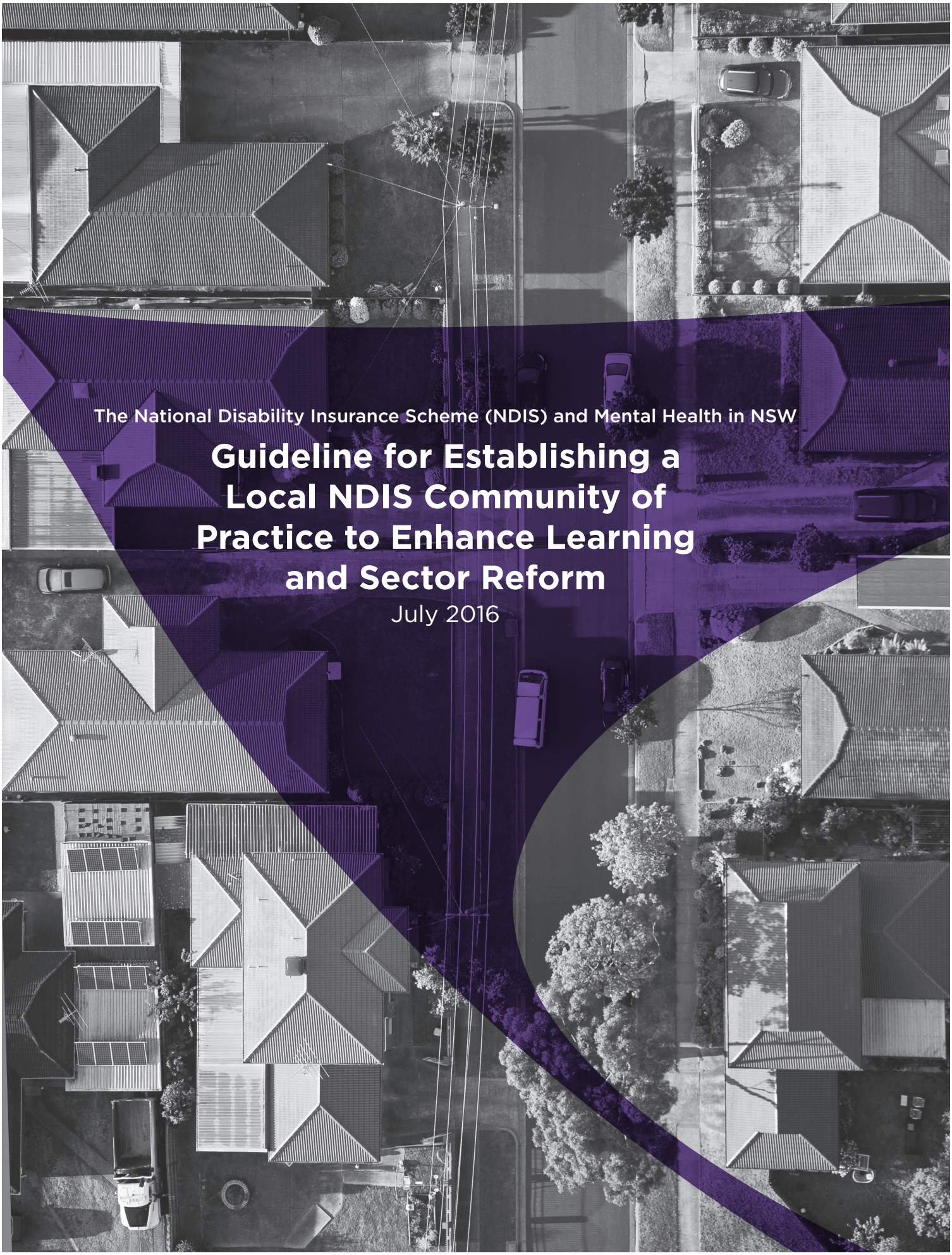

The National Disability Insurance Scheme (NDIS) and Mental Health in NSW

Guideline for Establishing a Local NDIS Community of Practice to Enhance Learning and Sector Reform

July 2016

MENTAL HEALTH COMMISSION OF NSW AND MENTAL HEALTH COORDINATING COUNCIL
NDIS AND MENTAL HEALTH ANALYSIS PARTNERSHIP PROJECT

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When referencing this paper please cite as follows:

Mental Health Coordinating Council (2016). *The National Disability Insurance Scheme (NDIS) and Mental Health in NSW: Guideline for Establishing a Local NDIS Community of Practice to Enhance Learning and Sector Reform*. MHCC, Sydney.
Author: Tina Smith

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Acknowledgments
MHCC respects and promotes people's fundamental human rights. We acknowledge the traditional custodians of the land and value the lived experience of people recovering from mental health related conditions – both past and present.

We also acknowledge the contributions of mental health consumers, their families and carers, and service providers to the consultative processes conducted during the course of the NDIS and Mental Health Analysis Partnership Project.

MHCC developed this guideline, supported by the Mental Health Commission of NSW.

Acronyms

ADHC	Ageing, Disability and Homecare (Department of FaCS)
CMO	Community managed organisation
DSS	Department of Social Services (Commonwealth government department)
FaCS	Family and Community Services (NSW government department)
HASI	Housing and Accommodation Support Initiative
HNELHD	Hunter New England Local Health District
HNEMHS	Hunter New England Mental Health Service
LHD	Local Health District
MHCC	Mental Health Coordinating Council
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Services
NMHCCF	National Mental Health Consumer and Carer Forum
NSW	New South Wales
PIR	Partners in Recovery
PIRO	Partners in Recovery organisation (consortium that deliver PIR)
PHN	Primary Health Network
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities

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1. Introduction

The Mental Health Commission of New South Wales collaborated with the Mental Health Coordinating Council (MHCC) between June 2013 and 2016 to undertake a *National Disability Insurance Scheme (NDIS) and Mental Health Analysis Partnership Project*. This activity supported directions of *Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024*, adopted by the Government in December 2014.[1]

The project focused on the three communities within the Hunter New England Local Health District (HNELHD) chosen to trial the NDIS: Newcastle, Lake Macquarie and Maitland.

The scaling up of the NDIS in NSW over the next three years will be a massive undertaking, and the project has helped to inform this journey from a mental health perspective.

A major achievement of the project was the establishment of the Hunter NDIS and Mental Health Community of Practice. The Community of Practice enhanced learning, increased opportunities and reduced challenges associated with implementation of the NDIS in NSW from a mental health perspective. The experience, learning, activity and outcomes of the *Hunter NDIS and Mental Health Community of Practice* has informed this Guideline.

The Guideline is about how to establish a Community of Practice. It also considers the purpose, benefits, qualities and next steps to establish a Community of Practice.

NSW HUNTER NDIS TRIAL IN HDELHD

NSW

Potential increase in NSW NDIS participants with pyschosocial disability

UP TO 19,000
participants in NSW with a psychosocial disability by the end of June 2019

1022
participants in the Hunter trail site with psychosocial disability at the end of June 2016'

1 NSW Mental Health Commission (2014). *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024.* Sydney, NSW Mental Health Commission.

Why did we develop this Guideline?

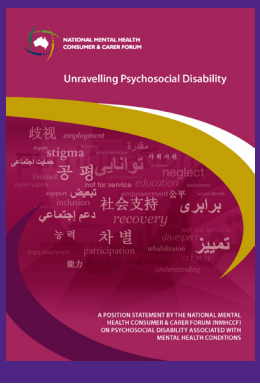
MHCC developed this Guideline to encourage local communities in NSW to establish a NDIS and Mental Health Community of Practice. Organisations that provide services to people affected by mental health conditions, and their carers and families, will find the Guideline useful. We encourage you to consider establishing a local Community of Practice to enhance learning arising from NDIS implementation and other mental health sector reforms.

The Guideline encourages inter-sectoral innovation, learning, leadership and local level action to maximise opportunities presenting through the NDIS and to strengthen reform capability of mental health in NSW.

Following this introduction, some basic knowledge and an illustration is provided about what a Community of Practice is (Section 2). We then think about how establishing a Community of Practice can enhance learning arising from the NDIS and related mental health sector reform (Section 3). Aspects of the scope and logistics of establishing a Community of Practice, starting with the important role of leadership, is then considered (Section 4). The Guideline then considers some next steps to establish a Community of Practice (Section 5).

The establishment of regional and/or local level NDIS and Mental Health Communities of Practice across NSW will help to ensure that our understanding of, and responses to, people with psychosocial disability are enhanced. The National Mental Health Consumer and Carer Forum (NMHCCF) originally identified the need for a greater understanding of the concept of psychosocial disability and the experiences of people living with it.[2] The NMHCCF developed a position statement in response to the inclusion of people with psychosocial disability in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).[3]

Unravelling Psychosocial Disability



[The] Position Statement developed by the NMHCCF, seeks to identify the needs of people with a psychosocial disability, and describe the issues that affect their capacity to participate in the community. The voice of people with psychosocial disability must be heard.

Graeme Innes, Disability Discrimination Commissioner, Foreword, p. 8

A complimentary report summarising the experiences and lessons learned in the Hunter through the *NDIS and Mental Health Analysis Partnership Project* during the three year NSW NDIS trial accompanies this guideline. [4] MHCC published a more detailed report on the first two years of the project from a community managed mental health sector perspective in August 2015.[5]

The Future of the NDIS in NSW

The NDIS will be rolled-out within NSW Local Health District (LHD) catchments between July 2016 and June 2018 according to the timetable summarised below.

From 1 July 2016	From 1 July 2017
■ the remaining population of the HNELHD (i.e., other than the three trial site LGAs)	■ Illawarra Shoalhaven
■ the remaining population of Nepean-Blue Mountains (i.e., other than the early start from 1 July 2015 for young people)	■ Mid North Coast
■ Central Coast	■ Murrumbidgee
■ Northern Sydney	■ Northern NSW
■ South Western Sydney	■ South Eastern Sydney
■ Southern NSW	■ Sydney
■ Western Sydney	■ Western NSW
	■ Far West

From 1 July 2016, the NDIS will begin to roll out across NSW. In the first year, seven districts will transition to the NDIS including Central Coast, Northern Sydney, South Western Sydney, Southern NSW, Western Sydney, and the remaining populations of Hunter New England and Nepean-Blue Mountains.

From 1 July 2017, the NDIS will be begin to be available in the districts of Illawarra Shoalhaven, Mid North Coast, Murrumbidgee, Northern NSW, South Eastern Sydney, Sydney, Western NSW, and Far West NSW.

People currently receiving supports through the NSW Government Department of Family and Community Services (FaCS) Department of Ageing and Disability (ADHC) specialist disability services program will be moving to the NDIS first. This is because the NSW Government plans to stop delivering ADHC funded services by July 2018 and following this will withdraw from the delivery of specialist disability support services in NSW (i.e., and close ADHC). Existing Commonwealth and state based supports will continue until people are covered by the NDIS.

The NDIS will provide support to more than 140,000 people in NSW by July 2018. This will include around 19,000 people with psychosocial disability. A NSW Government website provides more information about how and when people will move to the NDIS.[6]

2 National Mental Health Consumer and Carer Forum (2011). *Unravelling Psychosocial Disability: A Position Statement by the National Mental Health Consumer and Carer Forum on Psychosocial Disability Associated with Mental Health Conditions*, NMHCCF, Canberra.

3 United Nations General Assembly (2006). *Convention on the Rights of Persons with Disabilities*. Resolution adopted by the General Assembly, 24 January 2007, A/RES/61/106, United Nations, Geneva.

4 Mental Health Coordinating Council (2016). *The National Disability Insurance Scheme (NDIS) and Mental Health in NSW: Navigating the NDIS - Lessons Learned through the Hunter Trial*. MHCC, Sydney.

5 Mental Health Coordinating Council (2015). *Further Unravelling Psychosocial Disability – Experiences of the National Disability Insurance Scheme in the NSW Trial Site: A Mental Health Analysis*. MHCC, Sydney.

6 NSW Government (2015 a). NDIS website: http://www.ndis.gov.au/nsw

2. What is a Community of Practice?

A Community of Practice is ...

A group of people who share a concern, a set of problems, or a passion about a topic and who deepen their knowledge and expertise in this area by interacting on an ongoing basis. [7]

A Community of Practice is a group of people who share a concern or interest. Lave and Wenger first proposed the concept in 1991.[8] A Community of Practice can evolve naturally because of the members' common knowledge, interest or connections. They can also evolve deliberately with the goal of gaining knowledge related to a specific field. It is through the process of sharing created information and experiences with the group that the members learn from each other, and have an opportunity to develop themselves.

Members of a Community of Practice have the opportunity to develop both personally and professionally, while working towards solving problems facing the group. Group knowledge passes from novice to expert, and between peers.

Learning through Participation

Jean Lave (anthropologist) and Etienne Wenger (computer scientist) first suggested the idea of 'situated learning'. This means that learning is a social process and not just something that happens in the learner's head. Lave and Wenger say that learning as a social activity is about participation. Learners participate in communities of practitioners, moving toward full participation in the sociocultural practices of a community. Participation provides a way to speak about crucial relations between newcomers and old-timers and about their activities, identities, interests, tools, knowledge and practice.

Three characteristics are crucial - a domain (i.e., area) of knowledge, a notion of community and a practice.

- Domain - A domain of knowledge creates common ground, inspires members to participate, guides their learning and gives meaning to their actions.
- Community - The notion of a community creates the social fabric for that learning. A strong community fosters interactions and encourages a willingness to share ideas.
- Practice - While the domain provides the general area of interest for the community, the practice is the specific focus around which the community develops, shares and maintains its core knowledge.

The combination of these three things constitutes a Community of Practice. By developing these together you cultivate a community.

Examples of characteristics of the Hunter NDIS and Mental Health Community of Practice follow:

- Domain - The NSW trial of the NDIS and mental health/ psychosocial disability
- Community - The Hunter NDIS and Mental Health Community of Practice Forum
- Practice - Enhancing learning and opportunities arising from NSW NDIS trial.

The brief description of the reasons ('why'?) and process ('how'?) of establishing the *Hunter NDIS and Mental Health Community of Practice* are described next. A rationale for the need to establish Communities of Practice to enhance learning in the context of local, state and national NDIS implementation and mental health reform then follows (Section 3). This includes thinking about the important contribution of lived experience and consumer 'co-design' in all aspects of service delivery.

7 Wenger, McDermott and Snyder (2002). *Cultivating Communities of Practice: A guide to managing knowledge*. Boston, MA: Harvard Business School.

8 Lave & Wenger (1991). *Situated Learning: Legitimate Peripheral Participation.* Cambridge University Press, Cambridge, USA.

Why we established the Hunter NDIS and Mental Health Community of Practice

When the NDIS started in the Hunter trial site mental health service providers (i.e., practitioners) in both the government and non-government sectors – and also consumers and their families and carers – began to have a lot of contact with the National Disability Insurance Agency (NDIA), as summarised below. However, much of this contact was occurring in isolation for workers, programs, organisations and their clients and families and carers.

Most people with psychosocial disability related to a mental health condition needed a lot of support to explore their eligibility/access for NDIS funded services and supports. NDIS/NDIA contact included people with mental health conditions:

- Receiving Commonwealth funded mental health program services, including
  - Partners in Recovery
  - Personal Helpers and Mentors Service
  - Day to Day Living Program
- Living in Assisted Boarding Houses
- Funded through the NSW Department of FaCS/ ADHC (primarily current and ex-boarding house residents), and
- Who wanted to access new disability/recovery support services.

People wanting to access new disability/recovery support services included people/patients unable to leave psychiatric hospitals due to lack of adequate community care.

NDIA notions of 'choice and control' initially prevented community managed service providers to support people to access the NDIS. That is, the NDIA did not want service providers making or unduly influencing decisions for people. The need for agreed collaborative practice approaches was identified in the early stages of NDIS implementation and adopted over time.

By the end of March 2016, there were 616 people with psychosocial disability able to access NDIS funded services and supports in NSW and 1,602 nationally. [9] Many more people with physical, sensory and/or intellectual disability also living with a mental health condition/psychosocial disability also access the NDIS. The NDIS trial has resulted in considerable growth for community-managed organisations (CMOs) that provide services to people affected by mental health conditions. This also resulted in closer working relationships between government departments and CMOs providing treatment, rehabilitation and support to people with mental health conditions.

MHCC is now sharing the NSW Hunter trial site experience with others so it can be more widely understood and hopefully benefit others.

9 National Disability Insurance Agency (2016). *11th Quarterly Report to the Disability Reform Council.*

How the Hunter NDIS and Mental Health Community of Practice was established

From initial experience with the NDIS/NDIA we saw that learning was occurring in silos; for individuals, programs and organisations. For this reason, the Mental Health Commission of NSW and MHCC convened a meeting of community sector organisations in October 2013 where service providers could discuss their early experiences of the NDIS. At this meeting it was agreed to meet every three months to share experiences and learning and for meetings to be open to anyone with an interest in the NDIS and mental health/psychosocial disability.

Meeting participant's identified and considered existing mental health and/or disability interagency, networking and consultation structures but none were in a position to host the proposed NDIS and Mental Health Community of Practice.

The Mental Health Commission of NSW and MHCC hosted the *Hunter NDIS and Mental Health Community of Practice* Forum to meet ten times across the three-year trial (eleven if the initial meeting is included). Around 70 people attended each event. At the end of June 2016, the forum had engaged with 555 participants in total. A breakdown of forum participation across all events is below:

- 249 community sector workers from the trial site
- 106 community sector workers from outside the trial site
- 122 other people from the trial site (these are mostly Hunter New England Mental Health Service/HNEMHS staff)
- 60 other people from outside the trial site
- 18 consumers and carers.

Many other consumers and carers attended the forums as paid Peer Workers. Participants came from a wide range of mental health/health, disability, drug and alcohol, homeless, housing, emergency services, education, university and advocacy services.

Each meeting featured a discussion about a topic of interest as identified by participants, p. 13 provides suggestions for N*DIS and Mental Health Community of Practice* topics and content.

There were also regular updates related to NDIS implementation from the HNEMHS and the NDIA. A consumer perspective was included in the program over time as NDIS participants became comfortable speaking about their experiences.

Information about the *Hunter NDIS and Mental Health Community of Practice* Forum meetings can be found at the MHCC website (scroll down to the link that says 'With the Mental Health Commission of NSW''). [10] The MHCC website also includes a six-monthly newsletter used to share learning, and other opportunities presenting through the NDIS.

Evaluation of the Community of Practice Forum occurred regularly to identify both topics of interest for future forums and event quality improvements. Participants discussed and reflected upon evaluation findings.

10 MHCC website NDIS: http://www.mhcc.org.au/policy-advocacy-reform/influence-and-reform/ndis-and-mental-healthpsychosocial-disability.aspx

3. Establish a Community of Practice to enhance NDIS learning

Enhance learning, maximise opportunities and reduce challenges

The experience of the Hunter NDIS and Mental Health Community of Practice taught us that while there were initially no experts on the NDIS and psychosocial disability that in an implementation environment, this quickly changes. Through the individual and shared experience of the NDIS, people affected by mental health conditions learned together with those that provide services and supports to them about the opportunities and challenges presenting through the NDIS. Local Communities of Practice are important activities to enhance learning, maximise opportunities and reduce challenges associated with NDIS implementation from a mental health perspective.

National leadership and local approaches for both NDIS/disability and health/mental health reform will be increasingly important from 2016/17 onwards. The government's response to the National Mental Health Commission's Review of Mental Health Programme and Services describes reforms that commenced in 2016. [11] As the NDIS scales up the new Primary Health Networks (PHNs) will take on a greater role in local implementation of national mental health reform. PHNs will work with LHDs, GPs, other health care providers and hospitals to improve and better coordinate care across the local health system for people requiring care from multiple providers or at risk of poor health outcomes. The way in which PHNs will interface with social care providers and the NDIS will become important in addressing both individual and population mental health needs.

Local approaches

The experience of the NDIS trial in the Hunter from a mental health perspective has been profound. [11] Much learning occurred across the three years of the NDIS trial. The learning influenced approaches during the trial. The learning about mental health/psychosocial disability will continue as the NDIS grows and is further refined on the basis of the experience of other communities.

The trial site experience found that much of NDIS implementation was shaped by local communities for Individual Funded Packages (previously known as 'Tier 3'). This is because individuals, families and their communities have different services available to help address their needs. While directions for 'commissioning' Information, Linkages and Capacity Building (previously known as 'Tier 2') activity/s are only becoming clearer now local and community-based approaches will also likely be required.

It is local communities, through national leadership and state/territory implementation, which will lead the way in shaping both the NDIS and related mental health reform. This is why establishing local *NDIS and Mental Health Communities of Practice* is so important.

State implementation

As the NDIS scales up in NSW, the opportunities and challenges likely to arise from a mental health perspective will intensify. This is because the volume of contact between the NDIS/NDIA and people with mental health conditions will increase rapidly in NSW over the next two to three years. The NSW Government needs greater understanding of people's NDIS experience to guide and refine implementation that is responsive to local level needs.

Benchmarks for NDIS access for people with psychosocial disability are not yet established. The increase in local experiences and strengthened NSW learning of the opportunities and challenges arising will help to establish future benchmarks and practices.

NSW experience will continue to shape the NDIS and including through the work of MHCC and the Mental Health Commission of NSW. This must include discussion and learning shared by people with mental health conditions, their families and carers and those that provide services and supports to them. The important roles of PHNs and LHDs in NSW are critical.

Primary Health Networks (10)	Local Health Districts (15)
North Coast NSW	Northern NSW Mid North Coast
Hunter, New England & Central Coast	Hunter New England Central Coast
Sydney North	Northern Sydney
Central & Eastern Sydney	Sydney South Eastern Sydney
Western Sydney (WentWest)	Western Sydney
South Western Sydney	South Western Sydney
Nepean Blue Mountains	Nepean Blue Mountains
South Eastern NSW (Coordinare)	Illawarra Shoalhaven Southern NSW
Murrumbidgee	Murrumbidgee
Western NSW (Marathon Health)	Western NSW Far West NSW

11 Australian Government Department of Health (2015). *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services.* Canberra: Commonwealth of Australia.

12 MHCC (2016 & 2015). *Op. cit.*

National leadership

Taken together with national and state mental health reform, including the imminent arrival of the 5th National Mental Health Plan, this is an unprecedented time for achieving coordinated and integrated health and social services for people affected by mental health conditions. Ensuring access to NDIS funded services and supports that are both disability focussed and recovery oriented – along with a range of other health and social services - is a critical component of mental health reform.

The NDIA have recognised that a Community of Practice can be useful for enhancing shared learning. In 2014, they established a National NDIA Community of Practice to share ways of working with people with a psychosocial disability (i.e., the NDIA Mental Health Community of Practice: Enhancing Practice for People with Psychosocial Disability). NDIA trial site staff meet to share local issues and solutions arising from helping people with psychosocial disability. They are also developing knowledge of good NDIS and mental health/psychosocial disability practice. The group expanded during 2015 to include people from the NDIA's national office (e.g., the National Access Team and the Communications and Engagement Team). The establishment of local and/or regional Community of Practice initiatives will be useful to maximising learning about the NDIS and mental health.

Other meetings, projects and activities have occurred nationally to better understand how the NDIS will work for people with mental health issues. This includes activities undertaken by the:

- Commonwealth Department of Social Services (DSS; who develop NDIS policy)
- NDIA (who are responsible along with state and Commonwealth governments for implementing NDIS policy)
- NDIA Mental Health Sector Reference Group
- NDIS Independent Advisory Council
- Mental Health Australia NDIS Capacity Building Project (2013 to 2016).

Learning through co-design

CMOs, PHNs and LHDs are required to engage with consumers, their families and carers, and local communities in undertaking mental health reforms. Many LHDs have mental health interagency/s and/or advisory committees for this to occur. PHN Community Advisory Councils are one avenue for community consultation but more inclusive approaches are required to achieve good practice in the 'commissioning' (i.e., co-design/co-production) of services aligned to what people say they want and need, and to build mental 'wealth'. [13, 14]

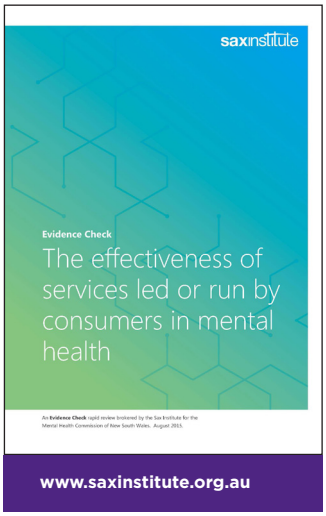
In time, new ways of working and emerging innovations in service delivery will contribute to the scaling up of the NDIS. Co-design and consumer led approaches are central to this. Communities of Practice provide a place to reflect on the evolving service delivery environment and to pursue opportunities for further innovation and reform.

The Mental Health Commission of NSW is progressing important work to encourage consumer-led innovation and reform. This includes the new Peer Work Hub that aims to support growth of the peer workforce resulting in both cultural and service delivery reform. [15]

13 Australia Government (Department of Health; 2016). *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Consumer and Carer Engagement and Participation.*

14 Co-design Initiative (2016). *Co-design: Shared Perspectives on Authentic Co-design – Putting Consumers and Carers at the Centre of Mental Health Reform.*

15 Mental Health Commission of NSW (2015 a): http://peerworkhub.com.au/what-is-peer-work/



The Commission's work also includes a rapid review of the evidence supporting the effectiveness of services led or run by consumers in mental health undertaken through the Sax Institute. [16]

The establishment of local level *NDIS and Mental Health Community of Practice* will help the sharing of local knowledge and experience to facilitate the learning, opportunities and challenges/risks that will present during NDIS implementation; and to help identify local innovations and solutions to unmet mental health needs. This means that it will be important to be aware of, and build upon, existing and/or emerging structures for interagency mental health discussion and reflective practice, both locally and at the NSW level.

State-wide structures for NDIS implementation across NSW began to emerge in late 2015. These include the establishment of both a NSW NDIS Bilateral Steering Committee and a monthly NSW NDIS Implementation Steering Committee. As there is no consumer, carer or community representation to these groups it will be increasingly important that there are avenues for local communities to share their experience of NDIS implementation as this relates to people with mental health conditions. Local level *NDIS and Mental Health Community of Practice* provide a pathway for this to occur.

Reflections on consumer participation

There were challenges for the *Hunter NDIS and Mental Health Community of Practice* in including consumers who are and/or are potential NDIS participants or their families/carers. There were large numbers of service providers and policy makers present and a complexity of topics discussed. While the number of consumers and carers attending forums increased over time this appeared to be a place where they were not always comfortable. The reason for this may relate to the newness of the NDIS and the significant social, cognitive and communication difficulties that are frequently associated with high levels of psychosocial disability.

Where there was success in meeting with, and supporting the NDIS experiences of people with mental health conditions/psychosocial disability, this was in environments where they are most comfortable (e.g., CMO centre based programs). Through a series of meetings at a centre based program, and with peer support – both paid and unpaid - the number of NDIS participants, and their families and carers, attending forums grew over time.

You are encouraged to give thought to this important lesson learned at the Hunter NDIS trial and to have conversations about this in advance of establishing your local Community of Practice activities. We need to ask how we can create spaces for service providers and planners to reflect on their practices that are also welcoming and inclusive of service user experiences and contributions?

16 Grey, F. and O'Hagan M. (2015). *The Effectiveness of Services Led or Run by Consumers in Mental Health: Rapid Review of Evidence for Recovery Oriented Outcomes: An Evidence Check Rapid Review Brokered by the Sax Institute for the Mental Health Commission of NSW.*

4. Guidelines for thinking about qualities of a Community of Practice

Consumer and carer participation at the Hunter NDIS and Mental Health Community of Practice Forum in June 2016

Communities of Practice: Getting people to be creative and take responsibility [17]

A 2016 review of Communities of Practice as a tool for getting people to take responsibility for their own learning and developing creativity and innovation found that successful groups are a story of autonomy and control. Members need autonomy in both in running and managing the Community of Practice and the content and direction of the topics it focuses on. The review found that being in control of learning increases the motivation of members of a Community of Practice.

The review advises that successful Communities of Practice require seeding in their initial stages until the group can take over responsibility and run the community themselves. This is one of the aims of a Community of Practice.

There are many ways to establish a Community of Practice. Approaches will vary according to the interests, needs, resources and preferences of local communities. Some guidelines to consider the scope and logistics of establishing a Community of Practice follow. The resources available to work with will limited establishment of an *NDIS and Mental Health Community of Practice*. This includes the level of leadership commitment within your local community. Strong and active leadership is required at all levels of our sector to improve outcomes for people using services and their families.

Leadership

Any new activity requires thinking about leadership approaches. This guideline acknowledges the importance of leadership in establishing a Community of Practice. It does not propose a preferred model for *NDIS and Mental Health Community of Practice* leadership. It is mostly a myth that there are no leaders in a true Community of Practice (see 'Myths about Community of Practice' on p. 17).

The NSW Mental Health Strategic Plan 2014-2024 promotes innovation, learning and leadership to strengthen the reform capability of mental health in NSW through:

- Knowledge exchange
- Innovation sharing
- Transfer and adaption of successful policy and service design
- Use of comparative data to drive service improvement
- Problem solving
- Support for change management, and
- Leadership and networking. [18]

The empowerment of leadership at a local level is an essential action of taking the Strategic Plan 2014-2024 forward. [19] Communities of Practice are one way of achieving this.

17 Oxford Review (2016). *Research Intelligence Brief: Getting people to be creative and take responsibility.*

18 NSW Mental Health Commission (2014). *Op. cit.*

19 Mental Health Commission of NSW (2015 b). *One Year On: Progress Report on the implementation of Living Well: A Strategic Plan for Mental Health in NSW 2014-2024.*

MHCC and the Mental Health Commission of NSW considered the following leadership options for establishing a NDIS and Mental Health Community of Practice:

- Consumer/carer – a consideration for this option is the availability of local/regional level resourced options for consumer and carer engagement, participation, representation and/or co-design/co-production
- Community sector service provider – a consideration for this option is perceived to represent a conflict of interest where the organisation is also an NDIS service provider and/or the added demands of NDIS readiness and providing information in support of NDIS access
- Partners in Recovery Organisations (PIR/Os; these are the consortium that deliver PIR) – for the next two to three years PIR is well placed in terms of their key areas of interest and activity, including their local and/or regional level presence and relationships, to consider hosting a *NDIS and Mental Health Community of Practice*. Some PIROs are better placed to do this than others (e.g., one NSW area does not have a PIR).

It is important that other key stakeholders with NDIS and/or mental health leadership roles including the NDIA, LHDs and PHNs contribute to discussions about establishing a *NDIS and Mental Health Community of Practice*. This is important because of the role that:

- the NDIA has in implementing the NDIS
- public mental health services have in working with people who are acutely unwell and needing treatment, and
- PHNs have and/or will have in local level implementation of health/mental health reform including GP engagement, stepped care approaches to mental health and the 'commissioning' of services for individuals, families and communities affected by mental health issues.

Medicare Local organisations that predated PHNs established most PIR consortiums in NSW in 2013. Some PHNs are still the lead organisations for PIR initiatives that are in-scope to transition to the NDIS.

Community of Practice leadership consideration needs should explore the capacity of existing local and/or regional networks, inter-agencies and other inter-sectoral structures that may lend themselves to hosting (see p. 18). Options for leadership in establishing a *NDIS and Mental Health Community of Practice* will vary against the needs and preferences of local communities.

A preferred model for Community of Practice leadership?

There is no preferred model for hosting an *NDIS and Mental Health Community of Practice*. This is because the needs, resources and preferences of local communities will vary.

LHD mental health services have a long history of relationships with people affected by mental health conditions that are living with high levels of psychosocial disability. Some LHDs have strong inter-agencies and other consultative structures that would lend themselves well to hosting COP events. The number of public mental health service clients that may access NDIS individual funded packages over the next three years and beyond is unknown at present.

PIRO consortiums have now been working for three years to engage and assist up to 7,000 people in NSW with 'severe and enduring' mental illnesses. The number of current PIR clients that may transition to NDIS individual funded packages over the next two to three years is unknown at present.

Both LHDs and PIROs have a very high level of interest in the NDIS and mental health interface and this lends them to being a preferred option for hosting a Community of Practice. Organisations delivering services to the 7,000 PHaMHS programs clients in NSW due to transition to the NDIS over the next two to three years also have high interest in CoP activities.

The ambitious targets for transition of Commonwealth funded mental health program clients to the NDIS will stretch organisations delivering these programs to consider hosting an *NDIS and Mental Health Community of Practice*. The current plan is for both PIR and PHaMS to cease operations by July 2019.

Some LHDs and PIR programs have strong structures in place to ensure systemic consumer and carer engagement, representation, participation and co-design. Where these are identified they may be an asset is establishing an *NDIS and Mental Health Community of Practice*.

Size

A Community of Practice can be of any size depending on a number of factors. They can be large and they can be small. For some communities a small group may be preferred and/or the only option. Some examples of this are:

- A small rural area with few health and community services
- An area that decides to place deep thinking in the hand of a select few people initially (this approach could work for communities not entering the NDIS environment until 1 July 2017).

Instances where a large group may work better are:

- Metropolitan areas that have a large number of organisations and/or programs assisting people with mental health conditions (as was the case with the Hunter trial site)
- Communities that are committed to inclusiveness and have high levels of existing consumer and carer participation and established inter-agencies and mechanisms for cross sector collaboration.

Another consideration for group size is whether you want the Community of Practice to be open or closed:

- Open groups (as was the case with the Hunter trial site) allow anyone with an interest in the knowledge area to join. They can, however, become very large and sometimes unwieldy to manage
- Closed groups limit membership to people with certain characteristics and tend to be smaller but this is not always the case (an example of this might be a group just for NDIS participants with psychosocial disability where the number of interested participants would to grow over time).

There are other pros and cons for small/large and open/closed groups. Undertaking an activity to understand pros and cons might help to identify what will work best for your community.

For the Hunter *NDIS and Mental Health Community of Practice* we decided to be open and large. This was to optimise the learning arising from the trial of the NDIS. A downside to this is that the large meetings of what were mostly service providers may not have been as welcoming of consumer/NDIS participant and family/carer participation that would have benefitted our learning.

Frequency

There does not have to be a set frequency for Community of Practice activities. The frequency of activities can considered and established through core/leadership group consultation with members. However, anticipation of regular activities can help with group cohesiveness and the member's sense of belonging and their contributions being valued.

Membership

There are other membership considerations to group size (i.e., whether you want similar or diverse members to participate). An example of this is if you want the group to be mental health specific (i.e., that is for consumers, carers and mental health specific service providers only. There are many other people interested in the NDIS and mental health. After all, mental health is everybody's business!

People with mental health issues usually experience diverse health and social difficulties and you will want to anticipate service users and workers from the following sectors also keen to be involved:

- Housing and homeless services
- Emergency services
- Drug and alcohol services
- Physical health care providers
- Other disabilities (e.g., intellectual, physical, sensory, acquired brain injury etc.)
- And many more.

The Hunter *NDIS and Mental Health Community of Practice* was large, open and diverse. This was to enhance the learning opportunities of the trial from the perspectives of many people.

Community of Practice membership participation

Wenger (2002) identifies three main levels of participation for Community of Practice members:

- The core group who participate intensely in the community through discussions and projects. This group typically takes on leadership roles in guiding the group
- The active group who attend and participate regularly, but not to the level of the leaders
- The peripheral group[20] who, while they are passive participants in the community, still learn from their level of involvement. Wenger notes the third group typically represents the majority of the community.

For the *Hunter NDIS and Mental Health Community of Practice*:

- The core group was the Mental Health Commission of NSW, MHCC, HNEMHS and the NDIA
- The active group was the core group plus many large CMO representatives from the trial site providing and/or wanting to provide NDIS services to people with mental health conditions, and a growing group of mental health consumer/NDIS participants emerging to share their lived experience – these people attended most forums
- The peripheral group were mostly other service providers from within and outside of the trial site with an interest in the NDIS and mental health – these people attended occasional forums.

Format

A Community of Practice can take many formats. This might include:

- Forums
- Workshops
- Speakers
- Consultations
- Newsletters
- E-group/s (e.g., internet websites/blogs, Facebook, Twitter, etc.).

The interests and resources of members will inform the blend of formats offered.

For example, the main format for the *Hunter NDIS and Mental Health Community of Practice* was the forum that met quarterly for four hours (10:00 AM to 1:00 PM). The Hunter forum was also supported through a six-monthly newsletter, other documents/publications and website hosted by MHCC.[21]

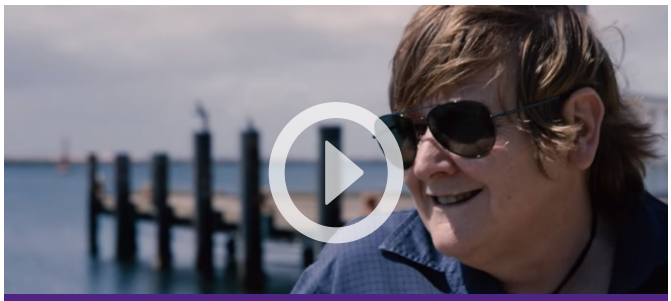
20 Wenger, Etienne; McDermott, Richard; Snyder, William M. (2002). *Op. cit.*

21 MHCC NDIS website: http://mhcc.org.au/policy-advocacy-reform/influence-and-reform/ndis-and-mental-healthpsychosocial-disability.aspx

Lived experience of the NDIS

An excellent addition to the format of any Community of Practice is a short film developed by the Mental Health Commission of NSW featuring the experiences of mental health consumer participants in the Hunter NDIS trial site. The film illustrates to policy-makers and the wider community the potential of NDIS to support people with psychosocial disability more effectively. You can view the NDIS Mental Health Perspectives video on YouTube. [22]

Also useful is the NDIA's 'Mental Health and the NDIS' webinar held during Mental Health Week, October 2015. [23]



NDIS - Mental Health Perspectives

Click to play, https://www.youtube.com/watch?v=9X-ea-O50Vg

Webinar: Mental Health and the NDIS

Click to play, http://webcast.viostream.com/?viocast=7837&auth=09bf0e32-3eac-49c5-8cbc-337067bc65ad

Content

Content should be specific and relevant to the Community of Practice and strongly influenced by group member preferences. For a *NDIS and Mental Health Community of Practice* this means including activities relevant to, for example:

Access

- outreach to, and engagement with, people with psychosocial disability
- processes related to eligibility, access, planning, and review for people with psychosocial disability, their families and carers, and those that provide services and supports to them
- appreciation of the experiences and perspectives of
  - consumers
  - carers
- exploration of the experiences of organisations and workers that provide services and supports to NDIS participants
  - community managed mental health sector
  - public mental health services
  - PHNs
  - private health/mental health service providers
  - other human services providers
  - the NDIA
- engaging Aboriginal and Torres Strait Islander Peoples and other diverse groups of people with mental health issues with the NDIS
- transition of Commonwealth funded mental health program clients to the NDIS
- approaches to gathering evidence of psychosocial disability/impairment
- transition of NSW FaCS/ADHC funded mental health clients

Readiness

- organisational readiness for the NDIS
- NDIS pricing and the cost of psychosocial disability/recovery support skills
- becoming a registered provider
- using the NDIA information portal
- psychosocial disability workforce issues
- the shift from block to individualised funding
- individual funds management
- customer service approaches
- marketing approaches

22 Mental Health Commission of NSW (2015 c). Mental Health Perspectives video on You Tube: https://www.youtube.com/watch?v=9X-ea-O50Vg

23 National Disability Insurance Agency (2015). 'Mental Health and the NDIS': http://webcast.viostream.com/?viocast=7837&auth=09bf0e32-3eac-49c5-8cbc-337067bc65ad

Impacts

- people not eligible for NDIS funded services and supports
- internal and external NDIA eligibility review processes (including the role of the Administrative Appeals Tribunal)
- cessation of ADHC and mental health sector impacts
- NDIA interface with NSW Ministry of Health funded mental health programs (including but not limited to the Housing and Accommodation Support Initiative/HASI and Pathways to Community Living program)
- coordination of supports
- Local area coordination roles and functions
- Quality and safeguarding framework
- the commissioning of Information, Linkages and Capacity Building quality and safeguards frameworks, including the role/s of both the NSW and Commonwealth Ombudsman

Outcomes

- promoting choice and control – and supported decision making – when working with people with cognitive-behavioural impairment
- outcomes framework
- evaluation.

Equally important to what NDIS and mental health issues are discussed are how issues are talked about. This is because learning around the NDIS and mental health can at times be overwhelming. Discussions, even when talking about difficult things, should be respectful and welcoming to the sometimes-differing views of others.

To address people's fears and anxieties about the NDIS MHCC worked to shape a shared learning culture where there were no experts in the mental health and NDIS space but rather we were working together to create that expertise. MHCC learned that each Community of Practice should have one key topic for consideration while also making space for discussion of a range of new information and experiences.

Establish a familiar program for Community of Practice Forums

The *Hunter NDIS and Mental Health Community of Practice* Forum quickly developed a standard and familiar program. This included a:

- Welcome, an Aboriginal and Torres Strait Islander acknowledgment, a lived experience acknowledgement and opening remarks by a host (in this case, the Mental Health Commission of NSW)
- NDIS and mental health update (information about recent activity provided by MHCC)
- Consumer update (this sometimes preceded the MHCC update)
- Keynote speaker – on a topic of current relevance to the Community of Practice and/or NDIS and mental health environment
- Consultation session – related to the keynote speaker topic
- NDIA update
- HNEMHS update
- Next steps and concluding remarks.

MHCC and the Mental Health Commission of NSW wish to thank the following people for their participation and many other contributions across the three-year trial:

- all Hunter NDIS and Mental Health Community of Practice Forum participants
- Debbie Hamilton (NDIS participant and consumer advocate/representative)
- the HNEMHS, and
- the NDIA.

Documentation

Decisions about documentation of Community of Practice activities are important. MHCC chose to fully document *Hunter NDIS and Mental Health Community of Practice* activities (e.g., 2016 and 2015 MHCC reports, forum programs, forum Minutes PPT presentations, six monthly newsletter, conference and other meeting presentations). This is because of the nature of the NDIS trial and the need to benefit from this opportunity. A limit to the ability of a local community to document Community of Practice activities is resources available but is encouraged. This is because learning about the NDIS and mental health/ psychosocial disability will continue for years into the future.

One advantage to documenting activities is an increased level of accountability in responding to challenges/opportunities identified and requests for information.

Evaluation

Evaluation and continuous learning are essential underpinnings for a Community of Practice. A *NDIS and Mental Health Community of Practice* should undertake evaluation activity/s to consider if they are making a difference to the quality and effectiveness of our understanding of the NDIS and mental health space. A standard survey can be developed and routinely used to evaluate Community of Practice activities.

For the *Hunter NDIS and Mental Health Community of Practice* Forums our evaluation forms collected information about:

- Registrations
- Attendance
- Whether the participant
  - was from within or outside of the trial site
  - was service provider, consumer, carer or other
  - felt more informed after the event
- Overall rating for each event
- Overall rating for each speaker at events
- Number of feedback forms completed
- Whether the time allocated for the forums was appropriate
- Whether the frequency of events was appropriate
- Suggestions for improvements and/or general comments.

MHCC provided forum participants with de-identified evaluation feedback.

In addition, the consultation session at each event provided participants with the opportunity to share written feedback. Written feedback collection allowed everyone in the large group events to share. Written feedback collection also recognises that some participants preferred not to share verbally in front of others.

Lifespan

A Community of Practice may have any given lifespan. Members of the group usually decide this. As learning about the NDIS and mental health is likely to continue for years, and interface with state and national health and mental health reform directions, one would expect the lifespan of a *NDIS and Mental Health Community of Practice* to be around three years.

This three-year lifespan through to the end of June 2019 would bridge the period of the national NDIS rollout, the planned cessation of ADHC in NSW, the transition of identified Commonwealth mental health programs to the NDIS and also the initial trialling of mental health services commissioning by PHNs.

Ultimately, the life span of a Community of Practice will likely be in accordance with the preferences of core and active group members (p. 12).

Actions to Cultivate Success in a Community of Practice [24]

What makes a Community of Practice succeed depends on the purpose and objective of the community as well as the interests and resources of the members of that community. Wenger (2002) identifies seven actions to cultivate success in a Community of Practice.

1. Design for evolution

Design the community to evolve naturally. Design Community of Practice activities to support change as interests, goals and members are dynamic and subject to change.

2. Open dialogue between inside and outside perspectives

Create opportunities for open dialogue across perspectives. While members and their knowledge are the Community of Practices' most valuable resource, it is also good to look outside of the Community of Practice to understand the different possibilities for achieving learning.

3. Invite different levels of participation

Welcome and allow different levels of participation (also see 'Reflections on consumer participation', p. 9).

4. Develop both public and private community spaces

While Community of Practice typically operate in public spaces where all members share, discuss and explore ideas, they should also offer private exchanges. Different members of the Community of Practice could coordinate relationships among members and resources in an individualised approach based on specific needs.

5. Focus on value

Focus on the value of the community. Communities of Practice should create opportunities for participants to discuss the value and productivity of their participation in the group.

6. Combine familiarity and excitement

Communities of Practice should offer the expected learning opportunities as part of their structure, and opportunities for members to shape their learning experience together by brainstorming and examining the conventional and radical wisdom related to their topic.

7. Create a rhythm for the community

Find and nurture a regular rhythm for the community. Communities of Practice should coordinate a thriving cycle of activities and events that allow members to meet, reflect, and evolve. The rhythm, or pace, should maintain an anticipated level of engagement to sustain the vibrancy of the community, yet not be so fast-paced that it becomes unwieldy and overwhelming in its intensity.

... and to this list we would add the need to evaluate the outcomes and impacts of activities of your Community of Practice!

24 Adapted from Wenger, Etienne; McDermott, Richard; Snyder, William M. (2002). Op. cit.

Myths about Communities of Practice [25]

The many types of Communities of Practice show that there is no one-size-fits-all. Here are some 'myths' about Community of Practice that you may want to reflect upon.

It is too difficult to evaluate a Community of Practice

Mostly false. It may be difficult to associate with 100% certainty the activities of a Community of Practice to a particular outcome. There is a good case using quantitative and qualitative data to measure different types of value created by a Community of Practice. Include how members are changing their practice and improving performance as a result.

Communities of Practice are always self-organising

False. Some communities do self-organise and are very effective but most need support to be sure that member's benefit from their participation.

There are no leaders in a true Community of Practice

Mostly false. Decisions about Community of Practice processes and planning need making. This includes decisions about strategic directions. Not all members see value in being involved in these processes. Whether or not you call them leaders someone needs to do it and it is as well to recognise them for the role they play.

True Communities of Practice are informal

False. There are many informal Communities of Practice and there are many formal ones too. A Community of Practice that is intentionally developed is more likely to have to go through some formal process to be recognised as such.

The role of a Community of Practice is to share existing knowledge

Partially true. The experience people have to share is clearly important. However, Communities of Practice also innovate and solve problems. They invent new practices, create new knowledge, define new roles and functions, and develop a collective and strategic voice.

Good facilitation is all it takes to get members to participate

False. Good facilitation is important but there are many other reasons why people may not participate. The value of participation needs recognition as being relevant otherwise members will not participate. Members need to see results of their participation and have a sense that they are getting something out of it.

Communities of Practice are harmonious places

Maybe. If a Community of Practice is totally conflict free, then be concerned that 'groupthink' may be settling in or voices silenced. Respectfully discuss differences and ensure that this contributes to learning.

There is a technology that is best for a Community of Practice

False. Online Communities of Practice exist even when no one is there! A tool or technology is only as good as it is useful to the people who use it and a forum is simply a forum until a Community of Practice occupies it.

Communities of Practice are the solution to everything!

False. Communities of Practice do not replace teams, networks, inter-agencies or other joint activities. Each has its own place in a learning system.

25 Adapted from Wenger-Trynor Introduction to communities of practice: http://wenger-trayner.com/introduction-to-communities-of-practice.

5. Guidelines for next steps to establish a Community of Practice

Champion establishment of a NDIS and Mental Health Community of Practice

Innovation, learning and leadership are critical to maximising opportunities for people with mental health conditions arising from the NDIS.

The Guidelines for next steps to establish a *NDIS and Mental Health Community of Practice* presented in this section are not necessarily linear. Leaders championing the establishment of a Community of Practice need to know or learn about their local community's preferred approaches to maximising opportunities presenting through the NDIS.

A person's NDIS journey commences by making contact with the NDIA to ask for an Access Request Form and in gathering evidence of psychosocial disability. The capacity for new entrants to access the NDIS in NSW during 2016/17 is limited. Therefore, identifying and supporting those people most disabled by their mental health condition first is important. It is from these initial experiences that an understanding of the opportunities of the NDIS will grow.

Local discussion about the benefits of establishing an *NDIS and Mental Health Community of Practice* - and what the leadership, scope and logistics of this might look like – is an important starting place for establishing a group. Some suggested next steps for establishing a Community of Practice follow.

1. Audit existing mental health consultative structures

Map existing mental health related inter-agencies, networks and other consultative structures of your local community. Understand where these are situated against both LHD and PHN boundaries. Where such structures exist, explore the pros and cons of these hosting a NDIS and Mental Health Community of Practice.

Existing mental health consultative structures can host an *NDIS and Mental Health Community of Practice* where well placed to do so. This may be because they are well established, have a history of inter-sectoral attendance and collaboration or have contributed well to other mental health reform processes in the past.

Other areas may not have well developed consultative structures or they may be restricted in their scope. In this case, further developing them to include opportunities for NDIS and mental health reflections may be an option. For LHDs that cover a large geographic area, the consultative structures may not be optimal for considering/consolidating reflections upon local NDIS experiences. Consider a consultative 'hub and spoke' approach within large geographic areas.

An NDIS and mental health consultative structure can be either short or long term. Consider what the immediate outcome is that you seek to achieve (awareness, knowledge, skill or capability).

Example of Hunter trial site consultative structures audit

Existing Hunter trial site structures considered to host a *NDIS and Mental Health Community of Practice* in late 2013 included:

HNEMHS Mental Health Interagency Meeting – this long standing and valued meeting's scope is for informal discussion of sector developments and issues

HNEMHS Mental Health NGO Forum – this long standing and valued meeting's scope is mostly for NSW Ministry of Health/HNELHD funded mental health program management

National Disability Services (NDS) NDIS Forum/s – the scope of leadership and frontline worker forums convened by NDS is all disabilities

NDIA Forums – the scope of forums convened by NDIA is all disabilities

HNELHD NDIS Operational Implementation Group (and Mental Health Working Group) – the scope of these groups is government representatives.

2. Consult with key stakeholders

Speak with key stakeholders including any local consumer groups, carer groups, CMOs, and regional NDIA, LHD, PHN and PIROs to understand their views and preferences to establish a *NDIS and Mental Health Community of Practice*. These conversations can be with key individuals, groups and/or at existing consultative events.

Conversations should include discussion of the pros and cons of existing or developing local/regional consultative structures to enhance learning arising from the experience of the NDIS. Be aware that different stakeholders may have different views about NDIS impacts and opportunities and the importance of being respectful of these.

During the first three months of the *NDIS and Mental Health Analysis Partnership Project* the Project Officer met with numerous key stakeholders using the range of methods described above resulting in identification of the need to convene a one-off sector meeting.

The importance of PHN and GP engagement

PHNs commenced operation in July 2015 and did not exist when the *Hunter NDIS and Mental Health Community of Practice* was established. The forum established a strong and important connection with the Hunter Medicare Local that was the lead agency hosting the trial site PIR program.

The important role that PHNs are to undertake in local implementation of national and state mental health reform is now better understood. This will include PHN related work in strengthening GP linkages; and in responding to people with complex and diverse needs in areas such as youth mental health, suicide, substance misuse and the disadvantage experienced by Aboriginal Torres Strait Islander and other marginalised groups of people.

For these and other reasons PHNs, along with GPs and LHDs, are critical key stakeholders in moving forward with the scaling up of the NDIS as this relates to people with complex and diverse health and social needs including mental health conditions.

3. Convene a regional meeting

Convene a one-off regional meeting to discuss the pros and cons of establishing a *NDIS and Mental Health Community of Practice*. Think about who you want to attend this initial meeting. You may prefer a small or large group meeting for this initial discussion. Considered the pros and cons of inviting representatives from all key stakeholder groups should be regardless of group size.

While the initial one-off regional meeting convened by the *NDIS and Mental Health Analysis Partnership Project* was limited to CMOs this was because the NDIS was so new to MHCC's membership. The potential identified for strengthening coordinated, integrated and collaborative practice resulted in the decision to establish a recurrent forum that was open to all interested people.

At this early stage of NDIS implementation in NSW it is recommended that initial meetings consider broad attendance. The involvement of service users and service providers - from both the government primary health care and community sectors - will maximise opportunities for consumers, their families and carers, and sector reform.

4. Seek agreement to establish a Community of Practice

At your one-off meeting, seek agreement to establishing a Community of Practice. If agreed, discussion could occur about whether this will be mental health/psychosocial disability specific. During the Hunter NDIS trial, the volume of potential mental health specific content was so great that this was the agreed focus; this did not exclude consideration of more generic content as the need arose. Examples of this are discussion about how organisations become NDIS registered providers and NDIA IT reporting and financial claims arrangements.

However, many discussions of seemingly generic content quickly identified unique elements from a mental health perspective. Examples of this are discussions about:

- access and eligibility,
- service planning and review, and
- the centrality of 'coordination of supports' related activity to recovery-oriented and trauma-informed practice.

After establishing agreement to the existence and scope of a Community of Practice explore what its activities might look like (see Frequency, Format and Content of pp. 12-13). Consider options for securing in-kind and/or financial resources to establish the Community of Practice.

5. Identify a leadership structure

Explore options to establish a core group and/or other leadership structure for your Community of Practice against available resources (see Leadership on p. 10). While a proposed leadership model has been put forward that, in the short term, builds on the substantial social capital that has been established by many PIROs and PIR program across NSW it is acknowledged that this may not be a preferred option for all communities.

What is important is local communities having discussions that result in an agreed and preferred leadership option that is best situated against the needs, resources and preferences of any specific community and that encourages group autonomy over time.

6. Develop agreements regarding the running of the Community of Practice

Following your one-off meeting, formalise agreements related to undertaking your Community of Practice. Consider developing written Terms of Reference for your group including consideration of group:

- Aims/objectives
- Outcomes
- Values
- Leadership
- Membership
- Strategies for strengthening group autonomy
- Activities
- Plans for review of the groups' agreements and work.

7. Develop a plan to evaluate the success of the Community of Practice

Before undertaking Community of Practice activities, think about the qualitative and quantitative measures that you will undertake to evaluate the quality and effectiveness of your Community of Practice.

Opportunities to evaluate your Community of Practice will align with the level of resources that you have to measure impacts. For more information about the evaluation approach taken by the *Hunter NDIS and Mental Health Community of Practice* see p. 15.

Evaluation Community of Practice [26]

The NSW Government has established an Evaluation Community of Practice. It provides an opportunity for people from government and non-government organisations to access relevant resources on evaluation.

The Government developed an Evaluation Toolkit to provide advice and resources for planning and conducting a program evaluation. The toolkit supports public sector managers commissioning or managing evaluation. It is also a reference for non-government organisations and external evaluators involved in evaluations with the NSW Government.

26 NSW Government (2015 b). Evaluation Community of Practice: http://evaluation.dpc.nsw.gov.au/

6. Concluding remarks

From a mental health perspective the NDIS 'market' is essentially the community managed mental health sector. The community managed mental health sector has a rich history of working together – and with consumers, carers and the public mental health sector – to provide services and supports to people affected by mental health conditions.

The opportunity of the NDIS means that the community managed mental health sector will grow as people with high levels of psychosocial disability access funded services and supports. In the Hunter trial site, this has included growth of the peer workforce (i.e., people with lived experience of recovery and skills to help others in their journey of recovery). A downside to this growth opportunity is the potential for competition between organisations rather than collaboration. Communities of Practice create a space where collaboration can thrive and reduce unhealthy competition, while encouraging innovation in service delivery and leadership in mental health reform.

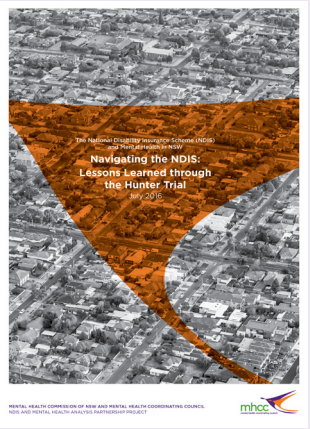
The role of PHNs in ensuring joint planning and accountabilities in nationally led and locally implemented mental health reform are anticipated to grow over time. It is important that while PHNs are growing into their new mental health roles and functions that the opportunity that is the NDIS is not lost.

Some important work will be undertaken over the next few years related to clarification and refinement of the NDIA's operational approach to the early intervention gateway, and in the context of mental health and the NDIS. This applies both for young people - given that 75% of mental difficulties begin before age 25 – but also for people of any age who develop a mental health condition with the potential to disrupt their economic and social participation. A *NDIS and Mental Health Community of Practice* provide a place for such conversations to occur. People's NDIS experiences – consumers, carers and service providers - inform these conversations.

Additionally, the NDIA indicate that further development and implementation of a national Mental Health and NDIS Engagement Strategy is of high priority in their current mental health work plan. This work is to include an explanation of how the NDIS will work for people with psychosocial disability, their families and carers. As many mental health conditions are 'cyclic', or vary in intensity, consumers are the critical reference group regarding the development of personally meaningful and flexible plans. Thus, the inclusion of consumers, and their families and carers, in both *NDIS and Mental Health Community of Practice* activities as well as NDIS co-production opportunities is encouraged.

This document provides guidance from the experience of the Hunter trial site and other local communities are encouraged to contribute to the learning and opportunities arising from the NDIS as this relates to their unique implementation experiences.

For further information



For background information to this guide, you may be interested to read:

Navigating the NDIS: Lessons Learned through the Hunter Trial

Available at www.mhcc.org.au

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