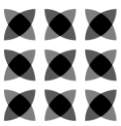
RESEARCH AND EVALUATION FINAL REPORT

Assisting Communities through Direct Connection Round 4

Prepared by the Centre for Social Impact

August 2025

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CENTRE *for* SOCIAL IMPACT



Acknowledgement of Country

In the spirit of reconciliation, CSI UWA acknowledges that their operations are situated on Noongar land, and that the Noongar people remain the spiritual and cultural custodians of their land, and continue to practise their values, languages, beliefs and knowledge. We acknowledge the Traditional Custodians of the country throughout Australia and their connections to land, sea and community. We pay our respect to their elders and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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Centre for Social Impact

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1. INTRODUCTION

1.1 Background

Since 2020, the Assisting Communities through Direct Connection (ACDC) Project has been funded by the Department for Social Services, and led by Community Mental Health Australia (CMHA), in partnership with organisations across all states and territories in Australia. As with the previous rounds, the Centre for Social Impact, The University of Western Australia (CSI UWA) was engaged by CMHA as research and evaluation partner for Round Four of the ACDC Project.

With the core idea of the project being 'direct connection', the project has always sought to connect with people who may be struggling with wellbeing and/or mental health issues, who might otherwise not be receiving information or opportunities to connect to support. The pilot project utilised a doorknocking methodology to reach people at homes in their communities. This was expanded on during Round One and Two, in which around 37,500 doors were knocked in 21 communities. Round Three saw the same approach, but with the development of more time and resources spent providing follow-up support for those who needed it. Round Three provided more in-depth evidence about some potential cohorts who were more likely to be struggling alone with mental health or wellbeing issues, without awareness of support available or without reaching out for support. There were also specific cohorts identified in this round as potentially more likely to be responsive to conversations about their wellbeing.

1.2 Round Four approach

Round Four represents a departure from previous approaches, with the thinking being that learnings from the first three rounds of ACDC have been comprehensive and integrated, and that drilling down into more depth would provide value and clarity about possible solutions to groups who are underrepresented in terms of receiving support for their mental health and wellbeing.

For Round Four, doorknocking was not pursued, but instead in-depth conversations were initiated with cohort groups in order to understand their needs and co-design solutions that would better meet these needs and, at the same time, help them overcome barriers to being supported. As with other rounds, a concern about reaching 'hardly reached' groups, and reflecting on the extent to which supports are meaningful and appropriate was the priority.

This report builds from the Research and Evaluation work conducted during previous rounds of the ACDC project. For Rounds One, Two and Three, the research and evaluation did not have a particular cohort focus, as the methodology was by nature, inclusive and broad. However, at this stage the research focus would benefit from understanding how to support specific cohorts – especially people who are 'less visible' to the service system and have less well-known or well-documented support needs, may be especially valuable. A survey was designed to capture service and support preferences, and it was hoped that this evidence could also support the models of care being developed as a Round Four activity.

1.3 Purpose of this research and evaluation report

The purpose of this research and evaluation report is to:

- Summarise the key survey findings regarding support preferences of participants in co-design processes run by organisational partners (in particular, the Queensland Alliance for Mental Health)
- Provide evaluation findings and summary analysis of the engagement processes utilised by partner organisations, and general learnings about what effective engagement and consultation looks like when working with underrepresented groups. These findings complement the reports submitted by both partner organisations.

2. ROUND FOUR OVERVIEW

2.1 ACDC Project Round Four

For Round Four two organisational partners – both peak bodies – were engaged to explore the needs of specific cohorts. They utilised a combination of evidence synthesis, summarising the key findings from literature on unmet psychosocial support needs (especially for the cohorts targeted), as well as findings from previous rounds of the ACDC Project, to ensure the work built on existing evidence.

They then aimed to explore needs and appropriate service models with each cohort. This initially involved consulting with community and organisational representatives about appropriate ways to engage with the cohorts. After this a series of engagement processes were used based on two related but distinct approaches – Place-based co-design and Living Lab methodologies.

2.2 Project partners

The core project activities were delivered by the Queensland Alliance for Mental Health and the Mental Health Coalition for South Australia. The Mental Health Community Coalition of the ACT initially began working on ACDC Round Four, and participated in several evaluation activities, however they withdrew from the project early and their work is not included in this report.

Table 1 - ACDC partners and their focus locations and cohorts

Key project partners	Locations	Cohorts
Queensland Alliance for Mental Health	Townsville	Aboriginal and Torres Strait Islander peoples Culturally and Linguistically Diverse communities Carers Older adults People living with disability Workers in high-risk industries
Mental Health Coalition of South Australia	Salisbury	Aboriginal people Carers South Asian born Women aged 65-74 years Employees in Construction, Manufacturing and Logistics

3. RESEARCH AND EVALUATION APPROACH

3.1 Purpose

The CSI UWA aimed to support CMHA and their Delivery Partners through undertaking two roles:

1) Research support via managing and analysing the data from the Round 4 survey, and presenting cohort and location-based findings as requested by the Delivery Partners, with summative findings presented at the end of the project.
2) Evaluation via providing a survey to co-design participants to reflect on their experience of the consultation process, which can provide the engagement evidence to support the service models.

The Mental Health Coalition South Australia did not engage with CSI UWA to the same extent that the Queensland Mental Health Alliance did, as the timelines did not allow for this, and also the South Australian approach involved Living Lab methodology which meant that they preferred to use multiple surveys that were tailored and designed with community representatives.

3.2 Key research questions

The Round Four ACDC survey was co-designed with three peak bodies - Queensland Alliance for Mental Health, Mental Health Coalition of South Australia and the Mental Health Community Coalition of the ACT.

The following key research questions guided the design and analysis of survey findings.

- Who responded to the survey (which demographic groups were represented)?
- What did survey findings indicate about people's current service engagement behaviours?
- What did survey findings indicate about people's preferences for delivering supports?

The key findings are provided as an Addendum to this report (in the format of a PowerPoint presentation).

3.3 Key evaluation questions

The following key evaluation questions guided the overall approach to evaluation data collection and analysis.

Effectiveness of engagement and recruitment

- Who engaged with the activities, which demographic groups were represented and what recruitment strategies were effective in driving engagement?

Effectiveness of co-design approaches

- What co-design approaches were implemented for Round Four?
- Were any changes needed to make the engagement more effective? What were the key implementation learnings for organisations hoping to conduct similar consultation?

Experiences of co-design

- How appropriate and valuable were these activities for people engaging with them? What was their experience of participating in the co-design activities?

Implications and recommendations

- What are the implications of the co-design findings?
- What are the recommendations for future approaches to building opportunities for people to have a say in service models?

4. DATA COLLECTION

4.1 Data sources

The research and evaluation approach included quantitative and qualitative data from sources outlined in Table .

Table 2 – Data sources

	Type	Description
Primary data collected by CSI UWA	Round Four ACDC survey	This survey was co-designed by representatives from CSI UWA, CMHA and the peak organisations implementing the project, and managed independently by CSI UWA. Partner organisations were given the link and responsibility for overseeing survey recruitment and participation. The survey asked participants to reflect on their mental health and wellbeing support options and barriers to service use, and service preferences. The evidence was provided as indicative findings to Delivery Partners to inform the development of models, as well as support consultations with information.
	Town Hall Evaluation Survey	Administered independently by CSI UWA, this survey asked participants to reflect on what worked well about the Town Hall. It was distributed at Town Hall event in Queensland at the end of April.
	Project Coordinator Interviews	CSI UWA conducted one-on-one interviews with project coordinators. Interviews were online and lasted 60 minutes.
Secondary data provided by Delivery Partners	Engagement data	Through registration information, attendance records and activity reports, Delivery Partners will provide CSI UWA with summary reports of demographic data of who engaged, how many people engaged in which activities, and which cohorts were represented.
	Key findings from consultations	Delivery Partners will provide CSI UWA with a summary report on the key findings based on their consultations.

4.2 Data analysis

Data was triangulated and analysed against the key evaluation and research questions. Data analysis incorporated the results of all quantitative and qualitative data collected, and included

secondary data provided by Delivery Partners (such as participation and activity data provided in summary form).

To develop learnings from the two consultation processes, an evaluation criteria matrix was used as a summative frame. We draw from the Organisation for Economic Co-operation and Development's six evaluation criteria, which are seen as "six lenses to analyse an intervention and its results". These criteria were thought to be good analysis points to examine the strengths of both approaches, which could enable decision-makers to understand when to use both approaches. The criteria are as follows:

1. **Relevance:** is the intervention doing the right things?
2. **Coherence:** how well does the intervention fit?
3. **Effectiveness:** is the intervention achieving its objectives?
4. **Efficiency:** how well are resources being used?
5. **Impact:** what difference does the intervention make?
6. **Sustainability:** will the benefits last?

Due to the lack of economic data, analysis or ability to forecast, the 'efficiency' and 'sustainability' criteria was excluded from this matrix.

5. EVALUATION FINDINGS

5.1 Two approaches to community and cohort consultation

Both partner organisations sought to reach cohorts that were underrepresented in mental health services and work with them to design solutions that would ensure their communities were better engaged in supports.

The Mental Health Coalition South Australia (MHCSA) led a co-design approach based on a Living Lab model whereby cohort needs and experiences were understood within existing community settings and with engagement processes designed by representatives of those cohorts. In this way, MHCSA initiated a deep dive into each cohort, to deeply understand their experiences and needs.

The Queensland Alliance for Mental Health (QAMH) sought to create a place-based approach whereby, seeking the views of diverse cohorts that were underrepresented in the service system, would help to inform a service model that could better service all people of Townsville. They facilitated co-design events (a workshop and a Town Hall) in which draft models were proposed and refined.

Co-design is a facilitated design process that focuses on solutions based on diverse points of view, arriving at user-centric products that can better meet the needs of people. The Living Lab approach involves reaching out to people in real-world settings (i.e., talking to people where they are) in order to understand their experiences and needs. The Living Lab approach also involves innovation, whereby people are invited to reflect on new approaches to problems.

A Living Lab overlaps with the co-design methodology in many ways, however a Living Lab approach is broader, less loosely defined and held, and focused on cohort experiences as the anchoring idea, whereas co-design processes might focus on the problem identification as the anchoring idea, and may involve strong facilitation skills and a process that brings together and synthesises diverse stakeholders and perspectives in order to shed light on the defined problem and arrive at a 'consensus' about what a solution could look like.

Round Four of the ACDC Project has benefitted from testing both approaches. This evaluation aims to describe both approaches and highlight the strengths. There were no agreed evaluative criteria provided to partner organisations and therefore any analysis based on the OECD criteria is just to provide a structure for reflection. The ACDC Round Four evaluation design cannot enable the CSI UWA Evaluation Team to make fair comparisons between these two projects about quality of value of each approach. Rather, both projects draw out interesting reflections on the strengths of each engagement. After describing both approaches and highlighting strengths, we will however, offer some summative reflections on learnings and recommendations.

5.2 Activity Summary

Reach and information provision

Through the digital engagement strategies applied by both organisations and their partner organisations, it is estimated that potentially **over 200,000 people** were reached and exposed to the mental health messaging and/or awareness of the project. In addition, the following metrics were recorded across various targeted activities – which differed from state to state.

Indicator	Qld	SA	Total
ACDC Survey promotion	10,496	N/A	10,496

Information distribution	5,474	367[1]	5,841
Fridge magnets distributed	767	N/A	767
Totals	16,737	367	17,104

**totals reflect the number of engagement events rather than number of individuals engaged*

Engagement with model development

In total, 345 people were able to participate in consultations appropriate ways to develop the care models, and care models. This includes 45 people who were consulted for their expertise and/or community leadership regarding the most appropriate ways to engage with community members and specific cohorts. The majority of people consulted about the model of care (165) did so through face to face, structured and facilitated events.

Indicator	Qld	SA	Total
Community representatives to design approaches	-	45[2]	45
Community members consulted about care models	81*[3]	84[4]	165
Survey about care models	20[5]	115[6]	135
Totals	**101**	**244**	**345***

**totals reflect the number of engagement events rather than number of individuals engaged*

Engagement with research and evaluation

Queensland participated in the research and evaluation activities, with South Australia providing primarily qualitative evaluation information (see Evaluation Report for further detail).

Indicator	Qld	SA	Other states and territories	Total
ACDC Round 4 Mental Health Survey	54	3	16	73
CSI Evaluation Survey	24	-		24
Totals				97*

**totals reflect the number of engagement events rather than number of individuals engaged*

5.3 Living Lab model

Overview

The Mental Health Coalition South Australia applied the Living Lab approach to five identified priority groups in the City of Salisbury:

[1] Carers = 119; South Asian Born = 35; Women Aged 65 - 74 = 26; Aboriginal and Torres Strait Islander = 22; Employees in Construction, Manufacturing and Logistics = 5; NDIS Support Workers = 120; Council Staff = 12; NGO staff = 28
[2] 13 Aboriginal, 5 carers, 20 South Asian born, 4 older women, 3 employees in construction, manufacturing and logistics
[3] This includes a total of 56 who attended the community consultations and 25 who attended the Town Hall

[4] 22 carers, 21 older women, 19 South Asian born, 22 Aboriginal engagement (includes Social and Emotional Wellbeing Workers from 2 Aboriginal services, and an 2 hour Aboriginal Social and Emotional Wellbeing Forum presentation)

[5] Employees in construction, manufacturing and logistics

[6] 83 carers, 32 South Asian born

- Aboriginal people
- Carers
- South Asian Born
- Women Aged 65-74 years
- Employees in Construction, Manufacturing and Logistics

Effectiveness of engagement and recruitment

For each priority population, representatives were selected to work closely with, in order to design engagement strategies, questions and approaches that would work for that cohort. Focus areas for this stage of the ACDC Project in The City of Salisbury included ways to start mental health conversations with priority population groups, the identification of barriers to help-seeking, utilising and strengthening "touch points" within the community (or the "first port of call" for each group), and ultimately finding people in need of psychosocial support (Mental Health Coalition South Australia, 2025, p4).

This led to five highly differentiated engagement strategies. Each priority population group selected different themes to focus on, based on what they felt were highly relevant, appropriate and resonant in terms of bridging conversations about mental health. The Mental Health Coalition South Australia's summary report (Mental Health Coalition South Australia, 2025, p4) describes some key differences across the cohorts:

Cohort	Advice about what to focus on	Suggested engagement approaches
South Asian Born	Discuss impact of fear of judgement from family and community on mental wellbeing Discuss stress due to family expectations	Educational workshops to facilitate mental health conversations
Carers	Focus on the lack of time available for carers to seek support Ask about access preferences and easy to access help such as support sessions of 30 minutes, or 5-10 minute phone chats, and online support	Variety of participation options including multiple face-to-face Roundtables, and a 5 minute survey
Older Women aged 65=74	Measures of loneliness and isolation Access to transport to attend services	Community organisation settings
Employees in Construction, Manufacturing and Logistics	Impacts of shift work, long work hours, pain or injury, stigma in the workplaces and role of GP in mental wellbeing	
Aboriginal people	Meet outdoors Yarning	Survey is not suitable One-to-one scoping interviews with staff from Aboriginal service providers

Effectiveness of the Living Lab approach

The Living Lab approach was highly effective in being able to develop nuanced and differentiated understandings of cohorts, from which has emerged fresh perspectives on what could be needed. For instance, the Living Lab conversations effectively took into account the barriers that were especially pertinent to each group, could uncover *how* to talk about mental health with each cohort (i.e., what to say, what not to say, how to set up conditions for the conversation), identity existing assets and opportunities that each cohort has, so that engagement can happen around those events and activities, and, in one case, the Living Lab exploration uncovered the importance of looking at the drivers of mental illness, rather than providing a service-based solution that would not work. These strengths are unpacked in more detail here.

Accounting for cohort-specific barriers and working with existing patterns of help-seeking

One strength of the highly tailored Living Lab approach, was that it enabled findings to be looked at in terms of cohort, and to understand that appropriate service models and even assumptions were very different across these groups.

For instance, even the example of utilising the GP as the first port of call for a conversation about mental health, was a very different scenario for a carer and a construction worker; with carers not finding it easy to make GP appointments for themselves (or even, sometimes, the person they were caring for), and construction workers finding it difficult to see a GP because of irregular hours or shift work.

Having a comprehensive understanding of the mindsets that people from different cohorts had, and their patterns of support seeking, was critical to why this approach was effective. For instance, Aboriginal service providers could highlight how Aboriginal people often sought help initially. For instance, Aboriginal people in the City of Salisbury will seek support from Nunkuwarrin Yunti services due to physical health concerns and picking up tent or food vouchers, and therefore this setting was considered appropriate for beginning conversations about mental health and social and emotional wellbeing, and prompting referral pathways for that support (Mental Health Coalition South Australia, 2025, p10).

Advice on tailoring mental health conversations

Approaching conversations about mental health is not a “one-size-fits-all” endeavour, and the nuanced Living Lab approach across different cohorts was effective at uncovering the differences in these needs and approaches.

For instance, for Aboriginal people it was felt that a “sandwich methods” whereby informal chats could be initiated and trust established before the topic of mental health and social and emotional wellbeing was discussed. And that the issue should be discussed alongside other topics such as family and community issues – not in isolation. Highly specific advice was also provided on culturally appropriate tools and assessment instruments that could support these conversations (Mental Health Coalition South Australia, 2025, p12).

Utilising existing assets and opportunities

The tailored, cohort-based Living Lab consultation was also effective in being able to identify how ideas for new supports could intersect with existing community events and activities. For example, South Asia Born community members identified that cultural activities – such as when community members come together to play a game Carrom (or engage in cricket, soccer, chai and chat), this is an opportunity to discuss mental health support options (Mental Health Coalition South Australia, 2025, p19).

Focus on the drivers of mental ill-health rather than just help-seeking

Investigating the mental health needs of construction, manufacturing and logistics workers highlighted that these engagement and co-design options were not effective in recruiting this cohort for participation. However, the limited conversations that were had, and analysis of

existing secondary data (such as the Beyond Blue's 'Boot the Blues 2024' Survey), found that workplace wellbeing and preventing drivers of stress, distress and conflict in the workplace could be a more effective and appropriate way to increase the wellbeing of this cohort.

Given that construction workers were reluctant to participate in a mental health conversation for this project, it is also likely that construction workers will not reach out for support when their own mental health and wellbeing is compromised. A less individual-focused, and more workplace-based, place-based intervention would therefore be considered highly appropriate.

Implications and recommendations

Overall, the learnings from the Living Lab process conducted in the City of Salisbury are significant. Firstly, the process identifies how strongly differentiated various cohorts are in terms of unmet needs, appropriateness of support options, support settings and effective strategies for reach, connection and engagement.

This raises questions about current working definitions of "mental health settings", and the findings call for potentially shifting some critical mental health support work away from GP practices and mental health clinics, and seeing it as something that can also take place in community settings. Whilst community settings may not be equipped to address all mental health issues, for the cohorts explored in the Living Lab, it seems the alternative is to go without support. The findings also suggest that community settings are trusted entry points for these conversations and for referral pathways into clinical settings if needed. These findings apply to all cohorts, however the construction, manufacturing and logistics worker cohort, may also require a focus on an important additional setting – the workplace. This seems critical for engaging in conversations about mental health, as well as for direct interventions to prevent mental ill health and distress caused by work conditions.

5.4 Place-based co-design model

Overview

Queensland Mental Health Alliance employed a place-based approach to exploring mental health needs and a model of care that could respond to local access barriers and experiences of mental health and wellbeing challenges. Townsville was selected as a site for consultation 'due to its regional setting, diverse population and known service gaps' (Queensland Alliance for Mental Health, 2025, p6). Six consultations were conducted with priority cohorts including:

- Aboriginal and Torres Strait Islander peoples
- Culturally and Linguistically Diverse communities
- Carers
- Older adults
- People living with disability
- Workers in high-risk industries.

Separate consultations were followed by a Town Hall that brought together diverse stakeholders to test and refine a model of care. A single, scalable model of care was developed which emphasised the need for early intervention, culturally safe supports, navigation and warm referral and connection through peer and community-based relationships. Barriers such as stigma, system complexity and digital exclusion were highlighted (Queensland Alliance for Mental Health, 2025, p6).

Throughout the facilitated workshops and townhall conducted in Townsville Qld, the following features were investigated:

- Level of mental health support need
- Most appropriate ways to begin mental health conversations
- Preferred method for accessing mental health support
- Preferred service delivery method
- Preferred provider of services
- Barriers to accessing mental health support
- Current and potential use of primary care services
- Potential models of care

Effectiveness of engagement and recruitment

The recruitment and engagement strategies were managed by Queensland Mental Health Alliance and were broad ranging, utilising a range of community networks and settings – such as Primary health Network of North Queensland, libraries and other Townsville-based organisations. This diversity may have ensured that opportunity to participate was cast widely (and also provided a valuable opportunity to spread mental health information and awareness across Townsville). Because participation in co-design events was paid, this created a very inclusive approach and the potential for new voices to contribute to understanding mental health need.

Effectiveness of a place-based co-design approach

Overall, the recruitment and participation that was built into this phased co-design process, provides integrity and confidence that representative views of diverse community members have informed this model. This can provide validity and the impetus (and political will?) to develop the model, especially if the model is proposed as a local solution, based on local understandings of the issue.

Targeted design arriving at one model of care is pragmatic

The co-design approach involved targeted workshops based around cohort-specific needs, followed by a Town Hall in which diverse stakeholders refine one model of care. The benefits of this approach is that each cohort group is provided the space to explore their needs (and potentially, particular needs), but that this is then workshopped into one product – i.e., one model of care that captures commonly-held viewpoints and represents the needs of diverse groups.

Opportunity for refinement into something that can be implemented

The phased approach – building on evidence synthesis, collecting cohort-specific insights, followed by drafting a model, presenting it for feedback, then refining the model based on that feedback, meant that something could be developed through various phases of working, potentially increasing the confidence in the final product.

The presentation of diverse ideas into a 'care model' (that has also been costed) also increased the chances that conversations had informed a tangible outcome.

Mixed methods help to build a representative, community-developed approach

The process brought together findings from a range of sources and methods – including desktop research, surveys, cohort workshops, consultations, and the Townhall co-design session. This ensured diversity of participation and voice, and especially where concerns were shared, this gave the model credibility in terms of it being community-led.

Experiences of co-design were captured

Community members were invited into a co-design process which was evaluated with a survey. This enabled capture of the experience of the workshop which 29.2% of participants thought was much better than expected or better than expected:

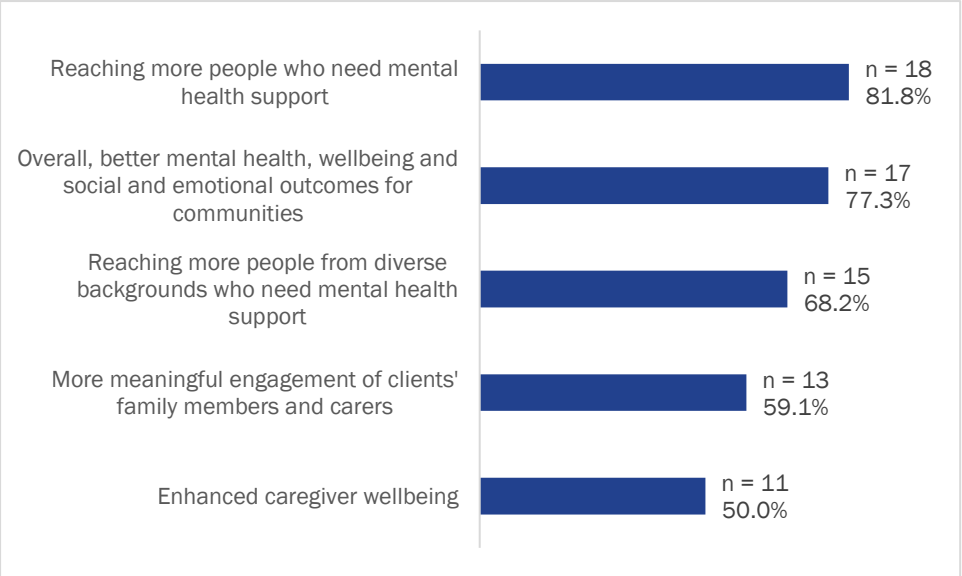
> *"It gave me a diverse insight into community mental health"*
>
> *"Today's event and the first event were the best workshops I have ever attended. The facilitators made the event successful."*

This also enabled learning about what community members think could be improved for next time:

> *"Info about how it fits for NDIS and intentions for use/context earlier in the day would be good."*
>
> *"I thought the facilitators would be more linked to each table. There were a lot of questions which were from carers which were missed."*

Evaluation data from community members who contributed to the model development, may also help facilitate implementation by capturing the community perspective on the need for it:

What kinds of benefits or impacts do you think this model could have if it was implemented?



The power of common themes across cohorts

The co-design process was able to synthesise the common experiences and concerns felt across diverse groups and this is powerful.

One overall finding, was that community members across all cohorts felt that their specific needs and preferences for mental health support would be resolved with more human, natural and connected facilitation, especially when entering into support and navigating to the right support. The need for Link Workers, peer workers and psychosocial supports outside of mental health service settings was a strong theme across all cohorts. The co-design process as it was done was able to legitimise and validate this need across diverse community members.

Implications and recommendations

The place-based co-design process has produced a powerful output – that is, a documented and costed model of care that is likely to will meet the needs of Townsville's most vulnerable, under-supported people. One downside is that the process itself tends towards abstraction – ideas shared are often vague especially when carried over into phases, and the consensus building

work of co-design and involving many people tends towards discussion of principles and ideals, rather than lifting up specific elements that might be more innovative and fresh. As one co-design participant pointed out, it's *"very hard to see any point of difference to existing models."*

However, for any potential commissioning body, the reports will provide the guidelines needed to create a model that meets the needs of community members. The process also reinforces conversations that have happened in the mental health sector for some time – based on the need to try radically different approaches.

6. SUMMATIVE EVALUATION MATRIX

The following criteria have been assessed according to a matrix, with a four point scale.

 To a Great Extent  Somewhat  Very Little  Not at all

Each criteria was assessed and provided with a justification statement. The assessment was based on evidence available and presented by the organisational partners, and should be seen as indicative only.

Criteria	Living Lab	Place-based co-design
Relevance The extent to which the process's design responds to beneficiaries' needs and priorities	 **Great extent** *The process allows beneficiaries to be authentic, and the product reflects, with fidelity and specificity, the views of beneficiaries.*	 **Somewhat** *Beneficiaries are engaged in a refinement process which enables oversight of how their views inform a model, however the consensus building process means some nuance may be lost.*
Coherence The extent to which the process has added value to the whole (i.e., the system, the sector) while avoiding duplication of effort	 **Great extent** *New and innovative considerations can emerge to help inform decision makers, encouraging new thinking and approaches.*	 **Somewhat** *Many ideas are abstractions and therefore already circulating, although the place-based approach reinforces the evidence base and its importance within a local context.*
Effectiveness The extent to which the process achieved, or is expected to achieve, its objectives and its results	 **Somewhat** *If implemented, the product is likely to effectively meet cohort needs. However, the product requires a commitment to cohort-level responses, which might not be as attractive to funders as more generalisable approaches that can service a more diverse range of clients.*	 **Great extent** *The presentation of ideas as a costed model of care may make it more likely to be implemented and commissioned; its emphasis on common barriers to access across diverse groups makes it a potentially effective solution for catering to 'hardly reached' groups.*
Impact The extent to which the process is expected to generate significant and potentially transformative effects – holistic and enduring changes in systems or norms	 **Great extent** *The potential impact of this approach is in enhancing understanding of ways to connect meaningfully with groups who are underrepresented in support systems. This has potential for*	 **Somewhat** *The strength of a co-design process and a model of care product is that it can be integrated within the system, whilst challenging current practice by adding elements that*

	generating new knowledge, and new community-led approaches that prioritise partnering with community groups.	*have been lacking (such as link Workers).*

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