Received: 5 April 2023 | Revised: 6 September 2023 | Accepted: 18 September 2023

DOI: 10.1002/hpja.813

Health Promotion Journal of Australia | Australian Health Promotion Association | WILEY

RESEARCH ARTICLE

Co-development of implementation strategies to assist staff of a mental health community managed organisation provide preventive care for health behaviours

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Funding information
The Australian Prevention Partnership Centre, Grant/Award Number: BP6; University of Newcastle internal higher degree research grant; National Health and Medical Research Council Early Career Fellowship, Grant/Award Number: 1142272

Handling editor: Mark Robinson

Abstract

Issue Addressed: People with a mental health condition are at risk of developing chronic physical disease due to smoking tobacco, inadequate nutrition, high alcohol consumption, low physical activity and poor sleep (SNAPS). Community managed organisations (CMOs) represent an opportune setting to support mental health consumers to improve their health behaviours through providing preventive care. Reporting of methods used to co-develop implementation strategies to assist CMO staff to deliver preventive care for SNAPS are scarce yet warranted.

Objectives: This study aims to: (1) describe a co-development workshop involving CMO staff and researchers to identify preferred implementation support strategies to help staff routinely provide preventive care; (2) describe the strategies that emerged from the workshop; and (3) report staff ratings of the workshop on four co-development principles.

Methods: A three-hour co-development workshop was conducted on two occasions with staff of one CMO in New South Wales, Australia. Twenty staff participated in the workshops.

Results: Participants generated and ranked a total of seven discrete implementation strategies within five categories (training, point of care prompts, guidelines, continuous quality improvement and consumer activation). Training for staff to have difficult conversations about behaviour change was ranked highest in both workshops. Participants rated the workshops positively across four co-development principles.

Conclusions: The co-development workshop enabled implementation strategies to be developed within the context in which they were to be delivered and tested, potentially increasing their feasibility, acceptability, appropriateness and impact.

So What? Implementation strategies selected from the workshops will inform a pilot implementation support trial to assist CMO staff to provide preventive care to people with mental health conditions.

KEYWORDS
co-development, community managed organisation, health behaviours, mental health, nominal group technique, preventive care, staff, workshop

1 | INTRODUCTION

People with a mental health condition have a higher prevalence of risky health behaviours, such as smoking tobacco, having poor nutrition, consuming alcohol at harmful levels, being physically inactive and poor sleep hygiene (SNAPS), contributing to a higher prevalence of chronic diseases compared to people without a mental health condition.[1] Preventive interventions that target multiple behaviours with the aim of reducing the risk of chronic disease for people with mental health conditions are required.[1–3] Research shows this population group are interested to change such behaviours and would like to receive care to do so.[4] The ask-advice-refer (AAR) framework is an evidence-based model of preventive care in health services[5] and is recommended at an international level, and at national and state levels within Australia.[6–8] The AAR framework guides clinicians to 'ask' about engagement in risk behaviours (i.e., screening), provide 'advice' to change, and 'refer' to behaviour change services[9] and has demonstrated effectiveness in behaviour change.[10] Seeking opportunities to integrate preventive care delivery into the service provision of settings which are accessed by people with a mental health condition is a priority.[11]

Community managed organisations (CMOs) are one type of service in the Australian mental health sector identified as an important setting to address the physical health of people with a mental health condition.[12] CMOs deliver recovery-oriented services (e.g., daily living skills, transport, attending health care appointments, employment, education and accommodation and housing) that aim to address holistic needs to improve overall wellbeing.[12] CMOs employ staff from a variety of professional backgrounds, including mental health work and peer work, who have frequent contact with consumers over extended periods of time.[13] Recent evidence demonstrates staff of CMOs recognise both the importance of supporting consumers to improve multiple health behaviours,[14] and that following evidence-based models such as the AAR framework improves the consistency of preventive care delivery.[12,15] However, research investigating the current levels of preventive care in CMOs demonstrate variable levels across behaviours.[15,16] For example, a survey of 268 staff from an Australian CMO reported delivery of preventive care based on the AAR model ranged from: 42% (alcohol) to 57% (smoking) of clients for 'ask'; 36% (alcohol) to 56% (physical activity) of clients for 'advice'; and 17% (smoking) to 30% (physical activity) of clients for 'refer'.[16] These findings suggest preventive care is not being delivered consistently across SNAPS to all consumers, despite the importance of routine and consistent delivery of preventive care in supporting healthy behaviour change. There is a need for implementation support strategies that assist CMO staff to systematically provide preventive care that aligns with evidence-based models such as AAR.

Reviews suggest implementation strategies can increase the delivery of preventive care for health behaviours in mental health settings.[2,3] In a systematic review by Fehily et al.[2] including 20 controlled studies conducted in a variety of mental health settings, including both inpatient and outpatient services, meta-analysis and narrative synthesis indicated that implementation strategies effective for improving at least one element of AAR for at least one risk (categorised according to the Effective Practice and Organisation of Care (EPOC) Taxonomy[17]), were: task shifting (which may include embedding of specialised health care personnel), educational meetings, health information systems, local consensus processes, authority and accountability, and reminders. Although none of the studies in this review occurred in a CMO, it seems likely that findings may also have relevance for this setting. Further indication of implementation strategies that may increase the delivery of preventive care in this setting comes from a rapid review exploring the effectiveness of initiatives specifically in the CMO context, including 29 publications from peer-reviewed and grey literature.[3] Of twelve initiatives demonstrating positive changes (either descriptively or using significance testing) in at least one behaviour, eight included implementation support strategies, most commonly embedding specific practice change support personnel, training and resources and information for providers.

It is recommended that such strategies appropriately align with the setting in which they are being delivered to enhance feasibility, appropriateness, acceptability and potential impact.[18] One approach recognised as valuable to achieving this is the use of co-development with key stakeholders. Co-development has been a long-established, essential process in health promotion practice broadly. It considers the right of key stakeholders to participate in designing improvements to services aligned with their needs, and as such are more likely to be both well received by end-users and taken up into practice.[3,19] Regarding co-development methodology in research, it can occur through various methods of engagement (also referred to as 'collaboration techniques[20]'), including surveys, key informant interviews or focus groups to provide feedback, and forums, or workshops.[21] It has been recommended that researchers publish more explicit accounts of end-user involvement in co-development processes, including methods for achieving this contribution as well as participant reflection and/or perceptions of involvement.[20] This may aid knowledge translation and evaluation of co-development methods (particularly from the end-user perspective), assist with replication and understanding the experience of end-users and encourage methodological innovation and critical appraisal in the field.[22] Although there is varying terminology throughout the literature (e.g., co-development, co-design, co-creation, co-production),[20] 'co-development' is used here to refer to the activity of involving end-users (i.e., CMO staff) of the implementation support strategies to develop such strategies.

Despite the need, reporting of co-development in implementation trials that aim to increase the capacity of CMOs to deliver preventive care for SNAPS is scarce. For example, within the previously cited rapid review investigating the effectiveness of physical health initiatives in CMOs,[3] nine of the 29 publications made mention of incorporating stakeholder views into their development. These initiatives targeted service use,[23] tobacco smoking,[24,25] nutrition and physical activity,[26–29] oral health,[30] and multiple physical health risks,[31] and reporting of the methods used to incorporate stakeholder views were minimal across all publications. Some mentioned involvement of peer or support workers in designing programs,[23–25,30] consideration of patient and staff preferences[27] and one study briefly described how

the program was adapted to the needs of mental health consumers[26] without detailing methods. Other publications described methods such as surveys and focus groups used to collect feedback to inform programs,[28,29,31] however, it was unclear how information was then extracted and used to inform the interventions, or the accompanying implementation strategies.

This paper reports a component of a larger project, a pilot implementation support trial to assist CMO staff to provide preventive care for multiple health behaviours. The model of preventive care delivery proposed was the 'AAR' framework. The co-development element of the trial occurred in the planning and development stage and focused on collaborating with CMO staff to select implementation support strategies to assist staff to deliver the model of care. The co-development activity was a staff workshop run by the researchers. This manuscript aims to (1) describe the co-development workshop including the process of inviting staff and workshop format, content and delivery; (2) describe the implementation support strategies that emerged from the workshop (workshop outcomes); and (3) report staff ratings of and comments about the workshop on four co-development principles (workshop evaluation). In doing so, we present a case example of how to use co-development to plan and implement strategies for health promotion practices.

2 | METHODS

2.1 | Design and setting

The co-development process consisted of a three-hour workshop with staff of a local branch of a national CMO, one of the largest CMOs in Australia that deliver programs and services to support people living in the community with a mental health condition. Types of support provided by the CMO include daily living skills (e.g., cooking), transportation, access to health care, employment opportunities, education, provision of community links with drug and alcohol services, accommodation and housing, and homeless services. The organisation employs peer workers, mental health workers, team coordinators and managers. The branch was located within a large regional centre in NSW and employs approximately 60 staff across three sites. As the objective was to co-develop implementation strategies to support staff in routinely providing preventive care, staff were considered the end-users. Staff were therefore the target participants as opposed to consumers, and for this reason consumers were not involved in the co-development process. Within the workshop participants discussed and ranked implementation support strategies (workshop outcomes—see below) and completed an evaluation survey (workshop evaluation—see below).

2.2 | Participants and recruitment

Approximately 60 staff across all positions (e.g., management and client facing staff) within the branch were invited, via email, to take part in the co-development workshop. The recruitment email, sent by a team manager, included the Participant Information Statement and consent form. Two workshop times were available, and staff were to participate in the workshop once only. Staff interested in participating indicated which of the two workshop times suited them and the team manager confirmed the attendee lists with researchers. Staff returned completed consent forms to the researchers before the workshop commenced. To maximise the opportunity for participation due to COVID-19 travel and social distancing restrictions, a hybrid delivery format was utilised to allow staff to participate either in person or online via a videoconference link. Workshops were conducted in May and June 2021 which occurred in between the 2020 and 2021 Australian lockdowns during the COVID-19 pandemic.

2.3 | Workshops

The purpose of the workshops was for staff to provide feedback on potential implementation support strategies that would assist them to deliver preventive care (using the AAR model for SNAPS) and suggest how best to implement these strategies in the CMO. The AAR approach was considered by staff to be a good fit with how they currently supported clients, albeit a re-wording to 'CAC' (conversations, advice and connect) was thought appropriate. The workshop comprised eight components ranging from 15 to 30 min and utilised educational presentations, group discussion and individual survey activities (see Table 1).

The workshop process was based on Nominal Group Technique (NGT), a consensus method which uses structured small group discussion to achieve consensus among participants.[32] NGT typically follows these steps: (1) a facilitator asks participants to contribute ideas to generate a list; (2) the group then discusses, elaborates, clarifies and adds new ideas as appropriate; (3) each participant independently prioritises the ideas, for example, by voting, rating, or ranking; and (4) the facilitator summarises the scores to ascertain the overall group priorities. This method is useful for generating a diverse range of views and ideas in a structured manner, prevents participants from dominating the discussion, and promotes input from all members.[32] It has been used for setting priorities in chronic disease prevention research.[33]

The workshops in the current study were facilitated by two researchers, where one researcher facilitated the activities and prompted group discussion with questions (see Table 1), whilst the other monitored the online participant written contributions and took notes during the discussion (see below). To allow both in person and online participants to contribute to the discussion and view supporting information, Google 'Jamboard' software was used to capture discussion by recording electronic post-it notes. The electronic post-it notes and Powerpoint slides were screenshared during the group discussion and education components, respectively (see Supplementary material for snapshots of post-it-notes).

TABLE 1 Summary of the co-development workshop.

Length (mins)	Workshop component		Content	Prompt Qs used by facilitators
30	(1) Project overview and proposed preventive care model	Education	Facilitators presented the larger project, purpose and format of the workshop, evidence on the background and proposed model (CAC for SNAPS).	NA
15	(2) Discussion of component 1	Group discussion	Participants discussed model (CAC for SNAPS), prompted by facilitators.	What do you think of describing preventive care in this way? What are you currently doing? What aren't you currently doing?
15	(3) Implementation Support Strategy proposal	Education	Facilitators presented implementation support strategies (training, educational materials, guidelines, audit & feedback, point of care prompts, leadership or managerial support, and consumer activation) that could support CMO staff to deliver CAC for SNAPS.	NA
15	(4) Discussion of component 3	Group discussion	Participants discussed implementation strategies prompted by facilitators.	What do you need? What do not you need? What has or has not worked in the past? Might this differ by SNAPS?
15	(5) Strategies documented	N/A	Facilitators documented strategies which emerged from component 4 discussion and input into live survey for ranking (Table 2). Participants took a break.	NA
30	(6) Strategy ranking	Activity	Participants completed REDCap survey to rank strategies from component 4. Once complete, facilitators presented survey results to workshop participants.	NA
30	(7) Discussion of components 5 and 6	Group discussion	Participants discussed how strategies could work in the CMO, and features of strategies. Facilitators guided discussion so strategy ranked most preferred was talked about first.	Which strategies are most feasible to put into practice? Which strategies are least feasible to put into practice? Does this differ across teams and/or programs?
15	(8) Workshop evaluation	Activity	Participants completed REDCap survey to evaluate workshop that included ratings of four co-development principles and open response items.	NA

2.4 | Data collection and analysis

2.4.1 | Implementation support strategies

In component four of the co-development workshop, the research team introduced seven implementation strategies supported by Cochrane systematic review evidence[34–37] and classified according to the EPOC Taxonomy[17] (i.e., training, educational materials, guidelines, audit & feedback, point of care prompts, leadership or managerial support and consumer activation) for discussion with participants (Table 1). Strategies preferred by participants were documented by the facilitators. Whilst the research team facilitated discussion of seven implementation strategies, the number of strategies proposed as preferred by participants was not controlled by the researchers. In each workshop, it was coincidentally the case that participants generated a list of five preferred strategies during this workshop component. To enable participant ranking of these five strategies, facilitators entered a name and brief description for each strategy into REDCap software[38] in real time during the workshops. Participants then accessed the online activity via a QR code on their phones and individually and anonymously ranked the strategies from most preferred to least preferred (i.e., first through fifth preference). Facilitators exported and presented the rankings in component six of the workshop. To determine an aggregate ranking of the strategies, a reverse point system was applied, where the maximum number of points (5) given to the first ranked, and one point given to the last. Participants then discussed how the implementation strategies could be delivered in their services, commencing with the most preferred strategy. Observation notes were captured during this component, and key

TABLE 2 CMO staff rankings of implementation support strategies in co-development workshop.

	Workshop 1 ($n = 12$)			Workshop 2 ($n = 8$)		
Rank	Implementation strategy	EPOC category	Points[a]	Implementation strategy	EPOC category	Points
First	Training for all staff about how to have difficult conversations about behaviour change e.g., motivational interviewing skills[b]	Training	47	Training for all staff about how to have difficult conversations about behaviour change e.g., motivational interviewing skills[b]	Training	32
Second	Local referral services guide: a 'cheat sheet' detailing local behaviour change referral services including where and how to refer consumers and for what[b]	Point of care prompt	42	Training for new staff to increase awareness of role in preventive care delivery and creative approaches	Training	30
Third	Guideline about staff role in preventive care delivery	Guidelines	32	Regular reflective practice: monthly meetings between support worker and their supervisor/line manager to reflect on their preventive care delivery to discuss challenges, develop approaches, receive feedback and coaching.	Continuous quality improvement	21
Fourth	Consumer prompt sheet detailing snaps to use with general practitioner	Consumer activation	30	Local referral services guide: a 'cheat sheet' detailing local SNAPS related behaviour change referral services including where and how to refer consumers and for what[b]	Point of care prompt	20
Fifth	Visual aid/point of care prompt for staff to assist and guide care delivery that may be used with consumers (not recording tool)[b]	Point of care prompt	27	Visual aid/point of care prompt for staff to assist and guide care delivery that may be used with consumers (not recording tool)[b]	Point of care prompt	13

[a]Point system: one point for fifth, two points for fourth, three points for third, four points for second and five points for first.
[b]The first ranked strategy in workshop one and the first ranked strategy in workshop two were conceptually the same; the second ranked strategy in workshop one and the fourth ranked strategy in workshop two were conceptually the same; the fifth ranked strategy in workshop one and the fifth ranked strategy in workshop two were conceptually the same.

considerations raised during the discussion regarding implementation strategy delivery were summarised.

2.4.2 | Workshop evaluation

At the conclusion of the workshop, participants were invited to complete a workshop evaluation (programmed in REDCap[38]) on their phone accessed via QR code. The purpose of the workshop evaluation was to assess how well the workshop addressed four principles of co-development: (1) facilitating for improvement: enabling all participants to become the catalysts for improvement; (2) respecting capability: equally valuing the expertise and experience of all workshop participants and recognising the diversity of contribution; (3) power and reciprocity: workshop participants and researchers come together in a trusting and interdependent relationship, recognising differences in power, and setting mutually recognised responsibilities, expectations, and accountabilities; and (4) peer support connections: including opportunities for participants to explore and question individually and within their peer groups. These concepts, assessed using an evaluation tool adapted from a co-production self-assessment framework by Public Health Services Tasmania,[39] are detailed in previous frameworks and research.[40] Participants were asked to provide a rating level on a three-point scale for each of the four co-development principles (definitions were provided; see Supplementary) based on how well they perceived the workshop addressed each principle, and given the option of providing an open response about why they gave the corresponding rating and to provide an example to help explain the rating.

Ratings were summarised descriptively. To facilitate reporting, level 2 and 3 (moderate and high) were combined. Open responses were coded as 'strengths' or 'areas for improvement' for each principle and described thematically.

3 | RESULTS

3.1 | Participants

Twenty CMO staff participated in total; twelve and eight in workshop one and two respectively. Staff were employed in a range of roles

including managers, team coordinators, peer workers and mental health workers.

3.2 | Implementation support strategy rankings

Table 2 displays the aggregate results of participant rankings of strategies from most preferred (first) to least preferred (fifth) for both workshops, with strategies then matched to their relevant EPOC category.[17] Three of the five strategies generated in each workshop were conceptually the same across the two workshops, however differences in rankings of each occurred. The three strategies generated in both workshops were: training for all staff about how to have difficult conversations about behaviour change; a local referral services guide; and a visual point of care prompt for staff to guide care delivery. Four other strategies appeared in one workshop: training for new staff to increase awareness of role in preventive care delivery and creative approaches; a guideline about staff role in preventive care delivery; regular reflective practice; and a consumer prompt sheet detailing risk information about SNAPS to use with their general practitioner. From the discussion in component 7 (Table 1), key considerations emerged for implementing the top ranked strategy for both workshops which were (a) the target audience: training should involve all client-facing staff and team coordinators; (b) scheduling and length of training: a 2-h training session during team meetings followed by 1-h reflective practice was perceived as feasible, or, a continuous improvement approach using a series of shorter, 20 min sessions that could occur 'on the field'; (c) format: important to have face to face contact as shown from difficulties such as limited engagement using online/hybrid methods during the recent COVID-19 lockdowns; and (d) facilitator: a ground up approach would be feasible in which training should be delivered by a peer worker or team coordinator with lived experience of behaviour change (as well as a mental health condition) to ensure participant perspective and real-life experiences are voiced.

Across both workshops, a local referral services guide was identified. Implementation considerations raised included: (a) format: hard-copy and laminated ring bound book-lets that could be placed in work cars, at properties and in the office, as well as an electron-ic version as all staff owned a smartphone for work; and (b) content: clearly detail whom, where and how to connect/refer consumers for support for each SNAPS behaviour.

An important point raised during component seven of the workshops, relevant across all identified strategies, was the nature of CMO staff experience and expertise. CMO staff are largely non-clinical service providers and are not clinically trained health experts. However, as part of their role they often accompany consumers to appointments with al-lied health providers and clinically trained specialists who often communicate health in-formation in clinical or expert terms. Participants highlighted the need for CMO staff to receive education in communicating health behaviour change benefits to clients in non-jargon terms to better understand health conditions and suggested care and improve up-take of recommended care.

3.3 | Workshop evaluation

3.3.1 | Quantitative data: Ratings

The workshop evaluation was completed by 19 staff. Between 12 and 18 responses were recorded per co-development principle rating. Across both workshops, participants largely rated principles at a level 2–3 (moderate to high): $n = 17/18$ (95%) for facilitating for improvement; $n = 13/14$ (93%) for respecting capability; $n = 15/16$ (94%) for power and reciprocity; and $n = 12/12$ (100%) for peer support connections.

3.3.2 | Qualitative data: Comments

A total of 35 reasons were provided, 14 for 'facilitating for improvement', 8 for 'respecting capability', 8 for 'power and reciprocity' and five for 'peer support connections'. Feedback received from participants in open responses was largely positive for each co-development principle, with most identified as a 'strength' and few responses coded as an 'area for improvement'.

Most participants felt as though the workshop used a collaborative approach, particularly the direction of discussions to be participant-led. One participant noted:

> The workshop participants were provided ample space for discussing ideas and contributing to the advancement of knowledge/understanding of the topics discussed.

and another mentioned

> I believe the research was conducted quite inclusively. I found the researchers mostly allowed participants to speak and lead conversations. I believe participants gave their honest opinions and I did not feel led by the researchers to give answers.

Participants reported the workshop involved equal and consistent contributions from all staff, and those suggestions were respected by the facilitators. For example, participants commented:

> Constant and consistent involvement by all participants in the process.

> Felt like an equal discussion.

> I felt as though our honest opinions were heard and valued without interference in terms of suggesting answers or responses.

Participants reported feeling included and opportunities for all participants regardless of role, and that all contributions were valued equally. For example, one participant commented:

> Researchers listened to what the participants had to say. Researchers explained confidentiality and how statements would be de-identified.

and another participant noted:

> Full inclusion of all participants. High trust between researchers and participants. All contributions valued and respected.

Participants reported feeling strong engagement across the group and that all participants were encouraged to engage in group discussion. For example, one participant noted:

> I felt all participants were able to and encouraged to speak with and discuss content together with the rest of the group.

whilst another commented

> Researchers made an effort to encourage the inclusion of opinions and comments to discussion from those participating online despite the possibility of focusing merely on those in the room.

Examples provided to illustrate these positive aspects of the workshop included the recording of results, and ongoing feedback provided throughout the session including the utilisation of post-it notes and task instruction.

The few areas for improvement noted by participants were to better cater for the diversity of experience within the participant group, the inclusion of consumers in the co-development process, and to reduce the number of workshop participants to enable discussion of more specific details. For example, one participant commented:

> Would be great to have only 3 people at a time to get more in-depth.

4 | DISCUSSION

This paper aimed to describe a co-development workshop, the resulting implementation support strategies that emerged, and staff ratings and perceptions of the workshop according to four co-development principles. This study is the first to describe in detail the method of co-developing implementation support strategies with CMO mental health staff, that aimed to assist staff to provide preventive care for multiple health behaviours. Engaging staff in a workshop with researchers through education, group discussion and a ranking activity, supported consideration of their capacity to deliver preventive care, offered a feasible method for researchers to understand the needs and preferences of staff, and resulted in a list of implementation support strategies that could be used for a pilot trial. Evaluation data indicated participating staff rated the process positively and provided some useful suggestions for improvement. This study demonstrates a valuable and robust methodology for co-development workshops and contributes to learnings about the planning and implementation of health promotion approaches.

The co-development workshop utilised a structured NGT process that engaged staff to identify and contribute ideas toward the topic of preventive care delivery in their service. While staff may have different values, needs and competing priorities regarding their role in preventive care delivery and subsequent involvement in the workshop, co-development aimed to overcome potentially diverse priorities to achieve consensus on a list of strategies that would benefit all. The workshops were designed to establish an open and supportive team climate. This was achieved through allowing space for participants to voice their individual and varied viewpoints, and through researchers taking a facilitation and guiding approach. The success of this approach was supported by evaluation feedback where participants described the workshop as collaborative, with participants reporting feeling included and that their contributions were valued equally. Previous studies which have employed a similar structured workshop process have similarly found that whilst it tends to elicit a diverse range of viewpoints as participants feel empowered to contribute, the group retains cohesion with a common sense of direction.[41] The current method offered a feasible approach to achieve consensus on staff preferred implementation strategies by providing an evidence-based reference point and generating ideas and synthesising group feedback in a structured manner, ensuring that the opinions of all participants were taken into account. As there is limited research that has considered how participants may perceive the usefulness and feasibility of such strategies, which is likely to impact on their effectiveness, findings in the current study can inform future implementation strategy development.

The current study considered the importance of four co-development principles by gathering ratings and qualitative feedback from participants, which subsequently indicated the workshop process positively addressed elements of facilitating for improvement, respecting capability, power and reciprocity and peer support connections. Inclusion of an evaluation is a strength as there are limited studies describing co-development processes that also evaluate the process from participants' perspectives. In a review of studies utilising co-production in the development and evaluation of interventions for the prevention of chronic disease,[20] only two studies could be identified that described perceptions by stakeholders of the co-design process.[42,43] One study which evaluated how co-design workshops were experienced by participants found that establishing and maintaining a genuine and equal partnership requires continuous use of participant contribution, allowing participants to influence the direction of discussion, and limiting excessive researcher input.[41] In the current study, whilst participant feedback also provided considerations for improvements in future research, such as limiting the group size and consumer involvement, overall, findings provide support for the workshops as an acceptable co-development method.

In the current study, meaningful outcomes were achieved using the NGT consensus method, whereby preferred implementation strategies were generated by participants. There was considerable similarity between the workshops with three discrete strategies common to both workshops and therefore a total of seven discrete strategies generated across both. These seven discrete implementation strategies are categorised within five EPOC[17] categories which have demonstrated effectiveness in initiating practice change in health care settings: (1) training (2/7 discrete strategies)[34]; (2) point of care prompts (2/7 discrete strategies)[35]; (3) consumer activation material (1/7 discrete strategy)[37]; (4) practice guidelines (1/7 discrete strategy)[36] and (5) continuous quality improvement (1/7 discrete strategy).[44] Of the seven EPOC categories presented by researchers to participants in the education component of the workshop, participants proposed support strategies that aligned with four categories and one additional strategy (reflective practice) that aligned with the category: continuous quality improvement, which was not initially presented (Table 2). Three EPOC categories presented to participants were not represented within the workshop outcomes (audit and feedback, educational materials, leadership or managerial support). Such categories may not have been perceived as needed due to particular support strategies already in place at the service including file reviews (audit and feedback), physical health promotion resources (educational materials) and a designated physical health promotion program manager (leadership or managerial supports).

Developing effective ways to integrate these strategies into practice aligns with the Ottawa Charter's call to reorient health services toward health promotion.[45] Successful integration requires consideration of strategy effectiveness, as well as the practicalities for how the strategies might be implemented. Both workshop groups ranked training for difficult conversations about behaviour change (e.g., when someone shows resistance) as the most preferred strategy. Whilst systematic review evidence demonstrates staff training to be an effective strategy in health care settings,[46] they do not provide evidence on the effectiveness of training in CMO settings specifically. However, of the limited number of past trials in CMOs that have utilised staff training to increase preventive care delivery in a single-strategy implementation trial[26,47–49] as well as trials with multiple implementation strategies,[24,27,50] improvements have been found for consumer health outcomes including weight loss,[27,50] tobacco consumption[24,48,49] and primary care appointment adherence[26] as well as staff outcomes such as program acceptability[24] and confidence to deliver preventive care.[47] Some studies have noted limitations of training including difficulties in implementation due to time constraints.[24,48] Such implementation challenges could be mitigated if training is to be brief and integrated with usual practices (e.g., staff meetings), as suggested by participants in the workshops.

In addition to training, the rankings highlighted other strategies including point of care prompts in hardcopy and online form such as a guide for local referral services and a tool to guide preventive care delivery, preventive care practice guidelines, regular reflective practice and consumer activation aids, as preferred by CMO staff. Whilst there is some evidence of improvement to professional practice and health care outcomes from these strategies,[35,36] only one trial could be identified could be identified that tested the effectiveness of implementation strategies other than training on preventive care delivery conducted in CMOs.[51] Sims & Delany (2017) aimed to record health risks and generate referrals to appropriate medical providers. Researchers employed brainstorming sessions with staff to initially develop a process of tracking health indicators and then refine this throughout the life of the project. Analysis revealed the monitoring system was somewhat effective in improving health indicator collection, however there were challenges to implementation of the monitoring system such as the site's information technology capacity and budget constraints. Authors suggested that collection of health indicator data should be implemented in conjunction with a documentation system that is user-friendly, organised, and accessible. Overall, a greater understanding of the implementation strategies required to support preventive care delivery in mental health CMOs, and how these might be integrated into practice, is needed. The evaluation of implementation support strategies co-developed in the workshops in the current study may add to this evidence-base.

The findings of this study should be considered in the context of a number of limitations. The workshops were conducted in between the 2020 and 2021 Australian lockdowns during the COVID-19 pandemic, and findings should be considered within this context. Results of the strategy rankings, considerations regarding implementation and workshop evaluation feedback are likely to be influenced by COVID-19 factors, such as rules and regulations related to social distancing, and adaptations to usual service provision, which all may or may not remain in the longer term. For example, staff mentioned they had experienced professional development training in an online format more so than face to face in the previous year due to COVID-19. Staff expressed this increased the value placed on face-to-face training as it provided social support and facilitated feedback from peers and leaders. Due to the explorative nature of this study and focus on the CMO setting, generalisations to other mental health settings regarding the co-developed implementation strategies is not intended. However, the co-development approaches employed met the current objectives and may be applicable to other settings. Whilst a consensus-based approach was utilised, it is not explicitly clear at what point consensus is reached in terms of each staff member having the same view, which is consistent with other co-development studies and studies utilising NGT methods. As staff were the direct end-users of the support strategies, they were the only participants involved in the co-development workshops. Future research may choose to involve consumer perspectives regarding the acceptability of preventive care approaches which can subsequently inform implementation strategy design. Despite these limitations, major strengths of the study included the heterogeneity of the participant group to enable feedback and input from a range of viewpoints, and the conduct of an evaluation of the co-development process and the transparent, detailed write up of such.

5 | CONCLUSIONS

In this study, a structured workshop utilising the NGT method was used to co-develop implementation strategies with CMO staff and managers, and an evaluation of this approach completed. This article detailed a robust co-development workshop methodology (including its planning, processes for conduct and evaluation) to inform health promotion planning and implementation; an area of Australian health promotion researcher that is poorly published. The workshop served as a useful method to co-develop strategies that may be delivered and evaluated as part of a pilot implementation support trial to assist CMO staff to provide preventive care for multiple health behaviours. The co-development approach allowed participants to voice their opinions on what the components should be and how best to implement them. Researchers or practitioners planning health promotion approaches could utilise a similar process to the way the workshops were conducted, participants invited, and techniques used to seek the data. The methods used and our findings can inform future research on co-developing implementation strategies for and with staff of a mental health community managed organisation in providing preventive care for health behaviours.

AUTHOR CONTRIBUTIONS

Casey Regan: Conceptualization, methodology, writing—original draft, writing—review & editing, project administration. **Julia Dray:** Conceptualization, methodology, writing—original draft, writing—review & editing, project management, supervision. **Caitlin Fehily:** Conceptualization, methodology, writing—review & editing, supervision. **Elizabeth Campbell:** Conceptualization, methodology, writing—re-view & editing, supervision. **Kate Bartlem:** Conceptualization, methodology, writing—review & editing, supervision, funding acquisition. **Mark Orr:** Writing—review & editing. **Sumathi Govindasamy:** Writing—review & editing. **Jenny Bowman:** Conceptualization, methodology, writing—review & editing, supervision, funding acquisition. All authors have read and agreed to the published version of the manuscript.

ACKNOWLEDGEMENTS

The authors would like to thank the participating community managed organisation for their support and contribution to the project. Open access publishing facilitated by The University of Newcastle, as part of the Wiley - The University of Newcastle agreement via the Council of Australian University Librarians.

FUNDING INFORMATION

This work was financially supported by The Australian Prevention Partnership Centre (BP6) as part of the Boosting Preventive Health Research Program (Medical Research Future Fund [MRFF]) and an internal higher degree research grant provided by the University of Newcastle. Dr Kate Bartlem is supported by a National Health and Medical Research Council Early Career Fellowship (#1142272). The funders had no role in the study design, conduct of the project, analysis, or dissemination of findings.

CONFLICT OF INTEREST STATEMENT

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

Ethical review and approval were obtained from the University of Newcastle Human Research Ethics Committee (approval no. H-2020-0435). Informed consent was obtained from all participants involved in the study.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Regan C, Dray J, Fehily C, Campbell E, Bartlem K, Orr M, et al. Co-development of implementation strategies to assist staff of a mental health community managed organisation provide preventive care for health behaviours. Health Promot J Austral. 2023. https://doi.org/10.1002/hpja.813