What is an Implementation Co-Evaluation? A Snapshot on the Framework and its application in Medicare Mental Health Centres

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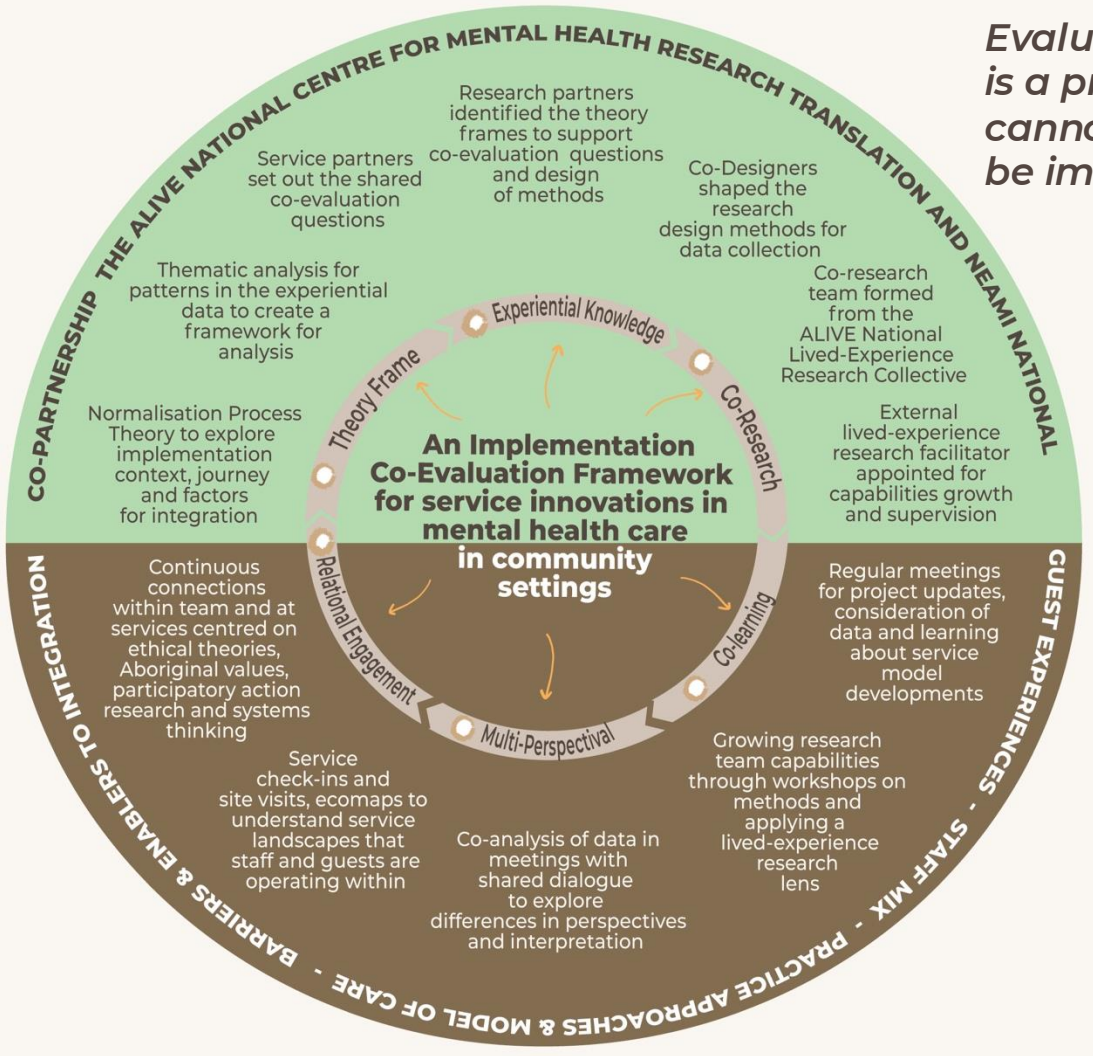

Evaluation/measurement of existing quality is a prerequisite for its improvement: what cannot be evaluated and measured cannot be improved." [1]

Co-Designers shared that the co-evaluation should ask about – waiting times, how accessible the service was (physical space, flexibility, appointments), how comfortable people felt, suggestions for Improvements, follow up and how connected people felt after sessions and would they come back, if this was the first time attending a Head to Health service, how is the guest getting on with the service and the team, the overall experience.

Image caption: The iterative design and development of an Implementation Co-Evaluation Framework.

What is an Implementation Co-Evaluation?

- An implementation co-evaluation is a collaborative exploration of how service innovations and new models of mental health care are being implemented.
- The co-evaluation means that work is conducted as a co-partnership between service-research organisations with a view to understanding the ecosystems of service settings.
- Co-evaluations have a commitment to co-learning and the involvement of multiple groups with vested interests.
- Co-evaluations are iterative and continuous throughout implementation.
- A co-evaluation seeks to elevate experiential knowledge by designing with experiential knowledge at the heart. Therefore lived-experience researchers play a critical role in framing and undertaking the research with embedded co-research essential.

Read more about the Implementation Co-Evaluation at the ALIVE National Centre Website:
https://alivenetwork.com.au/our-projects/head-to-health-implementation-co-evaluation/
This co-partnership was conducted during 2023 when sites were named Head to Health and in May 2024 the Federal Government renamed them Medicare Mental Health Centres.

Initial government goals of the new service models for co-evaluation focus

ACCESSIBILITY High visibility, extended hours; fee free, without referrals or appointments, immediate responses to significant distress and suicidality, an alternative to Emergency Departments.

REDUCED BURDEN front of house care and information sharing, a central point for assessment, needs-based service navigation, access to short and medium psychological therapies.

PERSON CENTRED improve wellbeing through episode of care model, trained peer workers; adequate supervision, student placement opportunities, interdisciplinary care, and strengths-based innovation.

The cycle of lived-experience research knowledge generation and translation

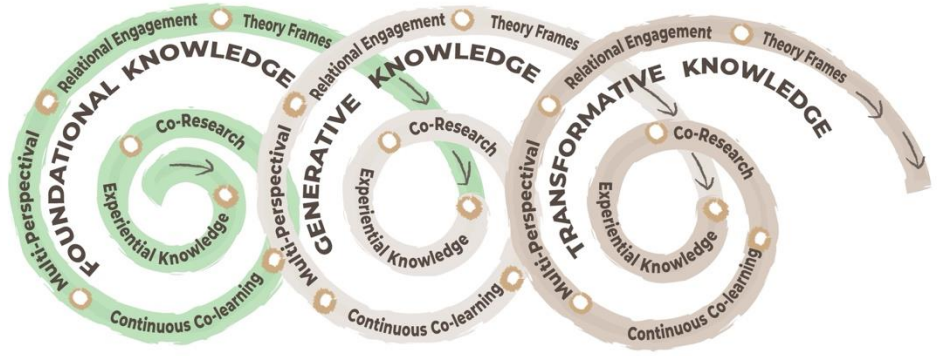

Figure 2: Cycle of Lived-Experience Research Knowledge Translation

The Co-Evaluation Framework and conduct can be understood through cycles of lived-experience research knowledge translation. For this, foundational experiential knowledge is the basis for methods to enable generative knowledge about guest and staff experiences to form within co-research teams and for co-analysis to produce transformative knowledge for integration and implementation.

What mattered for people living with mental ill-health and distress

Matching– requesting preferred researcher/s
Flexibility– time, place, a survey or an interview
Frequency– ask regularly not as a one off
Choice– choose to write response or use a scale
Respectful Engagement– careful and over time

"Most important is it happens wherever and whenever the person prefers, and this is flexible each time." (Co-Designer Principles).

Implementation Strategies to increase Co-Evaluation Frameworks in services

IMPLEMENTATION GAP 1 –There can be a narrow understanding of how to evaluate new service innovations and models of care.

IMPLEMENTATION GAP 2 – Data collected for evaluations can focus on service performance metrics and overlook experiential data. The YES survey is limited for improvements in new innovations and models of care.

IMPLEMENTATION GAP 3 - Few frameworks exist to guide the design, development and application of co-evaluations between service-research partners and wider communities.

INDIVIDUAL LEVERS: Standard data collection approaches do not always share what matters most for those most impacted.

ORGANISATIONAL LEVERS: A rethinking of what routine data is collected at service and government level is needed. Early co-evaluations mean that relevant implementation factors can be identified for future embedding.

COMMUNITY LEVERS: greater awareness of new co-evaluation frameworks will guide co-learning and implementation across multiple levels of community sectors and settings.

[1] Samartzis & Talias. 2020. Assessing and improving the quality in mental health. *Int. J. Environ. Res. Public Health* 17(1): 249.

Ethics approvals were obtained from: University of Melbourne Human Ethics Sub-Committee (ID 26525); Human Research Ethics Committee of NT Health and Menzies School of Health Research (NT HREC: ID 2023-4624); AH&MRC Ethics (ID 2133/23); Aboriginal Health Research Ethics Committee (ID 04-22-1066); NEAMI Research and Evaluation Committee.