Government of **Western Australia**
Mental Health Commission

Mental Health Network Review

January 2019

Contents

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Acknowledgement

The Mental Health Commission would like to thank all individuals, groups and organisations that provided submission or feedback for the Mental Health Network Review.

Acronyms

Co-Leads	Mental Health Network Co-Leads
DoH	Department of Health
EAG	Mental Health Network Executive Advisory Group
MHC	Mental Health Commission
MHC Liaison Representatives	Mental Health Commission Sub Network Liaison Representatives
MHN	Mental Health Network
Sub Networks	Mental Health Network Sub Networks
Sub Network Co-Chairs	Mental Health Network Sub Network Steering Group Co-Chairs
Sub Network Members	Mental Health Network Sub Network Members
Sub Network Sponsors	Mental Health Network Sub Network Sponsors
Steering Groups	Mental Health Network Sub Network Steering Groups
OCP	Office of the Chief Psychiatrist
The Plan	Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025
TOR	Terms of Reference
WAAMH	Western Australian Association for Mental Health
WAPHA	WA Primary Health Alliance

1. Executive Summary

The Mental Health Network (MHN) was launched in October 2014, and aims to improve outcomes for people with mental health issues by facilitating consumers, families/carers, health professionals, hospitals, mental health services, the Mental Health Commission (MHC) and the Department of Health (DoH) to engage and collaborate effectively, to enable health policy and increase co-ordination of care across Western Australia.

The MHC commenced a review of the MHN in December 2017 to examine its current structure and functions, thereby identifying ways to optimise the role of the MHN and its overarching goal to support collaboration, reform and innovation across the mental health sector.

The scope of the MHN Review was developed and approved by the Clinical Co-Lead of the MHN and the MHC, in November 2017.

The consultation was conducted via two online surveys, seeking direct feedback from key stakeholders of the MHN, including the Sub Network Steering Group (Steering Group) members, Executive Advisory Group (EAG) members, Health Service Provider Sponsors (Sub Network Sponsors) and targeted executive stakeholders from the Western Australian mental health sector.

All results and feedback from the consultation process were analysed and five key themes were identified:

- **Theme One** Consumer, family and carer engagement
- **Theme Two** Leadership, purpose and governance of the MHN
- **Theme Three** Communications and processes
- **Theme Four** Resourcing and support
- **Theme Five** Opportunity to influence and showcasing successes

Recommendations and related actions of the Review have been made based on the themes identified, and are categorised as follows:

1. Clarification and definition of each MHN entity
2. Orientation, professional development, training and support mechanisms
3. Meeting structures and record keeping
4. Communications
5. Monitoring and evaluation

2. Background

2.1 Mental Health Network

2.1.1 Establishment

The MHN was launched on Monday 6 October 2014 during Mental Health Week, by the Hon. Helen Morton, former Minister for Mental Health. The establishment of the MHN was instigated by Professor Bryant Stokes, the former A/Director General, DoH, in partnership with Mr Timothy Marney, Mental Health Commissioner.

The MHN was one of 18 health networks established by the DoH over an eight year span. However, the MHN structure is unique to the existing DoH health network structure, with the MHN establishing Sub Networks to aid in coordinating such a large network and to support the MHN to engage with and improve outcomes for specific cohorts of mental health service users (see 3.3 Mental Health Network Sub Networks).

The aim of the MHN is to improve outcomes for people with mental health issues by facilitating consumers, families, carers, health professionals, hospitals, mental health services, the MHC and the DoH to engage and collaborate effectively, to enable health policy and increase co-ordination of care across Western Australia.

Connecting these key stakeholders and peak bodies encouraged mental health services to become more responsive to people's needs, to be better coordinated, to have increased sustainability and to make decisions informed by evidence-based best practice care, resulting in an integrated mental health care system providing better care for better value.

In particular, the MHN supports the review and implementation of the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan), and focusses on addressing the following service streams and key actions:

- Specialised Statewide Services (key actions: 54, 55, 56)
- Forensic Services (key actions: 58, 63)
- Recovery-Oriented Practice (key actions: 67, 68, 69)
- Cultural and Social Diversity (key action: 79)
- System Integration and Navigation (key actions: 80, 83, 85)
- Research and Evaluation (key action: 86)

For a copy of the Plan, visit the MHC website.

Appendix 1 provides a list of the Plan's service streams and key actions addressed above.

2.1.2 Governance

Prior to 1 July 2017, the MHN reported to the System, Policy and Planning Directorate, DoH, as one of 18 Health Networks.

On 1 July 2017, the governance of the MHN transferred from the DoH to the MHC, following agreement between Dr David Russell-Weisz, Director General, DoH and Mr Timothy Marney, Mental Health Commissioner.

The Mental Health Network Co-leads retain links to the DoH (which remains a sponsoring agency) via regular meetings with the Executive Director of Patient Safety and Clinical Quality, the Manager of the Mental Health Unit, and also with the Health Network Directorate via membership of the Network Leadership Forum and Clinical Reference Group.

2.1.3 Leadership

Since its inception, the MHN has been overseen by two Co-Leads:

- Clinical Co-Lead – Dr Helen McGowan has been with the MHN since its launch in October 2014, and is employed by the North Metropolitan Health Service, DoH; and
- Community Co-Lead – Mr Rod Astbury was appointed as an independent consultant on 10 April 2018. Ms Alison Xamon was the inaugural Community Co-Lead until May 2017.
- Since inception, the role, aims and objectives of the MHN have evolved in response to advice from key stakeholders, changing governance structures, and level of support and new priorities.

2.1.4 Aim

Following the launch of the MHN, the inaugural Co-Leads Dr Helen McGowan and Ms Allison Xamon established the aim of the MHN in November 2014:

- Improve outcomes for people with mental health issues by enabling consumers, carers, health professionals, hospitals, mental health services, the MHC and the DoH to engage and collaborate effectively to facilitate health policy and increase co-ordination of care across the State.

Since inception, the MHN has also identified the need to engage with primary care and non-government agencies. It is a recommendation of this Review that the aim of the MHN is reviewed and updated by the Co-Leads in consultation with the EAG, and should include collaboration with primary care and non-government organisations (see Recommendation 1.1.4).

2.1.5 Objectives

The objectives of the MHN were established in November 2014 by the inaugural Co-Leads Dr Helen McGowan and Ms Allison Xamon, ensuring consistency with other DoH Health Network objectives, and are as follows:

- Contribute to improving the mental health and wellbeing of Western Australians;
- Draw upon a community of practice approach to share information, engage with the sector and community, foster collaboration and develop partnerships;
- Engage with organisations and individuals to support innovation and change;
- Develop an agreed set of strategic priorities across the mental health sector;
- Promote system change including continued development of a person-centred and recovery orientated culture, with better integrated and connected services; and
- Promote adoption of recognised best practice across the sector.

It is a recommendation of this Review that the objectives of the MHN are reviewed and updated by the Co-Leads in consultation with the EAG (see Recommendation 1.1.4).

2.1.6 Role

The roles of the MHN were identified by the inaugural Co-Leads following establishment in November 2014, and are reflected in the current Terms of Reference (TOR) for the EAG and the Sub Networks as follows:

- Facilitate an integrated mental health system, which can provide better care for better value;
- Provide a strategic platform 'to facilitate a statewide transformative process';
- Engage and connect policy makers, service users and providers across the relevant sectors;
- Support planning across the mental health sector, and other related sectors;
- Share information and ideas for innovation and improvement;
- Build engagement, co-operation and consensus across the spectrum of service providers (including public, private, hospital, community, primary care, NGO, community care), service users and policy makers;
- Build networks that are respectful, cooperative, efficient, person-centred and support recovery principles; and
- Produce documents that can be applied across Western Australia (or specific catchment area, if geographical Sub Network) and guide the development of products including:
    - Care Pathways;
    - Models of Care;
    - Clinical Guidelines;
    - Service Plans; and
    - Service Maps and Directories.

It is a recommendation of this Review that the role of the MHN is reviewed and updated by the Co-Leads in consultation with the EAG (see Recommendation 1.1.4).

2.1.7 Achievements

In addition to the establishment of ten Sub Networks, the facilitation of associated Sub Network open meetings and the development of Sub Network establishment reports, the MHN has achieved the following from November 2014 to October 2018:

- Development of the Principles for Delivery and Development of Trans-Regional Services;
- Development of a Trans-Cultural Model of Service: *'A model for an effective and sustainable state-wide Transcultural Mental Health Service for Western Australia';*
- Development of individual Sub Network work plans;
- Establishment of the Mental Health State-wide Model of Services Working Group;
- Establishment of the State-wide Mental Health Clinical Reference Group;
- Ongoing provision of high quality advice to the MHC, WA Primary Health Alliance (WAPHA), the DoH, and Office of the Chief Psychiatrist (OCP);
- Invited to present at the 2017 National Borderline Personality Disorder Conference;
- Provision of a submission to the Commonwealth Government regarding establishment of Specialist Dementia Care Unit;
- Provision of a submission to WA Parliament Select Committee into Elder Abuse;
- Co-development with Dementia Support Australia of the draft *Referral and Collaboration Care Guidelines*; and
- Presentation by the Youth Mental Health Network Sub Network to the Mental Health Advisory Council on the *Youth Mental Health Report*.

3. Mental Health Network structure and entities

The MHNs unique structure is comprised of the following entities:

- MHN membership
- MHN EAG
- MHN Sub Networks
  - MHN Sub Network membership
  - MHN Sub Network Steering Groups

As mentioned previously, the MHN is distinct when compared with other DoH health networks, as it includes a Sub Network structure. The Sub Networks were established to aid in coordinating such a large network and to support the MHN to engage with and improve outcomes for specific cohorts of mental health service users (see 3.3 Mental Health Network Sub Networks).

Whilst the Sub Network structure increases the capacity of the MHN and enhances its ability to focus on issues effecting specific cohorts, it also adds a layer of complexity, communication challenges and varying dynamics.

Compounding this complexity, the terminology of the MHN entities has often been confused. This has occurred from the time of establishment, both within and external to the MHN. For example, the Steering Groups (which are comprised of selected representatives for the relevant Sub Network) are regularly referred to in documentation and anecdotally as the 'Sub Networks', when in fact it forms part of the Sub Network in addition to the large Sub Network membership base that sits underneath the Steering Group. This misused terminology can create a misleading impression that the whole Sub Network membership base is providing advice in instances when the Steering Groups are consulted on policy and system reform. Processes are underway to ensure Steering Groups draw on the voices of the broader membership when compiling advice for decision making bodies (see Recommendation 4.3).

Other terminology commonly misused by stakeholders includes the Sub Network Co-Chairs referred to as 'Co-Leads', the Steering Groups being called 'Steering Committees', and the Sub Networks readily interchanged with 'Mental Health Networks'. Clarification and definition of the Sub Networks structure is underway (see Recommendation 1.2).

In addition, there is a risk that the MHN operates as a series of isolated, individualistic Sub Networks, rather than as a cohesive Network. The individual Sub Networks tend to work in silos from each other, with the Co-Leads the sole conduit for information sharing and networking across the Sub Networks.

Document ownership issues and instances of Steering Groups operating outside their designated lines of accountability could be minimised through greater reinforcement of the MHN as one organisation. A communication strategy is currently being developed to improve information sharing and enhance collaboration opportunities (see Recommendation 4.5). Lines of accountability and reporting are also currently being addressed (see Recommendation 1.3).

The accountability and reporting structure of the MHN can be found at **Appendix 2**.

3.1 Mental Health Network membership

Membership of the MHN is open to all. Current members include consumers and carers, health professionals, policy-makers and planners, researchers and academics, and people working for non-government organisations.

The MHN has a broad membership base, which has been established via a (voluntary) registration process. During this process, individuals are requested to indicate what Sub Network they would like to become a member of and receive information about, with the option to become a member of multiple Sub Networks. Individuals are also given the opportunity to indicate if they have a special interest area, including but not limited to, Aboriginal and Torres Strait Islanders, Child Community Based Treatment Services, and Rural and Regional.

Members of the MHN are informed of opportunities to get involved, attend networking events, participate in consultations, and other items relevant to individual areas of interest, via electronic mail-outs.

In addition, members receive a bi-monthly electronic newsletter informing them of the ongoing work of the MHN, and other sector updates where relevant.

3.2 Mental Health Network Executive Advisory Group

The MHN has an EAG which provides advice to the Co-Leads, thereby supporting the MHN to meet its objectives (outlined in 2.1.2 Governance). This advice is in respect to the merit and appropriateness of MHN and/or Sub Networks projects and products that will contribute to system reform and improvement. The EAG meets bi-monthly and these meetings are chaired by the Co-Leads.

The EAG is accountable to the Co-Leads, who in turn are accountable to the Mental Health Commissioner.

The EAG membership includes the following representatives:

- Aboriginal Mental Health representative;
- Assistant Commissioner, Planning, Policy and Strategy, MHC;
- Carer/family member;
- Chief Executive Officer, Consumers of Mental Health WA;
- Chief Executive Officer, Helping Minds;
- Chief Executive Officer, Western Australian Association for Mental Health (WAAMH);
- Chief Executive Officer, Western Australian Network of Alcohol and other Drug Agencies;
- Chief Mental Health Advocate;
- Chief Psychiatrist;
- Consumer member;
- Executive Director, Clinical Support Directorate, DoH;

- LBTQI Mental Health representative;
- Multicultural Mental Health representative;
- Primary Care representative;
- Principal Advisor, WAPHA;
- Program Manager, Mental Health Unit, DoH;
- Representative, Mental Health Clinical Reference Group, DoH;
- Representative, Rural and Remote Mental Health; and
- Representative System-Wide Mental Health Policy and Planning Advisory Group, DoH.

The Co-Leads may nominate persons to temporary membership of the group as required.

The initial recruitment and appointment process for the EAG membership was undertaken by the Co-Leads following stakeholder consultation, ensuring alignment with DoH's participant recruitment guidelines.

3.3 Mental Health Network Sub Networks

The Sub Networks were established to aid in coordinating such a large network, and to support the MHN to engage with and improve outcomes for specific cohorts of mental health service users. Ten Sub Networks were established based on identified need including: population-specific (e.g. a particular cohort), condition-specific (e.g. a cohort based on a common health status, illness or other medical problem), and geographical region (e.g. location). The establishment of each Sub Network followed a thorough process which aimed to be inclusive, exhibit broad representation, and reflect the concerns and views of the sector. Each Sub Network was launched via an open meeting, ensuring a broad audience was invited. These open meetings used a facilitator to capture the discussions and outcomes which were subsequently included in the relevant Establishment Report.

The original emphasis of the Sub Networks was to build a *community of practice* that could work collaboratively and focus on the needs of a particular cohort, be task orientated and to deliver products by bringing together the right people, from the community sector, DoH, consumers, carers and other interested parties.

A *community of practice* is a group of people who share a craft or passion and it can evolve naturally because of the members' common interest in a particular domain or area, or it can be created deliberately with the goal of gaining knowledge related to a specific field. It is through this process of sharing information and experiences with the group that members learn from each other, and have an opportunity to develop personally and professionally (Lave and Wenger 1991).

Whilst acknowledging clinical connotations associated with the terminology *community of practice*, this term has been supported and endorsed by the EAG, who deem it to be equally applicable to community-based contexts.

The Sub Network structure supports the MHN to build networks that are respectful, cooperative, efficient, person-centred and support recovery principles. Each Sub Network has broad membership and includes a Steering Group.

3.3.1 Mental Health Network Sub Network membership

Each Sub Network has a broad membership base of individuals established via the registration process outlined earlier (see 3.1 Mental Health Network membership).

3.3.2 Mental Health Network Sub Network Steering Groups

Each Sub Network has a Steering Group that is led by two Sub Network Co-Chairs, and is comprised of individuals with the relevant knowledge, skills and experience to address the endorsed purpose of the Sub Network. These individuals were invited to apply for membership on the Steering Group, and a consensus was formed with the MHN Co-Leads and advice from key stakeholders, ensuring each Steering Group was optimally representative.

These individuals include clinicians, consumer, family and carer representatives, researchers and practitioners from the community managed sector. The Steering Groups meet between 4-10 times per year to collaborate on a variety of projects; however this frequency varies between the Sub Networks and work plan commitments. In addition, the Steering Groups have adapted their agenda to manage varying levels of resourcing support from the Sub Network Sponsor, stakeholder interest, member capacity, communication support, and advice from Sub Network Co-Chairs.

In addition to fostering collaboration and sharing information, the Steering Groups, under the guidance of the Co-Leads, undertake specific tasks to support documentation of care pathways, models of care, clinical guidelines, service planning, service development and service improvements. Decision making bodies such as the MHC, the DoH and WAPHA can approach the Sub Networks for feedback and advice to assist in the development of policy and projects.

The ten Sub Networks are as follows:

- Eating Disorders;
- Forensic;
- Joondalup/Wanneroo Region;
- Multicultural;
- Neuropsychiatry and Developmental Disability;
- Older Adult;
- Peel and Rockingham, Kwinana Region;
- Perinatal and Infant;
- Personality Disorders; and
- Youth.

Each Steering Group is sponsored by a Health Service Provider. The Sub Network Sponsor is responsible for payment of consumer, family and carer representatives, providing minimal administrative support for meetings, supporting the Sub Network's work plan, and enabling clinicians to take part in the Steering Groups. Currently seven networks are sponsored by the North Metropolitan Health Service; two are sponsored by the South Metropolitan Health Service and one by Joondalup Health Campus.

The Sub Networks are supported by a MHC Liaison Representative (see 4.1 MHC Liaison Representatives).

4. Mental Health Commission

The Planning, Policy and Strategy (PPS) Directorate provides direct support to the MHN and Co-Leads, with daily administrative support provided by a recently created Project Officer position (Level 5, 0.5 FTE) within the Intergovernmental Relations (IGR) Team. The Project Officer performs a variety of roles, including provision of executive support for the EAG and Co-Leads, responsibility for communications between the MHN entities and for webpage updates, and liaison with relevant government and non-government agencies as required.

The PPS Directorate also provides support to the Co-Leads through monthly meetings with the Assistant Commissioner.

4.1 MHC Liaison Representatives

The MHC provides a designated MHC Liaison Representative, to support each Sub Network. These roles include the following:

- Monitor Steering Group meetings and activities; this does not require attendance at every meeting, however MHC Liaison Representatives should ensure they:
  - Are aware of and understand the status of projects or products being developed by the Sub Network they support;
  - Maintain regular email or phone contact with the Sub Network Co-Chairs; and
  - Review Steering Group meeting minutes and provide information as requested and if appropriate.
- Review and advise on Sub Network work plans, and provide advice to Steering Groups with respect to:
  - Merit and appropriateness of projects and products in relation to current MHC priorities and activities, in addition to alignment with the Plan;
  - Projects and products that align with the priorities and activities of other key stakeholders, such as the DoH, WAPHA or the OCP, and are relevant to the MHN; and
  - EAG feedback and advice on Sub Network work plans and activities.
- Advise the Steering Group with respect to relevant actions within the Plan.
- Undertake stakeholder consultation on behalf of the MHC on issues relevant to the Sub Network.
- While the MHC Liaison Representatives do not provide administrative support to the Sub Network, they may provide project support for specified projects if approved by the PPS Directorate, dependent upon current work load and priorities.

It is a recommendation of this Review that the role of the MHC Liaison Representative is reviewed and updated by the MHC (see Recommendation 1.3.6).

5. Mental Health Network Review

5.1 Consultation

5.1.1 Scope

The scope of the MHN Review was approved by the Clinical Co-Lead and the MHC, in November 2017 and included:

a) Review of communication processes with network members to optimise engagement and ensure that communication is streamlined and targeted;
b) Consideration of current and alternative processes and structures of governance within the MHN;
c) Review Sub Network structures and consider processes to increase efficiency of current Sub Networks. This includes frequency of Steering Group meetings, use of short term working groups for particular projects and exploration of the need for and viability of new Sub Networks to progress reform with respect of key issues for particular cohorts of consumers; and
d) Clarification from key stakeholders regarding the role of the MHN and identification of opportunities to support mental health reform and development by the DoH, WAPHA, the MHC, the OCP and WAAMH.

5.1.2 Methodology

The MHC developed two online surveys using Survey Monkey (Survey A and Survey B) to seek direct feedback from Steering Group members, EAG members, Sub Network Sponsors and targeted executive stakeholders. The two surveys were developed in consultation with the Clinical Co-Lead and distributed via direct email to the target audiences (as below). The surveys were open from 4 January 2018 to 19 January 2018. A copy of the survey questions can be found at **Appendix 3**.

These specific cohorts were identified as the appropriate survey recipients given the purpose of the MHN Review, as outlined above (5.1.1 Scope).

The broad membership base of the MHN were unable to be consulted with, due to unforeseen difficulties related to the transference of personal details during the change of governance, from the DoH to the MHC.

Survey A

Survey A was distributed to all Steering Group members (154 individuals) to capture data relevant to the respondents' Sub Network membership.

Survey B

Survey B was distributed to the EAG membership, Sub Network Sponsors and targeted executive stakeholders (17 individuals). This survey addressed broader issues regarding the governance of the MHN.

5.1.3 Response rate

Overall, 171 surveys were distributed, with 81 responses received. There was a total response rate of 47%; the response rate for Survey A was considerably higher (49%) than Survey B (29%).

These surveys included a combination of yes/no and open-ended questions, and captured a core group of members with representation across the ten Sub Networks, in addition to targeted executive stakeholders (see 5.2 Demographic survey data).

5.1.4 Data limitations

Whilst online surveys have many advantages (cost and time efficient, accessible, and design flexibility), they also have limitations including:

- Limited sampling and respondent availability;
- Poor response rates due to survey saturation and/or timing of survey dissemination;
- No interviewer to clarify the questions which can lead to less reliable data;
- Some responses may be difficult to analyse; and
- Lack of personalisation (hard to convey feelings and emotions).

The impact of these limitations, in particular distributing the survey during the holiday period, may have resulted in a lower response rate.

5.1.5 Additional feedback

The MHC conducted an internal review of MHN documentation, including Terms of Reference (TOR), templates, policies and procedures. In addition, the MHC sought feedback and advice from key stakeholders via email and face to face meetings, regarding MHN best practice. This feedback is reflected within section 5.3 Key survey findings.

5.2 Demographic survey data

This section provides an overview of survey responses and key stakeholder feedback.

5.2.1 Survey A: Overview of Sub Network respondents

A total of 76 responses were received (49% response rate) with Sub Network representation and affiliations as follows (in absolute numbers):

Q1: Which Mental Health Network Steering Group are you a member of?

Sub Network	Respondents	
Multicultural	11	14.47%
Neuropsychiatry and Developmental Disability	11	14.47%
Joondalup/Wanneroo	10	13.16%
Forensic	9	11.84%
Personality Disorders	8	10.53%
Eating Disorders	7	9.21%
Older Adult	7	9.21%
Perinatal and Infant Mental Health	6	7.89%
Youth	6	7.89%
Peel and Rockingham/Kwinana Region (PaRK)	4	5.26%

Q2: Is your affiliation with the Mental Health Network through (tick all applicable).

Affiliation	Respondents	
Department of Health employee	28	36.84%
Non-Government Organisation	21	27.63%
Lived Experience	10	13.16%
Other (please specify)	9	11.84%
Mental Health Commission employee	8	10.53%

5.2.2 Survey B: Overview of Executive respondents

A total of five responses were received (29% response rate) with representation as follows (in absolute numbers):

Q1: Is your affiliation with the Mental Health Network through (tick all applicable).

Affiliation	Respondents	
Executive Advisory Group	2	40%
Department of Health – Mental Health Unit	1	20%
South Metropolitan Health Service	1	20%
Peak body	1	20%

5.3 Key survey findings

The following are key survey findings that arose from the consultation process (Survey A, Survey B, and Additional feedback):

Does the Sub Network structure support the MHN aims and objectives?

- 100% of executive respondents agree the Sub Network model supports the MHN aims and objectives and is an effective way of focussing on the care needs of a particular part of the mental health sector.

What have been the key achievements of the individual Sub Networks?

- Sub Network respondents identified the development of work plans (58%) and other informal benefits (48%) as the key outcomes/achievements of individual Sub Networks.

What have been the main challenges of the Sub Networks?

- 75% of Sub Network respondents felt the Sub Networks are not adequately resourced to achieve their aims and objectives.
- Other significant challenges identified included lack of quorum/low attendance at Steering Group meetings, unclear scope and inclusiveness issues.

Do the Steering Groups contain an optimal mix of skills and knowledge?

- It was overwhelmingly felt there is an optimal mix of skills and knowledge in the Steering Groups (93%).

How committed are the Steering Groups members to maintain their involvement with the Sub Network?

- 80% of Sub Network respondents indicated they are either committed or very committed to maintaining involvement with their Steering Group.

What level of capacity do Steering Group members have to maintain involvement with the Sub Network?

- 96% of Sub Network respondents indicated they had the same capacity, more capacity, or a lot more capacity to continue to engage with the work of the Sub Network.

Do the Steering Groups utilise the Govdex file sharing system?

- Only 18% of Sub Network respondents indicated that their Sub Network uses the Govdex file share system, which is an online collaboration mechanism for use across government. Govdex is a secure, private web-based space that helps agencies share documents and information, and has the added benefit of being able to be used for 'in confidence' material.

5.4 Academic Review Interim Report

The Mental Health Networks – Best Practice Principles – Interim Report (Interim Report) (Ackermann, McGowan and Hill, 2018) is an unpublished report, completed in August 2018. The Interim Report aims to provide an overview of best practice in mental health networks within Australia, and is one of the deliverables for a research project entitled 'Collaborating in Mental Health – Designing effective strategic support for the sub-networks'. The Interim report is based on a combination of primary and secondary sources. The primary sources comprise of interviews with a range of individuals involved in the creation, management and overview of mental health networks Australia-wide. The secondary sources comprise a review of the academic and professional literature on mental health networks, concentrating on Australia but also exploring mental health networks in the United Kingdom.

The key findings from the Interim Report align with the themes identified in the MHN Review, reinforcing the need for the MHN to have:

- Clear objectives;
- Defined and effective governance;
- Engagement with the full MHN membership base; and
- Opportunity to influence, including measuring and celebrating MHN successes.

The Interim Report also identifies further reforms to be considered to support the work of the MHN as follows:

- Evaluating and monitoring the performance of the MHN – monitoring the MHNs progress against a work plan with a good evaluation framework and the establishment of KPIs, will assist in the development of an effective performance measurement system. It will then be possible to: monitor the MHN's work; reflect on the successes; review the TOR to ensure they are fit for purpose; and review Sub Network work plans to reflect new priorities, thereby completing the feedback loop.

- Identifying and monitoring tangible measures of success – developing a range of measures including monitoring the frequency of engaging with an NGO and monitoring the number and frequency of MHN members attending meetings, will allow for the tangible measures of success to be captured.
- Identifying and monitoring intangible measures of success – undertaking surveys to elicit qualitative measures on member's satisfaction with the MHN, will allow for the intangible measures of success to be captured.

6. Key themes and sub-themes

All results and feedback from the consultation process (Survey A, Survey B, and Additional feedback) were analysed and coded into five key themes.

These key themes and sub-themes are as follows, with supporting feedback:

Theme One: Consumer, family and carer engagement

The MHN has been conceptualised within the context of health networks, with area health services as sponsors and clinicians providing much of the representation on Steering Groups. Consideration needs to be given to ensuring consumer, family and carer representatives are equal stakeholders at all levels. This has been addressed in the revised EAG TOR (see Recommendation 1.1.5) and is currently being addressed during the revision of the Sub Network TOR (see Recommendation 1.2.2).

Consumer, family and carer representation on the EAG needs to be reviewed and updated, and consideration given to advocacy service representation, to ensure diverse engagement in line with the *Western Australian Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025*. The Co-Leads have addressed this in the revised EAG TOR (see Recommendation 1.1.5).

The Interim Report also recognises the importance of membership equality, in particular lived experience members, and that these members should be involved in decision making through: sharing power; equal access to meetings; appointment as Sub Network Co-Chairs; providing safe spaces; and encouraging attendees to view them for what they can contribute rather than who they are. This is currently being addressed through review of the Sub Network TOR (see Recommendation 1.2.2), and the development of role statements of both Sub Network Co-Chairs and Consumer, family and carer representatives (see Recommendations 1.3.3 and 1.3.5).

The Steering Groups currently include consumer, family and carer representatives, though a tension has been identified regarding assumption that consumer, family and carer consultants feel confident and comfortable contributing to critical discourse during Sub Network meetings, despite the fact that they are renumerated by the Sponsors and may therefore feel compromised regarding the provision of critical feedback. Feedback also captured that the role of the consumer, family and carer representative requires clarification. To address these concerns, a role statement is being developed to capture responsibilities, ensure the consumer, family and carer representatives feel confident and comfortable to contribute independently during Sub Network meetings, and additionally to guarantee the broader consumer, family and carer community voice is being heard (see Recommendation 1.3.5).

Feedback regarding a dominant clinical focus of some Steering Groups has been considered. Meeting structure review and Sub Network Co-Chair training is required to ensure hierarchical clinical processes are not replicated in Sub Networks. This is being addressed through the development of a role statement for Sub Network Co-Chairs, which includes shared responsibility processes, guidelines for managing conflicts of interest, and encouraging and capturing all voices (see Recommendation 1.3.3).

Theme Two: Leadership, purpose and governance of the MHN

Following the transfer of the MHN from the DoH to the MHC, the leadership, purpose and governance of the MHN requires further definition and clarity to ensure the MHN effectively supports mental health reform and development in Western Australia.

It was noted that the governance models of some health networks in other Australian states are separate from decision making bodies, ensuring independence. Whilst the MHN is now governed by the MHC, the importance of the MHN's role of providing independent advice requires further clarification, and any potential risks to this must be identified. The issue of independence is recognised as being highly nuanced and applied variably across the different MHN entities. A clear definition and common understanding of the MHN's role and function regarding the provision of independent advice is required. Emphasis is needed to clarify what the MHN can or cannot do, particularly in relation to supporting the development of policy. This clarification and definition is currently being reviewed in the EAG TOR, which contains a MHN Mission Statement (see Recommendation 1.1.1, 1.1.2, and 1.1.4).

As identified, the MHN is governed by the MHC and provides independent advice with the remit of building engagement, fostering collaboration and learning and offering expert advice to decision making bodies (MHC, DoH, and WAPHA). However it is clear key stakeholders do not have a shared understanding of this purpose. Without this clear understanding of purpose and if these expectations are not aligned with the espoused aims and objectives of the MHN, there is a risk the MHN will not be utilised effectively and stakeholder expectations of the MHN will not be met. Communication strategies to increase this understanding have commenced (see Recommendations 4.2 – 4.4).

The Interim Report also suggests that the MHN requires a clear purpose and a shared understanding of this purpose, to be effective. In addition the Interim Report identifies accountability and transparency as key aspects of an effective Network. Clarification and definition of the MHN's purpose, and lines of accountability, are currently being revised in the EAG TOR, which will lead to shared understanding and transparency (see Recommendations 1.1.1, 1.1.2, and 1.1.4). Development of work plan and project proposal templates has also commenced (see Recommendations 1.3.8 and 1.3.9).

It was noted that the roles and responsibilities of the Co-Leads requires clarification, in particular the role of the Co-Leads to take the opinion of the MHN forward without bias, and to efficiently Chair meetings ensuring they are focused, generate clear actions, and run to time to ensure efficiency and productivity. It was also noted that these leadership characteristics are needed at every level of the MHN. This clarification and capture of responsibilities, accountability, reporting, expectations and record keeping requirements has commenced (see Recommendations 1.3 and 3.2).

Feedback received questioned whether the change in governance has affected the EAGs role and subsequently influenced the EAG direction provided to Sub Networks. In addition, the role of the EAG requires clarification, in regards to whether the EAG has approval authority for Sub Network projects or is an advisory group only; this has been reviewed and updated in the EAG TOR (see Recommendation 1.1.1).

The pathway for the EAG to provide this direction, advice and feedback on Sub Network work plans is unclear and requires clarification (see Recommendations 1.1.3 and 1.3.9). For example, Steering Group members questioned whether Sub Network work plans should only include projects that align with the Plan, or whether they should also include other projects aligning to current needs of the mental health sector in Western Australia. This has been clarified in the revised EAG TOR (see Recommendations 1.1.1 and 1.1.4).

Issues regarding EAG representation was also highlighted as a barrier to ensuring projects align with sector requirements, and are progressed efficiently. In particular, it was noted that inconsistent attendance by the designated members results in insufficient decision-making authority by those attending on the designated member's behalf, resulting in inefficiency and delays in project progression. The membership and selection guidelines have been updated in the EAG TOR to address this issue (see Recommendation 1.1.5).

It was noted by key stakeholders that the Sub Network structure appears to be robust and has a strong footprint in the mental health sector. Opinions were divided amongst executive respondents regarding the question of devolving some Sub Networks and utilising fixed term working groups, however it was noted that working groups are a viable and potential option for specific projects with finite time lines. Key stakeholders also recognised that individual Sub Networks may enter a period of abeyance, and during these periods meet only bi-annually or as required, should they be called upon for advice. The Sub Network TOR are currently being revised to reflect this feedback (see Recommendation 1.2) and a plan is being developed outlining the processes for establishing time-limited working groups (see Recommendation 1.5).

It was suggested that a facilitated session for re-assessing goals and work plans could re-focus/reinvigorate the Sub Networks. These workshops, facilitated by Professor Fran Ackermann, are currently in progress (see Recommendation 1.6).

Feedback was received from the Steering Group members regarding the need for their role and function to be further defined and clarified at the Steering Group level, with direction to be provided by the EAG and Co-Leads. There was also significant feedback that more clarity and consistency with regards to project proposals and work plans will enhance efficiency, lead to better outcomes and restore the Steering Groups' confidence in the EAG. To address this, the EAG should provide clear, timely feedback/direction to Co-Leads regarding submitted work, which the Co-Leads will convey to the Sub Network Co-Chairs in a timely manner. This clarification and definition of Sub Network roles and responsibilities, in addition to the feedback process, are presently being addressed (see Recommendations 1.3.3 – 1.3.5, and 1.3.7 – 1.3.9).

It was also noted that individual Steering Group members have limited capacity and to mitigate the risk of burn out, expectations regarding output need to be realistic and cognisant of sustainability. In addition some Sub Network Co-Chairs reported that they feel they carry an unsustainable proportion of the workload of the Sub Network. This feedback is currently being addressed in the revision of the Sub Network TOR (see Recommendations 1.3.3 – 1.3.5) and will be further supported through provision of an orientation, professional development, training and support mechanism for each role (see Recommendations 2.1 – 2.3).

Ongoing promotional work is required to ensure the MHC and other key stakeholders in the Western Australian mental health sector understand the remit of the MHN. This increased understanding will allow them to effectively tap into the MHN as a resource and utilise its expert advice, most notably connecting with the Sub Networks for advice and feedback on topic-specific projects. This has been ear-marked to align with the release of this MHN Review (see Recommendation 4.3).

Feedback confirms that the MHN needs 'champions' or leaders, passionate and vocal members who can influence decision-making bodies (including the MHC, WAPHA and the DoH), and subsequently influence policy, whilst also ensuring that the consumer, family and carer voice is heard. In addition there is a need to ensure appropriate EAG representation, and management of conflicts of interest. This is being addressed in the development of role statements (see Recommendations 1.3.1 – 1.3.4); the revised EAG TOR (see Recommendation 1.1.5); and the Sub Network TOR currently under review (see Recommendation 1.2.2).

The question of whether there should be further advocacy representation on the EAG to ensure the diverse interests of mental health consumer, family and carers in Western Australia are represented remains. This representation would increase lived experience awareness of the MHN, therefore increasing membership and the possibility of significant lived experience contribution. This has been addressed in the revised EAG TOR (see Recommendation 1.1.5).

The Interim Report captures the requirement of the MHN to have provision for, and development of, leadership and collaboration skills. It notes that leadership consists of having the right people at the table (addressing co-production), designing meetings that are worthwhile and engaging (measures of success), setting realistic expectations, and ensuring good project management. This leadership should promote effective behaviours: the ability to work successfully with people from diverse backgrounds; build relationships to generate consensus (addressing *communities of practice*); and ensure transparency and inclusivity. This is being addressed in revision of the membership of both EAG and Steering Groups (see Recommendations 1.1.5 and 1.2.2) and development of role statements (see Recommendations 1.3.1 – 1.3.6).

The need to develop communication processes to ensure the MHC effectively utilises the Sub Networks to inform policy development, including requesting expert feedback on specific projects, was noted. Communication strategies to address this feedback have been identified (see Recommendations 4.3 and 4.4).

It was recognised there is a need for the MHN to foster strong engagement and collaboration with key stakeholders across rural and remote Western Australia, in order to be cognisant of, and responsive to, statewide mental health issues. This has been addressed in the revised EAG TOR (see Recommendation 1.1.5) and is currently being revised in the Sub Network TOR (see Recommendation 1.2.2).

Theme Three: Communications and processes

It is clear from feedback that effective mechanisms need to be implemented for improving communication between the EAG and Sub Networks.

Further observations associated with this theme as relating to specific aspects of the MHN are provided below:

a. Communication between MHC, EAG and Sub Networks

A possible disconnect between the EAG and Sub Networks has resulted in a lack of knowledge of the EAG's agenda and expectations, and therefore feelings of segregation exist between the Sub Networks and the EAG. There is confusion surrounding Sub Network work plan submissions and project proposal approval processes, and there is a need for regular coordinated and consistent messaging and communication from MHN to Steering Groups and Sub Network members, as well as information-sharing between Sub Networks. Strategies to improve the communications between these entities are currently being developed and implemented (see Recommendations 1.3.9, 3.1, 4.2, and 4.5).

b. Efficiency (including timeframes)

A lapse of time in communication between MHN and new members from open meetings to next piece of correspondence was noted. Feedback also included that at times Steering Group meetings do not reach quorum, and therefore no valid decisions can be made.
The quorum issue is currently being addressed in the revision of the Sub Network TOR (see Recommendations 1.2.2) and the lapse in communication has been rectified by the establishment of the bi-monthly MHN newsletters (see Recommendation 4.2).

c. Inclusion

Some Sub Network Co-Chairs expressed feelings of segregation from the EAG due to lack of communication pathways between the entities and perceived lack of shared purpose. Including the Sub Network Co-Chairs in EAG meetings may bridge the communication gap and reduce these feelings, and allow Sub Network work plans and project proposals to be considered and progressed in a timely manner. The Co-Leads have instigated this process (see Recommendation 3.1).

There was also a suggestion to explore the option of having a revolving attendance of Sub Network Co-Chairs at the bi-monthly EAG meetings to improve communication and understanding of roles. This process is underway (see Recommendation 3.1).

In addition, it has been recognised that the Sub Network Co-Chairs need to be inclusive and encourage all Steering Group members to contribute in meetings and be particularly cognisant of eliciting the consumer, family and carer voice. For this to occur, and to ensure they can perform their role effectively, a role statement is under development, and current and future Sub Network Co-Chairs will be provided orientation and professional development opportunities in early 2019 (see Recommendations 1.3.3 and 2.1).

There is also a concurrent need for Steering Group members and consumer, family and carer advocacy representatives to be offered training opportunities to aid transition into the role and build confidence. These development opportunities are planned for early 2019 (see Recommendations 2.2 and 2.3).

The findings of the Interim Report support this theme. To address internal communications processes, the following has been actioned: update work plan template for the EAG and Sub Networks; development of a project proposal template for the EAG and Sub Networks; and establishment of a project development and review process comprising guidelines and a project pathway (see Recommendations 1.3.7 – 1.3.9).

Theme Four: Resourcing and support

Increased resourcing and support are identified as requirements to support the Sub Networks achieve their aims and objectives, as outlined in their current Terms of Reference. Clarity is needed around the role of the Sub Network, whether they are working groups or advisory groups. It is a recommendation of this Review that the aims, objectives and role of Sub Networks be updated, ensuring their 'advisory role' is captured and references to a 'working group' (and policy development) role is removed. The Co-Leads commenced this revision in September 2018 (see Recommendation 1.2.1).

There is a strong perception among the Steering Group members that the MHN is under resourced. It was noted that networks are a key driver of Health policy and therefore need to be resourced accordingly. It was frequently stated that it is unrealistic to expect system wide changes without resourcing and that relying on in-kind support is not sustainable. It was suggested that funding be allocated for a Project Officer/Policy Officer to work across the Sub Networks, as some Steering Group members have little time to commit to Sub Network projects on top of full time workloads. Given that the Sub Network Sponsors are responsible for providing the support, it has been recognised that the current Service Agreements require review to ensure the level of support is clarified and is consistent across the different Sub Networks. The Co-Leads are currently undertaking this review (see Recommendation 1.3.10).

The review also indicates that a commitment is needed by Steering Group members and Sub Network Co-Chairs to effectively make use of member volunteers with relevant skillsets – some respondents indicated their relevant skillsets are being underutilised despite identified need. Whilst on the one hand Sub Network Co-Chairs carry a heavy workload in relation to the Steering Groups, it is notable that the majority of Steering Group members have indicated they have extra capacity to contribute to the work of their Sub Network. Discussion and planning at a Steering Group level needs to be cognisant of these findings. It is also unclear whether the Steering Group members received any training or induction upon commencement. To address this feedback, role statements are currently being developed and orientation and professional development opportunities are planned for early 2019 (see Recommendations 1.3.3, 1.3.4, 2.1 – 2.3).

It was regularly noted that low attendances and in many instances a lack of quorum at Steering Group meetings was affecting the Steering Groups capacity and ability to achieve its aims. The meeting quorum and proxy terms are currently being reviewed in the Sub Network TOR (see Recommendation 1.2.2).

The role and function of the MHC Sub Network Liaison Representatives requires further clarification to ensure realistic expectations, and review of this position is underway (see Recommendation 1.3.6).

The Interim Report also identifies that the members' perception of the MHN needs to be managed; that a key consideration is the 'buy in' of members to being part of the MHN and to any agreements actioned. This is being addressed in the revised Sub Network TOR (see Recommendations 1.2.1 and 1.2.2). The need for succession planning was also noted, which will be captured in the development of role statements (see Recommendations 1.3.3 – 1.3.5).

Theme Five: Opportunity to influence and showcasing successes

It was noted that it is difficult to measure the success and achievements of a Network as they are often intangible. Greater emphasis needs to be placed on recognising these intangible impacts, and celebrating the outcomes and benefits of the work of the MHN.

In addition it was recognised that all achievements need to be clearly acknowledged and communicated internally and to the broader mental health sector, in order to promote the work of the MHN to key stakeholders to drive increased engagement and possible investment.

To address these concerns, the MHN instigated publication of a bi-monthly newsletter in April 2018. These newsletters are sent to the MHN membership base sharing key learnings, project updates and celebrating achievements. Separate mail-outs are also periodically disseminated sharing key sector updates, consultations and events (see Recommendation 4.2).

Furthermore ongoing promotional work and information sharing is required to ensure the MHC and other key stakeholders in the Western Australian mental health sector understand the remit of the MHN. This improved understanding will drive increased engagement and allow MHC staff and key stakeholders to effectively tap into the MHN as a resource and utilise its expert advice, most notably connecting with the Sub Networks for advice and feedback on topic-specific projects. Communication strategies to increase this understanding have been identified and include the MHN hosting information sessions for the MHC on MHN function, including questions and answers (Q&A) and the development of frequently asked questions (FAQs). These sessions have been ear-marked to align with the release of this MHN Review (see Recommendation 4.3).

The Interim Report articulates the importance of not only recognising and celebrating, but evaluating and monitoring the performance of the MHN, including both tangible and intangible successes. To measure the MHNs performance an effective evaluation framework will be developed (see Recommendation 5.1).

In addition, a range of measures to identify and monitor tangible success were suggested in the Interim Report, and include monitoring the frequency of engaging with NGOs and monitoring the number and frequency of MHN members attending meetings. To identify and monitor intangible successes the Interim Report suggests undertaking surveys to elicit qualitative measures on member's satisfaction with the MHN. Different mechanisms to

identify and monitor these successes will be explored and developed (see Recommendations 5.2 and 5.3).

Whilst the Co-Leads and Sub Network Co-Chairs provide leadership and visibility, it is recognised that champions or leaders, at all levels, within health service providers and the mental health sector are required to advocate and promote the work of the MHN within their organisations and unique contexts. To address this, Sub Network Co-Chairs will be approached to identify these champions or leaders (see Recommendations 4.6).

The Interim Report notes this need for champions or leaders to drive influence is also supported by feedback received from the Steering Group members, where it was indicated that a perceived lack of influence is impacting on their morale and sense of purpose. Lack of evidence regarding the usefulness of work developed has led many Steering Group members to question the usefulness of their contributions and their ongoing commitment. This is particularly pertinent, given the majority of Steering Group members are providing their time on top of existing full time work loads. To encourage this investment and potential influence, the MHN aims to meet with MHC executives for information sharing and decision-making in regards to Sub Network work plans, in addition to discussing alignment of Sub Network allocation with MHC Liaison Representatives' current portfolios (see Recommendation 4.4). Celebrating MHN achievements will also reinforce the important role the Steering Group members play in contributing to mental health reform in Western Australia, and is underway via bi-monthly newsletters (see Recommendation 4.2).

The Interim Report also identifies that the MHN should aim to attract members that can potentially be patrons, sponsors and champions. The Interim Report recognises the need to ensure involvement of the wider community, stating that diversity in collaborative teams is an effective way of approaching complex problems. It suggests that broad representation should include different expertise areas beyond mental health, such as housing, corrections and disability. It is also noted that the Steering Group membership should be fluid to reflect the prioritised project areas. This is currently being addressed in revision of the membership of both EAG and Steering Groups (see Recommendations 1.1.5 and 1.2.2).

7. **Recommendations**

The following recommendations are made based on the review of the MHN; the majority of these recommendations are in progress.

Recommendation and related action	Theme/s addressed	Responsibility	Timeframe
1. Clarification and definition of each MHN entity			
1.1 Update EAG TOR, including the following:	Themes One, Two and Three	Co-Leads, MHC and EAG members	Feb 2019
1.1.1 Reflect the change in governance and lines of accountability, following the move to MHC from DoH.	Themes One, Two and Three	Co-Leads in consultation with EAG members	Feb 2019
1.1.2 Capture and define the independence of the MHN and its domains, to ensure it is clear and there is a common understanding.	Theme Two	Co-Leads in consultation with MHC	Feb 2019
1.1.3 Include linkage between EAG and Sub Networks.	Themes One, Two and Three	Co-Leads in consultation with EAG members	Feb 2019
1.1.4 Update the aims, objectives and role and include a Mission statement that explicitly states the direction and alignment of the MHN with the Plan, and other sector needs if appropriate.	Themes One, Two and Three	Co-Leads in consultation with EAG members	Feb 2019

1.1.5 Update membership and selection guidelines, to ensure they are fit for purpose for the updated aims and objectives, including rural, remote and lived-experience representation. The Assistant Commissioner is to be the MHC's representative.	Themes One, Two and Three	Co-Leads in consultation with EAG members	Feb 2019
1.2 Update Sub Network Steering Group TOR, including the following:	Themes One, Two and Three	Co-Leads, MHC and Sub Network Co-Chairs	April 2019
1.2.1 Update aims, objectives and role; ensuring their 'advisory role' is captured, and remove references to a 'working group' (and/or policy development) role.	Themes One, Two and Three	Co-Leads and MHC in consultation with the Sub Network Co-Chairs	April 2019
1.2.2 Update the membership, selection guidelines, recruitment, succession, and meeting quorum and proxy terms, to facilitate member participation and viability of the Sub Networks; in addition outline protocols for when Sub Networks enter a period of abeyance.	Themes One, Two and Three	Co-Leads in consultation with MHC	April 2019
1.3 Clarify and capture responsibilities, accountability, reporting, expectations, and record keeping requirements (where appropriate) – these are to be included as Addendums to the relevant TOR and communicated via the MHN webpage for transparency and education	Themes One, Two, Three and Four	MHC, Co-Leads, EAG Members, Sub Network Co-Chairs and Sponsors	Various

1.3.1	Develop role statement for EAG members, including selection guidelines and guidelines for managing conflicts of interest.	Themes One, Two and Three	MHC and Co-Leads in consultation with EAG members	Completed
1.3.2	Update role statement for Co-Leads, including selection guidelines, shared responsibility processes, guidelines for managing conflicts of interest, and encouraging and capturing all voices.	Themes One, Two and Three	MHC and Co-Leads	April 2019
1.3.3	Update role statement for Sub Network Co-Chairs, including selection guidelines, shared responsibility processes, guidelines for managing conflicts of interest, and encouraging and capturing all voices.	Themes One, Two and Three	MHC and Co-Leads in consultation with Sub Network Co-Chairs	April 2019
1.3.4	Develop role statement for Steering Group members, including selection guidelines and guidelines for managing conflicts of interest.	Themes One, Two and Three	MHC and Co-Leads in consultation with Sub Network Co-Chairs	April 2019
1.3.5	Develop role statement for Consumer, family and carer representatives.	Themes One, Two and Three	MHC and Co-Leads in consultation with Sub Network Co-Chairs	Completed

1.3.6	Update role statement for MHC Liaison Representatives.	Themes One, Two and Three	MHC and Co-Leads in consultation with Sub Network Co-Chairs	April 2019
1.3.7	Develop a project development and review process comprising guidelines and a project pathway (see example at Appendix 4).	Themes Two and Three	Co-Leads in consultation with Sub Network Co-Chairs	June 2019
1.3.8	Update the work plan template for the EAG and Sub Networks.	Themes Two and Three	Co-Leads in consultation with Sub Network Co-Chairs	June 2019
1.3.9	Develop a project proposal template for the EAG and Sub Networks.	Themes Two and Three	Co-Leads in consultation with Sub Network Co-Chairs	April 2019
1.3.10	Review and update the Sponsors Service Agreement to ensure clarity and consistency.	Theme Four	Co-Leads in consultation with Sponsors	April 2019

1.4 Implement strategies, such as a targeted communication plan to engage with non-government organisations, to expand membership to include rural and remote key stakeholders in order to be cognisant of, and responsive to, statewide mental health issues.	Themes One, Two and Three	Co-Leads in consultation with MHC	June 2019
1.5 Develop a plan outlining the processes for establishing time-limited working groups as a potential option for specific projects with finite time lines. If a working group is required the following is to be considered: ▪ How a working group will be identified as being needed; ▪ How the working group will be established; ▪ The resourcing and support that will be provided; and ▪ Time-limited function of the group.	Theme Two	Co-Leads in consultation with MHC	June 2019
1.6 Facilitate EAG and Sub Network sessions for re-assessing goals and work plans	Themes Two	Co-Leads and external workshop Facilitator	In progress
2. Orientation, professional development, training and support mechanisms			
2.1 Sub Network Co-Chairs Provide orientation and professional development, including opportunities to utilise the skill sets of EAG and Steering Group members, to ensure these roles are supported effectively.	Themes One, Three, Four, and Five	MHC in consultation with Co-Leads and Sub Network Co-Chairs	June 2019

2.2 Steering Group members Provide orientation and training opportunities for new Steering Group members to aid transition into the role and build confidence.	Themes Two, Three and Four	MHC in consultation with Co-Leads and Sub Network Co-Chairs	June 2019
2.3 Consumer, family and carer advocacy representatives Provide orientation and implement appropriate support mechanisms, including facilitating mutual support opportunities.	Themes One and Four	MHC and Community Co-Lead	June 2019
2.4 Develop guidelines to increase capacity of Sub Network Steering Groups for key projects, utilising: ▪ Students, where appropriate; and ▪ Broader membership base.	Theme Four	Sub Network Co-Chairs	Ongoing
3. Meeting structures and record keeping **The following will increase efficiency, transparency and ensure shared understandings across each MHN entity:**			
3.1 Invite Sub Network Co-Chairs to EAG meetings to present work plans and subsequent project proposals; explore the option of having a revolving attendance of Sub Network Co-Chairs at EAG meetings which may help to improve communication and understanding of roles.	Themes One and Three	Co-Leads in consultation with MHC	Underway
3.2 Include time allocations into all agendas.	Theme Three	MHC and Sub Network Sponsors	Completed
3.3 All meeting minutes and actions are to be documented and stored in TRIM (document management system).	Themes Two and Three	MHC	Completed

3.4 Propose the use of GovTEAMS file sharing system for projects.	Themes Two and Three	MHC and Sub Network Sponsors	Ongoing
4. Communications **Develop a MHN Communication Plan to improve communication between the EAG and Sub Networks, and ensure coordinated and consistent messaging. Include communication strategies to engage with internal and external key stakeholders to drive increased engagement, and ensure the MHN membership base is utilised during consultation processes. Some strategies include:**			
4.1 MHN to develop its own branding and logo, to promote its independence.	Themes One, Three and Five	MHC in consultation with Co-Leads	Completed
4.2 Publish monthly or bi-monthly newsletters to all MHN members to share key learning and project updates and celebrate achievements; need to reinforce MHC commitment to, and investment in MHN within first months of publication.	Themes One, Three and Five	MHC in consultation with Co-Leads	Ongoing
4.3 Extend MHC staff knowledge and understanding of MHN function and Sub Network expertise by holding information sessions (include Q&A) and develop FAQs, ensuring the opportunities to engage and consult with the broad MHN membership base are explicitly captured. The FAQs will be suitable for dissemination by MHC to key stakeholders to broaden sector knowledge of the MHN and its functions.	Themes One, Three, Four and Five	MHC in consultation with Co-Leads	June 2019

4.4 Invite MHC executives to MHC Liaison meetings for information sharing and decision-making to: ▪ Discuss Sub Network work plans and EAG-approved project; proposals, and what level of support can be provided by the MHC Liaison Representatives; and ▪ Discuss alignment of Sub Network allocation with MHC Liaison Representatives' current portfolios.	Themes Three and Four	MHC	April 2019
4.5 Implement information sharing strategies to improve communication between the EAG and Sub Networks, and ensure coordinated and consistent messaging. Strategies include: ▪ Sharing EAG minutes with each Sub Network; ▪ Sharing status updates and achievements between the Sub Networks; and ▪ Bi-monthly newsletters to MHN members and key stakeholders.	Themes One, Three and Five	MHC and Sub Network Sponsors	June 2019
4.6 Liaise with Sub Network Co-Chairs to identify champions or leaders at all levels, within health service providers and the mental health sector, to advocate and promote the work of the MHN within their organisations and unique contexts.	Themes Two, Three, Four and Five	MHC in consultation with Co-Leads	June 2019
4.7 Develop guidelines for managing external communications via the MHN mailbox.	Theme Three	MHC	March 2019
5. Monitoring and evaluation			
5.1 Develop an effective evaluation framework to monitor the MHN's work.	Theme Five	MHC in consultation with Co-Leads	June 2019

5.2 Develop a range of measures, such as tracking spreadsheets, to identify and monitor tangible measures of success: ▪ Monitoring the frequency of engaging with an NGO; and ▪ Monitoring the number and frequency of MHN members attending meetings.	Theme Five	MHC in consultation with Co-Leads	June 2019
5.3 Identify and monitor intangible measures of success by undertaking surveys to elicit qualitative measures on member's satisfaction with the MHN.	Theme Five	MHC in consultation with Co-Leads	June 2019

8. Implementation and review

The establishment of a committee, comprised of the IGR Team, MHC Liaison Representatives and Co-Leads, to oversee the implementation of the above recommendations is proposed. In addition, the MHC will work with key stakeholders to discuss the findings of the Review and how stakeholders can work together to ensure the recommendations are implemented in a timely manner. Progress updates on the Reviews' recommendations will be provided on the MHN webpage, in addition to the MHN seeking feedback from external stakeholders on a regular basis to ensure the MHN is functioning effectively.

The 'Collaborating in Mental Health – Designing effective strategic support for the sub-networks' (Academic review) is currently being conducted by the MHN Clinical Co-Lead Dr McGowan and Professor Fran Ackermann, Curtin University. The Interim Report is one of the deliverables of the Academic review, and was completed at end-August 2018 with its key findings aligning with the themes identified in the MHN Review, whilst also highlighting further reforms to be considered to support the work of the MHN. These further reforms have been captured in the Review recommendations. The completed Academic review is anticipated to be released in early 2019.

It is recommended that the MHN be reviewed by the MHC every three years to ensure MHN best practice, the next review to commence 2020-21.This review would occur via consultation with MHN members, EAG and Sub Network members, and key stakeholders.

9. Conclusion

The MHN has been operating for four years in alignment with its stated objectives. It has achieved some success to date, including the development of service delivery documents, establishment of state-wide mental health groups, and submissions to both state and commonwealth governments.

Following the MHN's change in governance in 2017, the MHC commenced a Review of the MHN, to examine its current structure and functions, governance and communications processes. The Review also sought to identify ways to optimise the role of the MHN and its overarching goal to support collaboration, reform and innovation across the mental health sector.

The Review recommends a number of changes to the MHN that will enhance its capacity to meet its aims and objectives. It is vital that consideration be given to ensuring consumer, family and carer representatives are equal stakeholders at all levels within the MHN. It is clear that greater clarity is needed regarding the MHN's remit. Roles and responsibilities and communication pathways at all levels, require greater definition. Ongoing promotional work and effective communication strategies are needed for the MHN to foster strong engagement and collaboration with key stakeholders in the mental health sector in Western Australia – including in rural and remote regions, where the MHN has a limited footprint.

It is noted that the Steering Group members are highly committed to maintaining their involvement with the Sub Networks. A significant number surveyed (96%), indicated they have the same capacity, or a lot more capacity, to continue to engage with the work of the Sub Network. These findings in particular, bode well for the continuation of the MHN.

The MHC will continue to review and evaluate the MHN moving forward.

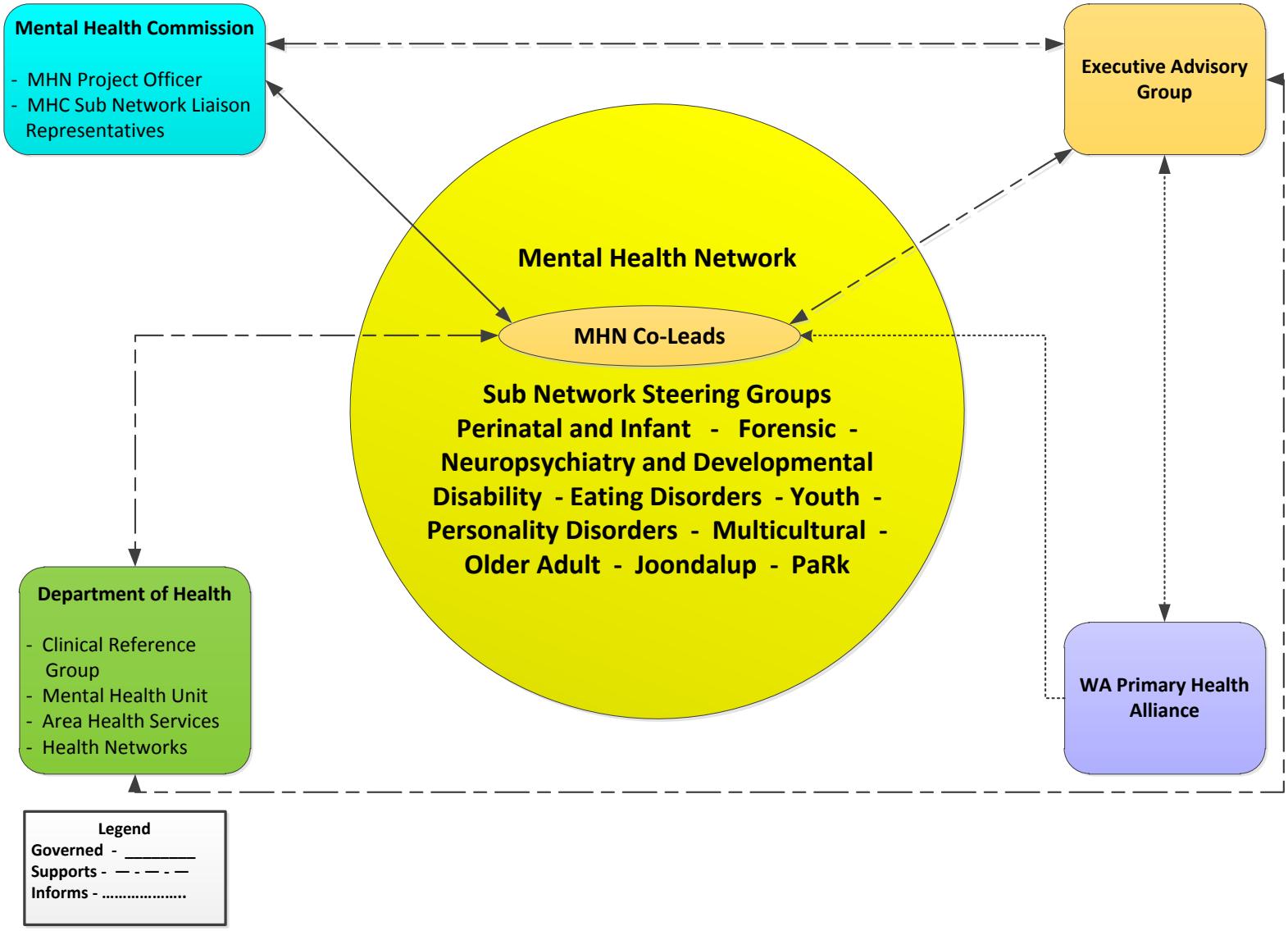
Appendix 1: The Plan service streams and key actions

Summary of service streams and key actions from Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan):

Service stream	Key action
Specialised Statewide Services	54. Established specialised statewide inpatient services for: a. Eating Disorders (24 beds) b. Neuropsychiatry and Neurosciences disorders
	55. Commence establishment or enhance community-based specialised statewide services including: a. Eating disorder services b. Perinatal services c. Neuropsychiatry and Neurosciences d. Attention Deficit Hyperactivity Disorder (ADHD) e. Co-occurring mental illness and intellectual, cognitive or developmental disability (including autism spectrum) service f. Hearing and vision impaired
	56. Commence planning of community-based specialised statewide services including: a. Sexuality, Sex and Gender Diversity service b. Children in Care program c. Transcultural services d. Homelessness program
Forensic Services	58. Research an evidence-base and establish forensic focused prevention programs which reduce the risk of individuals coming into contact with the criminal justice system
	63. Work with the Department of Corrective Services to develop models of service for in-prison treatment and support services and move service purchasing responsibility to the Mental Health Commission
Recovery-Oriented Practice	67. Investigate international best practice recovery culture change programs

	68. Incorporate recovery principles in the design of service models and associated practices, procedures, protocols, and commissioning practices
	69. Explore how the concept of recovery applies to the alcohol and other drug sector and how the principles of recovery-oriented practice can be embedded in service delivery where appropriate
Cultural and Social Diversity	79. Incorporate culturally competent principles in the design of service models and associated practices, procedures, protocols, and commissioning practices
System Integration and Navigation	80. Require commissioned services to develop coordination and communication strategies to ensure relevant services are integrated and people are supported to transition effectively between services, programs and regions. This may include: a. The establishment of integration, coordination and transition initiatives and policies such as the reciprocal transfer of staff between services b. The establishment of protocols for informing consumers, carers, families and GPs (throughout treatment and upon discharge) as to treatment plans and how to re-access services if required c. The development of communication and information flow protocols for accessing patient records and treatment plans, other communication and reporting between non-government organisations, public sector, and private sector, and across community, primary, secondary and tertiary services
	83. Together with key stakeholders, develop comprehensive models of service for all major service streams (including mechanisms for monitoring and reviewing) and commence commissioning of services based on agreed models of service
	85. Progress the expansion of the peer workforce across the service spectrum
Research and Evaluation	86. In collaboration with key stakeholders, identify research priorities and allocate resources according to identified priorities

Appendix 2: Accountability and Reporting Structure



Appendix 3: Survey Questions

Survey A - Steering Group members

1. Which Mental Health Network Steering Group are you a member of?
2. Is your affiliation with the Mental Health Network through (tick all applicable): Options: *Department of Health Employee; Mental Health Commission Employee; Non-Government Organisation; Lived Experience; Other.*
3. What have been the key outcomes/achievements of your Sub Network?
4. Please provide a brief description of any key outcomes/achievements of your Sub Network.
5. If resourcing of the Sub Network was not a constraint what would you key priorities be?
6. What are the key priorities for the 2017-2018 year?
7. How would you rate the effectiveness of the Sub Network Steering Group to meet its aims and objectives?
8. What do you think would increase the effectiveness of the Sub Network Steering Group? E.g. increased opportunities for sharing information and knowledge, administrative support, project officer support.
9. Does the sponsor of the Sub Network provide (tick all applicable): Options: *Administrative Support; Policy Support; Financial Support; Payment of consumer and carer representatives; Other.*
10. What have been the main challenges for the Sub Network in achieving its aims and objectives?
11. How clearly defined do you think the governance arrangements are in relation to the management of Sub Network project development and prioritisation?
12. If you are unclear on the governance arrangements, please provide details about how this can be improved.
13. Is the optimal mix of skills and knowledge represented in the membership of the Sub Network Steering Group?
14. What additional skillsets/content knowledge areas are required?
15. Is the Sub Network Steering Group adequately resourced to achieve its aims and objectives?
16. What additional support is required?

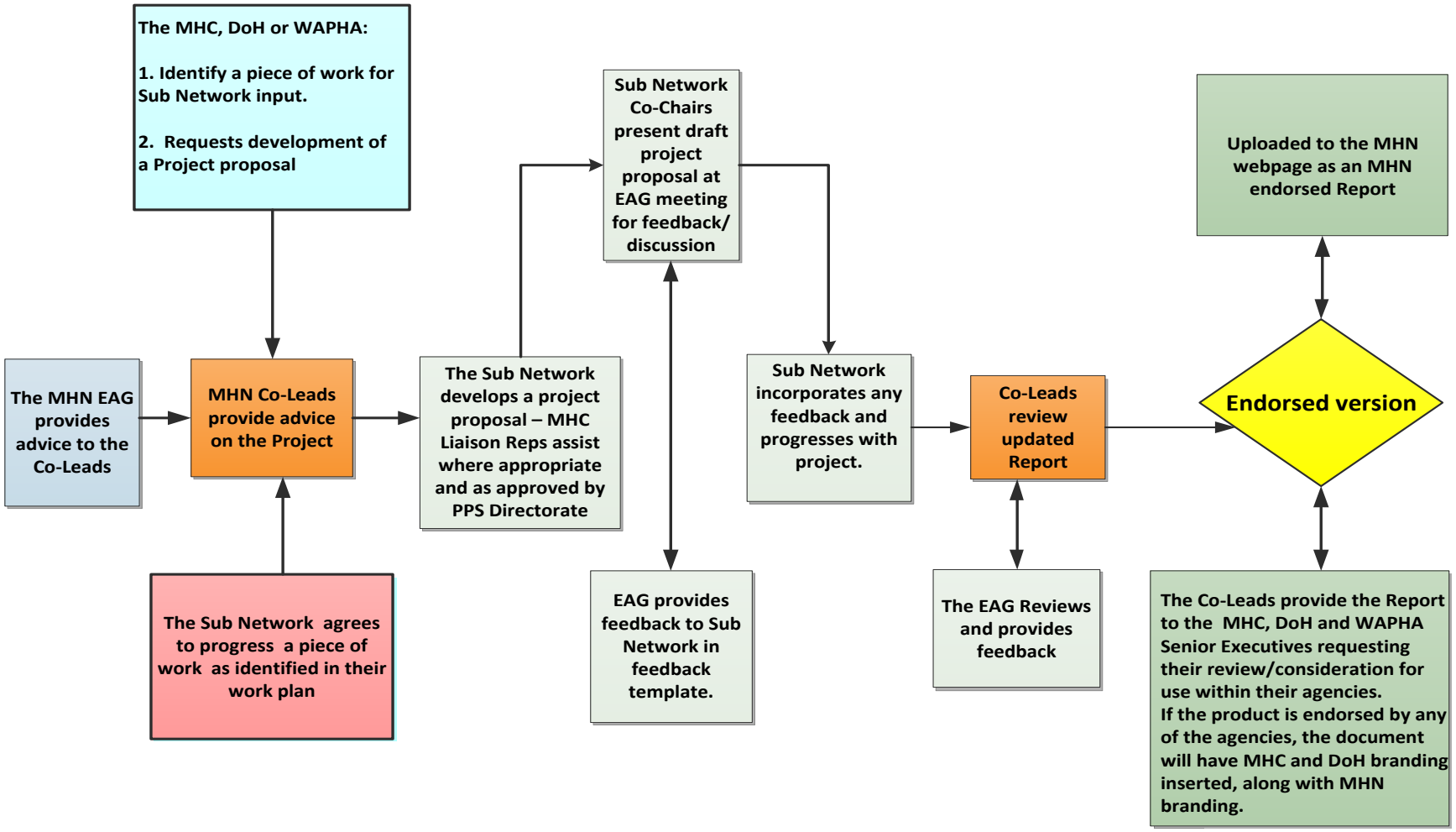
17. Does your Sub Network use the Govdex system for sharing information and documents?
18. If yes, please provide your experience of Govdex.
19. Has your Sub Network submitted work to the Mental Health Network Expert Advisory Group?
20. If yes, please provide feedback regarding this process.
21. On average how many hours per week do you spend on Sub Network business?
22. How committed are you to maintaining involvement with the Sub Network?
23. Given your response to Question 22, what is your capacity to continue to engage with the work of the Sub Network?
24. What are your recommended next steps to support the Sub Network to achieve its aims and objectives?

Survey B – EAG membership, Sub Network Sponsors and targeted executive stakeholders

1. Is your affiliation with the Mental Health Network through (please tick all): Options: *East Metropolitan Health Service; South Metropolitan Health Service; North Metropolitan Health Service; Western Australian Country Health Service; Department of Health – Health Networks Branch; Executive Advisory Group; Department of Health – Mental Health Unit; Other.*
2. Is your organisation a sponsor of a Sub Network?
3. If yes, please select from the below, the Sub Network your organisation sponsors and the types of support provided (tick applicable): Options: *Policy Support; Administrative Support; Financial Support; Consumer and Carer Payments; Other Support.*
4. Do you think the process for establishing Sub Networks i.e. open meetings, is an efficient and effective model?
5. Do you have any suggestions for improving the process for establishing Sub Networks?
6. Does the Sub Network model support the aims and objectives of the Mental Health Network?
7. If you answered No to question 6, please provide comment regarding what you think could be put in place to better support the aims and objectives of the Mental Health Network.

8. Is the Sub Network model an effective way of focussing on the care needs of a particular part of the mental health sector?
9. If you answered No to question 8, please provide feedback on what you think would be a more effective way of focussing on the care needs of a particular part of the mental health sector.
10. How can the Sub Networks operate more efficiently?
11. Should some Sub Networks be devolved or meet less frequently to address specific issues raised by stakeholders?
12. Would other structures and processes more effectively support service reform – e.g. fixed working groups established to advise key stakeholders on specific issues?
13. If you answered yes to question 12, please provide feedback on other structures and processes that you think may support service reform more effectively.
14. What is your role in the oversight of Mental Health Network projects?
15. What strategies do you think would improve the governance of Mental Health Network projects?
16. If you are a member of the Mental Health Network Executive Advisory Group, what in your opinion, are the key roles and responsibilities of the Executive Advisory Group?
17. In your opinion, what have been the main challenges for the Mental Health Network in achieving its aims and objectives?
18. In your opinion, what have been the key outcomes/achievements of the Mental Health Network?
19. How would you rate the effectiveness of the Mental Health Network to achieve its aims and objectives?
20. What do you think would increase the effectiveness of the Mental Health Network?
21. Is the Mental Health Network adequately resourced to achieve its aims and objectives?
22. What are your recommended next steps/actions to support the aims and objectives of the Mental Health Network?

Appendix 4: Example of pathway process for Mental Health Network project proposals



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Mental Health Commission